Figure 6. Elderly female patient, 1906.

Figure 7. Female patient, 1906.
Figure 8. Young male patient. 1906.

Figure 9. Elderly male patient. 1908.
Figure 10. Young male patient. 1910.

Figure 11. Young female patient. 1911.
power of expressing emotions in their accustomed manner ... they have lost the power of their most highly educated shades of expression. 16

Assessing the Patients

The doctors at Kew were clearly influenced by these ideas. The case notes reveal that in many instances they directly applied some of the criteria to the appearance of their incoming patients. The most common were comments about the patients’ eyes, often including the equality or otherwise of the pupils, twitching of the muscles and aspects of their tongues. Interestingly, it was more often the male patients who were scrutinised for specifically Physiognomic characteristics. Among these observations was the recording of the fact that among others, William Mason, a baker who was admitted in April of 1911, had an ‘inequality of pupils’, and a ‘twitching of the tongue’, as well as ‘muscular incoordination(sic)’.17 Walter Green had a ‘tremulous tongue’ and a ‘fine facial quiver with lack of expression’, although his ‘pupils appear equal’.18 George Henderson was another whose insanity was confirmed by his countenance and demeanour, described in physiognomic terms. Although according to his personal notes, his pupils were equal, their ‘reaction to light can only be described as sluggish’, and he displayed a ‘tremor of facial muscles’.19 Percy Jenkins, who was admitted in 1907, also exhibited ‘tremor of facial, labial and lingual muscles’, but his ‘eyes appeared normal’.20 Edwin McIntosh had ‘wandering eyes’.21 Another case described in similar manner was Thomas Lewis, admitted in May 1908 with, among other symptoms, ‘facial twitching, tremors of facial

17 PROV, VPRS 7398/P1, Unit 23, p.31.
18 ibid.,p.3.
19 ibid.,pp.3-4.
20 PROV, VPRS 7398/P1, Unit 20, p.129.
21 ibid., pp.15-16.
muscles in repose,' besides a tongue that 'protruded with a jerk and [was] quickly withdrawn'.\textsuperscript{22}

Descriptions like these graphically depict a list of symptoms which undoubtedly indicated some loss of control, whether mental, psychological or physiological. No doubt the 'tremulous hands, faces or tongues', were a vivid and accurate description of the characteristics exhibited by some patients in the latter stages of GPI, for example, or advanced cases of delirium tremens.

The doctors had observed, possibly quite correctly, in the case of Lewis for instance that his pitiable condition was due to 'overindulgence in intoxicants', and that although he was discharged he would 'probably relapse if he takes alcoholic liquors'.\textsuperscript{23} The apparent necessity felt by doctors to place their symptomatic observations within a context of balance and control, observed and measured through a terminology of geometric precision, merely served to illustrate their determination to further legitimise their scientific accuracy and thoroughness. However, this was diminished somewhat when it became apparent that the measurements explained in the \textit{Journal of Mental Science} article and implied in the dictionary definition were rarely applied. Rather, an arbitrary judgment was made by the asylum medical staff, who merely utilised the specific language of Physiognomy.

In addition, other descriptions of patients' appearance were blatantly articulated within a language more suited to opinion or value judgment. When these representations appeared alongside physiognomic portrayals the effect was often disconcerting. With equal solemnity and more regularity, patients' expressions were often depicted as, 'vacuous, vacant, vacant and dazed, apathetic, or anxious and startled'. Both women and men appeared equally subject to these less 'scientific' appraisals. In this manner, for example

\begin{footnote}{22}{PROV, VPRS 7398/P1, Unit 20, p.249.}
\end{footnote}

\begin{footnote}{23}{ibid.}
\end{footnote}
Alice Thompson, a 20 year old housemaid of ‘regular habits,’ who was admitted in November 1905 with suspected ‘dementia’, was said to have had at various times both a ‘vacuous expression’ and a ‘vacuous smile.’\(^{24}\) Similarly, Frederick Nalty, who came to the asylum in 1908, had a ‘vacant weak look’,\(^{25}\) while John Robert Steele had a ‘pallid countenance and insane look’.\(^{26}\) Amalia Broadbent was distinguished by her ‘facile or pleased’ expression.\(^{27}\) The elderly Charlotte Pinniger who arrived the same year, 1905, was said to have had an expression that was simply ‘vacant’.\(^{28}\)

An interesting case is that of Ellen Krug. She arrived in April 1906 in a deeply depressed state. She was also noted as having an expression that was ‘vacant and dazed’ and altogether a ‘strange appearance’. It was recorded after two months, that she was under treatment for ‘facial neuralgia and pain in ears’. This may have accounted for her odd expression. There are two photographs of Ellen; the earlier one taken on her admission is certainly indicative of a woman under considerable strain, her brow furrowed and with deep lines under her eyes. The latter photograph, taken days before she was discharged, shows a remarkable transformation. The image depicted is barely recognisable as the same woman, although clearly that is the case. In this one Ellen’s brow is clear, the lines under her eyes have vanished, and she appears years younger. Although the conclusions arrived at by the asylum staff regarding Ellen Krug may have been erroneous, the treatment she received at Kew almost certainly benefited her health and she left the asylum on 1 October 1906, apparently cured.\(^{29}\)

Less satisfactory for him personally, but perhaps of enormous benefit to others was the fate that was to befall Charles O’Mullins who spent well over 20 years at Kew. He was

\(^{24}\) PROV, VPRS 7397/P1, Unit 15, p.190.
\(^{25}\) PROV, VPRS 7398/P1, Unit 21, p.5.
\(^{26}\) PROV, VPRS 7398/P1, Unit 19, p.43.
\(^{27}\) PROV, VPRS 7397/P1, Unit 15, p.80.
\(^{28}\) ibid., p.90.
\(^{29}\) ibid., pp.363-64.
admitted twice, the latter occasion in 1880 when he was 35. Classified as a very violent man, he was said to have held his wife and children in terror of him prior to his admission. O’Mullins’ mind gradually deteriorated until he had no cognizance of even the most mundane of events. Thoroughly institutionalised by July 1906, he had completely lost track of dates and times, and had even forgotten the fact that he had been married. He had however become ‘quiet’, and gave ‘no trouble’. Irrespective of the state of his mind or behaviour, the fact that he was in the asylum for such a long time was no doubt of immense relief to his wife, to whom it was recorded he had, ‘at times been most brutal and violent’. In spite of this, O’Mullins was said to have been of ‘temperate habits’. In 1906, it was noted, apropos of nothing, that he had ‘steely looking eyes’. 30

The Language of Degeneration

The case books record alongside these vague and ambiguous descriptions, a conclusion or assumption about what they signified, couched in the language of degeneration. Of May Gardner, for instance, a domestic servant who came to Kew in 1911, it was said that ‘her movements are irregular and her facial expression is of one who is not of sound mind’. 31 In similar fashion, William Hellyer a 24 old clerk who was admitted in 1908, was said to have had a ‘facial expression indicative of a deranged mental condition’. 32 Edward Murphy’s ‘silly manner and aspect’, gave him simultaneously the ‘appearance of an imbecile’, and the ‘appearance of a degenerate’. 33 John Jellie James a 16 year old epileptic of ‘dirty habits’, had a ‘vacant imbecilic expression’ and the ‘look and manner of an imbecile’. 34 Alexander Balfour was a 24 year old carpenter who arrived in 1911. It was noted that he ‘has a squint and is an undersized, somewhat degenerate looking lad’. 35

30 PROV, VPRS 7398/P1, Unit 7, p.99.
31 PROV, VPRS 7397/P1, Unit 20, p.3.
32 PROV, VPRS 7398/P1, Unit 21, p.18.
33 PROV, VPRS 7398/P1, Unit 22, p.42.
34 ibid., p.31.
35 PROV, VPRS 7398/P1, Unit 23, p.42.
Some of the conclusions articulated made no pretence at relevance to the patient’s mental
capacity at all. They seemed merely to be a record of a conjecture which had occurred to
the staff member in writing the notes at the time. The assessments of two young men
admitted in 1906 illustrated some of the more personal criteria often applied. Thomas
Kerrin’s ‘boyish appearance’, and ‘pallid countenance’, gave him, in the opinion of the
person who wrote his case notes, ‘something of the manner of an artist’. Lionel Vincent
Gatis was ‘well dressed, [of] refined appearance, and delicate hue of complexion’.
In addition, a moral or judgmental tone began to be introduced into many references to
physical appearance. Thomas Kerrins was only 17 when he arrived at the asylum, so a
‘boyish appearance’, was hardly surprising, but his ‘pallid countenance’, besides
signifying his artistic bent also marked him as ‘an onanist’, or masturbator. Lionel
Gatis was also accused of the same heinous behaviour, in spite of his ‘refined
appearance’. It was also the opinion of the staff member that he seemed ‘to have been the
spoil’d boy at home’.

These descriptions of patients’ appearance that were either judgmental or simply
contemptuous, along with some rather odd conclusions that were gleaned from them,
became commonplace during the early years of the twentieth century. With barely
disguised scorn, George Henderson was described in October of 1906, two months after
his admission, as being ‘in gross condition’, and ‘fat and flabby looking’.

Frank McEntee who arrived in 1910, also stood accused of being ‘lazy, fat and
delusional’, or on another occasion simply, ‘fat and lazy’. It was concluded that, ‘without
doubt he is a masturbator’. This opinion was given in spite of the fact that by definition

\[\text{36 PROV, VPRS 7398/P1, Unit 18, p.392.}\]
\[\text{37 PROV, VPRS 7398/P1, Unit 19, p.13.}\]
\[\text{38 PROV, VPRS 7398/P1, Unit 18, p.392.}\]
\[\text{39 PROV, VPRS 7398/P1, Unit 19, pp.3-4.}\]
\[\text{40 PROV, VPRS 7398/P1, Unit 22, p.21.}\]
masturbators were supposed to have been thin, pale and wasted-looking. Edward Murphy who also arrived in 1910, was said to have been 'heavy, fat and confusional'. Another entry described him as 'fat and idle'.\textsuperscript{41} Thomas Lewis had 'fair health' but 'poor muscul arity'.\textsuperscript{42} Harry Lomas a tailor of 'irregular habits', was portrayed on his arrival in September 1906 as having 'a good physique and build'. However, by November of the same year he was considered 'in fat condition.' In December, he was declared 'obese and dull'.\textsuperscript{43} That the asylum diet may have contributed to the deterioration in his physical state was not a thought that apparently occurred to staff. By 1911, however, he had become 'very thin'. Lomas was also declared in his annual assessment to have been 'an inveterate masturbator'. By accepting unquestioningly the doctor's notions about what caused insanity, Harry Lomas virtually characterised himself as a degenerate type. He volunteered the information that 'masturbation and excessive cigarette smoking and also excessive indulgence in beer', had caused his condition. His masturbatory habit in particular, he confessed was one in which he had indulged 'more than twice a day', but he insisted that it was 'four years since he practised it'. This latter part of his confession was clearly disbelieved by asylum staff, who added rather enigmatically that 'thousands of his type may be seen at a Saturday afternoon football match'.\textsuperscript{44}

The fact that the descriptions of patients' features and demeanour owed more to the asylum staff's prejudices than to any scientific observation was most clearly illustrated by the depiction of Hey Soon. Hey Soon, a male cook was one of a small number of Chinese to be resident at Kew. He arrived in October 1906 from Geelong Gaol. He was portrayed as 'cunning, suspicious and untrustworthy', with a 'sinister expression', and 'of a low moral type'. An evocation of a more stereotypical representation of

\textsuperscript{41} ibid., p.42.
\textsuperscript{42} PROV, VPRS 7398/P1, Unit 20, p.249.
\textsuperscript{43} PROV, VPRS 7398/P1, Unit 19, p.53.
\textsuperscript{44} ibid.
contemporary society’s imagined ‘Chinaman’ would be difficult to conceive. Even the added information that he ‘plays a good game of draughts’, was designed to emphasise his Chineseness. As if to underline the point, it was also stated that: ‘he is too risky to try at work, and is useless because untrustworthy, moreover he will not work’. Finally, with some irony a member of the medical staff had decided by the end of Hey Soon’s first week in Kew that he was ‘not the type of Chinaman that an Englishman would seek to be surrounded with in a suburb of Peking’.\textsuperscript{45} Notwithstanding the staff member’s probable unfamiliarity with any suburb in Peking, Hey Soon as described, although no doubt undesirable, would have been exactly ‘the type of Chinaman’ they would have expected to find. The strong correlation between racism and ideas on degeneration, is a much larger topic than can be deal with adequately here, but clearly the case of Hey Soon was one where notions of race and insanity intersected.

Another belief that connected appearance and insanity, and was allied to a physiognomic approach was the notion that the brain of an insane or criminal person looked substantially different from that of a ‘normal’ person. The continuing interest in postmortems which bordered on an obsession at Kew, where after every single death a postmortem was conducted, testified to this. Although details about this procedure belong more properly in a medical rather than a social history, the interesting case of Samuel Alardice is worth recounting here. Alardice, committed to Kew in 1889, was a convicted murderer who had previously been at Yarra Bend, then Sunbury and prior to that had been held in the gaol at Sale. For many years, he was a constant source of concern to both doctors and fellow patients because of his conviction and also because of his volatile temperament. He does appear to have been a very violent man, for over 25 years his case notes recorded intermittently that this was the case. During December 1914, when he would have been 72, he was still declared to have been a man with ‘a bad temper who strikes other patients on any provocation’. Alardice was categorised as both criminal and

\textsuperscript{45} PROV, VPRS 7398/P1, Unit 19, p.62.
insane and he was to remain in the asylum until 1915 when he died, probably from heart failure. According to the post-mortem done on his body, his 'brains and membranes [were] normal in appearance'.46 Discoveries such as this however, failed to shake doctor's unswerving faith in their methods, but merely convinced them that they had yet to refine the process.

The Behaviour of Insanity

Irrationality and the National Image

As John Conolly once observed, 'Once confined, the very confinement is admitted as the strongest of all proofs that a man [sic] must be mad'.47 Although by the beginning of the twentieth century, asylums, or more properly hospitals for the insane, had gained a certain legitimacy, there was still a lingering concern with people being wrongfully incarcerated. So, while appearances had assumed major importance, the other guideline used to differentiate the insane from the sane, or the degenerate from the rational, was the behaviour of the person involved. While this may seem a fairly self-evident and legitimate criterion, what was considered aberrant behaviour was subject to change in accordance with prevailing cultural perceptions of normality and abnormality. An analysis of the behaviour considered to be indicative of mental illness around the turn of the century in Victoria, revealed that notions about deviance were, in part at least, tied to ideas of national identity.

The question of creating a distinctly Australian identity was of paramount importance as Federation approached. As Richard White has observed in Inventing Australia:

46 PROV, VPRS 7398/P1, Unit 11, p.84 and Unit 24, p.80.
Some sense of Australian identity did develop in the nineteenth century, especially towards its end. Its basis was a belief in the existence of an Australian ‘type’ ... the idea of a national type reinforced ideas about the importance of ‘character’ in the lives of men and women. In the same way that poverty was blamed on individual failings rather than social upheaval or environmental factors, national prosperity, morality, and so on were thought to result from the national character.\textsuperscript{48}

Thus, to belong to the non-rational population was automatically to fall outside the guidelines of the ‘national character’. This was seen as not only unproductive, but also unpatriotic and a threat to the vigour of the newly emerging nation. Although it was felt that ‘Australia was a society ... in imitation of Britain’, \textsuperscript{49} it was also considered to be in some ways an improved society as Australians felt pride and faith in their youth. They argued that the Australian environment could transform the British raw material and ‘create a new man, physically healthier and mentally more stable’.\textsuperscript{50} In 1896, the \textit{Australian Town and Country Journal} immodestly cited the ‘Anglo Australian [as] the foremost race of all the world’.\textsuperscript{51} Australia was also labelled the ‘Working’s Man’s Paradise’ and as a consequence nurtured the image of the ‘ennobled, independent worker’.\textsuperscript{52} This ‘independent worker’, despite the obvious narrowness of the stereotype, became the symbol of the newly emerging nation. This meant that although sections of the working class were allowed more status than in Britain, theoretically at least, more than ever, the ‘respectable’ working classes needed to be distinguished from the ‘non-respectable’.

\textsuperscript{49} S. Alomes, \textit{A Nation at Last? The Changing Character of Australian Nationalism 1880-1988}, Angus and Robertson, Sydney, 1988, p.73.
\textsuperscript{51} Quoted in M. Cawte, ‘Cranimetry and Eugenics in Australia; R.J.A. Berry and the Quest for Social Efficiency’, \textit{Historical Studies}, vol.22, no.86, (April 1986) p.44.
\textsuperscript{52} White, \textit{Inventing Australia}, p.67.
Male Bodies and Labour

Non-respectability which led to degeneration was, as it had long been, largely organised around notions of utility. Within the asylum system employment was considered to be ‘the most potent curative agent we possess,’ 53 while simultaneously, to be ‘workshy’ was used as an indicator of a degenerate type. In 1903, Dr. Robert Jones predicted in the Intercolonial Medical Journal that ‘in the immediate future, we shall have penal or educational settlements for the idle, or workshy, and suitable colonies for the care of the profligate, the vagrant, the prodigal, and the facile’. 54 As Lyn Finch has pointed out, since the beginnings of white settlement in Australia, ‘understandings of social order and social patterns ... gave an important role to a particular understanding of bodies. The significance of male bodies rested in their potential to labour. 55 This notion was testified to continuously in the male casenotes. From the beginning of asylum records, many an inmate was judged to be a ‘non-worker’ or ‘will not work’, with accompanying testimony as to his continuing diminished mental capacity. The summary on William Bendle, who came to Kew early in 1908 and was discharged in November the same year, succinctly encapsulates the notions about employment and certification: ‘He is now as well as he ever will be mentally, and is able to work for his living. Therefore he was today discharged recovered,’ 56 signified the conclusion to his time in the asylum.

The annual reports also made note of the number of inmates ‘usefully employed’, and in 1905 the Inspector of Asylums, W. Ernest Jones, was pleased to announce that more than half the male population was in this category, with 58.9 per cent working at various tasks about the asylum at Kew. 57 However, around the turn of the century the same

55 Finch, Classing Gaze, pp.20-21.
56 PROV, VPRS 7398/P1, Unit 20, pp.265-66.
puritanism that lead to the stern moral pronouncements on appearance also began to characterise utterances on willingness to work rather than simply ability to do so. Edward Murphy was described as a ‘non-worker’, who ‘sits idle’. One staff member opined that although he ‘does a little polishing at times but [he] cannot be kept at it’. Frank McEntee was another, who besides being described as ‘fat and lazy’, was accused of ‘sprawling in the sun all day’. On another occasion it was said that he ‘lies quietly like a log in bed’, and would become ‘abusive if any attempt is made to get him to work’. In addition, in February 1912 it was noted that he ‘slouches idly about the yard all day’.

When the unfortunate Hey Soon was ‘asked if he would do any work’ his reply was written in the manner of a parody, claiming that he answered ‘me likee killy you’. George Henderson was another who appeared to offend the staff at the asylum who wrote disparagingly of him in personal terms. As to his willingness to work, it was reported that although he appeared to be ‘working steadily in the yard ... the attendant in charge of him reports that he was doing very little work’. In 1910, Arthur Studley Franklin, a 27 year old book-keeper was admitted to the asylum partly because as a result of ‘several troubles’, he had ‘done no work for nine months’. Franklin had been steadily ‘improving since reception’, when he ‘had a relapse lasting about six days, when he refused to work’.

Just as Arthur’s refusal to work indicated a ‘relapse,’ the fact that Frederick Nalty, ‘commenced work at first digging, but since 2nd of month he has worked in the vegetable garden steadily and well’, suggested ‘much improvement in this case’. Nalty was eventually discharged ‘recovered’. Similarly, William Ward’s ‘working in the

58 PROV, VPRS 7398/P1, Unit 22, p.42.
59 ibid., p.21.
60 PROV, VPRS 7398/P1, Unit 19, p.62.
61 ibid., pp.3-4.
62 PROV, VPRS 7398/P1, Unit 22, p.8.
63 PROV, VPRS 7398/P1, Unit 21, p.5.
garden and occasionally at office work’, was taken as a sign from him that he wanted ‘to
go out of the asylum’.64 William Bishop who was ‘inclined to be dangerous’, and
‘claimed to have been charged with indecent exposure’, which he endeavoured to repeat
by going out ‘in the yard with very little on’, was discharged when he became ‘quiet,
rational and working’.65 In one sense at least, the ‘quiet rational worker’, fitted a little
more closely to the desirable national type.

Female Behaviour and The Family

The most obvious omission from the ‘national type’, of course, was women. Women
were not altogether nonexistent under its terms, but they were subsumed under that
‘cornerstone of social stability, the family’. Consequently ‘the significance of female
bodies ... relied upon their complex location as the site around which the basic unit of
social order, the family, was organised’.66

Although women were excluded from the image of the Australian ‘type’ the role of
women in the family took on added significance as the ‘mothers of the first generation of
Australians’ and motherhood became a patriotic duty. All women were meant to reject
anything which would prevent them from ‘fulfil[ling] their highest obligation to the State,
viz. Motherhood’[sic].67 Although this took place within a wider context of social policy,
medico-psychiatric discourse was one of the areas where it was avidly followed.
Commentators linked together ‘the decline of the birth-rate, and the increase in the
number of registered insane’. Inspector General Jones was one who deplored the
‘number of females employed in factories.’ In 1906, Jones lamented: ‘I view with
considerable apprehension the consequent deterioration of that best of all institutions-

64 PROV, VPRS 7398/P1, Unit 17, p.462.
65 PROV, VPRS 7398/P1, Unit 16, p.217.
66 Finch, Classing Gaze, pp.21 and 35.
home life; the interference with the training of housewives'. 68 He was to repeat the same
dire prediction in 1910, claiming the 'disproportionate rise in the number of female
factory labour ... is liable to prove disastrous to the birthrate and the efficiency of home
life and training of the young, particularly their training in the domestic arts'. 69
This meant that while women were also expected to be willing workers, the type of work
they were expected to do (and enjoy) was restricted to that which would normally be
done about the home. The differences between the perception and treatment of women
and men in the asylum will be dealt with more specifically in Chapters Six and Seven.
However, it is important to mention here that it was during the first years of this century
that women began to enter the asylum in larger numbers than before. At this time, there
existed in the wider society a situation that was potentially conflictual for women.
Although more women were entering the workforce, greater significance was being
placed on their ability to produce healthy offspring—options which were seen as
inherently incompatible. The key to a woman’s character lay largely in her apparent
suitability for motherhood and her capacity for homemaking. This type of thinking was
emphasised within the asylum context where women were still expected to fulfil their
housewifely duties and were employed in 'suitable fashion' most often in the kitchen,
sewing room and the laundry. In 1905, 62.76% of women were described as ‘usefully
employed’, most of them in sewing, fancy-work, kitchen duties or cleaning the wards.70
The asylum authorities did not interpret women’s willingness or not to work at
household tasks in quite the same way that they saw men’s enthusiasm to labour: rather it
was only one of a series of indicators that pointed more specifically to their general
character. This in turn, supposedly reflected their state of mind.

Jane Scruber, a 27 year old dressmaker, admitted with 'recurrent mania', in November
1900, 'was tried in the sewing room', but proved 'too unsettled to work'. This indicated

68  ibid.
to the asylum staff that she was ‘still flighty in manner’, therefore still considered insane.\textsuperscript{71} A similar case was that of Flora Stewart. Upon her admission in May 1901, Flora was ‘disinclined to speak’, or ‘to go the laundry’. Although by June she was reported as ‘working well’ she was still considered ‘flighty and incoherent’. Flora also expressed a desire ‘to go out and work, [and] says she does not want to go home’. Sent home on trial in April 1904, Flora was returned as ‘unmanageable’ by her mother in June 1906. She was eventually discharged, however, when a ‘situation [was] obtained for her’ that same month.\textsuperscript{72} Sarah Jane Glover, a laundress, was admitted in December 1904. In spite of the fact that she was said to be of ‘industrious habits’, she was noted as being ‘dirty and dishevelled, restless and irrational’. Her habits ‘gesticulating and posing’, and being ‘resentful of questioning at times’, all went towards earning her the diagnosis of ‘recurrent mania’. This analysis of her condition was confirmed by her behaviour, which at times was ‘swearing and abusive’, and her ‘sullen manner’. By May of 1905, however, she was reported as ‘working well in the laundry.’ By the following month, she was described as ‘much improved mentally, rational quiet and well-behaved’ and ‘working well’. She was eventually discharged in July. \textsuperscript{73}

An indication of how being a good housewife was accepted in the community as proof of a women’s mental well-being was given by one of the patients herself. Jessie Harding, who was admitted in November 1902, appealed directly to the superintendent for her discharge, on the basis that she was ‘a clean housewife’. She also insisted that she was a more suitable carer for her children than the young woman whom her husband had installed in her place. This woman, according to Jessie, neglected her ‘dear little children’, to the extent that their ‘heads were dirty with vermin’.\textsuperscript{74} The police sergeant at St. Arnaud where Jessie Harding resided, spoke in her defence. When he visited her at her home

\textsuperscript{71} PROV, VPRS 7397/P1, Unit 13, p.378.
\textsuperscript{72} ibid., p.534.
\textsuperscript{73} PROV, VPRS 7397/P1, Unit 14, p.748.
\textsuperscript{74} ibid., p.142, Letter from J. Harding,1 May 1905 .
while she was out on trial he found that not only did she, ‘converse quite rationally, the children and her house were clean and tidy’. At her husband’s insistence, she was however returned to Kew. Whilst in the asylum Jessie’s behaviour vacillated between being acceptable and outrageous. She seemed ‘somewhat settled’, by 17 November 1902 and was ‘anxious to work’. In February 1903, a staff member observed that she had shown ‘some slight mental and physical improvement’. During the next month, it was reported that she ‘had an attack of excitement a few days ago’, and became ‘very restless at night, trying to get out of windows’ adding that, ‘she refuses at present to converse or work’. On one particularly bad day, she ‘tried to burn herself in [the] laundry’. By September, she was, according to her notes, ‘more rational, quiet,’ an optimistic outlook reinforced by the observation that she now ‘sews’. Jessie was sent home ‘on trial’ in December 1904, but was back in the asylum by May of the following year, at which time she was appraised as being ‘mentally enfeebled, clean and tidy-works in the sewing room’. Although she was established as ‘quiet and working well in the laundry’, and was ‘recommended for OT [on trial]’ in June 1906 there is a lengthy gap in her case notes until 15 January 1909. On that date she was transferred, without explanation, to the asylum at Ballarat.

I do not mean to imply that simply being an incompetent or unenthusiastic housewife was enough to earn a woman admission to a lunatic asylum. Clearly this was not the case. Many, if not most of these women, probably did have underlying psychiatric problems. Sarah Glover, for instance, was beset by ‘auditory and visual hallucinations’, and spent at least one of her nights in Kew ‘banging all night with a piece of wood’. She also appeared neurotic, and was constantly plagued with unsubstantiated worries, chief of which was one about being robbed.

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75 ibid., Letter from Sergeant Hancock St. Arnaud police station, 6 May 1905.
76 PROV, VPRS 7397/P1, Unit 14, p.748.
Flora Stewart’s behaviour also indicated that there was a genuine cause for concern, as she was recorded as being ‘inclined to violence’. Specifically, she was accused of being ‘violent to [her] sister and mother’. Jessie Harding may have been justifiably depressed and confused by the treatment she received from her husband whom she accused of being a drunkard. The local police agreed that Harding was a man ‘of intemperate habits’. The senior officer, Sergeant Hancock, even expressed the opinion that Jessie’s husband ‘would be glad to get rid of his wife, and install another woman in her place’. However, Jessie’s claim that she could ‘tell by people’s eyes if they are murderers’, and her belief that unspecified people were trying to murder her, suggests at least a degree of paranoia.

Jane Scruber’s mental impairment must have been more serious than the asylum staff suspected. Her reluctance to work in the sewing room was of minor importance, compared to the deep depression that caused her to ‘suicide by poison’, when she was allowed home on trial 18 months after her admission. For these women, the manner in which their particular problem was imagined was grounded within categories of understanding that reflected contemporary ideological constraints and cultural norms. This understanding affected their daily lives. Regardless of the mental stability of these women and others like them, the discourse that emphasised their perceived proficiency or incompetency as homemakers formed part of the framework that circumscribed their lives in the asylum.

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77 PROV, VPRS 7397/P1, Unit 13, p.534.
78 PROV, VPRS 7397/P1, Unit 14, p.142, Report of Sergeant Hancock Midlands Police District, 6 May 1905.
79 PROV, VPRS 7397/P1, Unit 13, p.378.
Alcohol and Insanity

Drink as a Cause of Lunacy

An aspect of behaviour which remained a contentious issue in its relationship to madness was the part played by alcohol. In Britain, from the mid nineteenth century, doctors were quite certain that alcohol abuse was a causal factor in many social problems, including insanity.\(^{80}\) In colonial Victoria however, during the 1870s and early 1880s, there was an attempt by some members of the medical profession to disassociate problems affiliated with alcohol from those pertaining to insanity. Inspector Paley, in the 1872 Annual Report, attempted to distance the two by declaring that ‘the applying of the term ‘insane’ to drunkards is a euphemism which is not to be countenanced’.\(^{81}\) Similar sentiments were expressed in an article in the Australasian Medical Gazette in 1883 which read: ‘No person with the slightest trace of recent alcoholic excess should be committed as a lunatic, and drunkards should not be admitted among or near lunatics’.\(^{82}\) There remained among many other doctors, an underlying suspicion that overindulgence in alcohol could result in insanity, especially if there was a preexisting tendency to mental instability. Paradoxically, patients were routinely given brandy, or even whiskey, as part of their medication in the asylum. This, however, went unremarked in any discussion about alcohol and its effects.

An early case in which alcohol was implicated was that of John Gibson. Gibson was a doctor who was reputed to have had a longstanding drinking problem. Consequently, his insanity was directly attributed to ‘drink’. He had been, according to his case notes, ‘

\(^{80}\) The JMS in 1872 stated: ‘Drunkeness causes a great amount of the lunacy, pauperism and crime of the country ... ever man who is drunk is really insane while the intoxication lasts’. Source: Occasional Notes, ‘Legislation for Habitual Drunkards’, JMS, vol.xviii, no.81, (July 1872), p.421.


\(^{82}\) Hacon, ‘Lunacy Practice’, p.30.
drinking heavily for weeks', when he was committed in February 1876. \(^3\) Gibson's premature death on 24 June 1876 was directly attributed to this overindulgence. His neighbour reported that he:

saw a bottle of Holland gin taken from under his pillow last night after his death ...

it was a little more than half full, there were two other wine bottles with their necks broken off ... I have no doubt that the deceased had been drinking hard for the past week.\(^4\)

He ended with the conclusion that when, 'the deceased was not drinking he was right enough'. \(^5\) Although the actual cause of his death was poisoning from an 'overdose of prussic acid', it had been consumed whilst Gibson was 'labouring under a temporary derangement of mind caused by an overindulgence in spirituous liquors'.\(^6\)

During the next 20 years, within medico-psychiatric discourse alcoholic abuse was explicitly mentioned as part of the hereditary link in the causation of insanity as another indicator of degeneration. The *Journal of Mental Science* declared in 1877 that 'in the United States nearly one-half of the idiots are stated to be the offspring of intemperate parents'. \(^7\) These sentiments were echoed in Australia in a declaration of the Board of the Zox Commission in 1884. According to the Board, the 'excessive drinker it is proved beyond question is often the immediate progenitor of idiots or children who ultimately become insane.' Furthermore, 'insanity of a very large proportion of the occupants of our asylums has been caused directly or indirectly by the excessive use of alcohol'.\(^8\)

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\(^3\) PROV, VPRS 7398/P1, Unit 4, p.97.

\(^4\) PROV, VPRS 24, Inquest Deposition Files, Unit 344, Item 558 (1876)

\(^5\) ibid.

\(^6\) ibid.

\(^7\) Dr. Shuttleworth, 'On Intemperance as a Cause of Idiocy'. *JMS*, vol.xxiii, no. 103, (October 1877), p.373.

\(^8\) 'Final Report', Zox Commission 1886, p.289.
This was a view shared unequivocally by the influential Dr. W. Beattie Smith, who was superintendent of Kew from 1899 until 1903. He was unflinchingly critical and judgmental of any alcoholic abuses, being convinced that alcohol was the major cause of insanity and other societal evils. ‘Alcohol’, he declared, ‘induces trouble, brain and cord ... be careful to exclude alcoholism before giving an absolutely bad prognosis’, was his advice to the Ballarat branch of the BMA, upon his retirement as President of that august body in 1903.89 Beattie Smith was a believer in a degeneration theory in that he subscribed to the notion that the unrespectable chose to be thus. ‘All the pity in the world will never conquer weak will, selfish desires, dishonesty, and moral perversion; they should be held to be responsible like others, or shut up and treated properly till they become so’, was his firm conviction. The insane, no less than the alcoholic, were, he suggested, largely responsible for their own misfortune, and should be held accountable. ‘We also find recurrent insanity ... through vicious habits and alcoholic excesses’ he contended. He even went so far as to state that alcohol was ‘the most common cause of insanity, either producing it, or bringing into activity hereditary or acquired brain weakness’.90

**Alcoholism as an Inherited Characteristic**

W. Ernest Jones in his 1905 Annual Report, acknowledged that ‘alcoholism is assigned as a cause in less than 10 per cent of admissions, and direct hereditary is traceable in only 46 cases out of 738’. 91 This, however, he claimed only proved the fallibility of the figures. He went on to say there is:

> obviously some considerable fallacy in this return, and it only emphasises the difficulty of obtaining true returns in this causation. I have no hesitation in saying

90 ibid., pp.60,62, and 63.

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that in 40 per cent of cases some neurotic inheritance is present were the truth only
known.\textsuperscript{92}

This bracketing together of alcohol and hereditary influences was emphasised even more
strongly by the Inspector General the following year, when he claimed that:

If the heritage of other neuroses, such as alcoholism be added and the truth be told
as to the evil branches in every family tree, it will be found that some such
predisposing agency is present in nearly 60 per cent of the admissions.\textsuperscript{93}

Thus, as Daniel Pick has observed, alcoholism had become ‘not only a cause but also an
effect in a chain of degeneration’.\textsuperscript{94} This view also became accepted as part of wider
social understanding. As conventional wisdom had it the inclination to alcoholism or
other ‘weaknesses’, such as insanity, was part of the same inherited tendency that, if left
unchecked, would precipitate general social decline. Inheritance and alcoholism as cause
and effect are neatly summed up by Alexor Green, the wife of one asylum inmate.
Walter Green was admitted to the asylum early in 1909. Alexor wrote to the doctors at
Kew, attempting to establish a reason for her husband’s mental breakdown. Although
she explained that ‘two years ago our house was burnt down, which gave him a shock.
He never seemed to be himself since’. She also offered an underlying explanation, ‘his
father I think is addicted to Drink[sic] but only of late years’.\textsuperscript{95}

Intemperance in drink was a consistent factor mentioned under causes of insanity in
annual reports. Patients like the unfortunate Harry Lomas who freely admitted to all
manner of ‘vices’, automatically had ‘excessive indulgence in beer’, suggested as a cause

\textsuperscript{92} ibid.
\textsuperscript{93} Annual Report 1906, VPP 1907, vol.2, p.25.
\textsuperscript{94} Pick, \textit{Faces}, p.195.
\textsuperscript{95} PROV, VPRS 7398/P1, Unit 23, p.3, Letter from A. Green to The Medical Superintendent,
Kew, 4 March 1911.
of his condition. His habits were also noted as 'irregular'. Thomas Lewis came to the asylum in May 1908. Under the query 'habits of life', was baldly stated 'drinks too much', and subsequently 'overindulgence in intoxicants' was assigned as the cause of his deteriorated mental condition.

Dr. Gamble, who became superintendent of Kew in 1910, was also convinced that alcohol was a major cause of insanity. In his report during his first year in charge he was moved to suggest that 'this year alcohol plays rather a large part in the production of mental disorders'. Although hitherto alcoholism had been largely thought of as a predominantly male problem, Dr. Gamble was also dismayed to report that there had been a 'marked increase in an incurable form of alcoholic insanity among the women of this state'. Revelations such as these seemed to be borne out by women like Alice Sager and Henrietta Donald. Alice was 42 when she came to the asylum in 1911. She was described as being of 'intemperate habits', with the cause of her insanity as 'alcohol'. The staff were convinced that she had 'had [a] fairly recent bout of drinking', but she was however pronounced 'curable', presumably when she had 'dried out'. Before being admitted to Kew, Alice had spent some time at the Royal Park receiving house. The medical officer there wrote to the superintendent at Kew detailing what he believed to be the problem. Mrs. Sager in his opinion, was suffering from a 'case of delusional insanity of alcoholic origin'. He also couched his diagnosis in terms of a moral lapse. 'Although she characteristically denies it', he wrote, 'there is a good history of recessive alcoholism and associated moral degradation'.

Henrietta Donald, who also was admitted in 1911, was another woman whose diagnosis was that she was 'insane, suffering from terminal dementia of alcoholic origin'. Her prognosis however was that she was 'incurable'. Unlike Alice, who possibly came to the

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96 PROV, VPRS 7398/P1, Unit 19, p.53.
98 PROV, VPRS 7397/P1, Unit 19, p.214, Letter from R.S. Callander, Medical Officer, Receiving House Royal Park to Acting Superintendent, Kew, dated 25 January 1911.
receiving house during an attack of ‘delirium tremens’, the suspicion that Henrietta’s
madness was believed to be alcohol-induced seem to have been supplied by her estranged
husband. He wrote in a long letter to the ‘officer in charge, Kew asylum’, that ‘twenty
years ago I married [Henrietta] with whom I lived very unhappily through her drunken
habits for some two or three years’. William Donald then went on to describe his former
wife’s descent into moral degradation, complaining that she had eventually left him for a
‘Mr. Joseph Wright’, who had ‘some hundreds of pounds which they dissipated in drink ...
and as his money was all gone she got into tow with some other man ... until he got
full of her drunken habits and left’.99 When Henrietta entered the asylum she was in poor
physical health, with suspected heart disease, symptoms of peripheral neuritis, and such
poor muscle control that she could not stand unsupported. Although it was possible that
Henrietta’s ill-health could have been due to a number of factors, (including alcoholic
excess), it never occurred to the doctors at the asylum that attributing alcohol as a cause
was a subjective judgment. The fact that they were more likely to diagnosis alcohol than
anything else as a cause substantially added to the numbers of suspected alcoholic
abusers. In a sense they ‘proved’ their own assumptions by diagnosing more patients as
such.

In some instances, all that was needed was a suspicion that a patient was a drinker for
alcohol to be labelled as the cause of his or her insanity. When Kate Black, a 45 year old
widow of ‘temperate’ habits, was admitted in 1912 there was initially no mention of her
drinking habits. Her personal doctor from her home town Benalla at first wrote to the
superintendent expressing his surprise at Kate’s admittance. He detailed her previous ill-
health as consisting of such mundane illnesses as influenza and general debility.
Although he considered her to be a hypochondriac and ‘inclined to be melancholy ... I
was surprised’, he wrote, in the conclusion to his letter 24 May 1912, ‘to hear of her
insanity’. He must have revised his opinion, because just four days later he wrote again,

99 PROV, VPRS 7397/P1, Unit 20, p.91, Letter from W.L. Donald to Officer in charge Kew
Asylum, 26 January 1912.
stating that he considered that ‘her general aspect and demeanour always gave one the impression of an alcoholic or drug-taker’. He also accused her of being ‘accustomed to take spirits, chiefly whiskey and I have suspected her of secret indulgence’ but admitted, ‘I have no satisfactory evidence’. The medical superintendent’s report on Kate duly noted that her ‘terminal dementia’ was ‘possibly of alcoholic origin’. Kate died at Kew less than a fortnight after her admittance, probably from kidney failure. She was clearly quite ill when she arrived, with cystitis, and a throat so ulcerated that she resisted spoon feeding. Her illness, and the obvious illness of others like her, did not surprise the doctors who seemed to assume that physical illness was an expected accompaniment to mental illness. Before she died on 30 May the staff had concluded that Kate’s condition was ‘probably due to diabetes’.  

Alcohol and Responsibility

Alcohol remained a popular and convenient explanation of insanity. It remained vague enough to be unprovable, as alcohol ‘per se’ was not suggested as a cause, but ‘excessive use’ of it. (How much constituted excessive use was never discussed.) It also coincided with contemporary notions about people being largely responsible for their own problems. Further, it reinforced the idea that those susceptible were a particular group of people with inherited weaknesses: members of a class whose ‘defective qualities’ threatened the wider society. Ironically, prosperity was considered to exacerbate any tendency to insanity or crime, as well as alcoholism. This was due, it was believed to the general lack of self-control of this degenerate or defective class. As Inspector Jones explained it:

100 PROV, VPRS 7397 Unit 20, p.189, Two letters from Arthur Barrington to The Superintendent Hospital for the Insane, 24 May 1912 and 28 May 1912.
101 PROV, VPRS 7397/P1, Unit 20, p.189.
102 ibid.
It has been found that whenever a country is unusually prosperous ... rates of crime and insanity increase. This may be due to the abuse of luxuries and self-indulgences which prosperity may bring in its train. 104

Jones was still railing against alcoholism in 1913, claiming that the 'number of admissions in which the causation is alleged to be alcoholism, are annually increasing'. He then went on to list the numbers for the past four years as '1910 - 63 males and 21 females, 1911—56 males, 35 females, 1912 – 78 males and 36 females, 1913–96 males, 43 females'. 105 In 1914 the number of new admissions listed as being caused by alcoholic intemperance for all asylums had declined to 64 males and 15 females. 106 By 1915, Jones was forced to concede that 'admissions of cases where alcoholism is the prime factor have materially diminished. Only 56 have been returned as suffering from some form of alcoholic psychosis'. Jones saw this as part of a positive development in society, where the citizens, especially men, were becoming more responsible as a result of the First World War. As he saw it:

This coincides with the fact that less cases of alcoholism have been admitted to the Inebriates retreat, and fewer convictions have been recorded for drunkenness. It is possible that we have been more temperate in 1915, and the decrease is more noticeable in the male sex- pointing to a war influence. 107

Sexuality and Insanity

Self-abuse and Self-indulgence

Another behavioural trait that was linked to insanity was an apparent indulgence in ‘unsuitable’ sexuality. Like alcoholism, it was considered both a cause, and an indicator of incipient madness. It also was understood within notions of overindulgence, or prolificacy. As discussed earlier, masturbation had long been a prime focus of doctor’s attention with regard to insanity, ‘on the assumption that overindulgence in non-procreative sex weakened the brain’. 108 The enduring practice of assigning masturbation as a major cause of insanity remained undiminished in the early years of the twentieth century. Men like Edward Holder, William Ward, William Padre, and William Douglas were just a few out of dozens of men who were admitted to Kew in the first five years of the century, who had noted among the observations on them that they were ‘probably a masturbator.’ William Henry Hider, who was admitted in 1907 at the age of 37 with ‘confusional insanity ... admitted self-abuse when a boy but not of late years’. 109 In the case of Edward Holder it was concluded that the combination of ‘study and masturbation’ had occasioned his mental breakdown. 110 George Scott, a 22 year old labourer from Bairnsdale who arrived a few years later in 1911, was also labelled ‘an inveterate masturbator’. 111

Women were not exempt from the accusation and although there were fewer of them, their numbers tended to increase as the century wore on. Emily Smith, a 46 year old housewife of ‘temperate habits’ admitted in 1911, had many peculiarities mentioned in

108 Garton, Medicine and Madness, p.100.
109 PROV, VPRS 7398/P1, Unit 20, pp.7-8.
110 PROV, VPRS 7398/P1, Unit 16, p.398, Unit 17, pp.446 and 462, Unit 20, p.277.
111 PROV, VPRS 7398/P1, Unit 23, p.20.
her record. By far the most serious was 'a delusion that she had killed her mother'. But it was also considered important to mention that she was 'said to practise masturbation'. 112

As medical discourse and wider social policy became more entwined manifestations of what was considered unsuitable sexual activity—particularly during the time when the asylum was becoming the hospital—were also implicated in relation to insanity. According to Lyn Finch, ‘within psychological reasoning it was the late nineteenth century construction of sexuality which provided the grid through which individuals were fixed within their class category’. 113 Finch has indicated how this new construct of sexuality swept away the relevance of a concept of the legality of certain acts and precipitated a ‘concern with the natural’ with regards to sexual behaviour. While certain acts did remain ‘unlawful’, the addition of the ‘unnatural’ extended the nature of policing from the courts ... to [include] the medical practitioner.’ 114 For the insane, the old notions of utility and morality were not abandoned, but the addition of sexuality to the distinguishing criteria highlighted yet another more specific area of ‘unsuitable’ or indulgent behaviour, that pointed to a degenerate personality.

Appropriate sexual behaviour was defined in relation to monogamous marital sex. Although the range of acceptable behaviour was fluid (and often gender-specific), there was a growing apprehension within the medical profession that the number of people who were transgressing the boundaries was increasing. This was felt to be especially prevalent among the young. The concern was first given expression by the Inspector of Asylums in 1909. ‘During the year under review’, he commented, ‘one of the subjects that have attracted public interest is that of the alleged increasing immorality and overindulgence of the youth of this country’. 115 Superintendent Barker agreed with this

112 PROV, VPRS, 7397/P1, Unit 20, p.68.
113 Finch, Classing Gaze, p.147.
114 ibid., p.52.
assessment. He too warned of the dangers posed to the community by this increasing decadence of youth:

Another interesting but deplorable circumstance is the increasing number of mentally broken down young people of either sex that we are receiving, constituting a large proportion of the new admissions, and seemingly a dire menace to the rising generation.\(^\text{116}\)

The apparent steady increase in deaths of patients in asylums from GPI was the main factor that convinced both Ernest Jones and Dr. Barker of the rising tide of immorality in the community. A table published in 1909 estimated that while during the year 1905 only 16 inmates had died from this cause, by 1909 the figure had risen to 54 (See Table 5.1). What was of perhaps even greater concern was the changing gender distribution of its victims. ‘This fact is also borne out by the admission tables’, claimed Jones, ‘where it appears that general paralysis is commencing to be recognised more frequently amongst females’.\(^\text{117}\)

Many women however, who came to Kew without any sign of GPI had their sexuality remarked upon. Elizabeth Whitehouse, Jane Rudd and Ruby Kiss who arrived in 1903, 1905 and 1906 respectively were three women in good physical health who were all accused of having ‘sexual ideas’. Amalia Broadbent had ‘a sexual element in her thoughts’.\(^\text{118}\) Whatever else it indicated, these sort of utterances clearly reflected the growing significance placed upon the behaviour of women with regard to their morality, even if they strayed only in thought or word.

\(^{116}\) ibid., p.20.
\(^{117}\) ibid.
\(^{118}\) PROV, VPRS 7397/P1, Unit 14 p.352, Unit 15 pp.6-7 and Unit 16, p.18.
Table 5.1  General Paralysis as a Cause of Death.

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths from GPI</th>
<th>Total number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905</td>
<td>16</td>
<td>320</td>
</tr>
<tr>
<td>1906</td>
<td>24</td>
<td>293</td>
</tr>
<tr>
<td>1907</td>
<td>22</td>
<td>328</td>
</tr>
<tr>
<td>1908</td>
<td>46</td>
<td>379</td>
</tr>
<tr>
<td>1909</td>
<td>54</td>
<td>371</td>
</tr>
</tbody>
</table>


‘Unsuitable’ Female Sexuality

Illustrative of concerns about actual behaviour were the case files on Fanny Barlow and Agnes Murtaghe. Agnes was brought to the hospital by her brothers and the local police in September 1903. She was 23, unmarried and diagnosed as suffering from ‘delusional insanity’. Although she was ‘rational, quiet and well behaved’, she claimed to have been ‘falsely accused of immorality’. Agnes’s misdemeanours were both civic and sexual, as a staff member solemnly noted that she had been, ‘riding in tram cars and will not pay’, and that she was ‘stated to indulge in immoral talk with young patients’. Later, she was accused of ‘making offensive remarks to other patients’. Dr. Beattie–Smith, when called in as a visiting specialist to examine Agnes in November 1905, was convinced that she was prone to irresponsible sexual behaviour. ‘There is certainly some mental instability’, he concluded, ‘and a possibility of future prolificity...the individual is..probably incapable of controlling propensities sexually and broadly morally.’ Despite this, Beattie-Smith ended by announcing, ‘I do not see that a lunatic asylum is a fitting

119 PROV, VPRS 7397/P1, Unit 14 pp.378 and 386.
refuge at present'.\textsuperscript{120} Agnes was allowed out on trial with her niece in December 1905, and was eventually discharged in January 1906.

Fanny Barlow came to Kew in April 1905. Fanny was single and the cause of her illness was given as ‘disappointment in love’. Fanny’s imagination, however, had conjured up both a husband and child. As her manner was noisy and inclined to violence, her insanity was classified as ‘mania’, but it was her inappropriate sexual behaviour that occasioned the most comment in her notes. She was described variously as being ‘sexual in manner and conversation’, and that she ‘exposes herself and is offensive sexually generally’. At other times, it was recorded that she had ‘filthy sexual habits’ and ‘incoherent sexual delusions’. She was allowed out on trial in August of 1905, but ‘returned unmanageable’ by October. The reason given was that she had ‘thrown herself undressed on a bed with her cousin’s husband inviting intercourse’. A month later, according to her notes, she ‘says she is in love with her uncle’, and was ‘sexually inclined’.\textsuperscript{121}

As Daniel Pick has observed, ‘mental disorder in women was seen to follow any deviation from the sexual function of reproduction so crucial to society’s survival’.\textsuperscript{122} This meant that for women, insanity could be caused by lack of ‘proper’ marital sex, which could lead to frustration and hence insanity. On the other hand, any sort of sexual activity outside marriage, or even a desire for it, could have the same effect.

A further case that demonstrates how inappropriate sexuality and insanity were linked is that of Alice Thorne. Alice arrived at the asylum during September 1905. She expressed her unhappiness with her husband whom she accused of wanting to get rid of her. She also claimed that they had been living apart. Although the asylum staff had concluded that this was not true, they censoriously observed that she ‘wrote amorous letters to a man not

\textsuperscript{120} ibid., Letter from Dr. Beattie Smith 18 November 1905 to Messrs. Pigdon & Cornell, Solicitors.  
\textsuperscript{121} PROV, VPRS 7397/P1, Unit 15, p.20.  
\textsuperscript{122} Pick, Faces, p.212.
her husband'. The superintendent's report confirmed that she was suffering from 'delusional insanity—chiefly of a sexual nature'. Hers was, he reiterated, 'a case of Moral insanity [she] is depraved'. Although her husband wished to take her home on trial, the staff considered her, 'not fit to leave at present, as she would prove unmanageable outside ... her intense sexuality would easily lead to trouble outside'.\textsuperscript{123} Analysis of these remarks reveal the dual role medical discourse had constructed for the asylum. As a refuge for women with 'erotic tendencies', it simultaneously offered the community protection from the effects of these tendencies.

**Excessive Sexuality as Cause and Effect**

Inspector Jones was also becoming less convinced that alcohol was the main cause of insanity, and more convinced that it was inappropriate sexuality that was the problem. Rather than using the vague term 'immorality', by 1910, he was to write more explicitly that 'the returns of the last few years have shown an increasing number of patients received of whom it was alleged that abnormal sexuality was the determining factor'.\textsuperscript{124} In 1909, Dr. Montgomery from Perth, in an article in the Australasian Medical Gazette, referred to the 'scourge' of syphilis, citing it as 'the dominant factor' in many instances of insanity. \textsuperscript{125} This notion rapidly gained credence among his colleagues during the following years. When Dr. Gamble came to Kew he too was adamant that syphilis was the major cause of the insanity of inmates, even outstripping hereditary influences. In his report for 1912 he wrote:

\begin{footnotesize}
\textsuperscript{123} PROV, VPRS 7397/P1, Unit 15, p.144.
\textsuperscript{125} S.H. Montgomery, "Syphilis as a Cause of Insanity", AMG, vol.xxvii, no. 9, (August 1909) p.422.
\end{footnotesize}
As regards the causation of insanity in the patients received in 1912 it was found as
in the previous year that acquired syphilis was the chief causative agent, although
this year hereditary influences almost equalled syphilis as a cause of insanity.126

He estimated that 71 cases were caused by acquired syphilis, 69 by hereditary influences,
while the comparatively small number of 50 was caused by 'intemperance in drink'.127
Gamble became such an advocate of the relationship between syphilis and madness that
he began to describe it in much the same manner as alcoholism had been, as part of a
hereditary link in the causation of insanity. He was to write in 1913 that he had become
more 'convinced that the majority of victims of ... mental affliction are sufferers from
congenital syphilis in a more or less attenuated form'.128 By 1915, he attempted to
convince his fellow alienists that inherited insanity in reality was also the result of this
disease. Although the official report for Kew that year showed that the cause of insanity
in only 15 % of cases could be directly attributed to syphilis, and that 'hereditary
influences were detected in 92 cases out of 337 (27 %) Dr. Gamble believes that
hereditary influences mean nothing more or less than congenital syphilis of varying
severity'.129 Like the 'offspring of intemperate parents', the children of syphilitics could
also become insane, or at least inherit a predisposition to mental disorders.

Another doctor who was persuaded that this was the case was the government
pathologist Dr. Lind. In his report on postmortems from the asylum for the same year he
echoed Gamble's opinion:

127 ibid.
Syphilis appears in post mortem examinations to be the close associate of insanity

... these cases of syphilis incognito are, in my opinion, the possessors of a vulnerability of the nerve tissue, which renders them susceptible to stress.¹³⁰

Therefore syphilis, which was attributed to unsuitable sexuality, was constructed like alcoholism, as not only a cause but also an effect in a chain of degeneration.

The type of dilemma this presented to asylum staff is best illustrated by the case of Jane McAllister Horne. Jane was only 19 when she came to Kew in 1911. Her habits of life were suspected to have been ‘immoral’, an inherited response it seemed from her mother’s ‘nervous debility’. Jane was also ‘wilful, perverse, excitable and boisterous’, but undeniably healthy. Her case notes reveal that her heart and lungs appeared normal, her memory was acute and she was in ‘good bodily health and condition’. She was described as ‘a stout girl with regular features and good teeth’. This confounded the staff who looked for signs of degeneration in her appearance. Her behaviour on the other hand, was far from exemplary. She admitted, ‘having frequented the streets, and with having associated with jockeys etc. from the age of 14 and 15 [and] admit[ted] having been intoxicated’.¹³¹ Although the doctors felt there was clear evidence of promiscuity, eventually they were compelled to conclude that Jane was ‘not insane’. She was discharged less than a month after she was admitted.

In the case of Mabel Reitman, however, it seemed that disintegration in appearance was matched by worsening dementia. Mabel was 24, a housewife of ‘good habits’ when she was admitted in 1906, with ‘acute melancholia’. She was physically ‘generally run down by suckling her nine month old’, as well as being anaemic. Mabel was also so deeply depressed that the asylum staff feared that she was suicidal. Although her condition was initially diagnosed as being caused by ‘influenza, weakness and worry’, the staff

¹³⁰ ibid., p.32.
¹³¹ PROV, VPRS 7397/P1, Unit 20, p.35.
concluded that her insanity was 'probably lactational'. Whether her illness was what we would now call Post-natal Depression or, as is more likely, Mabel had some more serious underlying psychiatric problems, her condition rapidly worsened. She tried to suffocate herself, and then attempted to choke herself. Her appearance became more and more dishevelled and untidy, she became more and more withdrawn, sometimes squatting or lying on the ground for long periods. Mabel was classified as having 'terminal dementia' by the time she had been in the asylum for a year. A further 'indication' of her descent into incurable insanity was that in February 1907 it was noticed that she had 'lately begun to use obscene words and expressions'.

'Unsuitable' Male Sexuality

Although the range of acceptable or 'natural' sexual activity for women was more restrictive than that for men, there were nevertheless a large number of men in the asylum who were supposedly there because of their sexual behaviour. William Hellyer, whose face indicated a 'deranged mental condition', was not only 'a confirmed masturbator' but also confessed to other 'sexual abuses'. The cause of his insanity was therefore recorded as 'sexual perversion and masturbation'. Nevertheless, because of his 'unexceptional conduct', William was discharged just two months after admission. Not so lucky was William Douglas. He was also admitted in 1908, when he was 31. William was allowed out on trial in January 1909, and 'did very well for a time and went back to his work at wicker-working where he worked very steadily and well'. Unfortunately, according to his relatives, William embarked upon a sexual adventure that was to precipitate his downfall. They asserted that a 'certain married woman had a bad influence over him, and he would visit repeatedly and stay with her for hours. It is supposed he had sexual connection with her'. He was returned to Kew shortly after with 'some enfeeblement and inclination to low spirits'. By May 1912, he was classed as 'suffering from primary dementia of

132 PROV, VPRS 7397/P1, Unit 16, p.4.
133 PROV, VPRS 7398/P1, Unit 21, p.18.
catatonic type. Incurable.’ In August 1913, it was noted that he ‘presents the typical signs of GPI.’ William was to die in the asylum in December 1916.

Arthur Stanley Franklin epitomised the archetypal degenerate. He was 27 when he was admitted to Kew in 1910. He was single, and employed as a book-keeper, but his habits of life were regarded as ‘intemperate’. He was ‘run down ... argumentative and quarrelsome’ as well as being unwilling to work. He was also classed as ‘neurasthenic, probably due to self-abuse’. There were also several other comments about his sexual behaviour including:

- hypochondrial ideas directed to his sexual organs ... is very sexual in his ideas and expressions and on account of his sexual tendencies needs care and control ... ideas very sexual ... very sexual in his ideas he seems to live on them.

He also claimed that ‘the reason he is here [Kew] is because he is deprived of having a woman’. Franklin remained a difficult patient throughout a number of years at times becoming ‘abusive, threatening and violent as well as ‘sullen and resentful’. In 1912, it was also stated that he would answer polite questions by replying ‘go to buggery’. As he grew older, he appeared to adopt more appropriate modes of behaviour. The final entry in his notes conceded that he now ‘works well with front gardening gang’. He was by then considered ‘deeply demented’ but in good health. William Hider, whose adolescent habits were suspected of at least partially causing his mental breakdown, compounded his inappropriate sexual behaviour while in the asylum when he ‘made improper overtures to nurses’. Hider, however, while not questioning the medical profession’s claims for the causes of insanity wished to distance himself from at least some of the possibilities. He confessed that he ‘used to drink at one time, but never knocked about with women’.

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134 PROV, VPRS 7398/P1, Unit 20, pp.277-78.
135 PROV, VPRS 7398/P1, Unit 22, p.8.
136 ibid.
137 PROV, VPRS 7398/P1, Unit 20, pp.7-8.
Thomas Bolton Kyme on the other hand, seemed eager to assign the reason for his illness to his sexual activities. ‘I’m a bit of a lad after the women, that’s my vice and that is what brought me here’, he maintained. Kyme was ‘about 50’, at the time of his admittance to Kew in 1907. He had previously been in the Yarra Bend asylum on two separate occasions. Kyme’s overt sexuality— or exhibitionism— was to cause much consternation during his time at Kew. He was reported as using ‘profane language’, and of reading ‘poetry of a lewd kind’, although in general he ‘gives little trouble’. He was also accused of being ‘sexual in thoughts and language’.

The official medical superintendent’s report remarked that he ‘confesses to excessive sexuality’, and also more worryingly, that he ‘interferes obscenely with other patients’. From these observations, Dr. Barker concluded that Kyme’s was ‘a case of sexual insanity’. In his report a year later in August 1908 Barker repeated his comment that Thomas was ‘filthy in language’ and continued to talk ‘in a very sexual manner’. Kyme wrote a very indignant letter to the Inspector General proclaiming his sanity in January 1909. He was formally discharged in April of that year, because in the opinion of Superintendent Barker, he was ‘well enough to look after himself’. 138 William Hider was also eventually discharged at his wife’s insistence.

The inclusion of sexuality as a category in determining a patient’s state of mind was part of a wider discourse that linked medical and social theory even more closely and helped facilitate the fulfilment of the psychiatrist’s yearning to become ‘agents of social regeneration’. Confident in what they perceived as their extended role, many of the asylum doctors were also involved in a process of reassessing the treatments and cures offered.

138 PROV, VPRS 7398/P1, Unit 20, pp.27-28.
Treatments of the Early Twentieth Century

The Persistence of Traditional Remedies

In 1903, Beattie Smith outlined the treatments he considered essential:

Give sunshine, exercise, out-of-door occupation, and baths. Avoid drugs, alcohol infrequently – don’t recommend sea voyages and travel—travel per se is not a health restorer. Order change of air, scene, and occupation, within easy access of home ...

It is wise to depend on ... manual labour, cheerful society, liberal and wholesome diet.139

These innocuous, even gentle, if slightly eccentric therapies were fast losing popularity however. As the medical profession embarked on its mission of social regeneration the emphasis shifted to preventative measures. In 1906, an article appeared in the Intercolonial Medical Journal. It was entitled ‘The Evolution Of Insanity’. In it Dr. Robert Jones, superintendent of the London county asylum, declared, ‘of all known diseases there is not one in which there is either a greater need of prevention, or one which permits of more effectual limitation by precautionary measures than insanity’.140

The means by which these preventative measures would be developed it was anticipated, was through rigorous scientific methods. What was needed it was thought, were hospitals, fundamentally isolationist in nature, where the study of insanity could proceed unhindered by the presence of those inmates who simply required a permanent refuge. It was this type of thinking that prompted the annual report to state unequivocally in 1909 that Victorian asylum superintendents maintained that ‘admission into a general asylum


... of all cases of varying degrees of intensity and curability is undesirable’. In this rare instance, the Inspector General also felt compelled to question the traditional British methods hitherto followed, claiming that they had failed to provide a truly scientific model. He considered that:

Our British methods by their recourse to legal intervention and safeguards have alienated the study of the diseases of the mind from that of the body, and from the regions of scientific inquiry in the laboratory and the medical school to the realms of pastoral pursuits and partial oblivion.\(^\text{141}\)

The adoption of a European or American model was suggested, as they were considered more rigorous in approach, and hence more aligned with contemporary notions about insanity. Jones continued:

There we have ... our greatest need, an institution such as the German Psychiatric Clinic at Munich or the Central Hospital for the Insane at Indianapolis, U.S.A. ... but such an institution must be recognised as a Mental Hospital ... must be easily accessible, must be staffed with specially selected permanent officials and visited constantly by consultants and scientific workers.\(^\text{142}\)

This would provide it was hoped, the knowledge that could come ‘by adding to our empirical work and observations a scientific comparative study of the homologies of a disease’.\(^\text{143}\) Within this discourse, it was no longer the patient who was being treated, but the disease itself. Selected patients were still required however, for it was they who held the disease within their body. In Foucault’s words, ‘the interiority of the disease means that it is buried in the patient, concealed within him like a cryptogram.’\(^\text{144}\) However, only

\(^{142}\) ibid.
\(^{144}\) Foucault, *Birth of the Clinic*, p.59.
those patients for whom it was felt a cure was possible were required. With the asylum now refashioned within medical discourse as the laboratory, many alienists were convinced that more and better methods of curing insanity would be rapidly forthcoming. Unfortunately, the remaining constant was still the lack of any truly effective treatment for mental disease. While many of the more barbarous forms of humoral therapy, such as blistering and purging had been abandoned, the expected new and successful therapies had not emerged. In practice, the treatment had changed little from the methods of 30 years earlier.

The most favoured forms of treatment outlined in the Australasian Medical Gazette in 1911 illustrated how similar the therapies remained. They included:

Fellow’s syrup or cod-liver oil, or potassium iodide ... Chlortal in 25 grain doses, with or without potassium bromide, is often useful where there is insomnia with cerebral excitement. The drug most frequently used by us as a hypnotic is sulphonol ... The latest drug to be vaunted as a calmative and hypnotic is adalin. 145

Even the old standby brandy, 'may be given at night for a few times'. The article did, however, caution against too liberal a use of hypnotics and suggested that 'warm baths and warm drinks at bedtime are exceedingly useful, and should always be tried'. In addition, for certain cases the most beneficial methods were still considered to be 'plenty of liquid foods ... and saline laxatives'. 146 For melancholicas, opium was promoted as an remedy, paradoxically it seems for its hallucinogenic qualities. It was recommended in these terms:

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146 ibid.
If therefore you can help your patient to see the world in brighter, and therefore
more normal colours ... you will be on the road to success. This is precisely what
opium does in very many instances.147

Some ‘Successes’ and ‘Failures’

Many patients were still simply given sleeping draughts, laxatives and tonics and
‘recovery’ remained an ambivalent notion. Patients were more likely to be discharged
‘recovered’, if they had someone willing to look after them. A constant stream of
inquiries from relatives was also often a prelude to recovery. Patients that did leave were
more likely to do so within a year. Some brief case histories illustrate how familial
support facilitated in ensuring patients’ stays were brief. Jessie Bayne was admitted in
April 1906 as an ‘acute melancholic’. Jessie had experienced two tragedies recently in
her life: her mother had committed suicide by poisoning herself and her daughter had
died from typhoid. In these circumstances, a deep depression would seem to be a
reasonable response. Jessie’s sadness, however, was so debilitating that she became
suicidal. She was to spend three months in the asylum but was discharged when she
became ‘less suicidally inclined’, was ‘working well in the sewing room’, and sleeping
well. After she returned home, Jessie’s husband wrote to Dr. Gamble thanking him for
‘the kind attention which she received while under your care’, and assuring him that
Jessie continued to take the ‘night draught and tonic regularly and has been able to sleep
fairly well with one dose of the former’. He also reported that his wife was still
somewhat depressed. ‘Although she cannot be described as very cheerful ... she has lost
the desire to leave the world’, was his opinion.148

147 ibid.
148 PROV, VPRS 7397/P1, Unit 15, pp.351-52, Letter from E. Bayne to Dr. Gamble, 5 August
1906.
Agnes Riddell also spent a relatively short time at Kew. Her form of insanity was said to be 'acute mania' when she was brought by her brother in January 1906. Agnes's behaviour fluctuated from being 'noisy and violent', to 'rational and composed, quiet, darning stockings', to 'noisy...undressing in airing court' or 'dull and quiet, answers in monosyllables'. By July, the asylum staff had decided that she was 'mentally enfeebled'. Nevertheless, she was allowed out on trial with her brother and finally discharged into his care in April 1907. Dr. Gamble inquired as to her health after her discharge to which her brother replied that she was 'much better and continues to steadily improve her mind'. He also reassured the doctor that he was looking after her according to his instructions. 'She sleeps well' he assured him, 'and her appetite is unfailling, the diet being in accordance with what you advised, three pints is still the minimum daily allowance of milk. Your tonic which she has taken from time to time with excellent results has been practically the only medicine required'.

Whatever the condition of the patient, it was ultimately whether or not they had family or friends willing to care for them which determined if they left or stayed in the asylum. Dr. Mullen, as acting medical superintendent, made this clear in a letter he wrote regarding Ellen Fowler. Ellen, whose age was not given, was a housewife who had been in the asylum since June 1896. Before her incarceration, she resided with her publican husband in the tiny township of Buln Buln near Warragul. Mullen was considering her discharge in October 1901, when Ellen expressed the suspicion that her husband was 'carrying on with servants and girl visitors', and may have been less than pleased to have her back. Mullen hastily wrote to the police in her home town to inquire as to the feasibility of sending Ellen home. The letter, addressed to the officer in charge of the Buln Buln police station rather coyly inquired:

It is my intention to discharge the above patient [Mrs. E. L. Fowler] from this asylum. Will you please forward me a confidential report regarding her husband

149 ibid., pp.261-62, Unsigned, undated letter addressed to Dr. Gamble.
who is the proprietor of the Turf Club Hotel Buln Buln. I should like to get some
information regarding him as it may serve to assist me in dealing with her
discharge. 150

The reply from Constable Steadman was more curious than helpful. Although he insisted
that Mr. Fowler was ‘a most respectable person’, he hesitated before giving more
information ‘if I could get any clue of the information required ... as letter is very vague
what is wanted’. 151 Finally, Mullen was forced to voice his suspicion:

I purposely did not state the nature of what I wanted but you have struck on the real
matter. Mrs. Fowler has been here since 1896, but is now sufficiently recovered for
discharge, if she can get that care which every man ought to show his wife. I
thought there might be a disturbing element as he has shown no anxiety to take her
out. Can you tell me definitely whether there are reasonable grounds for thinking he
lives connubially with the housekeeper, or any other person? 152

Whether Dr. Mullen’s reticence was due to consideration for his patient or a natural
shyness is not apparent. The situation between Ellen’s husband and the housekeeper is
not made clear, but Ellen did gain her discharge when arrangements were made for her
son to collect her.

William Padre, however, seemed destined to remain at Kew for the rest of his life, as
much because of his social situation as his health. Of ‘sober’ habits, Padre was 49 when
he came to the asylum in November 1903. Reportedly suffering from ‘dementia’, he was
considered to have been ‘always weak-minded’. By July 1906, the superintendent
considered that he ‘could go out on probation, only the Master-in Lunacy says his affairs

150  PROV, VPRS 7397/P1, Unit 11,p.701, Letter from W.L. Mullen Superintendent, Kew Lunatic
Asylum to The Officer in Charge, Police Station, Buln Buln 21 October 1901.


152  ibid., Letter from W.L. Mullen October 24 1901.
are complicated'. Proust-Webb, the Master-in-Lunacy, sent a memo to the asylum to that effect, which read:

Referring to your reports herein please note that this patient's affairs are rather complicated, and I think that it will be better to detain him as a patient as there is no one who could be found to look after him and it will take some time to get his affairs in proper order. 153

At the end of July 1907, William Padre was still languishing in the asylum, and there is nothing further recorded about him.

From the Turkish Bath to the Laboratory

Three non drug-related methods tried in the early twentieth century are of interest. They involved the use of water, and more radically the use of electricity and surgery. Surgery was used selectively, almost always on women and within overt gender-based assumptions. For this reason I feel it is more appropriate to simply mention its existence here, and examine it comprehensively in Chapter Seven which deals directly with women. Of the other two, their application was also limited at Kew, with water-based treatments slightly more common.

One of the contemporary applications of water treatments was described in the Intercolonial Medical Journal in 1906 as the 'long immersion'. As the article insisted, this was not so much a new therapy as an adaptation of old methods with a history going back centuries. 154 The receiving hospital at Royal Park was established to provide the

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153 PROV, VPRS 7398/P1, Unit 17, p.446, Memo from Master-in-Lunacy's Office, undated.
154 Jones, 'Evolution of Insanity' IMJA, vol.xi, no.10, (October 1906),p.528. As mentioned in the previous chapter the use of 'water treatment ' was being urged on doctors in 1873 as an 'early form of treatment that should not be neglected' (Source:JMS,vol.xviii, no.81, (January 1872),p.543.) In addition the dual purpose of water treatment at Kew as treatment and 'punishment' has been comprehensively discussed in Chapter Two of this thesis.
laboratory-like conditions where water treatment among other scientific procedures were to be tested. As the Inspector General explained in 1909:

[At Royal Park] a room for medico electrical therapeutics has been fitted up, and a commencement has been made for its utilisation ... and it is greatly to be hoped that a medical bath-house, which will include a small Turkish bath, needle spray, plunge and Sitz baths will be erected. 155

In 1910, the Australasian Medical Gazette proclaimed that, 'The modern study of insanity is highly scientific and is taking its place with its sister sciences ... Medicine, surgery, hydrotherapy and electricity are our handmaidens'.156 Regardless of this type of rhetoric, these therapies were used to a limited extent at some asylums, but rarely at Kew. In general, the overcrowding and presence of long-term patients made their application impracticable from the medical staff's point of view. Kew asylum was never in the vanguard of new treatments. Even by the standards of the time, it was considered to be old-fashioned in its methods and many therapies were discredited before they were even tried there.

There is some evidence that electrical treatment was used, but probably to a limited extent. Although the use of electricity had been discussed in Australian medical journals since the 1880s it was not until 1906 that a case was recorded about an inmate at Kew. The patient was Lionel Gatis. Gatis had only been in the asylum for a week when on 25 May his notes confirmed that the 'electrical battery was applied this morning for about ten minutes. One electrode was held in the left hand the other applied to the nape of neck and to the exterior muscles of the forearm'.157

157 PROV, VPRS 7398/P1, Unit 18,p.392.
Interestingly, many of the inmates' delusions around this time concerned the notion of electricity being applied to their bodies. George Goodlet, who came to the asylum in 1904, 'vaguely expressed delusions regarding medical men experimenting'.\textsuperscript{158} Bernard Thomas, who was admitted the same year, claimed that he was taken to 'D Ward where they tortured him and experimented on him with electricity'.\textsuperscript{159} Frederick Salmon, a composer who was admitted in November 1907, was convinced that 'he [was] full of electricity'.\textsuperscript{160} In a similar vein Agnes Colthurst, who came to Kew in 1905, wrote to her sister complaining among other things that 'the battery is hardly ever off me'.\textsuperscript{161} In 1911, Alice Sager expressed the belief that the 'medical staff treat[ed] her severely with electric batteries'.\textsuperscript{162} These patients had other persecutory delusions also, and it is probable that their electrical nightmares were no more real than them. Nevertheless, the suggestion of electricity was clearly one which had provoked their already fevered imaginations, and it is possible that their asylum experience provided the catalyst for such aberrations.

Gatis' reaction to his 'real' electrical treatment was not recorded, but it was noted that, on 31 May, he was:

so excited, talkative restless and gesticulative, that he was transferred to the side airing court for a day in order that he might have the experience of being associated with more confirmed insane persons.\textsuperscript{163}

Gatis was only 18, and his insanity was reputedly of recent duration. It is probable that he was considered 'curable', and that therefore he would have received any treatment that was available. Why he should be subjected to the experience of associating with persons

\textsuperscript{158} PROV, VPRS 7398/P1, Unit 17, p.652.
\textsuperscript{159} ibid., pp.539-46.
\textsuperscript{160} PROV, VPRS 7398/P1, Unit 20, p.129.
\textsuperscript{161} PROV, VPRS 7397/P1, Unit 15, p.82.
\textsuperscript{162} PROV, VPRS 7397/P1, Unit 19, p.214.
\textsuperscript{163} PROV, VPRS 7398/P1, Unit 18, p.392.
more insane than himself is unclear. It was Dr. Beattie-Smith who declared rather enigmatically in 1903, that, ‘so far as associates are concerned, the incurable is frequently a better companion for the curable than the curable’. 164 Whatever the reasoning, the practice of moving patients to different wards or airing courts was a common one throughout the life of the asylum. Very often it was the only ‘treatment’ many inmates received.

The boarding out system also remained popular at Kew in the early twentieth century. In 1913, the superintendent’s report noted that the ‘probationary system of allowing patients out of the asylum is still much availed of in this institution, with beneficial results’. 165 The transferring of patients back into the community under this scheme for long or short periods of time, under some supervision, as a prelude to permanent discharge, would seem to make some therapeutic sense. Less fathomable was the moving of patients from ward to ward, or especially from asylum to asylum. How this restricted mobility was of benefit to patients was never explained, but such an idiosyncratic procedure seemed to sit oddly with the avowed scientific principles that were espoused. In the same report that praised the probationary system, Dr. Gamble also claimed:

the pathological work in this asylum is being carried out on sound principles, and I venture to predict that the accumulated pathological results and findings from the metropolitan asylums of Victoria will in a few years rank in scientific value and enlightenment with those of the famed laboratory of the London County Council under Dr. Mott. 166

Although effective scientific cures for insanity did not emerge from the newly-fashioned ‘laboratories’, there were some major changes in lunacy administration, both ideological

166 ibid.
and practical. The change that would have had the most beneficial effect at Kew was immensely practical: in 1914, ‘sewering of the main institution began’.167 Another large hospital at Sunbury was completed in 1914. This must have alleviated the overcrowding at all other Victorian asylums to some extent.168 In addition, the long-awaited pathological laboratory was established at the Royal Park Receiving House in 1915.169 The other change that affected all asylums was the introduction of voluntary admission to hospitals for the insane. This officially commenced in 1915.

But a profound ideological change was just beginning, almost imperceptibly. This was a change in the entire notion of insanity, precipitated by the prevailing social conditions, most notably World War One. As soldiers returned from the battlefields exhibiting symptoms of hysteria, and other forms of mental instability that had previously been aligned with a particular set of environmental conditions and a specific section of society, the assumptions about inherent weaknesses became more and more difficult to sustain. As Daniel Pick explained it, ‘from 1915 hereditarian ideas about degeneration collided with the quintessential nobility attributed to war volunteers’.170 This meant that gradually the degeneration theory fell into disrepute. The resultant struggle to place mental illness within a recognisable, socially coherent framework was to be long and arduous and, in a sense, still continues to-day.

168 ibid.
170 Pick, Faces, p.232.
Part 3: The Asylum Population

6. A Gendered Malady - The Male Experience
7. A Gendered Malady - The Female Experience
8. Families and Insanity
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