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Hysterical Women: Moral Treatment of Female Patients in the Fremantle Lunatic Asylum, 1858 – 1908

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HYSTERICAL WOMEN: MORAL TREATMENT OF FEMALE PATIENTS IN THE FREMANTLE LUNATIC ASYLUM, 1858 – 1908

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DECLARATION OF AUTHORSHIP

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

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ABSTRACT

From 1858 to 1908, at least 452 women were admitted to the Fremantle Lunatic Asylum. Through an exploration of nineteenth-century theories of moral treatment, new insights into female patient experiences will allow for greater understanding of Fremantle's working-class women in the nineteenth and early twentieth centuries, including those behaviours that were considered insane. The appraisal of moral treatment techniques also allows for a new investigation into the enforcement of nineteenth-century, socially-accepted ideas of womanhood.

In its three parts, using patient records, case books, and other sources, this thesis examines understandings of women's insanity as they evolved in nineteenth-century Britain. It determines how Western Australia responded to such understandings in the provision of care to "insane" women. It also interrogates evidence of patient treatment in the Fremantle Lunatic Asylum in order to determine how moral treatment was implemented and experienced in the care of female patients. Finally, this thesis reveals that the application of moral treatment was used without regard to patient circumstance and diagnosis, and had varied outcomes for women.

Evidence within this thesis is explored through a feminist lens. I make a unique contribution to scholarship through analysis of new data, and socio-biographical case study investigations of the women admitted to the asylum. The thesis creates new understandings between female lunacy, morality, and the expectations of womanhood in nineteenth-century Western Australia.

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Lastly, I acknowledge the trauma and triumphs of the women admitted to the Fremantle Lunatic Asylum and consider myself privileged to have been able to provide them with a voice.

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INTRODUCTION

Honora "Nora" Fitzgerald was admitted to the Fremantle Lunatic Asylum on 15 June 1861, aged thirty-two, Irish Roman Catholic, and married with five children.[1] Her history on admission revealed that she was from Limerick, Ireland; her father was a baker who died of consumption and her mother of fever.[2] Nora arrived in the Swan River Colony in 1851 on the *Pyrenees* with her husband Michael, a Pensioner Guard, who was placed on the enrolled force at the Sound.[3] They remained in there until February 1861 when Michael was 'attacked with cancer' and sent to Perth Hospital while Nora and her children went to the Perth Poor Home.[4] It was at the Home that 'doubts of her sanity arose', and a medical board recommended Nora's removal to the asylum in Fremantle.[5] Upon arrival, Nora was described as a 'healthy looking woman with an eager and honest expression', she could answer questions readily with a good memory.[6] However, the main concern of the asylum's Medical Superintendent, Dr George Attfield, was of Nora's delusions regarding her children. He reported that 'she states however that her eldest boy has been stolen from her and that her other children are obliged, at the Home in Perth, to lie in filthy rags and damp beds'.[7] Attfield maintained that 'these ideas are no doubt the result of delusion'.[8] Nora's fears may not have been unfounded; although the Women's Poor Home in Goderich Street was reported in 1864 as being 'perfectly clean and well ventilated' the arrival of so many immigrant women in the 1860s strained the Home for space and resources.[9]

For the next three months in the asylum, Nora had trouble sleeping; she was sometimes rational and at others severe, noisy, and troublesome. By the end of September, she was sleeping well again and 'she talks quite rationally about her husband and family'; which would have been

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[1] *Register of Female Patients*, 1858-1873, Folio 39, 15 June 1861; Rica Erickson, "The Bicentennial Dictionary of Western Australians pre-1829-1888 Vol I-IV,": http://www.friendsofbattyelibrary.org.au/the-bicentennial-dictionary-of-western-australians: F, 1060: Mary Ann (1851); Department of Justice: Births, Deaths, and Marriages (BDMWA): *Certificate of Birth*: Thomas (2127/1853), Ellen Rose (2823/1855), Joseph (3686/1857), Georgiana Harriet (4517/1859). From 1858-1865 a warehouse in Fremantle was used to house insane patients until the Fremantle Lunatic Asylum was constructed.

[2] Ibid.

[3] Ibid; King George's Sound (later Albany); Pensioner Guards were soldiers who arrived on convict ships as guards which transported nearly 10,000 prisoners to Western Australia in the years 1850-1868. After arrival they continued with military duty or remained as settlers.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Penelope Hetherington, *Paupers, Poor Relief and Poor Houses in Western Australia, 1829 to 1910* (Crawley: The University of Western Australia Publishing, 2009), 47-49.

encouraging if not for the following note: 'her eye has a very stony expression like many other lunatics'. [10] A month later, Dr Attfield reported that 'during the last three weeks up to yesterday this patient had very much improved, was rational in her conduct, cheerful and well conducted. She is now however in a very flighty state, talking irrationally and very noisy and troublesome in conduct'.[11] Although not mentioned in her records, Michael died on 3 November 1861.[12] During that week, Nora was restless day and night, scarcely slept, and disturbed other patients.[13] Her sudden change in behaviour suggests that she was informed of her husband's death. In February 1862, Nora still differed in her behaviour, possibly due to grief; however, she was 'very much improved in general appearance, manner, and behaviour since her admission'.[14] Two months later, there were noticeable changes in the reporting of Nora's behaviour; Attfield stated she was cheerful and 'very willing to do any household work'.[15] Her improvement continued, as her willingness to work earned her positive descriptions; 'decidedly improving is quiet and well conducted and is very diligent and hardworking'.[16] However, she wandered when talking about her children and struggled with her memory.[17] It is important to note that there is no evidence in the records that Nora had seen or heard about her children in over a year. Although in early 1863, Attfield stated that 'she seems very contented and happy and she is in robust health, she works well and is very cheerful, she is flighty at times and talks and laughs incoherently'.[18] Under a month later he reported, 'she has been improving daily and may now be considered convalescent. The female side of the asylum being overcrowded, she has been specially recommended as fit to be transferred to the Poor House Perth'.[19] Nora remained at the Poor House until November 1864 and was 'very useful in attending to the children at the House'.[20] Her domestic work in both institutions led to her release.

The emphasis on domestic work as rehabilitation for women in asylums was developed by nineteenth-century physicians attempting to implement moral treatment. In Britain, theories of moral treatment in asylums attempted to cure patients by treating them humanely without restraint in therapeutic and home-like domestic environments.[21] These theories stressed the importance of

[10] *Register of Female Patients*, 1858-1873, Folio 41, 25 September 1861.
[11] Ibid, 17 October 1861.
[12] BDMWA: *Certificate of Death Registration:* Michael Fitzgerald (1863/1861).
[13] *Register of Female Patients*, 1858-1873, Folio 41, 10 November 1861.
[14] Ibid, 20 February 1862.
[15] Ibid, 9 April 1862.
[16] Ibid, Folio 54, 6 September 1862.
[17] Ibid.
[18] Ibid, 12 January 1863.
[19] Ibid, 5 February 1863.
[20] Ibid, 17 June 1863.
[21] Elaine Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (London: Virago Press, 1987), 28-29.

enforcing "good" habits in patients, teaching them to be good citizens; therefore, the asylum needed to provide opportunities for social re-education which included work, amusements, and exercise.[22] However, for women, this translated into domestic tasks like cleaning, laundry, or sewing. As Elaine Showalter notes, these tasks were training in the discipline of femininity.[23]

Nineteenth-century Australian society, strongly influenced by that of Britain, had specific definitions for "good" women and their behaviour. This required quietness, modesty, and cautiousness.[24] Most importantly, it was thought, a woman should be a wife and mother. In this role, she would preserve the moral values of society, guard her husband's conscience, and guide her children.[25] However, women who were unable to function within the nineteenth-century idea of womanhood could find themselves in an asylum. Furthermore, physicians believed that the female body, reproductive system, and motherhood, were associated with madness, 'prompting in all too many cases the shipwreck of the intellect, the collapse of the will, and the dissolution of all semblance of self-control'.[26] British sociologist, Ann Oakley writes that 'veiled by the mystiques of feminine psychology and deterministic biology, mothers' reactions to motherhood have been regarded by medical and social science as in a class of their own'.[27] Therefore, nineteenth-century society deemed that women were almost predisposed to madness because of their biological functions. Thus, moral treatment aimed to aid female patients to return to their domestic lives and reinforced nineteenth-century ideas of womanhood.

Moral treatment and attitudes were again displayed in Nora's case, when she was readmitted to the asylum twenty-four years later (aged fifty-nine) on 10 June 1888.[28] The new Medical Superintendent Dr Henry Calvert Barnett reported that 'she suffers from various delusions and has been removed from her daughter (Mrs [Mary Ann] Burgess, Russel St Fremantle) on account of her wild behaviour'.[29] However, Nora was an old hand at institutionalisation and merely five days after her admission, she was behaving quietly.[30] Two months later, she was quiet and well behaved and was discharged into the care of relatives.[31] Nora, even in her old age and distressed state,

[22] Showalter, *Female Malady*, 31.
[23] Ibid, 81.
[24] Andrea Nicki, "The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma," *Hypatia* 16, no. 4 (2001): 90. https://www.muse.jhu.edu/article/14208.
[25] Sally Mitchell, *Daily Life in Victorian England*, 2nd ed. (Connecticut: Greenwood Press, 2009), 266.
[26] Andrew Scull, *Hysteria: The Disturbing History* (Oxford: Oxford University Press, 2009), 73.
[27] Ann Oakley, *The Anne Oakley Reader: Gender, Women and Social Science* (Bristol: The Policy Press, 2011), 179.
[28] *Case Book Female Patients*, 1878-1897, Folio 132, 10 June 1888.
[29] Ibid.
[30] Ibid, 15 June 1888.
[31] Ibid, 13 August 1888.

seemingly understood that if she were quiet, well behaved, and willing to do domestic chores, it would lead to her release. Nora needed help, and perhaps her time in the asylum was curative; however, it was her ladylike behaviour—quietness, and willingness to perform domestic chores—that were considered to be the major indicators of sanity. Nora is one of many women who entered the Fremantle Lunatic Asylum from 1858 to 1908. In this thesis, through the patient registers and case books, their experiences will be explored, their voices heard, and their lives remembered.

Literature on Fremantle, Women, Asylums and Moral Treatment

The nineteenth-century social, political and medical contexts in which the Fremantle Lunatic Asylum operated, and in which its female patients lived, is crucial in understanding the experiences of those patients like Nora. The following section will provide the context and historiography concerning the significant themes of this thesis.

The south-west region of Western Australian is home to the traditional custodians, the Noongar people, with a history spanning at least 45,000 years, and the land in Fremantle is home to the Whadjuk people.[32] White colonisation of this area was established by the British with the Swan River Colony on 2 May 1829 when colonists arrived on the HMS *Sulphur* and *Parmelia*. The colony differed to that of New South Wales and Van Diemen's Land, as it was free; populated by migrants with indentured servants. The town of Fremantle served as the colony's port, situated at the mouth of the Swan River; it was an idea, 'the next great experiment of the British Empire'.[33] However, the colony struggled in its first decades, experiencing slow land sales and maintaining a small population.[34] Therefore, in 1850, the colonists accepted transported British convicts for the first time, relying on them as a new source of cheap labour.[35] The first of the convicts arrived on the *Scindian* in June 1850 and began building the Convict Establishment (Fremantle Prison).[36] The convicts were all men and mostly English; no female convicts were sent to Western Australia.[37] Though this introduced a significant gender imbalance in the population, Howard Willoughby

[32] South West Aboriginal Land & Sea Council, "Kaartdijin Noongar—Noongar Knowledge," accessed July 25, 2019, www.noongarculture.org.au.
[33] Deborah Gare, "In the Beginning: Empire, Faith and Conflict in Fremantle," Studies in Western Australian History 37 (2016): 7. <https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=160596023500023;res=IELAPA> ISSN: 0314-7525.
[34] J.S. Battye, *Western Australia: A History from its Discovery to the Inauguration of the Commonwealth* (Oxford: Clarendon, 1924), 174.
[35] Battye, *Western Australia*, 202-206.
[36] Robert Reece and R. Pascoe, *A Place of Consequence: A Pictorial History of Fremantle* (Fremantle: Fremantle Arts Centre Press, 1983), 18-19.
[37] Howard Willoughby, *Transportation: The British Convict in Western Australia: A Visit to the Swan River Settlements by the Special Correspondent of the "Melbourne Argus"* (London: Harrison & Sons St. Martin's Lane, 1865), 31.

confessed that 'the absence of foul-tongued dissolute women, whose influence is the most corrupting of all, is admitted now to have been a great thing for both the convicts and the colony'.[38] After eighteen years, in 1868, convict transportation ended; however, legacies of the convict system persisted for decades. At least half the male population of Fremantle in 1868 consisted of expirees and ticket-of-leave men.[39]

In 1890, after decades of rule by a governor and a small executive council, Britain granted responsible government to Western Australia.[40] The discovery of gold in Coolgardie and Kalgoorlie in 1892 allowed for Western Australia's new political independence.[41] Fuelled by the widespread recession, high unemployment, and industrial strife in eastern Australia, approximately 25,000 men travelled to Western Australia, most from Victoria and South Australia.[42] The demographic impact on the colony's community was significant, and by the turn of the century, the population in Western Australia had grown from 48,500 to 180,000.[43] Anne Summers states that 'it was inevitable that the social engineers of Australian society would look to England...for the values they wished to implant'.[44] Therefore, like all the Australian colonies, Western Australian society was heavily influenced by British culture and values. From 1901 its people saw themselves as citizens of the state, of the federated Australian Commonwealth, and the British Empire.[45]

Moral influence and reproductive abilities defined nineteenth-century Australian women.[46] A prevailing social ideology was that a woman's primary function was to care for her husband and family. Sarah Stickney Ellis wrote in 1843, that 'the love of woman appears to have been created solely to minister; that of man, to be ministered unto'.[47] Penelope Hetherington writes that English marriage laws were transplanted to the Australian colonies with different effects partly determined by the religious beliefs of each governor.[48] She states that the controls surrounding the institution of marriage demonstrated male dominance in all areas of public life; the laws were made and enforced

[38] Willoughby, *Transportation,* 31.
[39] Reece and Pascoe, *A Place of Consequence*, 35.
[40] Deborah Gare, *Lady Onslow's Legacy: A History of the Home of Peace and the Brightwater Group* (Osbourne Park: Brightwater Care Group, 2001), 13.
[41] Geoffrey Bolton, *Land of Vision and Mirage: A History of Western Australia since 1826* (Crawley, University of Western Australia Publishing, 2008), 62.
[42] Bolton, *Land of Vision and Mirage*, 62.
[43] Gare, *Lady Onslow's Legacy*, 13.
[44] Anne Summers, *Damned Whores and God's Police* (Sydney: NewSouth Publishing, [1975] 2016), 428
[45] Bolton, *Land of Vision and Mirage*, 85.
[46] Frank G. Clarke, *The History of Australia* (Westport: Greenwood Press, 2002), 68.
[47] Sarah Stickney Ellis, *The Wives of England, their Relative Duties, Domestic Influence, and Social Obligations* (London: Fisher, 1843), 76.
[48] Penelope Hetherington, *The Marriage Knot: Marriage & Divorce in Colonial Western Australia, 1829-1900* (Crawley, University of Western Australia Publishing, 2014), 6.

by men.[49] Therefore, as Alecia Simmonds writes, the English model of 'sanctified and legitimate heterosexual unions were considered to be the foundation of the moral and social order'.[50] Thus, marriage was the defining feature of women's lives: 'it satisfied her instinctual needs, preserved the species, provided appropriate duties, and protected her from the shocks and dangers of the rude, competitive world'.[51] These ideas reinforced the social construct of public and private spheres; women would inhabit the private sphere while men could move in-between both. However, during the late 1840s, organisations to provide women with better education and employment had begun to form.[52]

The redefining of the public and private spheres began in the late nineteenth century with the inception of the women's suffrage movement. In Australia, groups formed like the Woman's Christian Temperance Union (WCTU); The West Australian WCTU formed in 1892. These groups promoted abstinence from drugs and alcohol and the welfare of women and children; however, they became increasingly involved with women's suffrage, believing this would achieve their goals.[53] The vote was achieved for white women in Western Australian in 1899, and the federal franchise was extended to all white women in 1902.[54]

Nonetheless, private and public spheres were continually redefined across the nineteenth century but ultimately maintained as a fundamental characteristic of societal organisation.[55] Kirsten McKenzie notes that for colonial Australian women suitability as a marriage partner was increasingly intertwined with personal status and that 'being accepted as a respectable wife and mother could be a financial necessity'.[56] Even women's education during this period stressed that the achievements of women should not surpass those of men; their education should prepare them to be man's helpmate.[57] However, many women did work, although they were limited in their employment opportunities. In polite circles, the only respectable occupations were teaching, governessing or paid

[49] Hetherington, *Marriage Knot*, 6.
[50] Alecia Simmonds, "'Promise and Pie-Crusts were Made to be Broke': Breach of Promise of Marriage and the Regulation of Courtship in Early Colonial Australia," *Australian Feminist Law Journal* 23, no.1 (2005): 100, doi: 10.1080/13200968.2005.10854346.
[51] Mitchell, *Daily Life in Victorian England*, 267.
[52] Ibid, 7.
[53] Marilyn Lake, *Getting Equal: The History of Australian Feminism* (St Leonards, Allen & Unwin, 1999), 25.
[54] Lake, *Getting Equal*, 27; In contrast, British women did not receive full enfranchisement until 1928, and it was not until 1962 all Indigenous peoples received the vote in Australia.
[55] Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (Oxon: Routledge, 2002), xvi.
[56] Kirsten McKenzie, *Scandal in the Colonies: Sydney and Cape Town, 1820-1850* (Carlton: Melbourne University Press, 2004), 91.
[57] Joy Damousi, *Colonial Voices: A Cultural History of English in Australia, 1840-1940* (Cambridge: Cambridge University Press, 2010), 138.

companionship.[58] However, menial possibilities included becoming maids and cooks, washerwomen, barmaids, sales assistants, dressmakers, nurses, waitresses and, at worst, prostitutes.[59] Though, in colonial Australia, women were often assisted in migrating to enter paid domestic service. Jan Gothard suggests that, over the space of half a century, colonial societies absorbed over 90,000 domestic servants.[60] Therefore, domestic service would have been the dominant employment opportunity for working-class women.

However, "undesirable" or "insane" male and female citizens were a problem in both Britain and Australia and institutions to house them, beyond prisons, were developing in the nineteenth century. Understandings of madness were differentiated by gender. British psychiatrists perceived there were different kinds of madness for men and women: an 'English malady, associated with the intellectual and economic pressures on highly civilised men, and a female malady, associated with the sexuality and essential nature of women'.[61] Andrew Scull notes that 'for Victorian physicians, few facts were more incontestably established than that the female of the species was, as Carroll Smith-Rosenberg and Charles Rosenberg have felicitously put "the product and prisoner of her own reproductive system"'; a 'woman's place in society—her capacities, her roles, her behaviour—was ineluctably linked to and controlled by the existence and functions of her uterus and ovaries'.[62] British asylum and insanity historiography is detailed in Part I of the thesis.

Nineteenth-century asylums began to develop new treatments, particularly influential, was moral treatment. In the nineteenth-century, patients began to be perceived as 'sick human beings, objects of pity whose sanity might be restored by kindly care'.[63] Tuke's Retreat in York, England, established in 1792, was one of the founding institutions that implemented moral treatment, considered to be a humane approach to asylum care. Samuel Tuke, the grandson of its founder, stated that insanity was 'deviance from morality, and the treatment centred [on] restoring moral virtue'.[64] Anne Digby's work in 2004 provides a detailed analysis of moral treatment, practised at the York Retreat, and emphasises the influence of Quaker religious belief, which promoted self-

[58] Clarke, *History of Australia*, 68-69.
[59] Ibid.
[60] Jan Gothard, *Blue China: Single Female Migration to Colonial Australia* (Carlton South: Melbourne University Press, 2001), ix.
[61] Showalter, *Female Malady*, 7.
[62] Scull, *Hysteria*, 72.
[63] Showalter, *Female Malady*, 8.
[64] Samuel Tuke, *A Description of the Retreat: An Institution Near York for Insane Person of the Society of Friends*, (London: Dawson, 1813).

control.[65] Showalter's work, from the 1980s, broadly examines how British asylums implemented moral treatment. She notes that once admitted, male and female patients were expected to work; this was an aspect of the evolving methods of moral treatment which involved work as rehabilitation. Showalter argues that British 'Victorians hoped that home-like mental institutions would tame and domesticate madness and bring it into the sphere of rationality'.[66] She states that paternal surveillance, religious ideals, and domestic chores replaced fear and force in treatment.[67] Thus, Leonard Smith writes in his 1999 study of English asylums, that moral treatment incorporated the reformed practice of non-restraint.[68] Nancy Tomes' work from 2004 reveals that in England, non-restraint was not universally incorporated and had an element of covert and non-covert use.[69] She argues that custodial practices were still part of the asylums.[70]

Catherine Coleborne and Dolly MacKinnon wrote, in their important 2003 study on Australian mental health histories, that British approaches to moral treatment had a significant influence on the construction, layout, legislation, medical practices and therapies of Australian asylums.[71] They state that by the mid-nineteenth century, colonial asylums were sites for shaping colonial identities in medicine, with discourse and classification based on gender, class and race.[72] However, society often used asylums as a place to control deviant behaviours or "different" identities.[73] Coleborne also addresses the requirement of domestic chores as part of moral treatment. She states that the asylum economy depended upon patient work, and in the asylum, work had different meanings according to gender.[74] Coleborne writes that in the eastern colonies of Australia, asylum employment for male patients included skilled occupations.[75] However, a female

[65] Anne Digby, "Moral Treatment at the Retreat, 1796-1846," in *The Anatomy of Madness: Essays in the History of Psychiatry, Vol 2: Institutions and Society*, eds. William F. Bynum, Roy Porter, Michael Shepherd (London: Routledge, 2004).
[66] Showalter, *Female Malady*, 17.
[67] Showalter, *Female Malady*, 8.
[68] Leonard D. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999).
[69] Nancy Tomes, "The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century," in *The Anatomy of Madness: Essays in the History of Psychiatry*, *Vol III: The Asylum and its Psychiatry,* eds. William F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 2004).
[70] Tomes, "The Great Restraint Controversy".
[71] Catharine Coleborne and Dolly MacKinnon, eds., *"Madness" in Australia: Histories, Heritage, and the Asylum* (St Lucia: University of Queensland Press, 2003), 4.
[72] Catharine Coleborne and Dolly MacKinnon, "Psychiatry and its Institutions in Australia and New Zealand: An Overview," *International Review of Psychiatry* 18, no. 4 (2006): 371-380. doi: 10.1080/09540260600813248.
[73] Coleborne and MacKinnon, *"Madness" in Australia*, 6.
[74] Catharine Coleborne, "Space, Power and Gender in the Asylum in Victoria, 1850s-1870s," in *"Madness in Australia: Histories, Heritage, and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), 55.
[75] Coleborne, "Space, Power and Gender", 55.

patient's refusal to work would be deemed a rejection of attempts to "reform" and "tame" her.[76] Stephen Garton's 1988 work on insanity in New South Wales, reveals how social, political and economic factors influenced asylum practices.[77] He argues that Australia's penal origins resulted in a delay in non-restraint, but that British innovations in treatment, including moral treatment, influenced their development. Kenneth Kirkby's 1999 study of psychiatry in Australia also revealed the connection between Britain and Australia, with Australian asylums developing a more humane approach to mental treatment.[78] Lee-Ann Monk's research into asylum work in colonial Australia provides significant insights into both patient and attendant work.[79] She also argues that work was demarcated by gender and was connected to improvements in mental health. The architecture of the asylums was also a crucial element for moral treatment. Susan Piddock notes in her 2017 study that physicians did not intend for patients to remain in the asylum for life, it was supposed to be curative. The aim was that 'after a short time they would be returned to sanity' through reform methods and treatment and released back into society.[80] Piddock's work on South Australian and Tasmania asylum archaeology reveal how British moral treatment pioneers influenced the construction of curative asylums in Australia.[81]

Historiography concerning the Fremantle Lunatic Asylum has varied in its focus from the architecture of the building to inmate experiences. Most research on the Fremantle Asylum was undertaken in the 1990s; however, there has been renewed interest in the history of mental health in Western Australia. A.S. Ellis' research into the development of mental health services in Western Australia is one of the earliest works. Initially published in 1914 and re-published in the 1980s, Ellis' work does not include the experiences of the patients.[82] Patient experience is also lacking in Roger Virtue's article published in 1977, concerned with the social, political, and economic factors that led to several late-nineteenth-century social reforms.[83] It was not until the late 1980s and 1990s that historians began to consider the patients within the system. Norman Megahey's article published in 1993 employed primary records of the Fremantle Asylum, police, magistrate and pauper files of the

[76] Coleborne, "Space, Power and Gender", 55.
[77] Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales 1800-1940* (New South Wales: The University of New South Wales Press, 1988).
[78] Kenneth C. Kirkby, "History of Psychiatry in Australia, pre-1960," *History of Psychiatry* 10, no. 38 (1999): 191-204.
[79] Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (New York: Editions Rodopi B.V., 2008).
[80] Susan Piddock, *A Space of Their Own: The Archaeology of Nineteenth Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York: Springer, 2007), 1.
[81] Piddock, *A Space of Their Own*.
[82] Archie Samuel Ellis, *Eloquent Testimony: The Story of the Mental Health Services in Western Australia, 1830-1975* (Nedlands: University of Western Australia Press, [1914] 1984).
[83] Roger Virtue, "Lunacy and Social Reform in Western Australia, 1886-1903," *Studies in Western Australia*, no. 1 (1977): 29-65.

Colonial Secretary's office to explore the behaviours of the men and women who were committed and the social context in which the committal took place. Megahey argued that the influence of socially constructed ideas and beliefs concerning class, gender, and race support the argument that insanity is socially constructed.[84]

Bronwyn Harman's work is among the few to focus on female patients in the Fremantle Asylum. Harman's article and PhD thesis, both published in 1993, explores the female experience at the Fremantle Asylum.[85] Harman uses statistical analysis of fifty female patients in the Fremantle Asylum based on gender, class, marital status, and religion. She states that an association with criminality often applied in the Fremantle Lunatic Asylum; while all other colonies had established separate accommodation for the insane, the latest being Victoria in 1848; insane patients in Western Australia were often housed with prisoners.[86] Reasons for admission to the Fremantle Asylum varied from "predisposing" causes, such as heredity and congenital factors, as well as "exciting" causes, such as alcohol or even sunstroke.[87] Sunstroke was increasingly a concern for colonial physicians who believed it caused insanity in white bodies.[88] However, the asylum could become a "dumping ground" for women who were disruptive in the family and community.[89] Harman also discusses the use of work, stating that work and exercise were encouraged, and the main tasks included cleaning, laundry, and self-cleanliness.[90] Harman also argues that a reluctance to perform domestic tasks was punishable, incurring prolonged incarceration; however, willingness was praised.[91] Harman's work is a valuable contribution to Australian and Fremantle asylum history. This thesis aims to build on existing historical knowledge and widen the scope. This thesis covers all the female patients across the fifty years that the asylum was in operation while exploring various themes with a focus on moral treatment.

More recently work on the Fremantle Asylum has expanded in its scope. In 2006, Margaret McPherson's work examined the impact of convict lunatics on the Western Australian asylum

[84] Norman Megahey, "More Than a Minor Nuisance: Insanity in Colonial Western Australia," *Studies in Western Australia*, no. 14 (1993): 46.
[85] Bronwyn Harman, "Women and Insanity: The Fremantle Asylum in Western Australia, 1858-1908," in *Sexuality and Gender in History*, ed. Penelope Hetherington and Philippa Maddern (Nedlands: University of Western Australia Press, 1993).
[86] Ibid, 20.
[87] Bronwyn Harman, "Out of Mind, Out of Sight: Women Incarcerated as Insane in Western Australia 1858-1908," (PhD thesis, University of Western Australia, 1993).
[88] Leigh Boucher, "Masculinity Gone Mad: Settler Colonialism, Medical Discourse and the White Body in Late Nineteenth-Century Victoria," *Lilith: A Feminist History Journal* 13 (2004): 56. https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=580564562688592;res=IELAPA.
[89] Harman, "Out of Mind, Out of Sight,".
[90] Ibid.
[91] Ibid.

system, and the connection between the prison and the asylum.[92] In 2010, Philippa Martyr's article examined the diagnosis and treatment of lunacy for Indigenous men and women in Western Australia. She concludes that asylum physicians did not connect the poor treatment of Indigenous people to diagnoses of insanity.[93] Jane Hall published a small book in 2013 with a brief overview of the history and ghost stories of the Fremantle Asylum; this was intended to be a companion to the museum at the Fremantle Arts Centre which has since closed.[94] Susan Piddock's article, published in 2016, contains substantial work specifically on the Fremantle Asylum.[95] Piddock argues that by examining the built environment of the Fremantle Asylum and the uses of space, it is possible to understand the experiences of the inmates and the attitudes towards the insane. She also compares nineteenth-century lunacy reformer John Conolly's descriptive framework for the ideal asylum with the Fremantle Asylum. This study allows for an understanding of Fremantle's building and layout. In 2017 Martyr's article used archival research to examine the history of forensic mental health services in Western Australia, which she argued was 'historically poorly managed, under-resourced, and inconsistently delivered'.[96] However, her article published the same year, on Medical Superintendent Dr Henry Calvert Barnett is the most recent work on the Fremantle Asylum. Martyr's article provides a brief biography of Barnett using a range of primary sources and argues that his contribution to mental health in WA was genuine and worthwhile.[97]

Thus, analysis of the Fremantle Lunatic Asylum from 1858 to 1908 and its use of nineteenth-century moral treatment enables new understandings of female patient experiences and the society in which they lived. The appraisal of moral treatment techniques through original data collection also allows for further investigation into those treatment methods in Fremantle that reinforced nineteenth-century, socially-accepted ideas of womanhood, and interpretation of behaviours that were considered insane.

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[92] Margaret McPherson, "A Class of Utterly Useless Men: Convict Lunatics in Western Australia," *Studies in Western Australian History*, no. 24 (2006): 62-70. https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=200703232;res=IELAPA.

[93] Philippa Martyr, "'Behaving Wildly': Diagnoses of Lunacy among Indigenous Persons in Western Australia, 1870–1914," *Social History of Medicine* 24, no. 2 (2010): 316-333. doi: 10.1093/shm/hkq046.

[94] Jane Hall, *May They Rest in Peace: The History and Ghosts of the Fremantle Asylum* (Carlisle, WA: Hesperian Press, 2013).

[95] Susan Piddock, "A Place for Convicts: The Fremantle Lunatic Asylum, Western Australia and John Conolly's Ideal Asylum," *International Journal of Historical Archaeology* 20, (2016): 562-573. doi: 10.1007/s10761-016-0361-6.

[96] Philippa Martyr, "A Brief History of Forenensic Mental Health Services in Western Australia," *Australasian Psychiatry* 25, no. 3 (2017): 297-299. doi: 10.1177/1039856217689914.

[97] Philippa Martyr, "Unlikely Reformer: Dr Henry Calvert Barnett (1832-1897)," *Australasian Psychiatry* 25, no. 5 (2017): 497-500. doi: 10.1177/1039856217715992.

Research Aims

It is, therefore, my aim in this thesis to:

i. examine understandings of women's insanity as they evolved in nineteenth-century Britain;
ii. determine how Western Australia responded to such understandings in the provision of care to "insane" women; and
iii. interrogate evidence of patient treatment in the Fremantle Lunatic Asylum; to
iv. determine how moral treatment was implemented and experienced in the care of female patients in the asylum.

As a result of my analysis, I will demonstrate that Western Australia applied moral treatment to female patients in the asylum. By making use of a wide range of case studies, it will be clear that this approach to treatment was applied without regard to patient circumstance and diagnosis. Furthermore, the use of moral treatment—which had mixed outcomes for patient health—reinforced nineteenth-century social expectations of "ideal" womanhood.

Method, Theory, and Structure

The thesis is presented in three parts. First, in Part I, I analyse women's insanity as it was understood by evolving medical science in nineteenth-century Britain. Secondly, I examine the provision of care to Western Australian women considered to be insane, notably via the design, placement and operations of the Fremantle asylum. Part III deepens that analysis through the interrogation of patient data and discussion of case studies. Whereas Part I achieves the first of my thesis aims, together Parts II and III achieve the remaining aims.

In its entirety, this research is informed by feminist theories on mental health, sexuality, and gender performance. It considers the work of such writers as Phyllis Chesler, Gayle Rubin, and Judith Butler. For nineteenth-century mental health care, a double standard in the treatment of male and female patients can be observed through the therapies and treatments for female lunatics. Phyllis Chesler argues that there is a culturally perpetuated idea that men are generally allowed a greater range of acceptable behaviours than women are.[98] She argues that psychiatric hospitalisation or labelling of madness related to what society considered unacceptable behaviour.[99] Thus, 'since women are allowed fewer total behaviours and are more strictly confined to their role-sphere than men are, women, more than men, will commit more behaviours that are seen as ill or

[98] Phyllis Chesler, *Women and Madness* (New York: Palgrave Macmillan, [1972] 2005), 99.
[99] Chesler, *Women and Madness,* 99.

unacceptable'.[100] Andrea Nicki states that 'the derogatory label of "craziness" serves to silence communication of differences in ideas or intensity of emotion'; 'calling someone "crazy" keeps that person and her differences away, but it also reinforces the belief that "crazy" or mentally ill people are less than fully human and not deserving of respect'.[101] Nicki agrees with Chesler that 'women who are denounced for their mania are rejected for their "unwomanly" abilities or behaviour'.[102] She states that 'conventional feminine behaviour involves quietness, self-effacement, and cautiousness' and not 'risky involvement in pleasurable activities like sexual affairs or financial investments'; activities encouraged for men.[103] Therefore, 'women who display mania are doubly deviant, defying norms of femininity and challenging an Aristotelian paradigm of humanity as self-controlled and moderate, occupying a mean between extremes'.[104]

Foucault argued that during the nineteenth-century 'sexuality was carefully confined; it moved into the home. The conjugal family took custody of it and absorbed it into the serious function of reproduction. On the subject of sex, silence became the rule'.[105] Gayle Rubin's essay *Thinking Sex* introduces the idea of socially acceptable and unacceptable forms of sexuality. For Rubin, western society has structured sexuality through social frameworks to control it, which leads to her invention of the "Charmed Circle".[106] Through this 'virtually all erotic behaviour is considered bad unless a specific reason to exempt it has been established' and the 'most acceptable excuses are marriage, reproduction and love'.[107] She argues that 'the line appears to stand between sexual order and chaos' and if anything is allowed to cross the line then 'the barrier against scary sex will crumble, and something unspeakable will skitter across'.[108] Therefore, marriage and procreation stand as the socially accepted norm for women and men, especially in the nineteenth century.

Another critical theory is one of the social constructions of gender. Simone de Beauvoir wrote in 1949 that 'one is not born a woman, but, rather, becomes one' arguing that gender is culturally constructed, a variable cultural accomplishment.[109] Judith Butler's work in *Gender Trouble* further explored these ideas. Butler maintains that 'whatever biological intractability sex appears to have, gender is culturally constructed, hence gender is neither the casual result of sex nor as

[100] Ibid.
[101] Nicki, "Abused Mind," 87.
[102] Ibid, 87.
[103] Ibid, 90.
[104] Ibid, 90.
[105] Michel Foucault, *The History of Sexuality: Volume One: An Introduction*, trans. R. Hurley (New York: Vintage Books, 1990), 3.
[106] Gayle Rubin, *Deviations* (London: Duke University Press, 2011), 147.
[107] Rubin, *Deviations*, 148.
[108] Ibid, 151.
[109] Simone de Beauvoir, *The Second Sex*, trans. E.M. Parshley (New York: Vintage, 1973), 301.

seemingly fixed as sex'; therefore, your behaviour creates your gender.[110] She writes that 'the action of gender requires a performance that is *repeated*. This repetition is at once a re-enactment and re-experiencing of a set of meanings already socially established, and it is the mundane and ritualised form of their legitimation'; 'the performance is effected with the strategic aim of maintaining gender within its binary frame'.[111] Thus, 'cultural construction is designated by gender', and '"persons" only become intelligible through becoming gendered in conformity with recognizable standards of gender intelligibility'.[112] Therefore, '"identity" is assured through the stabilizing concepts of sex, gender, and sexuality, the very notion of "the person" is called into question by the cultural emergence of those "incoherent" or "discontinuous" gendered beings who appear to be persons but who fail to conform to the gendered norms of cultural intelligibility by which persons are defined'.[113] Thus, society and behaviour dictate gendered characteristics and anything outside the gender norm is punished.

All of these theories of women and madness, sexuality, and the social construction of gender can be seen operating in the admissions, experiences, diagnoses, treatments, and discharges of the female patients in the Fremantle Lunatic Asylum. However, Ann Oakley states 'feminism is a perspective rather than a particular set of prescriptive values. A feminist perspective consists of keeping in the forefront of one's mind the lifestyles, activities and interests of more than half of humanity—women'.[114] The three parts of the thesis are guided by these feminist theories and other methods throughout which will now be discussed in greater detail.

Part I: Insanity and Hysteria

The first part of the thesis delivers the first aim through extensive research and review of scholarly literature, which allows for a comprehensive assessment of theories of insanity and the evolving mental illness treatments in the nineteenth century. Chapter One explores how society defined madness through psychiatric theories and arguments while exploring the ideas of deviance and moral transgression. These ideas reveal how society further stigmatises women for behaviour deemed outcast. An analysis of the Victorian understandings of madness allows for the appraisal of the invention of moral treatment in Britain and Australia. Once ideas of madness, particularly for women, are established, Chapter Two investigates the labelling, diagnosis, and treatment of women

[110] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990), 8.
[111] Butler, *Gender Trouble*, 191.
[112] Ibid, 10-22.
[113] Ibid, 23.
[114] Oakley, *The Anne Oakley* Reader, 190.

nineteenth-century women deemed "insane". This chapter analyses the historiography of hysteria and the emerging professional male-dominated medical industry.

Through the examination of these topics in Part I, the connection between morality and women's madness within nineteenth-century male-dominated institutions and practice contributes essential context for the thesis and the experiences of the women in Fremantle.

Part II: The Fremantle Lunatic Asylum

The second part of the thesis determines how Western Australia developed the Fremantle Lunatic Asylum, interrogates the evidence of the female patient experiences, and determines how moral treatment was implemented in the care of such patients. The methods employed in this part of the thesis includes the interpretation of primary sources (patient records), socio-biographical studies, and analysis of case studies.

Socio-biographical studies are an important method of my research in Parts II and III. Barbara Caine writes that individual lives and stories provide ways of understanding both contemporary societies and the process of social and historical change; thus, a biographical approach in history offers 'a way of accessing subjective understanding and experience' by mapping individual lives across various records.[115] Yvonne Downs affirms that historical research and biography 'attends not only to the life stories of the individuals concerned, but also to the meaning of those stories in their broader historical, social, political, cultural and geographical contexts'.[116] Biography in historical research also enables new insights into historical periods, individuals or groups who have previously been ignored in the framework of historical analysis; this is particularly important in social, feminist, and post-colonial histories.[117]

Therefore, the second part of the thesis uses a socio-biographical method to determine how Western Australian understood insanity, approached the care of its insane women, and made used of moral treatment methods within the asylum. Chapter Three examines the establishment, facilities, and staff of the Fremantle asylum, within the broader context of mental health treatment in Western Australia. For this chapter, the existing secondary research on the asylum was a significant resource, particularly, the work of Bronwyn Harman, Susan Piddock, and Philippa Martyr. Completed in 1993, Harman's article and thesis exploring the female experience at the asylum provides statistics on a small sample of fifty female patients, based on class, marital status, and

[115] Barbara Caine, *Biography and History* (Hampshire: Palgrave Macmillan, 2010), 1.
[116] Yvonne Downs, "Testing the Potential of Auto/Biographical Life History," *Qualitative Research Journal* 16, no. 4 (2016): 363. doi: 10.1108/QRJ-09-2015-0088.
[117] Caine, *Biography and History*, 1.

religion.[118] Harman's sample study is the only work to focus on female patients but also provides some insights into the function and staff in the asylum. Piddock's 2016 article contains substantial work on the asylum building.[119] She provides a framework based on nineteenth-century lunacy reformer John Conolly's "ideal" asylum. The framework provides assessments of the building per moral treatment standards. Martyr's 2017 article on Medical Superintendent Dr Henry Calvert Barnett is a crucial biographical resource on the asylum staff.[120] While not intending to cover the entire history of the asylum staff, it does provide insightful information on a prominent physician at the asylum.

While the qualitative methods in this thesis enable understandings of the asylum through the primary and secondary literature, this thesis relies substantively on quantitative research. The thesis, and in particular, Chapter Four formulates data collated and analysed from within the asylum's female patient records, kept between 1858 to 1908.[121] McCarthy, Coleborne, O'Connor and Knewstubb write that statistics are an important aspect in the study of insanity, these can determine socio-demographic characteristics of patients through the creation of data from the asylum records.[122] The data from Fremantle provides exhaustive information on the age, nationality, causes for admission, occupation, and marital and religious status of its patients; while, data on admissions and discharges also reveals who controlled those processes. Classification and diagnosis in the asylum are also explored with a particular examination of visual indicators to diagnose patients. The quantitative research in the thesis employed descriptive statistics using averages and means to describe data in summary, while also supplying inferential data in tables to allow for meaningful inferences.[123] The patient registers and case books are not without complications as historical sources: the Medical Superintendents did not always record information consistently, and not every patient has a complete entry.[124] Another factor that should be considered regarding the patient

[118] Harman, "Women and Insanity", 167-181.
[119] Piddock, "A Place for Convicts".
[120] Martyr, "Unlikely Reformer".
[121] Sources used were accessed at the State Records of Western Australia (SROWA): *Register of Female Patients*, 1858-1873; AUWA S507, Cons 112004; *Female Register Fremantle Lunatic Asylum Case Book*, 1873-1878; AUWA S2219, Cons 57591; *Case Book Female Patients*, 1878-1897; AUWA S2219, Cons 272403; *Case Book Female Patients Chronic Medical Conditions*, 1901-1908; AUWA S2219, Cons 310301; *Case Book Female Patients*, 1901-1908; AUWA S2219 Cons 310001; *Case Book Female Patients*, 1906-1908; AUWA S2219 Cons 272404.
[122] Angela McCarthy, Catharine Coleborne, Maree O'Connor, and Elspeth Knewstubb, "Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health," *Medical History* 61, no. 3 (2017): 360. doi:10.1017/mdh.2017.33.
[123] Gillham, *Case Study Research Methods*, 10.
[124] The differences in the patient records are detailed in Chapter Three. The nature of handwritten historical records also proves problematic and there is potential for misspelling of the patient's names, the best attempt has been made to ensure they are accurate. A list of patients admitted can also be found in the Appendix.

records is that they are not written from the perspective of the women; they were written by male medical professionals whose interpretations and diagnosis was influenced by their own context. Most of the women admitted to Fremantle were illiterate and these patient notes are likely the few remaining sources that provide some insights into their experiences. Patient data kept across fifty years reveals identifiable trends across the records, emphasising how medical authorities viewed mental illness and female gender roles which adds to understandings of the women's experiences.[125]

The remaining chapters of the thesis, employ case study and textual analysis techniques. Important in socio-biographical research, case studies gather information from different sources to provide greater insights.[126] Bill Gillham writes that the close description of a case can have a more significant impact than other forms of research reports as it has the potential to challenge or provide insights into people's lives to provide better understandings.[127] Multiple types of evidence must be accumulated and assessed for relevance and trustworthiness, then organised and stored, which is then woven into a narrative account.[128] Therefore, textual analysis has a vital role within the remaining chapters of the thesis as interpreting the available texts allows for a sense of how people and cultures make sense of the world around them at particular times.[129] This method is a data-gathering process whereby one attempts to understand the likely interpretations of texts.[130] Thus, alongside the asylum registers and case books, the thesis employs the asylum's Medical Superintendent reports and Fremantle Prison records within the State Records Office of Western Australia (SROWA). Other resources that are examined include the *Police Gazettes* through the State Library of Western Australia (SLWA), contemporary newspapers, and the Department of Justice Births, Deaths, and Marriages Index of Western Australia (BDMWA) records.

Chapters Five and Six analyse the application of moral treatment to female patients within the Fremantle asylum. Through the methods of case study and textual analysis, Chapter Five investigates an aspect of moral treatment experienced by the female patients in Fremantle, domestic chores as rehabilitation. With patient examples from the registers and case books, I reveal how willingness and an ability to do domestic work could lead to discharge from the asylum, as women were deemed well enough to care for their families. Therefore, this chapter supports the

[125] The data collation is detailed in Chapter Four.
[126] Bruce Lawrence Berg, *Qualitative Research Methods for the Social Sciences* (Neeham Heights: Allyn & Bacon, 2001), 255.
[127] Bill Gillham, *Case Study Research Methods* (London: Bloomsbury Publishing Plc, 2000), 101-102.
[128] Gillham, *Case Study Research Methods*, 20.
[129] Alan McKee, *Textual Analysis: A Beginner's Guide* (London: SAGE Publications Inc, 2003), 1.
[130] McKee, *Textual Analysis,* 1-2.

argument that moral treatment methods reinforced traditional nineteenth-century gender roles. Chapter Six develops further insight into aspects of moral treatment with an emphasis on punishments and rewards. This method was particularly apparent in the use of mechanical restraint and seclusion as punishments for bad behaviour, while, entertainment, exercise, and activities were offered as rewards. Also utilising patient records and experiences, this chapter expands on arguments made in Chapter Five as it reveals which behaviours were considered acceptable or unacceptable for female patients based on punishment or reward.

Part III: Female Patient Experiences

The third part of the thesis offers greater understandings of female patient experience and moral treatment techniques. The quantitative and qualitative methods of case study and biography in the preceding section are extended, and several specific cases of women admitted to Fremantle are examined. All the women discussed in the case studies within Part III were subject to moral treatment techniques, the findings of this chapter emphasise that that regardless of diagnosis, women generally experienced the same treatment. Therefore, good, quiet behaviour and an inclination to domestic duties were seen as improvements and could lead to a patient's discharge from the asylum.

This part begins in Chapter Seven, with an analysis of experiences of patients with nowhere to go, identifying examples amongst the elderly, intellectually disabled, and epileptic patients. This chapter reveals the impact that family had on admission and discharge. Chapter Eight then examines the impact that men and marriage had on female patients who experienced widowhood, desertion, separation, heartbreak, sexual assault, and marital cruelty. Given the important role women had as wives, the loss of this identity or the abuse of it resulted in trauma with possible mental and physical repercussions. In Chapter Nine, I investigate how nineteenth-century understandings of the female body and reproductive madness informed treatment in the asylum. This chapter examines how female biological functions were understood and treated as pathological in the nineteenth century and reveals misunderstandings of trauma and postnatal responses as insanity. The final chapter of the thesis explores experiences of "deviant" women or those female patients labelled with moral insanity. The chapter makes use of patient case studies in pruriency, alcohol and drug use, and prostitution. These women were more likely than other patients to have been suspected or convicted of criminal offences, and therefore, reveal the interchangeable nature of punishment and treatment of female public nuisances in prisons and asylums. Such cases demonstrate nineteenth-century anxieties over women's expressions of sexuality and unladylike behaviour.

Significance

This thesis provides new data on female patients at the Fremantle Lunatic Asylum. It encompasses a wide range of patients across 1858 to 1908 while exploring the female patients' experiences with greater emphasis on moral treatment methods operating in the asylum.[131] This data allows for the examination of trends and an analysis of the evidence of the female patients' experiences within the asylum. I will also provide significant understandings of the application and outcomes of moral treatment in Fremantle, which contributes to international investigations of moral treatment. This will enable insights into the asylum care methods, the lives and experiences of the women admitted, and "ideal" womanhood in nineteenth-century Fremantle.

[131] See Appendix for full list of 452 women admitted to the Fremantle Lunatic Asylum.

PART I

Insanity and Hysteria

CHAPTER ONE

Madness and Deviancy

To examine women and madness, the context of the society that dictates the meaning of madness, gender, and behaviour must first be understood. Therefore, Part I addresses the first of the thesis aims. Feminist psychiatrist Jane Ussher writes that women have consistently been "othered" in history, keeping women at the bottom of the pile.[1] She argues that women are simultaneously 'worshipped and defiled, evoking horror and desire, temptation and repugnance, fear and fascination'.[2] Women are powerful through 'their ability to reproduce, and their role as the mother'; while powerless through their supposed frailty, fertility, and weakness.[3] This 'powerlessness is maintained by the positioning of women as "other"' and is evident in the treatment of women who fall into the category of insane.[4] Chesler argues that 'psychiatric hospitalization or labeling [of madness] relates to what society considers unacceptable behaviour'.[5] Since women are 'more strictly confined to their role-sphere than men', she claims, women 'will commit more behaviours that are seen as ill or unacceptable'.[6] Ussher maintains that 'it is through the misogynistic practices of society that women are re-formed, re-invented', their bodies distorted, minds controlled, ordered, altered: she asks 'is it surprising that we are made mad?'.[7]

This chapter uses extensive literature to explore the theories on insanity, definitions of deviance and morality, moral transgression and women's double deviancy. It also analyses Victorian attitudes to madness and the emergence of moral treatment in the nineteenth century. These examinations will allow for greater understanding of the realities of nineteenth-century women's experiences in asylums.

Desperate Communities of the Powerless: Theories on Insanity

'All societies judge some people mad: any strict clinical justification aside, it is part of the business of marking out the different, deviant, and perhaps dangerous'.[8] Roy Porter wrote that as part of

[1] Jane M. Ussher, *Women's Madness: Misogyny or Mental Illness?* (Hertfordshire: Harvester Wheatsheaf, 1991), 20.
[2] Ussher, *Women's Madness*, 21.
[3] Ibid.
[4] Ibid.
[5] Chesler, *Women and Madness*, 99.
[6] Ibid.
[7] Ussher, *Women's Madness*, 21.
[8] Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), 62.

humanity's psychological and anthropological drive to order the world by 'demarcating self from other', we stigmatise people or groups: 'setting the sick apart sustains the fantasy that we are whole'.[9] This demonising process 'involves projecting onto an individual or group, judgements as to what is inferior or disgraceful'.[10] The process firstly signals out difference, calls it inferior and blames "victims" for their otherness.[11] In 1857 John Kitching wrote that 'the study of all mental phenomena involves difficulties of great magnitude. Operations of the mind are so various, that the attempt to discover the laws by which these are regulated had engaged the profoundest attention of the most gifted men'.[12] Therefore, various disciplines like psychiatry, anthropology, medicine, and philosophy have attempted to define and understand insanity.

From a constructionist sociological perspective, madness is a social problem. Birenbaum and Sagarin define a social problem, in similar ways as Porter did, through stigmatising. They write that 'a social problem exists when the collective society is rent by, at the very least, a public recognition that there is a sector of society, represented by its practices, which threatens or prevents others or themselves from establishing or maintaining their claims to membership'.[13] Spector and Kitsuse argue that the constructionists, 'conceive all social problems to be the activities of individuals or groups making assertions about perceived social conditions which they consider unwanted, unjust, immoral, and thus, about which something should be done'.[14] Therefore insanity, as a social problem, can be argued to be subjectively defined: many psychiatrists have put forward this case.

Michel Foucault defined mental illness as a cultural construct sustained by medical and psychiatric practices.[15] For Foucault, madness is not natural but a changeable phenomenon that depends on the society and its various cultural and economic structures.[16] In the seventeenth century, 'madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group; the moment when madness began to rank among the problems of the city'; determining the experience of madness as a cultural construct and influenced its course in history.[17] Thomas Szasz agrees with Foucault, writing that mental illness is not a disease but a myth

[9] Porter, *Madness*, 63.
[10] Ibid, 62-63.
[11] Ibid, 62.
[12] John Kitching, *The Principles of Moral Insanity Familiarly Explained in a Lecture* (York: William Simpson, 1857), 6; Kitching was medical superintendent for the Friends' Retreat York 1849-1874.
[13] Arnold Birenbaum and Edward Sagarin, *Social Problems: Private Troubles and Public Issues* (New York: Charles Scribner's Sons, 1972), 16.
[14] Malcolm Spector and John I. Kitsuse, *Constructing Social Problems* (Oxon: Routledge, [1987] 2017), xi.
[15] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (Oxen: Routledge, [1961] 2005).
[16] Foucault, *Madness and Civilization*.
[17] Ibid, 59.

perpetuated by psychiatrists and endorsed by society as it provides easy solutions for problem people.[18] Szasz argues that the brain is an organ and diseases of the brain manifest themselves as disturbances of behaviour.[19] He argues that 'diseases of the brain are brain diseases; it is confusing, misleading, and unnecessary to call them mental illnesses'.[20] For Szasz, although mental illness may not exist, mental patients do.[21] He argues that a person becomes a patient when they define themselves, or when others define them as a patient, and when that definition is formally supported as legitimate.[22]

In direct response to Szasz, Martin Roth and Jerome Kroll argued that the stability of psychiatric symptoms over time reveals that mental illness is a real psychopathological entity.[23] Neil Pickering agrees that mental illness does exist, that it or specific diagnoses exist in so far as we create or invent them.[24] Pickering writes that 'if we look more closely at the struggle, the argument about the nature of madness…[it] appears integrally entwined with the social changes'.[25] He argues that we should take the scepticism seriously but still reach a non-sceptical conclusion.[26] Andrea Nicki also writes, 'that many instances of mental illness are not best understood as having primarily genetic or biological causes in no way means that these illnesses are not real or genuine'.[27] Nicki states that 'mental illnesses, like physical illnesses, involve difficulties in social adaption that, without proper accommodation, sources of support, and aid, can be seriously disabling'.[28] She adds, that 'just as anyone can become severely physically ill and disabled, so also can anyone fall severely mentally ill and disabled, with illness of both types exacerbated in those with unequal access to health care, social resources, and support'.[29] Thus, feminist Kate Millet noted:

> Madness is worse than a crime; crimes merit trials, counsel, stated sentences if convicted. If acquitted of crime, one is free to go. You will never get acquitted and, as a matter of fact you are not nearly as innocent as you claim. Because you were daft, thought daft thoughts, said daft things. Daft is mad, is a terrible and frightening disease to the world. People have been

[18] Thomas Szasz, *Insanity: The Idea and its Consequences* (New York: Syracuse University Press, 1997); *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Syracuse University Press, 1997); *The Myth of Mental Illness: Foundation of a Theory of Personal Conduct* (London: Paladin, 1972).
[19] Szasz, *Insanity*, 49.
[20] Ibid.
[21] Ibid, 100.
[22] Ibid.
[23] Martin Roth and Jerome Kroll, *The Reality of Mental Illness* (Cambridge: Cambridge University Press, 1986).
[24] Neil Pickering, *The Metaphor of Mental Illness* (Oxford: Oxford University Press, 2006), 1.
[25] Pickering, *Metaphor of Mental Illness*, 105.
[26] Ibid, 1.
[27] Nicki, "Abused Mind," 81.
[28] Ibid.
[29] Ibid.

> totally unable to cope with it, now or ever. Your madness is their possible madness. And it must be stamped out. It is all the hidden gears of the mind in losing itself.[30]

Millet's observations, from her own first-hand experiences, reveals society's fear of mental illness, of the other. In an attempt to keep themselves sane society will marginalise problematic deviation.

Deviancy, Moral Transgression, and Women

Insanity encompasses ideas regarding "other"; deviancy exists as differing from the norm or the moral ideals of a society. Paul Rock writes that 'the "deviant" is the occupant of a special role which is recognised and ordered in the process of interaction'; a 'social construct fashioned by the members of the society in which it exists'.[31] Howard S. Becker argues that 'social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders' .[32] Becker states that 'deviant behaviour is behaviour that people label so'.[33] As Rock argues, society is a network of small social worlds; each is an organisation of roles, beliefs, and loyalties, each somewhat differentiated from its neighbours, and the boundaries between them shape communication.[34] The organisation is also a moral order in that its prescriptions and proscriptions are sources of identity and guidance.[35] Therefore, the moral organisation of families, friends, communities, and formal associations are simultaneously threatened and consolidated by deviant members.[36] He states that all such worlds devise means of identifying and managing deviancy to preserve the integrity of the moral organisation.[37] Therefore, legislators, judges, magistrates, police officers, bailiffs, psychiatrists, and prison officers form a loosely coordinated system with shifting internal boundaries; a differentiation of power, function, and intricate linkages forged out of internal conflict, exchange, and cooperation.[38] Thus, deviants offend against the moral as well as the political structure when they break the rules; among them, the mentally ill are often associated as they are relatively incapable of dissembling their deviance.[39]

Therefore, an understanding of morality is required to examine deviance. Philosopher Bernard Gert stated that morality consists, not merely of rules, but also ideas.[40] Anthropologist Ruth

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[30] Kate Millet, *The Loony-Bin Trip* (Chicago: University of Illinois Press, 2000), 232.
[31] Paul Rock, *Deviant Behaviour* (London: Hutchinson & Co Publishers Ltd., 1973), 19.
[32] Howard S. Becker, *Outsiders: Studies in the Sociology of Deviance* (New York: Free Press, 1963), 9.
[33] Becker, *Outsiders*, 9.
[34] Rock, *Deviant Behaviour*, 128.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Ibid, 122-123.
[39] Ibid, 151; 90.
[40] Bernard Gert, *Morality: Its Nature and Justification* (Oxford: Oxford University Press, 1998), ix.

Benedict argued that 'morality differs in every society, and is a convenient term for socially approved habits. Mankind has always preferred to say, "it is morally good," rather than "it is habitual".[41] Gert wrote that 'moral virtue involves justifiably following the moral rules or ideal significantly more than most people do'; whereas 'moral vice involves acting contrary to the guide provided by morality substantially more than most people do'.[42] He argued that 'moral virtues and vices involve free, intentional, voluntary actions related to the moral rules and ideals'; moral vice is 'a disposition to respond to a conflict between a moral rule and one's interests or inclinations, in a way that involves unjustifiable violation of that rule'.[43] English physician Kitching wrote in 1857 that morality is the way in which we decide to behave publicly and with others:

> We feel that we have affections which render us kindly disposed to each other; that prompt us to love our friends and all others who love us; that dispose us to relieve the wants of those who are about us; that lead us to desire the good opinion of others, or to entertain a good opinion of ourselves; that incite us to a reverential feeling towards our Creator, to persevere in the decisions of our own will, or, on the other hand, that we have faculties which render us eager in opposing anything which we dislike, which make us triumph in the surmounting of difficulties, and resolute in the battle against oppression and injury; also that we have instincts which lead us to take every care for the preservation of our lives, and the satisfaction of our bodily wants. These various powers and faculties, so distinct from the former set, are conveniently designated by the term "moral and instinctive faculties." They are called moral, because they preside over the regulation of our conduct towards others, and determine our sentiments and affections.[44]

Therefore, moral transgression is deviant behaviour. Psychologist Elliot Turiel states that a genuine moral transgression must involve an action that is intrinsically harmful to others.[45] Geoffrey Goodwin argues that Turiel's statement has met criticism, as it conveys a unified view of the moral domain; and that harm may not be necessary for it to be defined as moral transgression as harmless yet offensive actions also provoke judgements of wrongness.[46]

For women, deviancy and moral transgression take on more meaning. Shani D'Cruze and Louise Jackson write that, the term "deviancy" for women refers to 'the processes through which women's behaviours have been viewed as outside of accepted social parameters…the opposite of

[41] Ruth Benedict, *An Anthropologist at Work: Writing of Ruth Benedict*, ed. Margaret Mead (Boston: Houghton Mifflin, 1959), 276.
[42] Gert, *Morality*, 283.
[43] Ibid.
[44] Kitching, *Principles of Moral Insanity*, 14.
[45] Elliot Turiel, *The Development of Social Knowledge: Morality and Convention* (Cambridge: Cambridge University Press, 1985).
[46] Geoffrey P. Goodwin, "Is Morality Unified, and Does this Matter for Moral Reasoning?" In *Moral Inferences*, ed. Jean-Francois Bonnefon and Bastien Tremoliere (Oxon: Routledge, 2017), 13.

behaviours that were likely to command honour, respect, and social status'.[47] Including 'behaviours that have been legislated as "criminal" as well as those that were not technically illegal but which placed some women on the margins of the community'.[48] They argue that 'perceptions of appropriate gender roles' resulted in women's sexuality becoming 'an area of anxiety in relation to constructions of deviancy'.[49] Therefore, women's deviance and offending have often 'been viewed not merely as unusual, but…"doubly deviant", in that it contradicts gendered assumptions about "caring" femininity as well as threatening broader social norms through the act of law-breaking' or transgressing social boundaries.[50] Silvestri and Crowther-Dowey argue that 'social anxiety about the criminality and deviancy of girls and their transgression of the legal, social, and moral order', manifested into 'five persistent cultural myths about the female offender'.[51] That she is not violent; she more likely to be mad than bad; she is a liar and deceiver; that through her sexuality, she is both dangerous and risky; and she needs both care and control.[52] Fuchs and Thompson write that this idea spread in the nineteenth century due to 'the new urban, middle-class men who rose to power set forth hegemonic cultural ideals as one way to delineate themselves as a group apart from the "other," which were women, the poor, and the colonized'.[53] 'Building upon their concepts of individual property, inheritance, and reproductive strategies to protect their property, they established a moral ideal and system of habits, delineating gender roles to affirm their power and property transmission'.[54] Therefore, the regulation of women's sexuality maintained this ideal. Thus, 'women's sexuality became a major subject of nineteenth-century rhetoric of repression that linked morality with sexuality, for the good of society'.[55] 'Women, in this instance, were both powerful and powerless. They were powerless in that they were legally and discursively confined to a secondary and submissive role'.[56] However, 'they were powerful because that same discourse that confined them to the private sphere also assigned them sexual power. Women bore children and were also supposed to be the moral influence in the family and society'.[57] Thus, their behaviour needed to be beyond reproach; deviancy and moral transgression threatened this motherly moral paradigm.

[47] Shani D'Cruze and Louise A. Jackson, *Women, Crime and Justice in England since 1660* (Hampshire: Palgrave Macmillan, 2009), 2.
[48] D'Cruze and Jackson, *Women, Crime and Justice*, 2.
[49] Ibid, 29.
[50] Ibid, 15.
[51] Marisa Silvestri and Chris Crowther-Dowey, *Gender and Crime: A Human Rights Approach*, 2nd ed. (London: Sage Publications, 2016), 45.
[52] Silvestri and Crowther-Dowey, *Gender and Crime*, 45.
[53] Rachel G. Fuchs and Victoria E. Thompson, *Women in Nineteenth-Century Europe* (New York: Palgrave Macmillan, 2005), 34-35.
[54] Fuchs and Thompson, *Women in Nineteenth-Century Europe*, 34-35.
[55] Ibid.
[56] Ibid.
[57] Ibid.

The fear of madness, other, deviance, and moral transgression, in all genders, has intrigued people for centuries. The Victorians had their prejudices and definitions for how to diagnose, label, and treat insane people, which will be further explored in the following section.

Global Headquarters of Insanity: Victorians and Madness

In 1830, physician John Conolly defined insanity 'as an impairment of one or more of the faculties of the mind'.[58] In 1835, British physician James Cowles Prichard wrote that insanity was 'a chronic disease, manifested by deviations from the healthy and natural state of the mind, such deviations consisting either in a moral perversion, or a disorder of the feelings, affections, and habits of the individual'.[59] In 1845, French physician Jean-Étienne Esquirol stated, that 'insanity, or mental alienation, is a cerebral affection, ordinarily chronic, and without fever: characterised by disorders of sensibility, understanding, unintelligence, and will'.[60] These early nineteenth-century definitions of insanity were influenced by the societies in which they developed.

Historian Stephen Garton argues that the British Industrial Revolution in the early 1800s resulted in significant upheaval in rural and urban life, which 'necessitated new forms of control', notably prison, professional police forces, and asylums; thus incarceration of the insane maintained the status quo and capitalist social order.[61] The status of the asylum and its regime within a total social system of control, punishment, and regeneration meant that increasing proportions of those admitted to nineteenth-century asylums were now from a class not always associated with traditional lunatics.[62] Among these were habitual drunkards, victims of tertiary syphilis, and a whole range of neurological defects, sensory-motor disorders, ataxias, paralyses, and epileptics.[63] The broad range of symptoms that could be attributed to insanity was typified by Joseph Mortimer Granville, who wrote in 1877 that 'speaking generally the causation of insanity everywhere, special

[58] John Conolly, *An Inquiry Concerning the Indication of Insanity, with Suggestions for the Better Protection and Care of the Insane* (London: John Taylor, 1830), 302; Conolly (1794-1866) psychiatrist and resident physician at Middlesex Asylum Hanwell.
[59] James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert, and Piper, 1835), 7; Prichard (1786-1848) English physician and entomologist was physician at Bristol Infirmary from 1810, and from 1845 served as a Medical Commissioner in Lunacy.
[60] Jean-Étienne Dominique Esquirol, *Mental Maladies: A Treatise on Insanity*, trans. E.K. Hunt (Philadelphia: Lea and Blanchard, 1845), 21; Esquirol (1772-1840) physician-in-chief of Maison Royale des Alienes de Charenton and member of the Royal Academy of Medicine.
[61] Garton, *Medicine and Madness*, 3.
[62] William F. Bynum, Roy Porter and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry*, *Vol III: The Asylum and its Psychiatry* (London: Routledge, 2004), 5-6.
[63] Bynum, Porter and Shepherd, *Anatomy of Madness*, 5.

organic disease apart, is an affair of three W's—worry, want, and wickedness. Its cure is a matter of the three M's—method, meat, and morality'.[64]

The types of madness present in nineteenth-century asylums varied in intensity, culpability, and social rejection. The most common types of mood and behavioural disturbance, mania and melancholia, were singled out in ancient Greek medical practices.[65] The Greeks defined mania as 'a condition marked by excess and uncontrollability', which 'found vent in fury, excitement, and cheerfulness'.[66] In acute forms, a manic person could be violent or grandiose but was also associated with euphoria and deliriums; while melancholia was a severe mental disturbance of which 'anguish and dejection were its essential elements'.[67] It also involved 'powerful emotions springing from sensations of suspicion, mistrust, anxiety, and trepidation'.[68] Importantly, the Greeks noted, a person could have variations of one or both mania and melancholia.[69]

Nineteenth-century definitions of insanity were influenced by the ancient Greeks but expanded to cover more manifestations of madness, as evidenced by Prichard in 1835. Mania, he wrote, was 'raving madness, in which the understanding is generally deranged; the reasoning faculty, if not lost, is confused and disturbed in its exercise; the mind is in a state of morbid excitement and the individual talks absurdly on every subject to which his thoughts are momentarily directed'.[70] Whereas, melancholia was 'a gloomy character, or connected with sadness and despondency'.[71] Mark Stevens notes that sufferers of melancholia are the most aware of the patients; they can suffer from delusions or hallucinations, some becoming paralysed or unable to speak, as well as having drooping posture and movement.[72] Another variation of mania and melancholia was monomania; this was a kind of partial insanity 'in which the understanding is partially disordered or under the influence of some particular illusions...while the intellectual powers appear, when exercised on other subjects, to be in great measure impaired'.[73] Other types of madness defined by Prichard were incoherence or dementia, which involved a 'rapid succession or

[64] Joseph Mortimer Granville, *The Care and Cure of the Insane: Being the Reports of The Lancet Commission on Lunatic Asylums 1876-6-7 for Middlesex, the City of London, and Surrey,* Vol I (London: Hardwicke and Bogue, 1877), 48; Organic Disease is caused by a physical or physiological change to tissue or organs of the body, in contrast with mental disorders.
[65] Porter, *Madness*, 45.
[66] Ibid, 47.
[67] Ibid, 45-46.
[68] Ibid.
[69] Ibid, 47.
[70] Prichard, *Treatise on Insanity*, 7.
[71] Ibid, 26.
[72] Mark Stevens, *Life in the Victorian Asylum: The World of Nineteenth Century Mental Health Care* (South Yorkshire: Pen & Sword History Books Ltd., 2014), 47.
[73] Prichard, *Treatise on Insanity*, 6.

uninterrupted alteration of insulated ideas, and evanescent and unconnected emotions; continually repeated acts of extravagance; complete forgetfulness of every previous state; diminished sensibility to external impressions; abolition of the faculty of judgement; perpetual activity'.[74] Lastly, he defined moral insanity, which across the nineteenth century, came to have wide-ranging symptoms. He stated that moral insanity was 'madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination'.[75] He wrote that the usual suspects of moral insanity included a 'morbid depression and excitement' and an 'unusual prevalence of angry and malicious feelings, which arise without provocation or any of the ordinary incitements'.[76] Thus, '"moral insanity" redefined madness as deviance from socially acceptable behaviour'.[77]

Consequently, the cornerstones of Victorian psychiatric theory and practice were guided by morality.[78] Institutions began to develop moral treatment methods which abolished physical restraint, harsh conduct, and instituted 'close supervision and paternal concern'; to 're-educate the insane in habits of industry, self-control, moderation, and perseverance'.[79] In 1887, during the Victorian branch meeting of the British Medical Association, the paper by J.A. O'Brien on asylum management was presented which stated 'when placed in dormitories and watched carefully during the night by a special attendant, the destructive element may be gradually overcome, and the wet and dirty patient made clean and tidy'.[80] Thus, supervision was a key part of the asylum management. Moral architecture was also instituted to construct asylums 'as therapeutic environments' where patients could be 'exposed to benevolent influences' without force.[81]

Moral Treatment

In the late eighteenth and early nineteenth centuries, inspired by Enlightenment ideas on 'the importance of moral and physical environments in shaping each individual', physicians began to condemn the state of lunatic asylums in Britain, Europe, and North America.[82] William and Daniel

[74] Ibid, 7.
[75] Prichard, *Treatise on Insanity*, 6.
[76] Ibid, 20-21.
[77] Showalter, *Female Malady*, 29.
[78] Ibid.
[79] Ibid.
[80] J.A. O'Brien, "Some Points of Interest in the Management of the Insane," *Australian Medical Journal* ix, no. 5 (May 1887): 2213. http://hdl.handle.net/11343/23151.
[81] Showalter, *Female Malady*, 29.
[82] Stephen Garton, "Seeking Refuge: Why Asylum Facilities Might Still Be Relevant for Mental Health Care Services Today," *Health and History* 11, no. 1 (2009): 28. https://www.jstor.org/stable/20534502.

Tuke in Britain, Phillipe Pinel in France, Benjamin Rush and Dorothea Dix in America, 'and many other like-minded reformers' became instigators 'of a more humane attitude towards the insane'.[83] Pinel, who first instituted moral treatment in France, argued that patients were 'much more easily and effectually diverted by moral remedies and especially by active employment'.[84] He stated that 'attention to these principles alone will, frequently, not only lay the foundation of, but complete a cure: while neglect of them may exasperate each succeeding paroxysm, till, at length, the disease becomes established, continued in its form, and incurable'.[85] He argued that 'the successful application of moral regimen exclusively, gives weight to the supposition, that, in a majority of instances, there is no organic lesion of the brain nor of the cranium'.[86]

Nineteenth-century England became the centre of lunacy reform and from the 1830s 'experiments in the humane management of madness' made English asylums a learning and research hub for doctors and social investigators from across the world.[87] The new method was moral treatment which originated when William Tuke founded the York Retreat in 1796.[88] The founder's grandson Samuel Tuke wrote in 1813 that 'intellectual, active, and moral power, are usually rather perverted than obliterated' and with moral instruction could be cured.[89] Moral treatment aimed to enforce 'good habits in patients, in an effort to teach them the steadiness and self-discipline of good citizens'; therefore, the asylum needed to 'provide opportunities not only for social re-education but also for work', including amusements, and exercise.[90] Tuke also noted that work was an important aspect of moral treatment; for women in particular, when they were engaged 'in sewing, knitting, or domestic affairs...regular employment is perhaps the most generally efficacious; and those kinds of employment are doubtless to be preferred, both of a moral and physical account'.[91]

[83] Garton, "Seeking Refuge," 28.
[84] Philippe Pinel, *A Treatise on Insanity: In Which are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders Than Has Yet Been Offered to the Public*, trans. D.D. Davis (Strand, London: Cadell and Davies, 1806), 224; Pinel (1745-1826) pioneering physician in moral treatment at the Salpêtrière (1795-1826).
[85] Pinel, *Treatise on Insanity*, 5.
[86] Ibid.
[87] Showalter, *Female Malady*, 25.
[88] Ibid, 30.
[89] Tuke, *Description of the Retreat*, 134.
[90] Showalter, *Female Malady*, 31.
[91] Ibid, 156.

Therapeutic labour was first introduced into asylums in the 1830s at John Conolly's asylum, Hanwell.[92] 'Male patients were taught a trade or pursued their own' while female patients did needlework or laundry.[93] In 1856 Conolly wrote:

> The daily life of most men, and of most women, is made up of small details, and when important occupations are withdrawn, the details become limited to such as have been enumerated…women, severed from home associations and domestic duties, and to men debarred from the performance of all daily and customary occupations, and from all habitual relaxations…It is by the operation of such influences, and by the general and indirect effect of the new habits of life induced in a good asylum, and substituted for the perverted habits of disordered minds—It is by the impressions there made, and also by the impressions from thence excluded, that the great majority of patients are more benefitted than by the direct effect of medicines.[94]

He believed that the most striking instances of the efficacy of moral treatment could be found with women and was proudest of his success with prostitutes, even these 'wretched outcasts', he claimed, could be tamed by 'patience and kindliness', so that eventually they became almost ladylike.[95] These women 'had been the cause of ruin and shame to their families, and the history of their wild life had closed with madness'; the 'young women of ungovernable temper...sullen, wayward, malicious, denying all domestic control; or who want that restraint over the passions without which the female character is lost'.[96] 'Thus, the more patients an asylum could put to work, the higher its reputation for humanitarian progress'.[97]

However, work as rehabilitation was 'originally intended for the curable and convalescent, it was gradually extended to the chronic' or intellectually disabled patients.[98] 'At first, the best-occupied inmates were women, a feature common to most types of nineteenth-century institutions, since it was comparatively simple to employ them in household tasks'.[99] However, Showalter argues that these tasks, less so for their pleasure, were 'training in the discipline of femininity'.[100] Physician Joseph Mortimer Granville commented that setting women to work would mean they would be too

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[92] Ibid, 40.
[93] Ibid.
[94] John Conolly, *The Treatment of the Insane Without Mechanical Restraints* (London: Smith, Elder & Co, 1856), 147-148.
[95] Showalter, *Female Malady*, 78-79.
[96] Conolly, *Treatment of the Insane*, 127; John Conolly, *A Remonstrance with the Lord Chief Baron Touching the Case Nottidge versus Ripley*, 3rd ed, (London: John Churchill, 1849), 3.
[97] Showalter, *Female Malady*, 40.
[98] Anne Digby, "Moral Treatment at the Retreat, 1796-1846," in *The Anatomy of Madness: Essays in the History of Psychiatry, Vol 2: Institutions and Society*, eds. William F. Bynum, Roy Porter, Michael Shepherd (London: Routledge, 2004), 63.
[99] Digby, "Moral Treatment", 63.
[100] Showalter, *Female Malady*, 81.

busy to talk.[101] The most highly touted women's work was laundry, due to its therapeutic effects.[102] 'The aggressive activity of pounding the wet clothes, wringing them out, hanging them and ironing them was thought to be an effective outlet for the superfluous nervous energy (or anger) of women patients'.[103] Conolly believed that 'the activity of the laundry prevented asylum washerwomen from becoming violent'.[104] In England, laundry was divided into categories and assigned according to 'the nature of their madness': 'the delirious washed, the imbeciles carried the linen to dry, the melancholy ironed it, and the monomaniacs folded and put it away'.[105] In 1887 O'Brien wrote of the colonial asylums in the eastern states:

> Success in asylum treatment in a great degree depends on the amount of occupation that can be given to those under care. There are a number of patients, however, who will not engage in work of any kind, and others whom it would be practically impossible to occupy in manual labour, such as farm or garden work. For these an effort has been made to overcome idle habits; certain days are set aside for drill and walks in the asylum grounds. If this is faithfully carried out, the patient is not only improved in health, but his general tone and state are much happier...Pure air and bright sunshine are a great help, and serve to improve the bodily tone, and thus give a better chance of recovery.[106]

In Fremantle, as will be explored in greater detail in Chapter Five, work was an important aspect of treatment.

The logical extension of moral treatment was in non-restraint, a system that involved the total abolition of all methods of restraining patients, even if they were violent.[107] Leonard Smith notes that, in the eighteenth century, restraint was a necessary element in the regiment of an asylum.[108] John Haslam, the apothecary at the notorious asylum Bethlem in London, 'maintained that restraint and the fear of punishment established habits of self-control, and that recovered lunatics credited it with their cure'.[109] Dr John Ferriar of the Manchester Lunatic Hospital advocated for the system of 'mild discipline' that included confinement of the legs and arms of the "furious" and shutting them in a darkened cell.[110] By the nineteenth century, the old physical methods of treatment, bleeding, purging, frequent use of intimidation to cow the patient, leg-locks, and

[101] Ibid.
[102] Ibid, 82.
[103] Ibid, 83.
[104] Ibid.
[105] Ibid.
[106] O'Brien, "Some Points of Interest in the Management of the Insane," 213.
[107] Showalter, *Female Malady*, 83.
[108] Leonard D. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999), 248.
[109] Showalter, *Female Malady*, 31.
[110] Smith, *Cure, Comfort and Safe Custody*, 248.

straitjackets were becoming discredited.[111] 'The idea that large numbers of patients could be handled without recourse to physical restraint won wide acceptance' in nineteenth-century England.[112] Robert Gardiner Hill implemented the new idea when he abolished physical restraints at the Lincoln Asylum in the 1830s, stating 'moral treatment with a view to induce habits of self control is all and everything'.[113] Tuke believed that 'the violence of manic patients was in large part caused by the harsh way they were treated'; treating the patient like a rational person was 'the best way to cultivate the sense of self-esteem that would lead to self-control'.[114] Tuke had proved in York that it was possible to treat patients through social means, with trust, sympathy, and simple forms of group activity.[115] Therefore, nineteenth-century asylums began to reduce mechanical restraint 'to an absolute minimum, substituting in its place primarily seclusion and manual restraint by attendants'.[116] However, Nancy Tomes writes that the implementation of non-restraint 'was neither complete nor consistent: even at the height of enthusiasm for the system, most superintendents did not endorse the concept of total abolition'.[117] Although where there was dissent on humanitarian grounds, it concerned the means of restraint rather than a questioning of the essential premise.[118]

A prominent advocate of non-restraint was John Conolly; he argued that 'restraint vitiates everything, neutralises all moral treatment, and reflects disgrace and even ridicule on attempts of any higher kind. It is not so when the patients are treated with uniform kindness'.[119] When the method was taken up at his asylum, Hanwell, then the largest asylum in England, it was a courageous decision, for he had 1,000 patients under his care.[120] Conolly became an authority within moral treatment; patient management and the asylum environment had replaced physical restraints and inmates were allowed the freedom to control their behaviour under the observation of the

[111] Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (Oxon: Routledge, [1960] 1998), 9.
[112] Showalter, *Female Malady*, 31.
[113] Robert Gardiner Hill, *Total Abolition of Personal Restraint* (London: Simpkin and Mashall, 1839), 45; Hill was resident medical officer at the Lincoln Asylum 1835-1840.
[114] Showalter, *Female Malady*, 31.
[115] Jones, *Mental Health*, 9.
[116] Nancy Tomes, "The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century," in *The Anatomy of Madness: Essays in the History of Psychiatry*, *Vol III: The Asylum and its Psychiatry*, eds. William F. Bynum, Roy Porter and Michael Shepherd, (London: Routledge, 2004), 190.
[117] Tomes, "Great Restraint Controversy", 196.
[118] Smith, *Cure, Comfort and Safe Custody*, 248.
[119] Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London: John Churchill, 1847), 177.
[120] Jones, *Mental Health*, 9.

attendants.[121] Above all, the asylum was required to be 'light, cheerful, and liberal in the space provided'.[122] In 1856, he wrote:

> Amusements, occupation, instruction, secular and religious, were laughed at, in those old institutions, as the suggestions of philanthropic craziness. There was no relief or pleasure for the eye, or ear, or any sense of faculty. Whilst there was everything calculated to distress the disordered mind, there was nothing to promote its recovery.[123]

Conolly also emphasised other important moral treatment features stating that 'discouragement of the evil habits of mind' was needed in conjunction with 'exercise in the open air; customary and general activity; regular hours; [and] a moderate attention to music and other accomplishments'.[124] Conolly's "ideal" asylum provided curative environments where patients illnesses could be classified and provided with employment and activities.[125] Patients who were, to an extent, going about their business and pleasure, as usual, were seen to be able to produce habits of steadiness and self-discipline.[126] Conolly wrote that 'recreations and amusements were introduced for the benefit of the listless and apathetic, as well as for those the activity of whose minds required external means of relief'.[127] Therefore, in England by 1854, 'twenty-seven of the thirty county asylums had adopted the new method', with moral treatment (and non-restraint) as 'the symbol of Victorian psychiatric leadership'.[128]

In Australia, the colonies attempted to follow the lead of their English counterparts; the patterns of institutional care paralleled those of England during the colonial era.[129] Although focused on implementing humane moral treatment principles, restraint remained an active part of treatment in the colonies, which had its origins in the emphasis on punishment and containment of convicts.[130] The theories were also inhibited by a general lack of funding, which hindered immediate reform.[131] Despite this, the concept of moral treatment had taken hold in the eastern colonies of Australia and that staff in some asylums had abolished restraint.[132] In 1870, the Inspector of Asylums in Victoria,

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[121] Susan Piddock, "The "Ideal Asylum" and Nineteenth-Century Lunatic Asylums in South Australia," in *Madness in Australia: Histories, Heritage and the Asylum*, eds. Catherine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), 38.
[122] Piddock, "Ideal Asylum", 38.
[123] Conolly, *Treatment of the Insane*, 357.
[124] Ibid, 161.
[125] Piddock, "Ideal Asylum", 47.
[126] Showalter, *Female Malady*, 37.
[127] Conolly, *Treatment of the Insane*, 184.
[128] Showalter, *Female Malady*, 33.
[129] Kenneth C. Kirkby, "History of Psychiatry in Australia, pre-1960," *History of Psychiatry* 10, no. 38 (1999): 192; examples were drawn from across the British Isles but English practices dominated Australia psychiatry.
[130] Kirkby, "History of Psychiatry in Australia", 193; 199.
[131] Garton, "Seeking Refuge," 33.
[132] Harman, "Out of Mind, Out of Sight," 110-112.

Dr Edward Paley, found in Ararat Asylum, there was little restraint or seclusion necessary for the patients.[133] In 1869 in the Adelaide Asylum, Dr Paterson, the Resident Medical Officer, implemented the more humane method to quieten patients through seclusion in a padded room.[134] However, by the early twentieth century even seclusion was called into question; in the 1909 Royal Commission, Dr Barker, the Medical Superintendent of Kew Asylum in Victoria, gave evidence that 'we do not find it necessary to use the padded rooms, which are an antiquated idea. I have had about thirty years' experience in lunacy work, and do not see the necessity of them'.[135] The attitude in Adelaide, however, contrasted with this as in the same Royal Commission, the Matron of Parkside Lunatic Asylum admitted to using the practice of isolation of patients, as well as restraining jackets and gloves.[136] However, as Peta Longhurst notes, the presence of government funded asylums from 1838 in New South Wales is reflective of the colonial inclination to reform the treatment of the insane.[137] In Fremantle, the staff were also influenced by these theories, the primary Medical Superintendents, Drs Attfield, Barnett, and Montgomery, supported the introduction of moral treatment methods into the asylum.[138] However, as will be explored in Chapter Three and Six, the Superintendent's intentions did not always translate into actions in the asylum. While they often supplied amusements and work, restraint and seclusion were used well into the twentieth century.

The asylum in Australia had 'a history of being used by members of society as a place to control deviant behaviour or "different" identities'.[139] For nineteenth-century Australian women, insanity was connected to their body and social expectations, as such lunacy was a lens for viewing deeper cultural anxieties.[140] Australian doctors were influenced by the theories that women's biological characteristics were attuned to nature's demands and their destiny as mothers, and that they had the most sensitive nervous systems.[141] By the late nineteenth century, doctors focused on secretions from female organs and emphasis for female insanity was placed on puberty, childbirth, and menopause.[142] The female reproductive cycle was viewed as inherently pathogenic, and lunacy in women was inseparably linked to sexuality; as such moral insanity could represent delinquent

[133] Coleborne, "Space, Power and Gender", 54.
[134] Piddock, "Ideal Asylum", 41.
[135] Ibid.
[136] Ibid, 112-113.
[137] Peta Longhurst, "Madness and the Material Environment: An Archaeology of Reform in and of the Asylum," *International Journal of Historical Archaeology* 21 (2017) 863. doi: https://doi-org.ipacez.nd.edu.au/10.1007/s10761-017-0399-0.
[138] Their methods are explored in more detail in Chapter Three.
[139] Coleborne and MacKinnon, *"Madness" in Australia*, 6.
[140] Stephen Garton, "Asylum Histories: Reconsidering Australia's Lunatic Past," In *Madness in Australia: Histories, Heritage and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), 17.
[141] Garton, *Medicine and Madness*, 137-138.
[142] Ibid, 137.

sexual behaviour or even the shame associated with having an illegitimate child.[143] Chesler argues that 'feminine norms of dependency, vulnerability, and helplessness' can manifest as a mental illness for women to escape constraining traditional female roles.[144] She maintains that this behaviour is determined by social norms: 'women are conditioned to be depressed, full of self-doubt and guilt, in the same way, that they are conditioned to diet, attract male attention, or find husbands'.[145]

Chapter Conclusions

Through extensive research and review of scholarly literature, an examination of insanity and its construction as a social problem reveals the way societies stigmatise and "other" any deviation from the socially approved norm. For women, not only do deviants threaten broader social norms, but they also transgress gendered assumptions about the female role; therefore, they become labelled doubly deviant. An examination of Victorian definitions of madness reveals a broad range of symptoms; they viewed insanity as a deviation from the healthy state of morals, feelings, and habits. With the attention on morality, the moral treatment movement in asylums emerged.

This chapter reaffirms the connection between society, morality, and madness, with a particular focus on women. Understandings of these theories allow for greater insights into the development and implementation of moral treatment in Western Australia. However, the link between women and madness is further explored in the following chapter as perceptions and management of women's madness impacted the experiences of the female patients in Fremantle.

[143] Barbara Taylor, *The Last Asylum: A Memoir of Madness in Our Times* (London: Penguin Books, 2015), 171.
[144] Nicki, "Abused Mind," 83.
[145] Ibid, 85-86.

CHAPTER TWO

Sad, Mad and Bad: Hysteria and Physicians

While insanity itself has no gender, society has always perceived differences in how madness manifests in women and men. For nineteenth-century women, insanity could be understood and diagnosed as hysteria. In 1887, Thomas Clouston wrote: 'typical hysteria, pure and simple, always has a mental complication. The volition, or the feelings, or the morals, are always affected along with the purely bodily symptoms'.[1] H.B. Donkin, in 1892, defined 'the general definition of hysteria in its physical basis as a disorder or defective development of the functionally higher layers of the cerebral cortex, with manifestations of both mental and bodily phenomena in varying proportion, and occurring mostly in the female sex'.[2] Thus, hysteria became an umbrella term for the varying types of female insanity, including religious ecstasy or sexual deviation.[3] Showalter argues that 'within our dualistic systems of language and representation', women are 'typically situated on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind'.[4] Therefore, medical authorities of the nineteenth century did not solely base their opinions on scientific fact but bent reality to the cultural perceptions and needs of their universe.[5] Scull writes that the 'emergence of a self-conscious and organized group of professionals who laid claim to jurisdiction over mental disturbance…[was] largely a phenomenon from the period from the nineteenth century onwards'.[6] Madness was then 'viewed through a medical lens, and the language preferred by psychiatrists had become the officially approved medium through which most' communicated.[7]

This chapter explores the ways in which women were diagnosed and treated in the nineteenth century with emphasis on hysteria and the rise of male medical professionals. Thus,

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[1] Thomas Clouston, *Clinical Lectures on Mental Diseases*, 2nd ed. (London: J & A Churchill, 1887), 487; Clouston (1840-1915) was a Scottish physician at the Royal Edinburgh Asylum.
[2] Horatio Bryan Donkin, "Hysteria," in *A Dictionary of Psychological Medicine Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment, and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland, Vol. 1,* ed., Daniel Hack Tuke (Philadelphia: P. Blakiston, 1892), 619.; Donkin (1845-1927) was physician and lecturer at the London School of Medicine for Women.
[3] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," In *Hysteria Beyond Freud*, ed. Sander L. Gilman (Berkley: University of California Press, 1993, 227.
[4] Showalter, *Female Malady*, 3-4.
[5] Robert Muchembled, *Orgasm and the West: A History of Pleasure from the Sixteenth Century to the Present,* trans. J. Birrell (Cambridge: Polity Press, 2008), 160.
[6] Andrew Scull, *Madness in Civilization: A Cultural History of Insanity, from the Bible to Freud, from the Madhouse to Modern Medicine* (London: Thames & Hudson Ltd, 2015), 12.
[7] Scull, *Madness in Civilization*, 12.

through the analysis of wide-ranging literature, this chapter also delivers the first of the thesis aims. The chapter examines the historical context of hysteria from the ancients to the nineteenth century and the connections made between female sexuality and madness. Secondly, the chapter appraises the establishment of a professional male-dominated medical industry in the nineteenth century and the extreme procedures employed. This section further emphasises the control these men had over diagnosis and treatment, and therefore, the lives of the women labelled insane. Analysis of this nineteenth-century development allows for greater understandings of the experiences of both the male medical staff and female patients at the Fremantle asylum.

The History of Hysteria

It has been argued that hysteria was first described by the ancient Greeks who placed the uterus at the heart of many female disorders.[8] However, this idea is contested. The first assertion that Hippocrates defined hysteria was from Ilza Veith in 1965, who stated that 'in the Egyptian papyri the disturbances resulting from the movement of the womb were described, but had not yet been given a specific appellation'.[9] She argued that 'the connection of the uterus (hystera) with the disease resulting from its disturbance is first expressed by the term "hysteria"'.[10] However, Helen King argues that hysteria has no Hippocratic origin as Veith misinterpreted translations.[11] King suggests the section could mean issues with the womb or afterbirth.[12] Despite the disagreement, the ancient Greeks and Romans held theories on the uterus, believing that hysteria came from the womb. Hence, the development of the word: hysteria, that which proceeds from the uterus.[13] Plato outlined his definition in *Timaeus* circa 36 BCE:

> In men the organ of generation—becoming rebellious and masterful, like an animal disobedient to reason, and maddened with the sting of lust—seeks to gain absolute sway; and the same is the case with the so-called womb, or uterus, of women; the animal within them is desirous of procreating children, and, when remaining unfruitful long beyond its proper time, gets discontented and angry, and, wandering in every direction through the body, closes up the passages of the breath, and, by obstructing respiration, drives them to extremity, causing all varieties of disease.[14]

[8] Scull, *Hysteria*, 30.
[9] Ilza Veith, *Hysteria: The History of a Disease* (Chicago: University of Chicago Press, 1965), 10.
[10] Veith, *Hysteria,* 10.
[11] Helen King, *Hippocrates' Woman: Reading the Female Body in Ancient* Greece (London: Routledge, 1998), 206.
[12] King, *Hippocrates' Woman*, 207.
[13] Rachel P. Maines, *The Technology of Orgasm: Hysteria, the Vibrator, and Women's Sexual Satisfaction* (Baltimore: The Johns Hopkins University Press, 1999), 21.
[14] Plato, "Timaeus," In *Plato: Collected Dialogues,* ed. Edith Cameron and Huntington Cairns, trans. Benjamin Jowett (Princeton, NJ: Princeton University Press, 1978), 1210.

Roman physicians shared this view as Aretaeus noted the womb 'delights also, in fragrant smells, and advances toward them; and it has an aversion to foetid smells, and flies from them; and, on the whole, the womb is like an animal within an animal'.[15] The ancient view on women maintained an ideal of feminine irrationality and pathologising of their bodies, especially those connected with reproduction. As Coleborne argues, 'the female body became the site of much fashioning of notions of pathology across Britain and Europe'.[16]

It was not until the seventeenth century that hysteria's migration from the uterine organs to its new incarnation as 'a nervous complaint' emerged.[17] In 1681, Thomas Willis argued against the idea of a "wandering womb"; 'the former opinion, although it plead antiquity, seems the less probable, for that the body of the womb is of so small a bulk, in virgins, widdows [sic], and is so strictly tyed [sic] by the neighbouring parts round about, that it cannot of itself be moved, or ascend from its place, nor could its motion be felt, if there were any'.[18] Scull argues that disease of all kinds, during the seventeenth and eighteenth centuries, were considered constitutional, 'a symptom of an underlying disorder of the body that was systemic'; the symptoms were manifestations of 'deep-seated disturbance of the body's equilibrium'.[19]

It was in the Victorian era, Ussher argues, that an 'important change in the discursive regimes which confined and controlled women' became apparent.[20] 'It was in this period that the close association between femininity and pathology became firmly established within the scientific, literary, and popular discourse: madness became synonymous with womanhood'.[21] In France, 'by the 1880s, the director of the Salpêtrière hospital in Paris, Jean Martin Charcot, and his followers, dominated the investigation of hysteria in Europe'.[22] The Salpêtrière came to be known as a feminine inferno, confining over four thousand women during its time as a mental institution.[23]

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[15] Havelock Ellis, *Studies in the Psychology of Sex: Volume 1: The Evolution of Modesty, the Phenomena of Sexual Periodicity, Auto-Erotism*, 3rd ed, (Philadelphia: F.A. Davis Company Publishers, [1900] 1913), 210; Ellis (1859-1939) English physician and social reformer who studied human sexuality.
[16] Catharine Coleborne, "Insanity, Gender and Empire: Women Living a 'Loose Kind of Life' on the Colonial Institutional Margins, 1870-1910," *Health and History, Health and Place: Medicine, Ethnicity and Colonial Identities 12*, no. 1 (2012): 85. doi: 10.5401/healthhist.14.1.0077.
[17] Scull, *Hysteria*, 25.
[18] Thomas Willis, *An Essay on the Pathology of the Brain and Nervous Stock* (London: Dring, Harper and Leigh, 1681), 78; Giovanni Battista Morgagni (1682-1771) Italian anatomist whose work *The Seats and Causes of Diseases Investigated by Anatomy* (1761) cemented Willis' claims.
[19] Scull, *Hysteria*, 26.
[20] Ussher, *Women's Madness*, 64.
[21] Ibid.
[22] Julia Borossa, *Ideas in Psychoanalysis: Hysteria* (Cambridge: Icon Books Ltd., 2001), 16; Charcot (1825-1893) French neurologist and professor of anatomical pathology, famous for his work on hysteria.
[23] Georges Didi-Huberman, *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpetriere*, trans. Alisa Hartz (Cambridge: The MIT Press, 2003), xi.

When Charcot became fascinated by hysteria in the 1870s, he had already made his name studying a variety of neurological ailments: therefore, his assessment of hysteria was based on disturbances of the nervous system and heredity.[24] Charcot 'insisted that hysteria was no impenetrable mystery but, like any other neurological disorder, was marked by definite law-governed, predictable, clinical manifestations'.[25] Charcot's focus on the nervous system allowed for a male diagnosis, establishing a special wing for male hysterics; however, he saw hysteria as a female malady.[26] The majority of his patients were women whom he would hypnotise and exhibit at public lectures; his representation of female hysteria was central to his work as he began to assemble an album of photographs of female hysterics, most famously Louise Augustine Gleizes.[27]

As evidenced by Charcot in France, the causes of hysteria widened during the eighteenth and nineteenth century to include the nervous system; men were now able to be diagnosed with hysteria. However, Ussher emphasises that hysteria 'was always considered a "woman's disease", a disorder linked to the essence of femininity itself'.[28] Mark Micale argues that what was seen as hysteria in women was considered hypochondria in men.[29] In 1892 Donkin argued that 'the subjects of hysteria are, in a very large proportion, of the female sex, the symptoms most often appearing at or soon after puberty' and that 'marked cases occur not infrequently in men…the typical subject of hysteria, however, is the young woman; in her organism and her social conditions the potential factors of hysteria are present in a notable degree'.[30] Italian physician Cesare Lombroso argued that women lacked rationality and self-control, which made them more inherently emotional and thus more susceptible to hysteria.[31] Lombroso believed that women had an 'instinct for lying'; 'woman is, in conclusion, a great child, and children are liars par excellence. It is all the easier for women to lie in that they have more reasons for lying than we do'.[32] Some of the reasons Lombroso suggested were: 'weakness', 'menstruation', 'shame', 'sexual struggle', 'desire to be interesting',

[24] Borossa, *Hysteria*, 16-17.
[25] Porter, *Madness*, 139**.**
[26] Showalter, *Female Malady*, 148.
[27] Ibid, 148-149; Asti Hustvedt, *Medical Muses: Hysteria in 19th Century Paris* (London: Bloomsbury, 2012), 167. It is important to note that this work was done with no or very tenuous consent from the women involved.
[28] Jane M. Ussher, "Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology," *Feminism & Psychology* 23, no. 1 (2013): 63, doi: 10.1177/0959353512467968.
[29] Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, Harvard University Press, 2008), 28.
[30] Donkin, "Hysteria", 619.
[31] Cesare Lombroso and Guglielmo Ferrero, *Criminal Women, the Prostitute, and the Normal Woman*, trans. Nicole Hahn Rafter and Mary Gibson (London: Duke University, [1893] 2001), 288; Lombroso (1835-1909) Italian physician, considered to be the father of criminology.
[32] Lombroso, *Criminal Women*, 77-79.

'suggestibility', and 'the duties of maternity'.[33] These broad reasons for hysteria continued, in 1887, Clouston stated:

> The usual type of case classified as hysterical insanity consists of mania or melancholia in a young woman, with one or more of the following characteristics well marked, viz., a morbid ostentation of sexual and uterine symptoms, feigned bodily illness to attract attention and secure sympathy, marked erotic symptoms cloaked by something else, a morbid concentration of mind on the performance of the female functions, semi-volitional retention of urine, hysterical convulsions, a morbid waywardness, or ostentatious and real attempts at suicide. The fasting girls, the girls with stigmata, those who see visions of the Saviour and the saints and receive special messages in that way, the girls who give birth to mice and frogs, some of those who fall into trances, and those who live on lime and hair, are all cases of this disease.[34]

British physician Robert Lawson Tait wrote in 1877, that 'the majority of cases of eccentric hysteria occur in women to whom nature has denied the external attractions of beauty, or in whom there is not the compensation of a refined and cultured intellect'.[35] Tait argued that 'it is therefore in neglected and ill-educated women that these objectionable forms of hysteria are chiefly to be met with'.[36] Therefore, the definition of hysteria included a spectrum of illnesses and behaviours associated with women. Ussher's modern analysis notes that 'women diagnosed with hysteria could exhibit symptoms of depression, rage, nervousness, the tendency to tears and chronic tiredness, eating disorders, speech disturbances, paralysis, palsies and limps, or complain of disabling pain'.[37] Micale suggests that by the late nineteenth century because seemingly every known human ill was attributed to hysteria, 'the diagnosis ceased to mean anything at all'.[38]

Therefore, it was generally accepted in the nineteenth century that 'women were more vulnerable to insanity than men because of the insatiability of their reproductive systems'; it 'interfered with their sexual, emotional, and rational control'.[39] Thus, nineteenth-century theories surrounding 'female insanity were specifically and confidently linked to the biological crises of the female life-cycle—puberty, pregnancy, childbirth, and menopause—during which the mind was weakened, and the symptoms of insanity might emerge'.[40] In 1835, Prichard wrote, that 'states of the constitution connected with irregularities of the uterine functions are well known to coexist or to display themselves in connection with various disorders of the brain. Among these madness is

[33] Ibid, 78.
[34] Clouston, *Clinical Lectures on Mental Diseases*, 488.
[35] Robert Lawson Tait, *Diseases of Women* (London: Williams and Norgate, 1877), 298.
[36] Lawson Tait, *Diseases of Women*, 298.
[37] Ussher, "Diagnosing Difficult Women," 64.
[38] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton, NJ: Princeton University Press, 1995), 220.
[39] Showalter, *Female Malady*, 55.
[40] Ibid.

one'.[41] In 1878, Bucknill and Tuke wrote, that 'the reproductive organs are frequently the seat of disease or abnormal function'.[42] Therefore a 'woman's place in society—her capacities, role and behaviour—was ineluctably linked to and controlled by the functions of her uterus and ovaries'.[43] In 1887, Scottish-Melbournian physician James Jamieson wrote:

> Mere differences of habit and mode of life, which are most distinct during the adolescent and early adult periods, may go some way to account for the greater diversity then; but probably it is chiefly due to the dominant influence of motherhood, actual or potential, on the physical and mental economy of women. The reproductive function undoubtedly has a larger place, for good or evil, in the life of woman than in that of man. It is little wonder, therefore, that peculiarities of every kind are most marked during the time when that function is in fullest activity.[44]

Female bodies, not to mention their minds, were viewed as madness-inducing, as they are so vastly different from the male body, the standard by which everything else was compared.[45]

The Hysteroneurasthenic Disorders

Similar to hysteria was the nervous disorder of neurasthenia, a form of nervous exhaustion.[46] American physician George M. Beard first identified neurasthenia, believing the cause was industrialised urban societies, competitive business and social environments, and the luxuries, demands and excesses of life on the fast track.[47] Showalter notes that like hysteria, neurasthenia encompassed a staggering range of symptoms, from blushing, neuralgia (nerve pain), vertigo, headache, tooth decay, insomnia, depression, chronic fatigue, fainting, and uterine irritability.[48] But unlike hysteria, neurasthenia was an acceptable and potentially valuable illness for men.[49] Beard argued that it was most frequent 'among the well-to-do and the intellectual class, and especially among those in the professions and in the higher walks of business life'.[50] It was the neurosis of the

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[41] Prichard, *Treatise on Insanity*, 207.
[42] John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine Containing the Lunacy Laws, the Nosology, Aetiology, Statistics, Description, Diagnosis, Pathology and Treatment of Insanity*, 3rd ed. (Philadelphia: Lindsay and Blakiston, 1874), 595.
[43] Scull, *Hysteria*, 72.
[44] James Jamieson, "Sex, in Health and Disease," *Australian Medical Journal* ix, no. 4 (April 1887): 146. http://hdl.handle.net/11343/23151.
[45] Rebecca Kukla, *Mass Hysteria: Medicine, Culture, and Mother's Bodies* (Maryland: Rowman & Littlefield Publishers Inc, 2005), 3.
[46] Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (New York: New York University Press, 1996), 130.
[47] George M. Beard, *American Nervousness: Its Causes and Consequences*, 1881 and *Sexual Neurasthenia: Its Hygiene, Causes, Symptoms, and Treatment*, 1884; Elaine Showalter, "Hysteria, Feminism, and Gender," In *Hysteria Beyond Freud*, ed. Sander L. Gilman (Berkley: University of California Press, 1993), 294.
[48] Showalter, "Hysteria, Feminism, and Gender," 294.
[49] Ibid.
[50] George M. Beard, *Sexual Neurasthenia: Its Hygiene, Causes, Symptoms, and Treatment* (New York: E.B. Treat & Co., 1884), 204.

male elite: middle-class male intellectuals were 'tormented by vocational indecision', overwork, sexual frustration, internalised cultural pressure to succeed, and repressed emotional needs.[51] While in working-class men, the main causes of the disease were sexual excess, trauma, and overwork.[52]

However, in England, Showalter argues, 'neurasthenia quickly lost its sheltering power for men and became a female malady' like hysteria.[53] The English maintained that neurasthenia was not a new American disease but one long associated with spinal irritation or nervous weakness, mainly manifested in young women.[54] Childbirth and reproductive disturbances were the most frequent causes of the illness, with overwork a factor for working-class women, and attending university a factor for middle-class women.[55] Sex in any form was also associated with the disease; a lack of desire could be explained by devotion to intellectual tasks; on the other hand, overindulgence in sex could lead to intellectual decline.[56] Sigmund Freud emphasised the sexual component of neurasthenia in his 1895 work *Studies in Hysteria*; he argued that in women neurasthenia was a direct consequence of neurasthenia in men, stating it was frequently *coitus interruptus* that induced it in both genders.[57] Hysteria, Freud argued, was also a conflict between desire and defence against desire, with a past traumatic experience involved, specifically sexual and quickly repressed.[58] Rachel Maines argues that almost anything could be a symptom of neurasthenia as the interpretation of its symptoms in women 'included many elements consistent with the normal functioning of female sexuality under social conditions that interpreted it as pathological'.[59] Therefore, the explanations for neurasthenia in women were the same as the explanations for men, but with different moral emphasis.[60] 'Women's energy, post-Darwinian scientists believed, was naturally intended for reproductive specialisation'; thus, 'women were heavily handicapped in intellectual competition with men'.[61] Nervous disorder would manifest when women defied their "nature" and 'sought to rival men through education and work, rather than to serve them and the race through maternity'.[62] 'While the competition was a healthy stimulus to male ambition, it was disastrous for women'.[63] 'For

[51] Showalter, "Hysteria, Feminism, and Gender," 294-295.
[52] Francis Gosling, *Before Freud: Neurasthenia and the American Medical Community* (Urbana: University of Illinois Press, 1987), 55.
[53] Showalter, "Hysteria, Feminism, and Gender," 296-297.
[54] Showalter, *Female Malady*, 136.
[55] Gosling, *Before Freud,* 55.
[56] Showalter, "Hysteria, Feminism, and Gender," 295-296.
[57] Elisabeth Young-Bruehl, *Freud on Women* (New York: Random House, 2003): https://books.google.com.au/books?id=74oav-BartEC&printsec.
[58] Young-Bruehl, *Freud on Women*, n.p.
[59] Maines, *Technology of Orgasm*, 35.
[60] Showalter, "Hysteria, Feminism, and Gender," 297.
[61] Ibid.
[62] Ibid.
[63] Ibid.

many late Victorian female intellectuals, especially those in the first generation to attend university, a nervous illness marked the transition from domestic to professional roles'.[64]

Interestingly, neurasthenic women were viewed more favourably than hysterical women. In 1892, William Smoult Playfair wrote that neurasthenic women were 'sensible, not over sensitive or emotional, exhibiting a proper amount of illness' and 'a willingness to perform their share of work quietly and to the best of their ability'.[65] They were thought to be 'cooperative, ladylike, and well-bred', 'just the kind of woman one likes to meet with'; which was the opposite of the disagreeable and disliked hysterics.[66] The aversion to hysterical women was noted in 1885 by American physician Silas Weir Mitchell who stated that 'a hysterical girl is a vampire who sucks the blood of the healthy people around her'.[67] However, the similarities in the symptoms between hysteria and neurasthenia meant that even specialists could not always distinguish between them.[68] This similarity suggests a level of discretion on the part of the physician and class bias. By the end of the nineteenth century, neurasthenia, hysteria, and chlorosis were classed under the generic term "hysteroneurasthenic disorders".[69]

Desperate Communication of the Powerless

There are arguments to suggest that women's high rate of mental disorder was due to their social situation, both as their confining roles as daughters, wives and mothers, combined with the possible mistreatment by a male-dominated medical and psychiatric profession.[70] Chesler argues that madness could be considered 'an expression of female powerlessness and an unsuccessful attempt to reject and overcome this state'.[71] She states that 'perhaps what we consider "madness", whether it appears in women or in men, is either the acting out of the devalued female role or the total or partial rejection of one's sex-role stereotype'.[72] Showalter notes that it is 'possible to see hysteria within the specific historical framework of the nineteenth century as an unconscious form of feminist protest'; however, she maintains that such claims can 'come dangerously close to

[64] Showalter, *Female Malady*, 137.
[65] William Smoult Playfair, "Functional Neurosis," in *A Dictionary of Psychological Medicine Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment, and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland,* Vol. 1, ed. Daniel Hack Tuke (Philadelphia: P. Blakiston, 1892), 851.
[66] Showalter, *Female Malady*, 134-135.
[67] Silas Weir Mitchell, *Lectures on Diseases of the Nervous System Especially in Women* (London: J.A. Churchill, 1885), 266.
[68] Showalter, *Female Malady*, 134.
[69] Maines, *Technology of Orgasm*, 35-36; Chlorosis or "green-sickness" was associated with menstrual disorders such as amenorrhoea, vague symptoms included apathy, hypochondria, anaemia and iron deficiency.
[70] Showalter, *Female Malady*, 3.
[71] Chesler, *Women and Madness*, 76.
[72] Ibid, 116.

romanticizing and endorsing madness as a desirable form of rebellion, rather than the desperate communication of the powerless'.[73] Andrea Nicki also warns that these ideas can carry 'the implication that their conditions are actively and wilfully self-imposed' and that 'women escape from one female domestic role only to enter into another, more lethal female role of self-sacrifice'.[74] Shoshana Felman argues that madness is quite 'the opposite of rebellion'; 'madness is the impasse confronting those whom cultural conditioning has deprived of the very means of protest or self-affirmation'.[75] Nicki notes that 'many specific constructions or "discoveries" of mental illness have served to support the status quo and to enforce the oppression of various social groups based on gender, class, race, sexual orientation, or ability'; however, there were legitimate illnesses that needed treatment.[76] Chesler's argument encourages consideration of gender roles and women's reaction to them as contributing factors to their mental illness. She maintains that whether the nineteenth or the early twentieth-century female patient was entirely sane, upper or working class, abused or fatigue due to her home life or employment, 'she was rarely treated with kindness or medical expertise'.[77] Ussher argues:

> Madness is more than a hormonal imbalance, a set of negative cognitions, a reaction to a difficult social situation, or the reflection of underlying unconscious conflict. Madness is more than a label. It is more than a protest. It is more than a representation of women's secondary status with a phallocentric discourse, a reaction to misogyny and patriarchal oppression. To understand madness we must look further and wider than the individual to the whole discourse which regulates "women." Yet we must also look beyond the category of "women" to the reality of the pain and desperation which is part of this experience for the individual in distress.[78]

Susan Hubert agrees, noting that we should not lose sight of the women at the heart of the debates about madness, 'although we need to understand the societal implications of "madness," our explanations cannot ignore the real suffering experienced by those who are perceived to be mad'.[79] Therefore, as Ussher states, women 'are regulated through the discourse of madness. But the woman herself is real, as is her pain, we must not deny that. So we must listen to women'.[80]

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[73] Showalter, *Female Malady*, 5.
[74] Nicki, "Abused Mind," 85.
[75] Shoshana Felman, "Women and Madness: The Critical Phallacy," *Diacritics* 5 (1975): 2.
[76] Nicki, "Abused Mind," 83.
[77] Chesler, *Women and Madness,* 5.
[78] Ussher, *Women's Madness*, 289.
[79] Susan Hubert, *Questions of Power: The Politics of Women's Madness Narratives* (London: Associated University Press, 2002), 22.
[80] Ussher, *Women's Madness*, 306.

Although, both Chesler and Showalter have been subject to criticism regarding ideas of 'the overwhelming numbers of women admitted to public asylums during the Victorian era'.[81] David Wright notes that although, '[these women's] disorders and disabilities are no less worthy of historical scrutiny and analysis', the researcher must place them 'within their appropriate context' with 'the recognition that both women and men were incarcerated in numbers proportionate to their representation in the general adult population'.[82] The combination of 'interest in cultural history in the 1990s encouraged researchers to look at Victorian asylum records from a new "gendered" perspective and to revisit the alleged "feminisation" of madness', and this was particularly apparent with 'scholars working on colonial asylums, which were notable for the heightened admission of *male* patients'.[83] Bronwyn Labrum, writing on the experiences of female and male patients in Auckland, New Zealand, notes that 'the existence of feminine notions of respectability affirms the importance of gender in studies of madness'.[84] Yet, female patients in Auckland 'were not labelled mad solely because of their failure in the pursuit of femininity' and 'neither does there seem to be evidence of the "feminization" of madness, nor of the overwhelming existence of a prevailing perception of a fundamental alliance between "woman" and "madness", as Showalter claims for England'.[85] Labrum argues that 'the material conditions in which individuals and their families lived emerge as equally crucial factors'.[86] In 1887 Jamieson noted that 'presumably in Australia as a whole, insanity among males, all correction being made, is relatively, commoner than in England. There is more alcoholism, and more strain and excitement generally, these influences telling of course more strongly on men than women'.[87] This idea will also be explored further in the female patients at Fremantle asylum in Chapter Four, in which men generally outnumbered women in incarceration rates across 1858 to 1908.

Jane Ussher writes that representations of women as mad, ranging from the harridan to the melancholic maiden, 'all stand as reminders of the potential danger or vulnerability lurking beneath the mask of beauty that signifies "woman"'.[88] She states that the labels of madness are tied to what

[81] David Wright, "Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England," In *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (Amsterdam: Editions Rodopi B.V., 2004), 171.
[82] Wright, "Delusions of Gender?", 171; 151.
[83] Ibid, 151.
[84] Bronwyn Labrum, "Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910," *New Zealand Journal of History* 26, no. 2. (1992): 144. Accessed: National Library of New Zealand: http://www.nzjh.auckland.ac.nz/docs/1992/NZJH_26_2_02.pdf
[85] Labrum, "Looking Beyond the Asylum," 144.
[86] Ibid.
[87] Jamieson, James. "Sex, in Health and Disease," 155.
[88] Jane M. Ussher, "Unravelling Women's Madness: Beyond Positivism and Constructivism and Towards a Material-Discursive-Intrapsychic Approach," in *Women, Madness and the Law: A Feminist Reader*, Wendy

it means to be a woman at a particular point in history.[89] Therefore, analysis of the evolving medical industry in the nineteenth century provides crucial insights into the connections between women, madness, and treatment.

The Guardians of Female Honour

In nineteenth-century Britain and Australia medicine began to crystallise as a profession suitable for the middle class, with new heavily restricted educational and training standards, as well as membership of professional groups such as the British Medical Association and the Royal College of Surgeons.[90] However, as the new colonies formed, they became 'home to a golden age of unrestricted medical practice': regional healers, allopathy, and homeopathy found markets in rural and isolated areas.[91] Philippa Martyr writes that much like Britain, medicine had associations with "quackery" and in an effort to overcome this shameful ancestry, mainstream medicine created a more distinguished pedigree: the legendary ancient Greek healer Hippocrates; the Roman-era medical theorist Galen; the talented early modern surgical pioneer Ambroise Pare, those who would help construct a canon of medical truth.[92] With this new professionalisation, came power: medicine was an institution of control and medical advice carried the force of a moral imperative.[93]

Medical practitioners were usually middle-class men who recycled the old sense of Christian guilt regarding sexuality and reformulated it into the form of a health regime.[94] Barrett and Roberts argue that medicine is a bourgeois patriarchal institution that 'legitimates and endorses the status quo in relation to the status of women'.[95] It 'fulfils an ideological function as an agency of disguised social control'; 'doctors would use the authority of their medico-moral language to offer not neutral, clinical, advice but a set of prescriptions based on the conventional wisdom of their own social milieu'.[96] In the nineteenth century, women's sexual and reproductive health transferred 'from the hands of midwives to those of male doctors'; while often marginalising midwives from their

Chan, Dorothy E. Chunn and Robert Menzies, eds., (Coogee, NSW: The GlassHouse Press, 2005): https://books.google.com.au/books?id=Rmo-VsrPS_IC&dq.

[89] Ussher "Diagnosing Difficult Women," 67.

[90] Philippa Martyr, *Paradise of Quacks: An Alternative History of Medicine in Australia* (Sydney: Macleay Press, 2002), 11.

[91] Martyr, *Paradise of Quacks*, 63; 13.

[92] Ibid, 11.

[93] Michele Barrett and Helen Roberts, "Doctors and Their Patients: The Social Control of Women in General Practice," In *Women, Sexuality and Social Control*, ed. Carol Smart and Barry Smart (London: Routledge & Kegan Paul Ltd., 1978), 42.

[94] Muchembled, *Orgasm and the West*, 160.

[95] Barrett and Roberts, "Doctors and Their Patients", 42-43.

[96] Ibid.

profession, associations, and groups.[97] 'Midwives' approach to sexuality and birth had been to advise and to support natural processes'; while the 'male doctors' model of dealing with the vagina and uterus was one of "heroic medicine," or, sometimes violent, intervention'.[98] This change was represented in the rise of gynaecology and obstetrics. Scull writes that by the mid-nineteenth century, the term gynaecologist began to refer to male doctors treating women's illnesses; they dealt with some of women's most intimate needs, and their presence at childbirth ensured them a recurring role in their patient's lives.[99] The advance of gynaecology as a medical speciality simultaneously produced and was dependent upon the increasing amount of technology in the birth process.[100] In 1867, the editor of the *British Medical Journal* wrote that 'beyond other men, are not only guardians of life, but, by force of circumstance, often also the guardians of female honour and purity'.[101] At the April 1867 Debate at the Obstetrical Society, Sir Francis Seymour Haden stated:

> We have constituted ourselves, as it were, the guardians of [women's] interests, and in many cases...the custodians of their honour. We are, in fact, the stronger, and they the weaker. They are obliged to believe all that we tell them. They are not in a position to dispute anything we say to them, and we therefore may be said to have them at our mercy...under these circumstances, if we should depart from the strictest principles of honour, if we should cheat or victimise them in any shape or way, we would be unworthy of the profession of which we are member.[102]

This statement reveals not only the level of control the physicians had over their female patients but an awareness of this power. The physician's moral and pastoral responsibilities were an essential foundation of their claim to authority; anything that cast a shadow upon the appearance of moral rectitude threatened the profession's social standing and mandate.[103] In 1882 the *Australian Medical Journal* stated that 'cautions which should be observed before examining women in duress' and that 'every woman should first be asked before witnesses if she were willing to be examined: if she answered in the affirmative, no action would lie; but if the practitioner assumed that she were willing, he would be liable to an action for criminal assault'.[104] Therefore, propriety in patient-doctor behaviour was also a topic for colonial physicians.

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[97] Naomi Wolf, *Vagina: A New Biography* (London: Virago Press, 2012), 192.
[98] Wolf, *Vagina*, 192.
[99] Scull, *Hysteria*, 75.
[100] Ibid.
[101] "The Debate at the Obstetrical Society," *British Medical Journal*, 6 April (1867): 388.
[102] "Debate at the Obstetrical Society," 396; Francis Seymour Haden (1818-1910) gynaecologist and member of the obstetrical society of London.
[103] Scull, *Hysteria*, 82.
[104] Australian Medical Journal, "Indequate Renumeration for Medico-Legal Services," *Australian Medical Journal* iv, no. 2 (February 1882): 69. http://hdl.handle.net/11343/23146.

However, from the late eighteenth through the mid-nineteenth century, there were criticisms of the new involvement of male obstetricians in childbirth and labour.[105] It was not until the end of the nineteenth and beginning of the twentieth century that one of the pioneering female gynaecologists, Helen C. Putnam, began practising in the United States.[106] Therefore, although a small number of women contributed to the debate on care for women, it was mostly decided among men.[107] Two such pioneers of gynaecology and obstetrics were William Tyler Smith (1815 to 1873) and Robert Lawson Tait (1845 to 1899).

William Tyler Smith was an English physician and obstetrician at St Mary's Hospital in London for twenty years.[108] He raised the position of obstetric medicine through teaching and the foundation of the Obstetrical Society of London in 1858, of which he became the president (1861 to 1863).[109] In 1848, he outlined treatments to cure hysteria in women, such as 'a course of injections of ice water into the rectum, introduction of ice into the vagina, and leeching of the labia and cervix'.[110] These invasive "cures" reveal nineteenth-century medical attitudes that madness was directly connected to the female body. In the same year, Smith wrote *The Periodoscope* which traced the menstrual cycle of women, particularly when it was interrupted by pregnancy. He stated, 'in this circuit, parturition is the most important event; childbirth is the culminating point in the whole physical life of woman, towards which all tends, after which, all declines'.[111] His social opinion on women and motherhood can be seen to shape his medical practice and theories. In 1858 he stated in *A Manual of Obstetrics*:

> The knowledge of the modes of generation in different animals, of the anatomy and physiology of the parts concerned in reproduction in the human female, of the development of the embryo, and the pathological lesions to which the mother and ovum are liable, with the rules of practice derived from observation and experience, constitute the foundation of the science of obstetrics. On the other hand, the art of midwifery consists of the application of knowledge thus extensively derived, in the prevention and treatment of the accidents and diseases incident to pregnancy, parturition, and the puerperal state.[112]

Here, Smith represented obstetrics as scientific and midwifery as art, which, in a rapidly evolving scientific business, seemingly devalued the midwives' practices. He did maintain 'the object of both

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[105] Kukla, *Mass Hysteria*, 86.
[106] Marilyn Ogilvie and Joy Harvey, eds., *The Biographical Dictionary of Women in Science: Pioneering Lives from Ancient Times to the Mid-20th Century, Volume 2: L-Z* (New York, NY: Routledge, 2000), 1059-1060.
[107] Kukla, *Mass Hysteria*, 86.
[108] Leslie Stephen and Sidney Lee, eds., "Smith, William Tyler," in *The Dictionary of National Biography Vol XVIII* (Oxford: Oxford University Press, 1917), 575.
[109] Stephen and Lee, "Smith, William Tyler", 575.
[110] William Tyler Smith, "The Climateric Diseases in Women," *London Journal of Medicine* 1 (1848): 607.
[111] William Tyler Smith, *The Periodoscope: With its Application to Obstetric Calculations and the Periodicities of the Sex* (London: John Churchill, 1848), 9.
[112] William Tyler Smith, *A Manual of Obstetrics: Theoretical and Practical* (London: John Churchill, 1858), 1.

science and art is the assurance of the safety of mother and offspring', but that obstetrics was the best way to treat women.[113] Interestingly after he retired, he was elected the physician accoucheur (male midwife) at St Mary's Hospital.[114] Therefore, perhaps it was the air of mysterious female practices of old that his scientific education did not permit him to appreciate fully.

The connection between women's bodies and madness is also seen in Robert Lawson Tait's work. Tait was a Scottish physician and pioneering surgical gynaecologist.[115] In 1871, aged twenty-six, Tait became a founder and one of three Chief Surgeons of the Birmingham and Midland Hospital for Women, an institution devoted women's diseases.[116] In 1877, in his work *Diseases of Women,* he stated, 'the majority of women enter the married state with but a very hazy notion of what its functions are, a misfortune to which a large proportion of their special diseases may be attributed'.[117] His opinions on women, their body, and diseases are summarily linked to his views on their place in society. Tait was influential; he was the first gynaecologist in Britain to successfully treat a patient with an ectopic pregnancy in 1883.[118] He was also one of the founders of the British Gynaecological Society, serving as President in 1885 and became Professor of Gynaecology at Queen's College in 1887.[119] However, after 1891 his reputation and practice declined when he was sued for libel and 'accused by one of his nurses as being the father of her child', he denied this, 'but the damage had been done'.[120] His work influenced many of his contemporaries, and 'some of his methods are still part of the recommended procedure for ectopic operations today'.[121] Both Tait and Smith's works represent that social understandings of gender roles influenced medical practice.

The foundation of Victorian gynaecology was not an objective fact but a theory of social and moral control.[122] Cynthia Russett adds that significant disparities in the medical sophistication of Victorian doctors allowed medical science to be used as 'a weapon by men to rationalize the perpetuation of traditional sex roles and men's continued domination of women'.[123] Despite the

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[113] Smith, *A Manual of Obstetrics,* 1.
[114] Elsbeth Heaman, *St Mary's: The History of a London Teaching Hospital* (Kingston: McGill-Queen's University Press, 2003), 39.
[115] J. Glenn and L. M. Irvine, "Dr Robert Lawson Tait: The Forgotten Gynaecologist," *Journal of Obstetrics and Gynaecology* 31 (2011): 695, doi: 10.3109/01443615.2011.
[116] Glenn and Irvine, "Dr Robert Lawson Tait," 695.
[117] Tait, *Diseases of Women*, 36; Other works: *The Pathology and Treatment of Diseases of the Ovaries* (1874); *Lectures on Ectopic Pregnancy and Pelvic Haematocele* (1888).
[118] Glenn and Irvine, "Dr Robert Lawson Tait," 696.
[119] Ibid.
[120] Ibid.
[121] Ibid.
[122] Michael Mason, *The Making of Victorian Sexuality* (Oxford: Oxford University Press, 1994), 179.
[123] Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood* (Cambridge: Harvard University Press, 1989), 191.

lucrative market, hysterical patients seldom improved, and they blamed their continued debility on the failures of doctors.[124] Hysterics were perceived to be unrewarding patients: 'peevish, constantly complaining, with a mass of chronic, non-specific troubles, their protracted invalidism and frequent ingratitude were wearisome and provoking'.[125] Physicians saw them as temptresses, not victims, and generally agreed to disregard the hysteric to delimit who was in control, doctor or patient, male or female.[126] However, in 1887, Dr James Jamieson wrote in the *Australian Medical Journal*:

> It is not for me to venture to settle that great question, "Is woman mentally inferior to man?"…Of course, it has pleased men to confer on the other half of the race the title of the "weaker sex," and if mere physical strength alone is meant, there can be no doubt of its truth. But since mere strength reckons for comparatively little in the sum of qualities which have enabled man to render himself lord of the world, and to make obedient servants of animals stronger than himself, that physical potency cannot be allowed to count for too much in settling the relations between the sexes…With the progress of civilisation it counts for less and less, and, now-a-days, mature persons of both sexes are inclined generally to hold that the old dispute about the relative mental superiority of men and women is rather a barren one.[127]

Nonetheless, these attitudes did not always translate into asylum or psychiatric practice. Chesler notes that until the 1960s, psychiatric students were still taught that women were naturally mentally ill and suffered from penis envy, were morally inferior to men, were innately dependent, passive, heterosexual, and monogamous.[128] She argues that the false professionalisation of cultural education allowed diagnostic labels to stigmatise women.[129]

Extreme Treatments: Clitoridectomy and Ovariotomy

By the nineteenth century, the professionalisation of medicine and insanity produced all manner of surgical procedures attempting to cure women of their madness. Victorian male gynaecologists established many new conventions for women and medical examinations including reclining births. Reclining births were 'more comfortable for the doctor than the midwife's more active positioning of herself and her patient had been'.[130] First mentioned in the seventeenth century, Francois Mauriceau 'claimed that the reclining position would be more comfortable for parturient women as well as more convenient for the accoucheur' or physician.[131] By the nineteenth century, this practice

[124] Scull, *Hysteria*, 65.
[125] Ibid.
[126] Wolf, *Vagina*, 197; Borossa, *Hysteria*, 29.
[127] Jamieson, "Sex, in Health and Disease," 146-147.
[128] Chesler, *Women and Madness*, 1.
[129] Ibid, 9; 2.
[130] Wolf, *Vagina*, 193
[131] Lauren Dundes, "The Evolution of Maternal Birthing Position," in *The Manner Born: Birth Rites in Cross-Cultural Perspective*, ed. Lauren Dundes (Walnut Creek: Altamira Press, 2003), 57.

was a well-established; however, the supine position inhibits the otherwise helpful force of gravity and impedes blood circulation.[132] Lauren Dundes writes that the horizontal and supine birthing position has been the subject of controversy for the last 200 years as, before this, the recorded history of birthing indicates that upright postures were used extensively.[133] This new and arguably damaging practice was only introduced by a male medical elite who had managed to transform the ancient and characteristically gentle practice of midwifery into the science of gynaecology and obstetrics.[134]

One treatment for hysteria, that has been argued by Rachel Maines, was the practice of massage to orgasm. Maines suggests that many physicians 'systematically misunderstood' the role of the clitoris in orgasm 'since its function contradicted the androcentric principle that only an erect penis could provide sexual satisfaction to a healthy, normal, adult female'.[135] This androcentric focus 'camouflaged the sexual character of medical massage treatments' as believers in the penetration hypothesis 'could argue that nothing sexual was occurring when their patients experienced the hysterical paroxysm during treatment'.[136] However, nineteenth-century male physicians found the treatment to be taxing and time-consuming and a solution was not provided until the invention of electrotherapeutic devices.[137] However, there has been recent criticism of Maines' work in *The Technology of Orgasm*; Hallie Lieberman and Eric Schatzberg have argued that Maines provides 'no evidence that physicians ever used electromechanical vibrators to induce orgasm in female patients as a medical treatment'.[138] Primary records from the inventor of the first portable electronic vibrator confirm that male physicians did not all agree on the use of vibrators on female patients. British physician Joseph Mortimer Granville wrote in 1883: 'I have avoided and shall continue to avoid, the treatment of women by percussion, simply because I do not want to be hoodwinked, and help to mislead others, by the vagaries of the hysterical state or the characteristic of mimetic disease'.[139] Granville explained that in a range of maladies, including hysteria, disorderly vibration might be reduced by overpowering the disorder with order.[140] He argued that in both men and women, 'when

[132] Dundes, "Evolution of Maternal Birthing Position", 57.
[133] Dundes, "Evolution of Maternal Birthing Position", 55.
[134] Wolf, *Vagina*, 193.
[135] Maines, *Technology of Orgasm*, 9-10.
[136] Ibid, 10.
[137] Ibid, 4; 82.
[138] Hallie Lieberman and Eric Schatzberg, "A Failure of Academic Quality Control: *The Technology of Orgasm*," *Journal of Positive Sexuality* 4, no. 2 (2018): 25. Accessed: https://journalofpositivesexuality.org/wp-content/uploads/2018/08/Failure-of-Academic-Quality-Control-Technology-of-Orgasm-Lieberman-Schatzberg.pdf.
[139] Joseph Mortimer Granville, *Nerve Vibration and Excitation: Agents in the Treatment of Functional Disorder and Organic Disease* (London: J & A Churchill, 1883), 57.
[140] Granville, *Nerve Vibration*, 79.

nervous tissue acts, its essential elements—viz., cells and fibres—vibrate. It follows that by throwing these elements into vibration by mechanical movement, we establish a condition favourable to the discharge of nervous force from the centres affected'.[141] He stated that 'the female organism is characterised not inaccurately, though popularly, by the phrase "finely strung nerves"'.[142] He stated that it was chiefly among women that hysteria was observed; noting that when the symptoms do occur in men, 'the individual organism is generally of a feminine character'.[143] Despite his hesitation, his theoretical understanding was arrived at in 1862 to 1863 during clinical studies on mental and sensory phenomena; 'my first observations were made in connection with the paroxysmal, or recurrent, pains accompanying the uterine contractions in the natural process of parturition [childbirth]'.[144] Granville's view of hysterical women was not unlike his contemporaries who were highly critical of hysterical women.[145]

Thus, the Victorian period 'saw the dissemination of the theory that the clitoris was a cause of moral turpitude'.[146] Thus, more extreme procedures developed, such as clitoridectomy, which involved the removal of a woman's clitoris. The champion of clitoridectomy, but not the sole practitioner, was Dr Isaac Baker Brown, whose surgical practice developed from his belief that madness was caused by masturbation or sexual desire.[147] In invoking masturbation as a cause of hysteria and insanity, Baker Brown was scarcely advancing a novel hypothesis; masturbatory insanity had acquired new credibility through the growing emphasis on the importance of the conservation of energy.[148] Therefore, in opposition to physicians using genital massage to treat hysteria, Baker Brown implemented a "cure" to nerve irritation, writing in 1866:

> By repeated observation I was led to the conclusion that the cases which had puzzled me, and defied my most carefully conceived efforts at relief, depended on peripheral excitement of the pudic nerve [clitoris]. I at once subjected this deduction to a surgical test, by removing the cause of excitement. I have repeated the operation again and again...Daily experience convinces me that all unprejudiced men must adopt, more or less, the practice which I have thus carried out; and I have no doubt that, in properly selected cases, it will prove as successful in their hands as in mine.[149]

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[141] Ibid, 13.
[142] Ibid, 28.
[143] Ibid, 28.
[144] Ibid, 20.
[145] Ussher "Diagnosing Difficult Women," 63.
[146] Wolf, *Vagina*, 188.
[147] Showalter, *Female Malady*, 75; Baker Brown (1811-1873) gynaecologist and obstetrical surgeon, member of the Obstetrical Society of London, and founded the London Surgical Home for Women in 1858.
[148] Scull, *Hysteria*, 77-78.
[149] Isaac Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females* (London: Hardwicke, 1866), vi.

As Marjorie Levine-Clark notes, Baker Brown considered married women cured after the procedure if they adapted to their domestic and reproductive roles, while single women's cure was measured through post-operative marriage or return to work.[150] Showalter writes that the 'symbolic meaning' of clitoridectomy is 'central to our understanding of the sexual difference in the Victorian treatment of insanity' as the 'surgical enforcement of an ideology that restricts female sexuality to reproduction'.[151] She argues that the procedure attempted to eliminate women's sexual pleasure, as Baker Brown defined autonomous sexual pleasure as 'the symptom, perhaps the essence, of female insanity'.[152]

However, within a year of his book's publication, Baker Brown and his procedure came under scrutiny and were debated at the Obstetrical Society of London in April 1867. Some female 'patients had complained of being tricked and coerced into the treatment'; this seemed to be the Society's principal issue.[153] Due to nineteenth-century medical practitioners' fears of tarnishing their professionalism, they were sensitive on topics that threatened their social standing. A report written days after the meeting stated that 'the performance of clitoridectomy on a woman without her knowledge and consent…is an offence against medical ethics, needs not to be said'.[154] It continued, 'nervous young women, as it is well known, may be profoundly ignorant of the nature and drift of such questions. They delight to magnify their own sensations, they enjoy the Physician's sympathy and are sure to answer "yes" to any leading question whatever'.[155] Consequently, 'it is an offence against medical ethics, also, to obtain the woman's consent, nominally, while she is left in ignorance of the real scope and nature of the mutilation, and of the moral imputations which it involves'.[156] They argued that 'consent to a thing whose nature is not known, is like the consent of an infant or lunatic—null and void'.[157] Therefore, the issue with clitoridectomy was not the cruelty or failures of the treatment, as the issue of inefficacy was never seriously criticised.[158] Indeed they stated 'neither is it to the purpose to accuse Mr Brown of having performed an operation rashly, groundlessly, and unsuccessfully many such operations have been performed in the best faith'.[159] Hilary Burrage argues that in part, this resistance by other doctors is thought to have been triggered by professional

[150] Marjorie Levine-Clark, ""I Always Prefer the Scissors": Isaac Baker Brown and Feminist Histories of Medicine," in *Heath Humanities Reader*, eds. Therese Jones, Delese Wear, Lester D. Friedman (New Brunswick, Rutgers University Press, 2014): https://books.google.com.au/books?id=wqRvBAAAQBAJ&pg.
[151] Showalter, *Female Malady*, 76-77.
[152] Ibid, 77.
[153] Ibid.
[154] "Clitoridectomy and Medical Ethics," *Medical Times and Gazette London* 1 (13 April 1867): 391.
[155] "Clitoridectomy and Medical Ethics," 391.
[156] Ibid.
[157] Ibid.
[158] Scull, *Hysteria*, 79.
[159] "Clitoridectomy and Medical Ethics," 391.

jealousies rather than fundamental disagreements about medical facts and practice.[160] Clitoridectomy was a lucrative business and in good personal standing or not, Baker Brown managed to introduce the procedure to mainstream nineteenth-century society.[161] Despite this, Baker Brown was expelled from the Obstetrical Society of London in 1867.[162] However, in 1872, Australian surgeon James George Beaney, wrote that excessive sexual desire in women was a dangerous illness: 'should the clitoris have been long subject to undue excitation, and exceed its proper proportions...it can be reduced in size by excision, or be completely extirpated'.[163] Thus, the procedure also came to the colonies.

Further drastic cures for hysteria was seen in ovariotomy, the removal of a woman's ovaries. While many physicians practised this procedure, Dr Alfred Hegar, in Germany, was a leading figure. In 1872, Hegar performed and publicised an operation for the removal of ovaries; he regarded ovariotomy as a cure for asthma, epilepsy, and various types of women's neuroses such as hysteria.[164] Hegar's approach represented a broadening of medical explanations of mental disorder, as sexual neuroses and deviant behaviour such as morphine addiction could be explained and cured by attention to pathological signs throughout the body.[165] However, Hegar insisted that when the reproductive organs were healthy, the operation should not be carried out, conceding that his procedures had aroused criticism owing to the lack of caution shown by others.[166] Although, during the 1890s, Hegar's operation was recommended by psychiatrists for cases of hysteria, even though there were no degenerative signs in the ovaries.[167] Tait also implemented ovariotomy in nineteenth-century Britain as a treatment for nervous afflictions such as "menstrual epilepsy".[168] However, he noted that there should be different terminology used depending on the case; ovariotomy was the removal of diseased ovaries, whereas oophorectomy removed 'ostensibly healthy ovaries to alleviate a range of "women's disturbances", as generally, mental aberrations thought to derive from the functioning of the ovaries'.[169] He wrote in 1877 that 'hysteria is sometimes found in connection with ovarian tumours, and dependant directly upon them. In one of my cases this was markedly the

[160] Hilary Burrage, *Eradicating Female Genital Mutilation*: *A UK Perspective* (Oxon: Routledge, 2013), n.p.
[161] Burrage, *Eradicating Female Genital Mutilation*, n.p.
[162] Showalter, *Female Malady*, 77.
[163] James George Beaney, *The Generative System and its Functions in Health and Disease* (Melbourne: F.F. Bailliere, 1872), 34; Beaney (1828-1891) English-born Australian surgeon and politician. In 1860 he was appointed surgeon to the Melbourne Hospital and was a member of the Victorian Legislative Council.
[164] Paul Weindling, *Health, Race and German Politics Between National Unification and Nazism 1870-1945* (Cambridge: Cambridge University Press, 1989), 101.
[165] Weindling, *Health, Race and German Politics*, 101.
[166] Ibid.
[167] Ibid.
[168] Glenn and Irvine, "Dr Robert Lawson Tait," 695.
[169] Ibid.

fact, for the hysteria disappeared entirely after recovery from ovariotomy'.[170] He maintained that 'hysterical symptoms are in constant association with phantom tumours, and these cases, in the days of the early ovariotomists, were in several instances operated upon by mistake'.[171] Indeed, the idea of not operating on healthy ovaries was maintained, but there was seemingly little distinction between the two terms.

However, there was some debate on the topic on who first successfully performed an oophorectomy and who is should be named for. In the *Australian Medical Journal* in 1881 Isaiah de Zouche argued that in August 1872 Dr Robert Battey 'performed the operation successfully, both as regards the life of the patient and the relief of pain', while Hegar's and Tait's operations resulted in more fatalities.[172] He argued, along with Drs Sims and Aveling, that Battey should be credited with popularising the operation and priority of publication should belong to him.[173] This was evidently successful as the procedure became known as 'Battey's operation'.[174] In 1881, de Zouche was arguing that his operation, in Dunedin New Zealand, which he termed 'the Australian colonies', was among the first to use Battey's operation.[175]

Ussher writes that there was no reason for such procedures, other than the belief that madness was 'associated with "unnatural desires"' and it was 'located in the female body'.[176] Showalter argues that these surgical procedures were ceremonies of stigmatisation that frightened most of the women 'into submission or at least into greater secrecy and concealment of their discontent'.[177] The 'mutilation, sedation, and psychological intimidation' of "deviant" or "unladylike" 'women seem to have been efficient if brutal, forms of reprogramming' that revealed the power of the male medical elite over the definition of femininity and insanity.[178] One of the fundamental reasons for female genital mutilation is 'the need to control women's sexuality'.[179] Forms of this procedure have been used in several countries and cultures, and it 'is intended to reduce women's

[170] Tait, *Diseases of Women*, 258.
[171] Ibid.
[172] Isaiah de Zouche, "A Case of Battey's Operation, or Double Oopherectomy," *Australian Medical Journal* iii, no. 4 (April 1881): 153. http://hdl.handle.net/11343/23145; Robert Battey (1828-1895) American physician known for pioneering radical oophorectomy.
[173] de Zouche, "A Case of Battey's Operation", 153.
[174] Malcolm Potts and Roger Short, *Ever Since Adam and Eve: The Evolution of Human Sexuality* (Cambridge: Cambridge University Press, 2000), 259.
[175] de Zouche, "A Case of Battey's Operation", 145.
[176] Ussher, *Women's Madness*, 73.
[177] Showalter, *Female Malady*, 76.
[178] Ibid, 76-78.
[179] Anika Rahman and Nahid Toubia., eds., *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* (London: Zed Books, 2001), 5; Although the term female genital mutilation indicates harm caused by the practice, it must be noted that communities who practice this have found the term offensive as they have never considered the practice a mutilation.

sexual desire, thus promoting women's virginity and protecting marital fidelity in the interest of male sexuality'.[180] The procedure 'also results in the reduction of women's sexual fulfilment, thus aiding in the construction of parameters around women's sexuality'.[181] The extreme methods of treating and "curing" female madness are connected, if not directly linked, to their bodies.

Chapter Conclusions

The relationship between women and madness was further explored in this chapter. Hysteria in the nineteenth century encompassed virtually all kinds of female insanity. By the nineteenth century, the close association between femininity and pathology was established, and madness was linked with womanhood. The reasons for female madness were explored by feminists, who suggested that part of women's insanity was a response to their role in society. The male authority in the professionalisation of medicine and the rise of the male-dominated fields of gynaecology and obstetrics in the nineteenth century revealed that doctors used their authority to offer advice based on their social beliefs; therefore, medical advice was powerfully combined with morality. Thus, the treatments and procedures implemented were based on the belief that female madness was located in the female body and associated with "unnatural desires".

This chapter established the connections between women and insanity, with greater emphasis on their body, sexuality, and their roles in society. It provides critical contextual theories that influenced medical and asylum physicians throughout the Victorian world. As will be discussed in the following chapters, these theories impacted the women admitted to Fremantle.

Through the two chapters in Part I, the context of nineteenth-century theories of insanity, hysteria, and the establishment of a professional male-dominated medical practice was explored. These understandings enable the thesis to focus on the Fremantle Lunatic Asylum, providing analysis of one asylum in colonial Australia with an emphasis on the female patient experiences. The following part will examine the asylum space, staff, female patients and treatment.

[180] Rahman and Toubia, *Female Genital Mutilation*, 5.
[181] Ibid, 6; as recently as the 1950s, physicians in the UK and the USA also performed female genital mutilation to "treat" hysteria, lesbianism, masturbation, and other "female deviations"; while in some countries like Egypt, Sudan, and Somalia versions are still experienced as part of cultural practices.

PART II

The Fremantle Lunatic Asylum

CHAPTER THREE

The Asylum and Staff

The previous section of the thesis examined the Victorian theories on insanity and treatment, especially their impact on women. Understandings of gender roles influenced treatment and diagnosis, and this was also the case in Fremantle. Part II delivers the remaining aims of the thesis in determining Western Australia's response to British understandings of insanity and treatment through their provision of care for the female patients in Fremantle. The part then interrogates the patient registers and case books to provide insights into the women's experiences and treatment. Lastly, it determines how moral treatment, specifically, was implemented in Fremantle and further explores the women's experiences.

Chapter Three, however, will analyse the asylum space and staff, revealing how they were influenced by the previously discussed nineteenth-century ideas of womanhood. Through examinations of the history of lunacy in Fremantle, analysis of the built environment of the asylum, biographical investigations into the male and female staff, and appraisals of their record-keeping practices, this chapter provides perspective on the asylum and patient treatment through understandings of staff influence and attitudes.

The Asylum in Fremantle

The history of insanity in the Swan River Colony did not start with the imposing limestone building still standing in modern Fremantle. At first, patients were confined with criminals in the ship *Marquis of Anglesey* from 1830 until they were transferred in 1831 to the first major building constructed in the colony, the Roundhouse prison.[1] However, the prison was deemed an inappropriate place for treatment and due to a high number of "lunatics" among the convict population in the early 1850s plans were made for a purpose-built asylum.[2] The Convict Superintendent at Fremantle Prison Thomas Dixon stated that insane convicts or patients should be placed 'in some isolated building where the approved appliances both of science and humanity in regard to mental diseases may be put into operation'.[3] Norman Megahey notes that the introduction of the asylum in Western Australia was inevitable as it was 'part of the total cultural package introduced by colonisation' and a

[1] Phil Maude, "Treatment of Western Australia's Mentally Ill During the Early Colonial Period, 1826-1865," *Australasian Psychiatry* 21, no. 4 (2013): 398. doi: 10.1177/1039856213492863; The Colonial hospital also accommodated female lunatics during this period.
[2] Maude, "Treatment of WA's Mentally Ill," 400.
[3] Ibid; Dixon (1816-1880) was the first Superintendent of Convicts in Western Australia.

'response to both economic and social conditions'.[4] Construction on the Fremantle Prison began in the 1850s and, in demanding the resources of convict labourers, delayed the construction of a separate asylum.[5] The prison opened in 1855, and construction on the asylum began in 1861.[6] It is important to note that care for the mentally ill 'grew out of the Convict Establishment and remained, until 1886, an integral part of the institution'; therefore, the guiding concept was penal.[7]

The slow establishment of a permanent asylum resulted in a growing number of patients that needed care, and by November 1857 a temporary asylum was established in the warehouse of the harbourmaster, Daniel Scott.[8] Scott had 'leased the warehouse to the colonial government for the purpose of housing the newly arrived convicts', and so a section of the warehouse was dedicated as an asylum.[9] The 'construction of the temporary asylum and its staffing was well planned'. The estimated cost was around 173 pounds and 'included enclosing a space to form a yard, surrounded by a wall, ten feet high and one foot six inches thick, with a door and frame'.[10] The ground floor was made into a ward with 'security measures including iron bars on the windows'; it also had one cell which was lined with leather and coir (cocoa-nut fibre) padding.[11] The staff constituted three warders plus a reliever, while well-selected convicts became orderlies.[12] Lastly, there was a medical superintendent, and the recently arrived, Dr George Attfield was appointed.[13] At first, ten insane male convicts were transported to the warehouse, and in July 1858, female patients began to be admitted; the female patient records began on 12 July 1858 when Margaret Curley was admitted noted as deranged.[14]

The Fremantle Lunatic Asylum was finally completed in 1865 but began to admit patients from 1864.[15] Designed by Captain Edmund Henderson and officers of the Royal Engineers, the facade

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[4] Norman Megahey, "Living in Fremantle Asylum: The Colonial Experience of Intellectual Disability 1829-1900," in *Under Blue Skies: The Social Construction of Intellectual Disability in Western Australia*, eds. Errol Cocks, Charlie Fox, Mark Brogan, and Michael Lee (Perth: Centre for Disability Research and Development, Edith Cowan University, 1996), 32.
[5] Olimpia Cullity, "Reform and Punishment: Fremantle Prison, 1850 to 1890," *Studies in Western Australian History*, no. 31 (2016): 63-64. APAFT.
[6] Cullity, "Reform and Punishment," 63-64.
[7] Megahey, "Living in Fremantle Asylum", 42.
[8] Maude, "Treatment of WA's Mentally Ill," 400; Scott's warehouse was located where the Esplanade Hotel now stands in Fremantle.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid; *Register of Female Patients*, 1858-1873, Folio 1, 12 July 1858; The data collection for this study also includes the records from 1858 to 1864 as the first patient register includes these years with the establishment of the permanent asylum.
[15] Hall, *May They Rest in Peace*, v; 5.

was built in the Gothic Revival style popular in England, and reflected the English dominance of the colonial landscape; however, the building's functionality, roughly hewn limestone blocks, jarrah floors and she-oak roof shingles gave the architecture an Australian character.[16] Initially, the asylum was divided into two separate wings based on gender, one to contain "imperial lunatic prisoners" and "colonial male lunatics" and the other for "colonial female lunatics".[17] The asylum was governed by both the British government and the Colonial government; the British paid for the insane convicts, all of them male, while the colonial government bore the cost of all others.[18] However, as Margaret McPherson notes, the association between the Convict Establishment and the Fremantle Asylum 'would inevitably taint the occupants, Imperial or colonial lunatic, with the same contempt and discrimination by society'.[19] Both male and female patients in the asylum were issued with 'prison garb' and the influence of the penal system would remain until 1886, when Dr Barnett and the colonial government had full control.[20]

Originally only designed to accommodate forty-five patients, the new asylum planned to house thirty-two patients (sixteen convicts, one colonial prisoner, six male and nine female colonial lunatics); however, on opening officially in July 1865, it was already at capacity with twenty-eight males and seventeen females.[21] These admission numbers were a sign of overcrowding that was to plague the establishment.[22] By 1870, the asylum accommodated an average of eighty-five patients daily, and by 1887, this number had risen to 119, reaching a crisis point in 1896, with 190 patients.[23] Medical Superintendent Dr Henry Calvert Barnett, constantly complained of overcrowding in his annual reports but his pleas for improved facilities were ignored.[24] Overcrowding was a common issue for Australian asylums, The *Australian Medical Journal* reported in 1885 that 'the asylums were all crowded', especially Yarra Bend and Kew Asylum.[25] In Barnett's Annual Report for 1889, he noted 'the crowded state of the Asylum (where, while I write, three beds for females have to be used each night in the dining room)'.[26] He reported that 'the accommodation for female patients in the Lunatic Asylum at Fremantle being now fully occupied, Magistrates and others are requested to

[16] Ibid, v.
[17] Harman, "Out of Mind, Out of Sight," 24.
[18] Ibid, 24-25.
[19] McPherson, "A Class of Utterly Useless Men," 70.
[20] Ibid.
[21] Hall, *May They Rest in Peace*, 6; Some of the patients were transferred to the new building in 1864.
[22] Ibid; The difference in male and female population demographics during this period could account for the male patients usually outnumbering the female patients.
[23] Megahey, "Living in Fremantle Asylum", 44.
[24] Ibid.
[25] Australian Medical Journal, "Local Subjects," *Australian Medical Journal* vii, no. 7 (July 1885): 334. http://hdl.handle.net/11343/23149.
[26] Henry Calvert Barnett, *Report Upon the Lunatic Asylum at Fremantle, for the Year 1889, by the Surgeon Superintendent* (Perth: Richard Pether, Government Printer, 1890), 3.

communicate with the Surgeon Superintendent of the asylum before sending any further female patients for admission'; 'I am under the painful necessity of refusing to admit'.[27] Fremantle 'suffered because of its dual nature' as a convict and colonial asylum; it was not built necessarily for curative aims but to house convicts.[28] Barnett emphasised this issue in 1889:

> It must be remembered that the position of this Asylum is most exceptional. Originally merely a branch of the Imperial Prison, built, fitted and furnished as part of a Prison, with everything planned in the most bare, inexpensive, cheerless, and workhouse-like style, it is now the sole Asylum for the insane in this great Colony with its increasing population; and what is really required is not merely increase of buildings and of staff, but a thorough re-organisation and re-arrangement of the whole Institution.[29]

The British Government only provided forty-five pounds per annum per convict inmate for their treatment and maintenance.[30] However, 'this sum was thought excessive by the Imperial authorities', and in 1891 Barnett noted that 'the average rate for a pauper patient in an English county asylum was 200 pounds per annum, the cheapest was eighty-six pounds for the care of chronic and imbecile patients…this money would cover all expenses such as clothing, food, activities, and staff wages'.[31] Barnett complained that forty-five pounds would only 'cover their nakedness and keep them alive'.[32] Colonial disinterest in improving conditions within the asylum was evident in the funding, as the Fremantle Harbour was seen as the priority.[33] It was not until after 1886, 'when the Convict Establishment was transferred to the colonial authorities, that the Legislative Council', slowly and reluctantly, began to consider a serious overhaul for the asylum.[34]

Therefore, between 1886 to 1896, the Government Architect George Temple-Poole designed a series of additions that blended with the original asylum building.[35] Although the first smaller extension facing Finnerty Street echoed the monastic style of the 1865 facade, others favoured the "Domestic Revival" style with bay windows, verandas, and fireplaces, revealing Temple-Poole's humanistic approach.[36] The increasingly dominant moral treatment ideals in Britain may have influenced Temple-Poole's design. As previously discussed, John Conolly became a leader in moral treatment; he believed that 'by controlling the lunatic's environment down to the last

[27] Barnett, *Report Upon the Lunatic Asylum*, 3.
[28] Piddock, "Place for Convicts," *570.*
[29] Barnett, *Report Upon the Lunatic Asylum*, 3.
[30] Piddock, "Place for Convicts," 570.
[31] Ibid, 571.
[32] Ibid.
[33] Ibid, 570-571.
[34] Megahey, "Living in Fremantle Asylum", 45.
[35] Hall, *May They Rest in Peace*, v.
[36] Ibid.

detail, doctors and administrators hoped to make the new public asylums instruments as well as places of therapy: the building itself was a "special apparatus for the cure of lunacy"'.[37] In 1874 Conolly identified issues with the asylum environment and how a moral treatment regime could work in a large institution with 'all aspects of the physical environment' considered.[38] Conolly established a set of features representing an "ideal" asylum that embodied moral treatment, including its location, the building, light, and ventilation.[39] He even noted that 'the jingling of keys, the clang of the locks, and the violent opening or shutting of the doors of bedrooms and galleries, are generally considered of no consequence to the attendants; but they produce the most uncomfortable feelings in the patients'.[40] Conolly's solution was that 'the gallery doors should have large handles, enabling those who pass through to shut the door quietly…the state of a whole ward may immediately be altered by persons hastily passing through'.[41] Susan Piddock argues that 'by examining the built environment of the asylum and the uses of spaces within its walls, it is possible to understand not just the experiences of the inmates, but highlight attitudes towards the insane'.[42] Piddock compared Conolly's ideal asylum with the Fremantle asylum; she notes that 'the absence of plans showing the original layout and subsequent additions to the asylum' results in difficulties in determining exact room use; 'passing references in nineteenth-century documentary evidence is the only guide to the rooms and their use over time'.[43]

The Fremantle Lunatic Asylum 'consisted of one large two-storied building with wards over both floors', 'divided into male and female sides…by twin staircases in the middle of the building' with the largest dormitories 'located at each end of the building on the ground and first floors'.[44] In between the dormitories were smaller rooms, for single or multiple patients; 'these were located in the front part of the building with a corridor running behind them on both floors'.[45] 'On the ground floor of the male side to the rear of the main building were two separate sets of rooms that opened onto this corridor'; 'designed as extensions to the main building' they had separate roofs, with 'the general male exercise yard extending out beyond these buildings'.[46] 'The first set of rooms included eight cells', enclosed by the exercise court, and the second 'provided two rooms, possibly for staff'.[47]

[37] Showalter, *Female Malady*, 33.
[38] Piddock, "Place for Convicts," 563.
[39] Piddock, "Ideal Asylum", 38-39.
[40] Conolly, *Construction*, 29.
[41] Ibid.
[42] Piddock, "Place for Convicts," 562.
[43] Ibid, 567.
[44] Ibid, 565-566.
[45] Ibid, 566.
[46] Ibid.
[47] Ibid.

'The female side was a mirror image of the male side with a staff room and padded cell in the next building extending from the internal corridor'; 'three further cells and a warder's room connected to the large female dormitory on the ground floor'.[48] It was likely that 'more cells were constructed for the men, possibly with the discipline of male convicts in mind'; whereas 'the three cells on the women's side were for isolating refractory cases'.[49] 'Above the women's cells and the dormitory was another ward on the first floor. There was no matching ward on the male side until later, reflecting the different provisions made for the genders and the building's lack of symmetry'.[50] The building also contained a separate male and female dining room and also a women's day room; 'designations of these rooms and staff rooms changed to reflect the needs at the time, with sleeping space a priority'.[51] Regarding the staff, 'the Superintendent was not resident in the asylum and was given money for quarters instead'.[52] There was 'no separate dining hall for attendants', and there were 'problems finding quarters for the additional staff' required.[53] Thus, in 1884 the asylum's layout was listed as:

> (1) Male Division: eight dormitories, one dining room, eight cells and an office; (2) Female Division: two dormitories, one large day room, one dining room, two cells, three rooms for the Matron, washhouse and stores; (3) Quarters for officer in charge adjoining main building: four rooms, kitchen; (4) In rear of the building is a yard containing: cookhouse with coppers, wash house, shower house, and dead house.[54]

The bathhouse and kitchen were located behind the female section on the ground floor.[55] This may have been to allow the female patients better access to these areas where they would more than likely undertake domestic tasks. There were two shower baths, up to eight troughs (which were used as baths), five internal water or earth closets, and some in the airing courts; 'later additions included an external bathhouse near the women's section'.[56] By 1887, due to overcrowding, the women's day room and nurse's room were used as wards.[57]

'In the "ideal" asylum, each ward would be separate and self-contained. The lack of space and the arrangement of the Fremantle asylum with all its rooms emptying onto a single corridor made classification impossible and this failure led to considerable distress' for Dr Barnett, as 'the constant noise and disturbance from the refractory inmates made life difficult for quiet and

[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] Ibid.
[52] Ibid, 569.
[53] Ibid, 569-570.
[54] Ibid, 566-567.
[55] Ibid, 566.
[56] Ibid, 569.
[57] Ibid.

recovering patients'.[58] Conolly's model represented the best environment needed in treating the mentally ill and the conditions within Fremantle, even when reformed in the late nineteenth century, were ultimately not ideal.

The Male Medical Superintendents

The reformed asylum 'became increasingly like the family, ruled by the father, and subject to his values and his law'.[59] By the mid-nineteenth century, the term "alienist" was more commonly applied to the medical superintendent or resident medical officer but also referred to any medical professional who specialised in the treatment of the insane.[60] The term "psychiatry" first appeared in Europe, and by 1910 this term was widely used and associated with the professional care of insanity and lesser mental disorders.[61] However, in nineteenth-century Britain, asylum-based medicine remained stigmatised.[62] There was a perceived lack of professionalism and available formalised training; therefore, the men who worked in asylums became marginalised by mainstream medical professionals.[63] In the mid-nineteenth century, legislative changes expanded the county asylum network, and asylum practice became increasingly regulated as general recognition grew from the need for professionalisation; in Britain, The Association of Medical Officers of Hospitals for the Insane was formed in 1841 to raise the professional status of asylum physicians.[64]

The asylum medical superintendent had a significant role; they controlled every aspect of life in the institution as the head of medicine and staff management.[65] Medical superintendents generally ran the asylums in a patriarchal manner, although they delegated to assistants or medical officers, who assumed the day-to-day responsibility for the patients' medical care.[66] However, as Conolly noted, 'the medical assistants should be expected in all things to conform to the plans of the physician, and he should have authority to direct them in their duties'.[67] Medical superintendents usually held their posts for long periods which provided stability; while also imposing their beliefs and personal styles upon the daily routines and therapeutic regimes.[68] They prescribed medicines as

[58] Ibid, 569.
[59] Showalter, *Female Malady*, 50.
[60] Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto Publishers, 2014), 41.
[61] Shepherd, *Institutionalizing the Insane*, 41.
[62] Ibid, 42.
[63] Ibid.
[64] Ibid; Later renamed the Medico-Psychological Association in 1865.
[65] Stevens, *Life in the Victorian Asylum,* 54-55.
[66] Shepherd, *Institutionalizing the Insane*, 43.
[67] Conolly, *Construction*, 135.
[68] Shepherd, *Institutionalizing the Insane*, 41.

they were the only qualified medical practitioner working in the asylum; though the matron could use discretion with administering sleeping draughts, despite having limited medical training.[69] The medical superintendent was the link to the outside world; they decided which patient's letters were forwarded or received, and kept patient's families informed.[70] Medical superintendents had significant control and influence in the asylum. However, as the century developed and official scrutiny increased, they became answerable to Government committees and official Visitors, which resulted in demanding medical and administrative tasks.[71]

A medical superintendent generally oversaw the Fremantle Lunatic Asylum with the aid of wardens, matrons, and nurses. However, the position was part-time, and they were answerable to the Colonial Surgeon, who in turn, was accountable to the Colonial Secretary.[72] Margaret McPherson argues that this indicated 'a lack of commitment on the government's part to improve the conditions and treatment of patients within the asylum'.[73] Much like British physicians, Australian colonial doctors also had mixed reputations.[74] However, by the mid-nineteenth century colonial authorities were working to legislate the industry; the Western Australian *Lunacy Act 1871*, stipulated rules for superintendents: 'for every such Lunatic Asylum as aforesaid there shall be appointed some duly qualified medical practitioner as Resident or Superintending Medical Officer'.[75] The act stated that 'fit and proper persons to be visitors of every such asylum, and such Resident or Superintending Medical Officer and Visitors shall have and exercise the powers and authorities herein conferred upon them'.[76] However, 'the Resident or Superintending Medical Officer shall have the control and management of such asylum in all matters connected with the internal routine and discipline thereof, and shall be responsible for carrying out the duties by this Act'.[77] The Colonial Surgeon could also visit and inspect the asylum; however, in the early stages of the colony, the medical superintendents at Fremantle were often also colonial surgeons.[78]

As mentioned, the post of medical superintendent at Fremantle was a part-time position. For instance, Dr Barnett, in addition to being Medical Superintendent of the asylum, was Colonial Surgeon at Fremantle and ran a private practice.[79] Dr Hope, acting Superintendent from 1897 to

[69] Harman, "Out of Mind, Out of Sight," 118.
[70] Stevens, *Life in the Victorian Asylum*, 54.
[71] Shepherd, *Institutionalizing the Insane*, 43.
[72] Megahey, "Living in Fremantle Asylum", 43.
[73] McPherson, "A Class of Utterly Useless Men," 70.
[74] Martyr, "Unlikely Reformer," 497.
[75] *The Lunacy Act 1871*; Section 5
[76] Ibid.
[77] Ibid; Section 8.
[78] Ibid; Section 9.
[79] Megahey, "Living in Fremantle Asylum", 47.

1900, 'came under severe criticism in parliament because of the number of part-time positions he held'.[80] The expectations for the Australian colonial medical superintendent were much the same as their British counterparts. However, in 1889, Barnett reported:

> In other Asylums the Superintendent had Medical Assistants, his official work is only with the insane, and he has good quarters and good income in return for his services. Here the whole care and responsibility has been thrown upon me for the last eighteen years, merely as an extra item added to my ordinary daily work as Colonial Surgeon at Fremantle; with no holidays, no quarters and only nominal pay, less in fact than received by an Assistant Warder…In no other part of the world could such disparity be found between the importance and responsibility of the work and the salary given. It is simply a relic of the Imperial Prison time, when the Surgeon of the Establishment attended the lunatic convicts as one portion of his Imperial duty.[81]

Barnett then stated, 'so that I can give my whole time to this most important work…I must be treated liberally and have a free hand'.[82] Barnett also organised visiting Justices of the Peace and Regional Magistrates to support his bid for a 100-pound salary increase.[83] The government did make changes, allowing Barnett extended leave for a year in 1891, two years after the report. However, the struggle for funds and a massive work-load would have impacted the staff and their ability to treat patients. The lives of the four principal Medical Superintendents at Fremantle, Doctors Attfield, Barnett, Hope, and Montgomery, and their assistant medical officers, also reveal methods and interests of the staff who were treating the insane.

Dr George Cook Attfield was the first medical superintendent of the warehouse asylum and the Fremantle Lunatic Asylum, from 1857 to 1870. Attfield was born in England in 1835 and arrived in the Swan River Colony on 6 November 1857 aboard the *Dolphin*.[84] On 12 November 1863 Attfield married Alice Maude Roe, the daughter of the Surveyor General J.S. Roe, and from 1864 to 1870 had six girls.[85] He was appointed the Imperial Surgeon of the Fremantle Convict Establishment upon his arrival in 1857 until 1879, which included Medical Superintendent of the asylum.[86] Attfield attempted to introduce moral treatment methods; he emphasised human nature in the care for the mentally ill and was reluctant to use seclusion and restraint, which he opposed.[87] He supplied

[80] Ibid.
[81] Barnett, *Report Upon the Lunatic Asylum*, 4.
[82] Ibid.
[83] Ibid.
[84] Erickson, "Bicentennial Dictionary,": A: 88.
[85] Ibid; BDMWA: *Certificate of Birth*: Maud Cecil (8066/1864), Florence Mary (Unnamed F 9245/1866), Alice Isabell (10464/1868), Edith Blanche (11684/1869), Ethel Clare (12784/1870).
[86] Ibid.
[87] Maude, "Treatment of WA Mentally Ill," 400-401.

amusements such as books, ball games, and draughts in the evening.[88] However, women's amusement constituted washing, sewing and housework.[89] Attfield also ran a private practice and during the mid-1800s was the only medical man in Fremantle, having private patients, convicts, enrolled guards, warders and their families under his care.[90] After his retirement in 1874, he returned to England twice, finally with his wife and three surviving daughters Maud, Alice, and Ethel on 28 December 1878 aboard the *Helena Mena*.[91] In 1923, Attfield died in Sussex aged 101.[92] However, assistant to Attfield at Fremantle was Dr Henry William Dickey who took over his duties at the asylum from 1870 to 1872 until the position was permanently filled.[93] Dickey arrived in the colony in August 1866, after training as a surgeon in the United States; he was also the local Health Officer and Colonial Surgeon.[94] Both Attfield and Dickey often worked in harsh conditions to provide patient care, and Attfield was instrumental in the establishment of humane practices in Fremantle.

Dr Henry Calvert Barnett was appointed as Medical and Surgeon Superintendent to the asylum in 1872 and worked for twenty-five years until his death in 1897. Barnett was born in Antrim Belfast on 10 February 1832, the third son of Sarah Craig Milford and Richard Barnett, a dental surgeon in Belfast.[95] Philippa Martyr writes that parts of Barnett's life are unverifiable, 'he claimed to have qualified in medicine at Queens College Belfast, and also claimed membership of the Royal College of Surgeons, although his name does not appear in any published pass lists'.[96] Other claims such as 'his fellowship of the Royal Geographical Society, and his published articles come to similar dead ends'.[97] However, 'in 1864 he was the ship's surgeon on the *Kalabar,* travelling the west coast of Africa'; it was there 'he met thirty-six-year-old Mrs Ann Leatham (née Coplestone)', who had been married for eighteen years with two children.[98] Ann told Barnett of 'her husband's ill-treatment and her constant illness in the tropical climate', and so 'Barnett gave her money for passage back to England and was co-respondent in her subsequent divorce case'.[99] In March 1867, Henry and Ann

[88] Ibid, 400.
[89] Ibid.
[90] Joseph Keane Hitchcock, *The History of Fremantle: The Front Gate of Australia, 1829-1929* (Fremantle: Fremantle City Council, 1929), 40.
[91] Hitchcock, *History of Fremantle*, 40; Erickson, "Bicentennial Dictionary,": A, 88.
[92] Ibid.
[93] Ibid, D, 835.
[94] Ibid.
[95] Ibid, B, 134.
[96] Martyr, "Unlikely Reformer," 497-498.
[97] Ibid.
[98] Ibid, 498.
[99] Ibid.

'married in a registry office in London': they would go on to have two sons and two daughters.[100] On 5 June 1868, they arrived in the colony via the *Lady Lousia* and Barnett was appointed the Resident Medical Officer in York.[101] Soon after his arrival, 'either chronic knee trouble or an accident on the ship' resulted in the amputation of Barnett's left leg.[102] However, the stump later became gangrenous and under local anaesthesia, he re-amputated his leg at a higher level.[103] For some time after the operation, he used a wheelchair pushed by an ex-convict until he learned to use crutches.[104] In 1872, Governor Weld appointed him the Colonial Surgeon at Fremantle which included the asylum, Health Officer to the port, and the Aboriginal Convict Prison at Rottnest.[105] At the asylum, one of Barnett's first actions was to create *Rules for the Guidance of Attendants* (1872), which embraced the idea of moral care emphasising 'Gentleness, Firmness, Tolerance'.[106] His outlined aims for the staff and patient care were as such:

> (1) An Asylum is not merely a house for the accommodation of persons of unsound mind, it is an institution for the cure of those laboring under mental disease. (2) Patients must be employed as much as possible. The more heartily Attendants enter into amusements and encourage occupation of the patients, the more highly they will be esteemed. (3) In dealing with the insane it is wrong to suppose that any special line of conduct is advisable; the more nearly they are treated as sane and reasonable being the more easily they will be managed. (4) No kind of deception should be practiced towards the patients, either with a view to rendering them more amenable to management or of inducing them to undertake work; all promises made must be strictly kept. (5) Should violence towards the patient be proved against an Attendant, immediate dismissal will follow. (6) The study of the Attendants must be to induce the patients to apply themselves to some occupation; and the Surgeon will feel obliged to the Attendants for any suggestion tending towards the improvement of the health or comfort of the patients.[107]

These rules reflect moral treatment techniques, employed and active patients, no physical intimidation or harm, and treating patients like sane people. Barnett's care and management of the asylum also resulted in better chances of survival for both male and female patients.[108] The *W.A. Record* reported: 'those whose painful duty it was to visit the Asylum knew well how kindly and

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[100] Ibid; "Death of Dr. Barnett," *The Inquirer and Commercial News*, Perth WA, 5 November 1897, 12; Florence Annie (1866) was born months before their marriage, and Alexander Whytock (1867) were born in England and Henry "Harry" Calvert (1869) and Isabella Margaret Olive (1871) were in Fremantle and York.
[101] Erickson, "Bicentennial Dictionary,": B, 134; Martyr, "Unlikely Reformer," 498.
[102] Ibid.
[103] J.H. Stubbe, *Medical Background: Being a History of Fremantle Hospitals and Doctors* (Crawley: The University of Western Australia Press, 1969), 24.
[104] Stubbe, *Medical Background*, 24.
[105] Hitchcock, *History of Fremantle*, 58; Warren Bert Kimberly, *History of West Australia: A Narrative of her Past Together with Biographies of her Leading Men* (Melbourne, VIC: F.W. Niven & Co Printers and Publishers, 1897), 88.
[106] Martyr, "Unlikely Reformer," 498.
[107] Henry Calvert Barnett, *Rules for the Guidance of Attendants, Fremantle Lunatic Asylum, 1872*. Lunatics (Folios 12-106). SROWA. AU WA S2941- cons36, item 721.
[108] Martyr, "Unlikely Reformer," 498.

affectionately he looked after the health of an unfortunate number of the human race'.[109] He devoted his life 'to the office of trying to cure and, if not successful, trying to make happy the remaining years of the most afflicted human beings on earth'.[110] In his 1889 Annual Report, Barnett outlined that his aim was 'to do away with, as far as may be possible, the sad, gloomy, and poverty-stricken surroundings of the patients, and in some degree make the place a cheerful home for those unfortunates who suffer from this worst of all human calamities'.[111] Margaret McPherson notes that Barnett's annual reports, across twenty-five years, continually mentioned the issues with lack of funding, accommodation, and maintenance.[112] However, Barnett's personal life became dysfunctional; in 1877, Henry and Ann divorced due to Ann's affair with Thomas Stockley King. Ann received ten pounds a month, as long as she remained unmarried; however, she died in August 1879.[113] In 1880, Barnett married Emily Winn Stephens in Northampton after meeting her during a trip in Geraldton.[114] In 1891, he went on extended leave to England returning to Fremantle in 1892; Dr Hope was the acting Superintendent while Barnett was away.[115] In 1895, at his request, Barnett was relieved of his duties as Colonial Surgeon, and Hope was appointed; Barnett continued at the asylum.[116] However, by 1897, he was unwell, suffering for years with a rare and agonising condition "trigeminal neuralgia", which caused intense electric shock-like pain in the face, that he self-medicated with increasing doses of morphia.[117] However, on 5 November 1897, he died aged sixty-six, 'of an accidental overdose of sulphonal, which he had been using as a sedative for chronic insomnia'.[118] Days before his death, Barnett had requested a leave of absence for six months in consequence of ill health and Hope took over his duties.[119] Barnett's passing grieved the community, as was reported: 'we are sure that there is not a lover of the welfare of human race in West Australia, that will not grieve on hearing of the death of Dr Barnett'.[120] They stated: 'when spoken to about the sad duties of his office' he exhibited 'rich traits of Irish wit by trying to make comparisons between the sanity of his poor patients and those who were not so afflicted', and 'not unfrequently showed that beneath an apparently cold exterior he had a soft and warm Irish heart'.[121] 'We deeply regret the sad event that has deprived the poor patients of the Fremantle Lunatic Asylum of a good

[109] "Notes and Comments: Dr Barnett's Death," *The W.A. Record*, Perth WA, 6 November 1897, 9.
[110] "Dr Barnett's Death," *The W.A. Record*, 9.
[111] Barnett, *Report Upon the Lunatic Asylum,* 4.
[112] McPherson, "A Class of Utterly Useless Men," 70.
[113] Martyr, "Unlikely Reformer," 498.
[114] Ibid, 499.
[115] Kimberly, *History of West Australia,* 90.
[116] "Death of Dr. Barnett," *The Inquirer and Commercial News*, 12.
[117] Hall, *May They Rest in Peace*, 21-22.
[118] Martyr, "Unlikely Reformer," 499.
[119] "Death of Dr. Barnett," *The Inquirer and Commercial News*, 12.
[120] "Dr Barnett's Death," *The W.A. Record*, 9.
[121] Ibid.

doctor and real benefactor'.[122] Barnett was the longest-serving medical superintendent, and his influence was profound. His treatment methods and patient notes reveal that he cared for his patients and did the best he could with the resources available.

Dr James William Hope was the interim Medical Superintendent at the asylum from 1897 to 1901, when Dr Montgomery permanently filled the position. Hope was born in Hay, Wales in 1851, one of eleven children of John Edwin Hope.[123] While completing his medical education in London, Hope was 'visited by an Australian physician who had been charged by the Government of Western Australia to search for a suitable doctor to take charge of the hospital at Perth'.[124] He was appointed as district medical officer at York and arrived on 30 March 1875 aboard the *Eulie*.[125] In 1878, Hope married Helena Aurora Monger of York and they had seven children from 1879 to 1899.[126] In 1882, Hope took over from Barnett as the Medical Officer of Fremantle, including the Fremantle Prison, Convict Establishment at Rottnest, and health officer to the port and town of Fremantle.[127] From 1888 to 1904, Hope also established a practice in Perth with Drs White and Birmingham.[128] Therefore, when Hope was appointed to the asylum upon Barnett's death in 1897, he was already a busy man; however, this position lasted less than four years. Upon his retirement in the mid-1910s, Hope returned to England and for eighteen months and worked with the British Red Cross serving in France during World War One.[129] *The Brecon County Times* in Wales reported that 'upon being invalided to England he became a member of the Medical Tribunal for the district of Bath' while 'two of his sons [were] serving with the Australian Forces in France'.[130] Hope died shortly after returning to England on 28 November 1918, aged sixty-seven.[131] While Hope only worked in the asylum for a short period, he had a sizeable medical presence in Fremantle, and his continued service to the country after retirement is a testament to his dedication to medical care.

Dr Sydney Hamilton Rowan Montgomery was the final Medical Superintendent at the asylum, from 1901 to 1908, when the building closed and the patients were transferred to the Claremont Hospital for the Insane. Montgomery was born on 25 October 1869 in Belfast, Ireland, the

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[122] Ibid.
[123] Kimberly, *History of West Australia*, 210; "Hay," *The Brecon County Times*, Wales, 5 December 1918, 8: http://newspapers.library.wales/view/3859387/3859395/81/.
[124] "Hay," *The Brecon County Times*, 8.
[125] Kimberly, *History of West Australia*, 211.
[126] Erickson, "Bicentennial Dictionary,": H, 1525; BDMWA: *Certificate of Birth:* Arthur Henry Monger (20168/1879), Edwyna Mary Evelina (21999/1881), Mervyn Meredith (1369/1887 d. 353/1889), Ivan Meredith (942/1890), Beryl Gwenyfryd Meredith (1734/1892), Gwynnyth Muriel (982/1896), Adrian John (1500/1899).
[127] Kimberly, *History of West Australia*, 210.
[128] Erickson, "Bicentennial Dictionary,": H, 1525.
[129] "Hay," *The Brecon County Times*, 8.
[130] Ibid.
[131] Ibid.

second son of Rev. Robert Montgomery and Margaret Boyd Wylie.[132] After training to become a doctor, he pursued his interest in mental disorders and became an assistant at Nottingham City Asylum for the Insane in 1897.[133] At Nottingham, Montgomery met the architect, Mr Hine, with whom he learned the designs and planning of insane hospitals.[134] In July 1900, Montgomery married Mabel Callaghan at New Brighton, Cheshire, they had five children from 1901 to 1905.[135] Due to Montgomery's expertise in asylum building and function, he was offered an appointment in Western Australia, as the old Fremantle asylum needed updating.[136] On 20 June 1901, Montgomery arrived in Fremantle as the newly appointed Superintending Medical Officer of Asylums to Western Australia; 'responsible for the care and treatment of 231 patients' in the Fremantle asylum and forty-five at Whitby Falls.[137] Montgomery spent the first twelve months after his arrival reorganising and drawing plans for a new asylum, what would become the Claremont Hospital for the Insane.[138] The Chief Government Architect Grainger and Montgomery visited various institutions around the Australian states for inspiration, and upon their return, Montgomery drafted a new Lunacy Act.[139] The Act passed in 1903 and saw the Lunacy branch become separated from the medical department, of which Montgomery became the head and Inspector General.[140] In 1905, construction on the new asylum commenced and was opened in 1908 when the patients from Fremantle were transferred; the *West Australian* reported in 1916, that Claremont stands 'as a monument to his care and expert knowledge'.[141] In 1905, with Dr Birmingham, Montgomery 'established a three-year training course for mental nurses, with the award of a certificate of competency'.[142] In 1908, Montgomery also set up a "mental ward", at the Perth Public Hospital; the first of its kind in Australia, treating suspected insane patients in general hospital without the stigma of asylum incarceration.[143] In 1915, 'Montgomery influenced amendments to the Lunacy Act that increased the number of visitors to mental institutions from two to three, and for the appointment of a woman to the board'.[144]

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[132] Archie Samuel Ellis, "Montgomery, Sydney Hamilton Rowan (1869–1916)," *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, (1986): http://adb.anu.edu.au/biography/montgomery-sydney-hamilton-rowan-7630/text13339.
[133] Ellis, "Montgomery".
[134] "Family Notices: Dr Montgomery," *The West Australian*, Perth WA, 2 March 1916, 8.
[135] Ellis, "Montgomery"; Twins Robert Percy and Mabel (1901) were born in Cheshire; BDMWA: *Certificate of Birth*: Sydney (2287/1903), Mary Sheila (2883/1904 d. 1053/1905), Anthony Armstrong (1354/1905).
[136] "Family Notices," *The West Australian*, 8.
[137] Ellis, "Montgomery"; Whitby Falls was a farm used as overflow accommodation for the crowded Fremantle asylum established in July 1897.
[138] "Family Notices," *The West Australian*, 8.
[139] Ibid.
[140] Ibid.
[141] Ibid.
[142] Ellis, "Montgomery".
[143] Ibid.
[144] Ibid.

However, he died of heart disease a year later, on 1 March 1916, aged forty-seven. The *West Australian* reported upon his death: 'the Colonial Secretary (Mr Drew) …remarked that personally and officially he felt that the loss would be felt by the state as a whole'.[145] 'Dr Montgomery had been a man of superior talents and the good work done by him was not confined to his professional duties…he was an officer whom it would be difficult to replace'.[146] Montgomery was arguably the most influential contributor to improving asylum facilities and laws in early-twentieth-century Western Australia and his concern regarding staff education, especially for women, is commendable.

Dr William Edward Blackall also worked at the asylum as a medical officer while Montgomery was Medical Superintendent. Blackall was born on 8 July 1876 in Folkestone, Kent, the son of photographer Walter Blackall and Sarah Jane Gilbert.[147] He was offered the post of Medical Officer to the Fremantle asylum in 1904; he then married Ethel Gray Eldrid in Oxford on 24 May 1904, and they sailed to Perth.[148] Blackall worked in the asylum for six years and also took up general practice in Cottesloe.[149] However, due to Montgomery's pressing duties in updating the asylum facilities, Blackall seemingly took on most of the asylum work, detailing the case books from 1905. In 1916, he enlisted and served overseas during World War One, returning to Perth after the war, and in 1919, became an honorary medical officer to the Fremantle Public Hospital.[150] Blackall died in 1941 but had considerable influence over the patients from 1905, and his case book notes reflect a greater attempt to categorise and define the patients he treated.[151]

The medical superintendents and their medical officers had multiple roles in the community and an ever-increasing patient load, which would have made their jobs difficult. In 1891 Dr George Le Fevre, President of the British Medical Association's Victorian branch, noted that 'it is certain that however much of praise is to be accorded to the Superintendents of our asylums for their intelligence, their good management, and their special knowledge, the accommodation afforded is greatly within the limit of what is required'.[152] He stated that 'it is unfair to these gentlemen, whom I know to be most anxious to do all their duty to the unfortunate creatures under their care, that they

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[145] "Family Notices," *The West Australian*, 8.
[146] Ibid.
[147] B.J. Grieve, "William Edward Blackall (1876-1941)," *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, (1979): http://adb.anu.edu.au/biography/blackall-william-edward-5255.
[148] Grieve, "Blackall."; BDMWA: *Certificate of Birth*: Joan (2652/1905), John W. (75/1909).
[149] Ibid.
[150] Stubbe, *Medical Background*, 33.
[151] Ibid; Blackall was also a botanist and remains a world authority on Western Australian flora to this day.
[152] George Le Fevre, "British Medical Association, Victorian Branch Annual Meeting, Wednesday 21st January 1891: President's Address," *Australian Medical Journal* xiii, no. 2 (February 1891): 95. http://hdl.handle.net/11343/23155.

should be prevented from carrying out their good purposes by the overcrowded condition of the institutions of which they have the direction'.[153] Each of the asylum superintendents in Fremantle contributed their aims for modern treatment methods and regimes, which is a testament to their care for the patients. However defunded and dysfunctional the asylum could be, they did their best with the available resources and knowledge. However, on the women's side of the asylum, the matrons and nurses contributed much to female patient experience and treatment.

The Attendants: Matrons and Nurses

While there are rich biographical resources available on the superintendents, there is little on the day to day staff. Initially, under the control of the Imperial Government, the limited funding for mental illness care resulted in the use of convicts as attendants.[154] In fact, until at least 1895, convict orderlies were used for both colonial and Imperial patients in Fremantle.[155] However, they were untrained, and therefore, they could not contribute to a curative regime.[156] In the early nineteenth century, 'the duties of attendants were not clearly defined', though the latter part of the century 'saw a concerted effort to mould attendants into a more efficient and effective workforce'.[157] In Britain, reports were produced on the profession and handbooks began to provide 'formal instruction'.[158] In the Australian colonies, reliance on convicts to do nursing work resulted in convicts also working in asylums, the first mental health nurse was convict Martha Entwistle.[159] As such, until the 1860s nursing was a lowly occupation untaken by untrained men and women.[160] However, in the 1860s to 1870s training became essential for nursing and became almost exclusively a woman's job.[161] The professionalisation of nurses was underway by the 1890s.[162] In 1908, English physician Robert Jones wrote about the importance of a strong mind for mental nurses:

> It is of supreme interest therefore for the mental nurse to possess a well-arranged mind, for she has to be buoyant when hope can scarcely be entertained, and if her own mind is right it helps to correct what is wrong in others and to mollify what is hard in her special

[153] Le Fevre, "British Medical Association: President's Address," 95.
[154] Piddock, "Place for Convicts," 571.
[155] McPherson, "A Class of Utterly Useless Men," 70.
[156] Piddock, "Place for Convicts," 571.
[157] Jennifer Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients, and Practices* (Switzerland: Palgrave Macmillan, 2017), 124.
[158] Wallis, *Investigating the Body*, 124.
[159] Toby Raeburn, Carol Liston, Jarrad Hickmott, and Michelle Cleary, "Life of Martha Entwistle: Australia's First Convict Mental Health Nurse," *International Journal of Mental Health Nursing* 27 (2018): 455. doi: 10.1111/inm.12356.
[160] Odette Best, "Training the 'natives' as Nurses in Australia: So What Went Wrong?," in *Colonial Caring: A History of Colonial and Post-Colonial Nursing*, eds. Helen Sweet and Sue Hawkins (Manchester: Manchester University Press, 2015), 105-106.
[161] Best, "Training the 'natives'," 106.
[162] Ibid.

> surroundings. She has to dignify labour of whatever kind in order to educate and encourage those around her. She has to realise the maxim that sowing corn or writing epics is work which can be equally elevating, that the faculty of effort is necessary for both, and that to master things is to insist on oneself, and thus to be true to the best of our individual self.[163]

In Western Australia there is evidence of a two-year training for nurses from 1895 to 1897 in the Colonial Hospital.[164] The delay of training in Western Australia was due to the power that the Colonial Surgeon held and his refusal to relegate that power.[165] Thus, the colony suffered under a medical dictatorship, whereby medical knowledge was reserved for the men who were formally qualified to practice.[166]

However, attendant asylum work was considered to be fairly consistent employment that provided benefits such as board and lodging.[167] 'Many attendants, particularly women, possessed useful skills and experience in other institutions' and as the 'wage structure encouraged long service', they became 'increasingly experienced over time'.[168] The little evidence on the qualifications or employment history of the staff at the Fremantle asylum poses difficulties in assessing duties; however, some statistical information exists on the numbers of staff employed. There is no data available to determine how many of the attendants were assigned to male or female patients. However, as asylum work was delineated around gender, the female attendants generally only worked with female patients.[169] The number of attendants at the asylum from 1870 to 1875 stayed fairly static; only four in 1870 were employed solely to attend to patients on a permanent, residential, basis.[170] In 1870 the number of male inmates at the asylum averaged fifty-nine, and the average number of females was twenty-five; thus, there were only four attendants permanently employed to attend an average of eighty-four patients.[171] Six more attendants were employed to assist, but as they were not resident at the asylum, their availability is unknown.[172] Those six attendants were employed partially or only as servants, and therefore they would have been engaged in duties such as cook, baker, gardener, laundry attendant, cleaner, and kitchen hand;

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[163] Robert Jones, "The Mental Recreations of the Mental Nurse," *Journal of Mental Science* 54, no. 226 (1908): 495. doi: 10.1192/bjp.54.226.490.
[164] Victoria Hobbs, *But Westward Look: Nursing in Western Australia, 1829-1979* (Crawley: The University of Western Australia Press, 1980), 8.
[165] Hobbs, *But Westward Look*, 5.
[166] Harman, "Out of Mind, Out of Sight," 85.
[167] Lee-Ann Monk, "Working in the Asylum: Attendants to the Insane," *Health and History, Australian Asylums and Their Histories* 11, no. 1 (2009): 96. https://www.jstor.org/stable/20534505.
[168] Monk, "Working in the Asylum," 96.
[169] Lee-Ann Monk, "Gender, Space and Work: The Asylum as Gendered Workplace in Victoria," in *Madness in Australia: Histories, Heritage and the Asylum*, eds. Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), 62.
[170] Harman, "Out of Mind, Out of Sight," 86.
[171] Ibid.
[172] Ibid.

their duties as "attendants" probably only arose in either a minor disciplinary manner or in a crisis, such as locating an escaped inmate.[173] In 1875 one extra female attendant was employed due to the increase in female patients.[174] In the mid to late 1870s , the five resident attendants, assisted by the six non-resident attendants, presided over an average of thirty female and fifteen male patients.[175]

In the 1900 Annual Report on the asylum, Dr Hope noted eighteen male and twelve female attendants which included the principal warder, gardener, cook, baker and clerk on the male side; and the matron, cook and laundress on the female side who had 'little generally to do with the immediate control of the patients'.[176] The proportion of attendants was one to eight for the men and one in seven for the women.[177] Of the eighteen male attendants, only one had previous asylum experience, while the others had a combined variety of careers including gaoler, farmer, engine-driver, sailmaker, and shop assistant.[178] Hope stated that 'with one exception, the attendants are a body of untrained men, who have no appreciation of the scientific advances made in the modern treatment of lunatics'.[179] The majority of the female attendants had worked for more than one year, and four of them had been employed for more than two years.[180] However, little nursing experience was found amongst them, as only four had previous experience in another asylum, and the only certificated attendant worked as the laundress.[181] Even if the attendants had been previously employed in nursing, they were not necessarily competent to work with the insane.[182] Even up to the 1900s, one nurse at night frequently had charge of all female wards, which at that time, numbered approximately eighty-five patients.[183] Although, by 1900, there was a recognition that the care and treatment of lunatics required specialised training and education.[184]

The nurses who were employed at the asylum varied, some only staying for short periods, if the job did not suit, and others for longer periods. The patient registers and case books do not always reveal nurse information other than direct contact or incidences with the patients; however, the *Female Occurrence and Daily Strength Book, 1895 – 1901*, provided greater information on the

[173] Ibid, 86-87.
[174] Ibid, 87.
[175] Ibid.
[176] "Fremantle Lunatic Asylum: Acting-superintendent's Report," *The West Australian*, Perth WA, 2 July 1901, 3.
[177] "Fremantle Lunatic Asylum," *The West Australian*, 3.
[178] Harman, "Out of Mind, Out of Sight," 88; The attendant had worked at Gladesville Asylum in New South Wales for four years.
[179] Ibid.
[180] Ibid.
[181] Ibid.
[182] Ibid.
[183] Ibid, 90.
[184] Ibid.

nurse schedules and jobs. While referred to as nurses, their titles were attendants. The weekly routine was generally one nurse employed indoors, one extra, one relieving, two in the garden or yard, one at seven o'clock, and usually one, sometimes two, on night duty. They received week-long holiday breaks and occasionally nightly leave. The matron was also expected to check in on the night nurse and patients each night at varying times. The biographical information on the nurses who worked in Fremantle across this period is scanty at best, but based on the following information in the remaining records, they were generally young, single, and had little or no asylum or hospital experience.

H. McIlwaine was employed as a nurse at the asylum from at least January 1898. She was the acting Assistant Matron in 1899 during the influenza outbreak in the asylum that left Matron Patterson and Nurse Whealon ill and incapacitated.[185] Ada Hewitt worked with special patients from at least January 1898, and in May she was permanently placed in charge of the special patients.[186] E.A. Barnes was employed from no earlier than January 1898 until November when she no longer appeared in the weekly nurse roster.[187] Margaret Kerr was appointed as a nurse in January 1898 and Margaret Whealon in March 1899, they were both employed until at least 1903.[188] S. McCartney was a nurse from 1896 until August 1898, and M.A. McCormack from at least January 1898; however, both McCormack and McCartney were 'given notice to leave at the end of August' 1898, which they both did, noted at 'off duty in Asylum'.[189] Despite this, in November 1898 McCormack was assigned as the cook by Dr Lovegrove.[190] She eventually resigned in January 1900.[191] Margaret Dalton was appointed as an extra nurse in August 1898, and in January 1900, after McCormack resigned, Dalton complained about not getting McCormack's bedroom and of not having a dressing table.[192] Mary Sutherland was appointed in September 1899 following Wright's resignation; she worked until at least 1903.[193] Alice Sutherland was hired in August 1900, most likely sister to Mary, as they generally took their leave together; she also remained until at least 1903.[194] C. Lee was employed in October 1899 during the influenza outbreak and continued working in the asylum until 1903.[195] Ellie F. Reidy

[185] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 274; 550-551, 4 January 1898; 1-7 November 1899.
[186] Ibid, Folio 274; 332, 4 January; 18 May 1898.
[187] Ibid, Folio 274; 416, 4 January; 28 November 1898.
[188] Ibid, Folio 274, 27 January 1898; Folio 454, 7 March 1899; "The Public Service: Lunatic Asylums," *The West Australian*, Perth WA, 20 March 1903, 6.
[189] Ibid, Folio 378, 28 July; 31 August 1898; "The Executive Council," *The West Australian*, Perth WA, 25 June 1896, 3.
[190] Ibid, Folio 416, 30 November 1898.
[191] Ibid, Folio 584, 24 January 1900.
[192] Ibid, Folio 364; 584, 1 August 1898; 24 January 1900.
[193] Ibid, Folio 526, 1 September 1899; "The Public Service: Lunatic Asylums," *The West Australian*, 6.
[194] Ibid, Folio 656, 1 August 1900; Ibid.
[195] Ibid, Folio 546, 21 October 1899; Ibid.

was appointed in November 1900 and worked until at least 1903.[196] These women worked on rotating rosters spending considerable amounts of time with the patients.

The shorter-term or temporary nurses also had important positions to fill, often in aiding existing female attendants. Mary Campbell was employed in September 1898, a day after McCartney and McCormack were let go; she continued until November 1900.[197] Catherine O'Donnell was hired the day after Campbell in 1898 and resigned in March 1899.[198] Ophelia Thompson was appointed as a nurse in January 1898; she resigned under four months later.[199] J. Seabrook was recruited as a temporary nurse when Thompson resigned in May 1898.[200] Seabrook left after a month and was put in charge of patient Bertha Westley who was discharged into her care.[201] Bertha Matthews was employed as a relieving nurse in January 1899.[202] Matthews is presumably also the same Bertha Matthews admitted to the asylum as a patient in August 1894.[203] She was eighteen years old when admitted of unsound mind with delusions and mania. Matthews was incarcerated for seven months but worked so well that when she was discharged, she was employed as a cook at the asylum.[204] As a nurse, Matthews also had a violent altercation with the patient, Amelia Jeffrie/Jeffrey, who caught 'Matthews by the hair and scratched and knocked her about when she went in to let the patients out' on the morning of 15 February 1899.[205] However, as a patient, she had been violent herself, as in September 1894 she had 'beat Mrs Gaiford on the head—had to be taken out of bedroom and placed in padded room'.[206] However, after the incident with Amelia, Matthews left the asylum.[207] Another temporary nurse, Eva Mary Collinson was appointed in March 1899 when Matthews left, she was only 'engaged for holidays', and in May 1899 she resigned.[208] In February 1900 Collinson returned as a relieving nurse to cover the holidays of M. Sutherland and Lee; she left the asylum in June 1900.[209] Sarah Firns was hired in July 1899, and when Wright resigned, she was appointed as the special nurse.[210] However, in October 1899 Firns left the asylum for a holiday with her brother

[196] Ibid, Folio 702, 29 November 1900; Ibid.
[197] Ibid, Folio 378; 702, 1 September 1898; 30 November 1900.
[198] Ibid, Folio 378; 456, 2 September 1898; 8 March 1899.
[199] Ibid, Folio 274; 324, 21 January; 1 May 1898.
[200] Ibid.
[201] Ibid, Folio 338, 3-4 June 1898.
[202] Ibid, Folio 438, 26 January 1899.
[203] *Case Book Female Patients*, 1878-1897, Folio 169, 16 August 1894.
[204] Ibid, 28 February 1895.
[205] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 446, 15 February 1899.
[206] *Case Book Female Patients*, 1878-1897, Folio 169, 27 September 1894.
[207] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 458, 13 March 1899.
[208] Ibid, Folio 458; 486, 13 March; 23 May 1899.
[209] Ibid, Folio 592; 638, 7 February; 13 June 1900.
[210] Ibid, Folio 502; 526, 3 July 1899; 2 September 1899.

and resigned upon her return.[211] Nurse Smith and Hayes were recruited in October 1899 during the influenza outbreak; however, they were both temporary and left within a month.[212] L. Lloyd worked for less than a month when she was appointed as a temporary nurse in July 1900.[213] Elizabeth Craddom worked four days in December 1900.[214] Eliza Bestwick was appointed in December 1900 and worked until at least early 1901.[215] Other attendants listed in the 1903 public service record were: M. Hamilton, Ada Johnson, Florence Metcalf, and Margaret O'Connor.

However, some nurses left the asylum due to marriage. Mary Jane Jenkinson was employed as a nurse from at least January 1898 and resigned on 30 June 1899 presumably when she married Stephen Louis Simpson in Fremantle that year.[216] Sarah Wright was hired in 1896, and in September 1898 she was appointed as a special nurse by Dr Lovegrove.[217] Wright continued until September 1899 when she resigned and married William Neil.[218] Jane Pimblett was appointed in December 1898 and resigned in June 1900, as she married John Smith Cameron in Fremantle the same year.[219] It can be assumed that these women left paid employment due to their new roles as wives.

Other positions filled by women in the asylum were in the laundry and the kitchen. Helena Schwennesen was appointed as laundress and assistant nurse in September 1898.[220] In November 1900 she was violently assaulted by patients Eliza Oldfield and Matilda Bovell who 'dragged her by the hair through the laundry' and the following day 'Mrs Bovell tried to throw an iron basin full of water at Miss Schwennesen's head'.[221] This incident reveals the dangers of asylum employment. Schwennesen was employed as a laundress, until at least 1903.[222] Kate Larkin was the assistant laundress in 1903.[223] Martha Byers was appointed as a cook in January 1900 until at least early

[211] Ibid, Folio 548; 550, 26-31 October 1899.
[212] Ibid, Folio 544; 548, 16-24 October 1899.
[213] Ibid, Folio 648; 656, 9-31 July 1900.
[214] Ibid, Folio 702; 704, 1-4 December 1900.
[215] Ibid, Folio 708; 718, 12 December 1900; 15 January 1901.
[216] Ibid, Folio 274; 500, 4 January 1898; 30 June 1899; BDMWA: *Certificate of Marriage:* Mary Jane Jenkinson and Stephen Louis Simpson (629/1899).
[217] Ibid, Folio 378, 3 September 1898.
[218] Ibid, Folio 526, 1 September 1899; BDMWA: *Certificate of Marriage:* Sarah Alice Wright and William Neil (674/1899).
[219] Ibid, Folio 416; 642, 1 December 1898; 23 June 1900; BDMWA: *Certificate of Marriage:* Jane Pimblett and John Smith Cameron (709/1900).
[220] Ibid, Folio 380, 5 September 1898.
[221] Ibid, Folio 696, 13-14 November 1900.
[222] "The Public Service: Lunatic Asylums," *The West Australian*, 6.
[223] Ibid.

1901.[224] By 1903 Norah O'Connor worked as the cook, and Gertrude Clark was the kitchen maid.[225] These women were also integral to the running of the asylum.

Of all the women employed at the asylum, it was the matron who had the crucial role as a manager of asylum staff. Asylum 'matrons oversaw kitchens, laundries, dormitories, sick rooms, storerooms, workrooms, and washhouses'.[226] 'They attended to the everyday details of management and surveillance while also setting an example of respectability, sobriety, industry, cleanliness, and piety for the inmates'.[227] Further evidence for some of the matrons employed in Fremantle was recorded in newspapers and Western Australian settler indexes. Mrs Mary Ramsay was the matron in the mid-1800s and her husband Robert, former enrolled Pensioner and sergeant in the Royal Artillery, was also the keeper of the asylum.[228] Frances Anne Pyke was matron from 1873 to 1883.[229] Dr Barnett wrote that Pyke was 'gentle and firm with the patients and intelligent in following directions'.[230] Mrs Delia Campbell was the assistant matron in 1874 and also a midwife in Perth from 1886 to 1889.[231] Mrs C. Dodd worked at the asylum in the 1880s, and Mary Thompson was the matron in 1893.[232] Assistant Matron Mahoney worked at Fremantle into the 1880s; Barnett thought her 'quiet and gentle, understands the peculiarities of each patient and is unremitting in her care and exertions'.[233] In 1888, assistant matrons Nugent, Fay, and Catherine Pass (neé Devlin) worked with Matron Armstrong.[234] In 1898 to at least 1903, Miss Catherine Patterson was the matron.[235]

Margaret Armstrong was a prominent attendant and head matron at the asylum from at least 1885 to 1898, and assistant matron from at least 1880. Armstrong was born in 1842, and there is little biographical information about her until her death in 1923.[236] However, Armstrong was involved in the inquest into patient Alice Longmore's death at the asylum in January 1894 in

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[224] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 584; 715, 23 January 1900; 7 January 1901.
[225] "The Public Service: Lunatic Asylums," *The West Australian*, 6.
[226] Peter Davies, "Mistress of Her Domain: Matron Hicks and the Hyde Park Destitute Asylum, Sydney, Australia," *International Journal of Historical Archaeology* 19, no. 3 (2015): 553. doi:10.1007/s10761-015-0298-1.
[227] Davies, "Mistress of Her Domain," 553.
[228] Erickson, "Bicentennial Dictionary,": R, 2569.
[229] "The Colony's Pension List," *The Messenger*, Fremantle WA, 11 October 1895, 4; "Family Notices: Funeral Notices," *The West Australian*, Perth WA, 25 February 1908, 1.
[230] Martyr, "Unlikely Reformer," 498.
[231] Erickson, "Bicentennial Dictionary,": C, 452.
[232] Ibid, D, 850; "The Executive Council," *The West Australian*, 3.
[233] Martyr, "Unlikely Reformer," 498.
[234] "Greenough Relief Fund," *The Inquirer and Commercial News*, Perth WA, 22 February 1888, 4.
[235] "Lunatic Asylums," *The West Australian*, Perth WA, 24 November 1900, 11; "Libel Action," *The Albany Advertiser*, Albany WA, 14 March 1903, 3.
[236] "Funeral Notices: Armstrong," *The West Australian*, Perth WA, 10 December 1923, 1.

connection with sour milk.[237] Armstrong stated that Alice was put on a milk diet after she became ill but that the milk, which arrived good but turned sour by the afternoon, appeared 'thick and unfit for the patient' with an 'offensive odour'; however, as there was no lactometer at the asylum, she could not test the milk.[238] *The Inquirer and Commercial News* reported that Armstrong gave the milk to Mrs Longmore, 'she did not think that she had done wrong in giving milk in such a condition to a patient on a milk diet'.[239] This claim was odd considering they already stated she had reported the sour milk; Armstrong stated she complained and sent a sample to Dr Barnett.[240] This incident reveals that the matron was responsible for arranging food and drink for patients, reporting to the superintendent, and carrying out his orders.

Interestingly Armstrong was unmarried when traditionally the role of the matron, as the title denotes, went to a married woman. Conolly wrote in 1847 that:

> I believe that where the matron of an asylum is not the wife of the superintendent, it would generally be productive of harmony to have no matron, but in her stead, a head nurse and an assistant nurse in each ward…and perhaps a chief nurse over all, whose duty it would be to carry the superintendent's plans into effect on the female side of the house, reporting to him alone all circumstances appearing to call for his attention. The government of the female side of an asylum would then be assimilated to that of the male side of an asylum, where, certainly, more order generally prevails.[241]

The implication from Conolly was that men were more effective attendants in asylums. However, in 1874, a Visitor to Hanwell, previously run by Conolly, stated that 'nowhere are the ministrations of a gentlewoman with tact and intelligence more valuable than in a Lunatic Asylum, and nowhere is male meddling more misplaced than when interfering with the employments and amusements of female patients'.[242] They added that 'the inconveniences resulting from the natural reluctance of females to confide their bodily ailments as well as their mental grief to a man are often very serious', 'whereas a matron possessing such qualifications as are indicated becomes the trusted friend of the patient and understands and soothes their waywardness'.[243] Concluding, 'medical jealousy of female employment is well known, and redounds but little to the credit of a noble profession, which can well afford to give a fair field of peculiarly appropriate employment to women'.[244] Thus, not all physicians deemed women incompetent in asylum care. In Fremantle, Barnett noted in 1889 that

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[237] "The Lunatic Asylum: Adjured Inquest," *The Inquirer and Commercial News*, Perth WA, 19 January 1894, 29.
[238] "The Lunatic Asylum," *The Inquirer and Commercial News*, 29.
[239] Ibid.
[240] Ibid.
[241] Conolly, *Construction*, 137.
[242] Royal College of Psychiatrists, "Matrons in Lunatic Asylums," *Journal of Mental Science* 19, no. 88 (1874): 646. doi:10.1192/bjp.19.88.646.
[243] Royal College of Psychiatrists, "Matrons in Lunatic Asylums," 646
[244] Ibid.

'Principal Warder John, and Matron Armstrong, the Assistant Warders and Assistant Matrons, have attended carefully and efficiently to their difficult and unpleasant duties'.[245]

Attendants, matrons, and nurses had a profound impact on the patients and would have spent more time with them in their day to day activities and care, than the medical superintendents. It is a shame that more information on them did not survive, but they certainly performed essential duties in the asylum and helped to implement moral treatment ideals.

Keeping Patient Records

Amongst the many new practices that nineteenth-century asylums adopted, was the regular maintenance of detailed records and medical case books that recorded each patient's illness and subsequent treatment.[246] This development emphasised the importance of medical care and specialisation within the asylum, allowing professionalisation in the industry.[247] However, recording in case books was often erratic, and in long-term cases, note-taking deteriorated into rudimentary entries; revealing that medical staff broadly agreed on the unlikelihood of some patients ever improving.[248] The staff often recorded subjective views on patients and provided evidence on the difficulties experienced in trying to maintain an orderly therapeutic environment.[249] In Bethlem, the practice of keeping patient records started in 1815, in response to a parliamentary inquiry in 1814.[250] At first, two visitors were responsible for writing the case books when they visited two or three times a week; however, this was increasingly performed by one resident apothecary.[251] Each case was formatted with a paragraph including patient information taken at admission including the patient's mini-biography and pathography: name, sex, age, occupation, residence, marriage status, number of children, and progress of the disease.[252] From 1832, a handwritten standardised format with fixed sections was added, and in 1837, there was a printed version.[253] Information gathered at admission was followed by subsequent entries, including treatment, remarkable changes, general observation, and significant events such as violent attacks.[254] 'The doctors usually obtained the pre-admission information from those who brought the patient to the hospital…whereas the events

[245] Barnett, *Report Upon the Lunatic Asylum,* 5.
[246] Shepherd, *Institutionalizing the Insane*, 42.
[247] Ibid, 43.
[248] Ibid, 117.
[249] Ibid.
[250] Akihito Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century," in *Insanity, Institution and Society, 1800-1914*, eds. Bill Forsythe and Joseph Melling (Oxon: Routledge, 1999), 117.
[251] Suzuki, "Framing Psychiatric Subjectivity", 117.
[252] Ibid, 117-118.
[253] Ibid, 118.
[254] Ibid.

recorded in the post-admission entries were observed first-hand by them'.[255] James Dunk writes that among the early colonial asylums this asylum bureaucracy was also used, and 'the cure of the insane…was underwritten by paperwork'.[256] Dunk states that it was on paper that patients progress of treatment was recorded and stored among a collective of connected history.[257]

The Fremantle asylum female patient registers and case books followed a similar pattern. However, they were all handwritten and had several inconsistencies. In *Register of Female Patients, 1858 – 1873*, records usually stated at the top of each entry: name, age, marital status, and religion; occupation and residence were infrequent. It also contained whatever history was gleaned from the patient herself, who admitted her, and present symptoms. It had semi-regular monthly updates unless there was a significant event, such as violence or improvement. Some of the medicines administered were also listed. In *Female Register Fremantle Lunatic Asylum Case Book, 1873 – 1878* the full name, age, condition (marital status), religion, and disease were often listed at the top of the page. Information was also provided by the admitting person or sometimes even the patient. They were reported on reasonably regularly; however, occasionally, only the time of check-up was noted. In *Case Book Female Patients, 1878 – 1897*, name, age, and disease were included at the top of each entry, while religion and marital status were recorded sporadically. Information was provided on admission with reasons for insanity, and post-admission notes varied from detailed to merely 'no change', 'no alteration', or 'as usual'. After this case book, three years are missing between Barnett's death, Hope's acting superintending, and Montgomery's appointment. A *Female Occurrence and Daily Strength Book 1895 – 1901* exists but only details daily events for staff and patients, admission, and discharge, rather than single patient case entries; therefore, as there are no consistent patient details the estimated forty-six patients admitted during those years have not been included in the data analysis. The next remaining record was *Case Book Female Patients Chronic Medical Conditions, 1901 – 1908.* This case book is sparse in details, as most patients carried over from previous records, only age and date of admission are included, and all entries were made on the same days with general information. In *Case Book Female Patients, 1901 – 1908*, greater detail is provided. In this case book, a printed heading outlines details to be recorded: date of admission, religion, nationality, age, married or single, occupation, friend, relatives insane, attack and duration, age on first attack, cause, epileptic, suicidal, dangerous, result, disease. Most entries were comprehensive, but some did not have every section filled. It also contained sections for facts communicated, which later became information from the medical certificate; and facts observed, later renamed physical exam

[255] Ibid.
[256] James Dunk, "Work, Paperwork and the Imaginary Tarban Creek Lunatic Asylum, 1846," *Rethinking History* 22, no. 3 (2018): 348. doi:10.1080/13642529.2018.1486956.
[257] Dunk, "Work, Paperwork and the Imaginary Tarban Creek Lunatic Asylum, 1846," 348.

and mental condition. It contained monthly entries which became increasingly more medically focused. *Case Book Female Patients*, *1906 – 1908*, was set out similarly.

The different asylum Superintendents across fifty years, the changing practices, and advances in medicine would account for the differing recording styles. Dr Attfield and Barnett were nineteenth-century physicians, and so the first three case books reflect their knowledge and experience in a generally unregulated industry. They were also extremely busy in the colony with multiple medical roles, including their asylum work. Dr Montgomery and Blackall were twentieth-century physicians whose greater emphasis on medical diagnosis and terms reveal the era's move towards professionalisation.

Chapter Conclusions

This chapter examined the development of the asylum in colonial Western Australia, and the staff employed, revealing the issues and aims for mental health care. The analysis in this chapter illustrated the overcrowded and underfunded realities of the asylum, which impacted the female patient's admissions, discharges, and quality of life. The context of the medical superintendents provides an understanding of the men who kept the records of the female patients. Their busy lives also reveal how demanding the position at the asylum must have been and the potential absences from their role. Examinations of the matrons and nurses also reveal the impact that women had on the treatment of the female patients; they often had greater interaction with the patients and were also at higher physical risk. An investigation of nineteenth-century asylum record-keeping practices also revealed the kinds of information recorded by the medical superintendents and evolving practices.

The staff spent considerable amounts of time with the patients, and their beliefs and behaviours would have influenced patient treatment and care. However, the resulting inconsistencies across the records from different physicians across fifty years affected the detail in what stories remain. In the following chapters, the female patients will be explored through the patient registers and case books to provide greater understandings of their experiences.

CHAPTER FOUR

The Female Patients of the Fremantle Lunatic Asylum

Data within the patient registers and case books reveal much about patient lives and experiences. Such source material is not without its challenges: different approaches to record keeping by various physicians across fifty years result in partial information, and this is reflected in the data.[1] Despite this, at least 452 women were admitted to Fremantle from 1858 to 1908.[2] Each register and case book was examined providing information on the 452 women which was then collated into tables in order to formulate a range of quantitative data on the women admitted. The data assembled and appraised include the age, marital status, occupation, literacy, religion, and nationality of the patients. This chapter provides further insights into the second aim of the thesis and delivers the third aim by creating new knowledge and analysis of the women admitted to the asylum.

When women were first admitted to the asylum, their ages ranged most commonly between twenty to thirty-nine years old; 55.5% of the total female asylum population. The younger patients were aged nineteen and younger (7.3%) and those considered elderly included sixty and above (8%).

Table 4.1: Age of female patients on admission to the Fremantle Lunatic Asylum (1858 – 1908)

	Under 10	10-19	20-29	30-39	40-49	50-59	60-69	70+	N/A
Total	**3**	**30**	**128**	**123**	**69**	**40**	**24**	**12**	**23**
Percentage	0.66%	6.6%	28.3%	27.2%	15.3%	8.8%	5.3%	2.65%	5.1%

The marital status of the patients was also noted by asylum staff on admission. Of all female patients from 1858 to 1908, 45% were married on admission, 24.5% were single, 8.8% were widowed, 1.3% were listed as married and widowed, and 0.88% were recorded as both single and married. However, 19.5% were unknown. Across all registers and case books, married women were admitted

[1] Some information was not provided by physicians in the patient registers and casebooks and therefore not applicable (n/a) is used in the tables.

[2] The figures for all tables were compiled from the following records at the SROWA: *Register of Female Patients*, 1858-1873; AUWA S507, Cons 112004; *Female Register Fremantle Lunatic Asylum Case Book*, 1873-1878; AUWA S2219, Cons 57591; *Case Book Female Patients*, 1878-1897; AUWA S2219, Cons 272403; *Case Book Female Patients Chronic Medical Conditions*, 1901-1908; AUWA S2219, Cons 310301; *Case Book Female Patients*, 1901-1908; AUWA S2219 Cons 310001; *Case Book Female Patients*, 1906-1908; AUWA S2219 Cons 272404.

more than single women. Therefore, on admission to Fremantle, women were generally aged in their twenties to thirties and most likely married.

The nationality listed for women in the asylum was also quite diverse, although this information was not recorded for 45% of patients. Most were listed as colonial or as Australian (31%),[3] and the next largest percentage was British and Irish (19%). However, Victorian was the biggest single 'nationality' (10%).[4] These figures suggest that British and Irish women continued to be admitted, while more women came to be seen as Australian into the twentieth century.

Table 4.2: Nationalities of female patients on admission to the Fremantle Lunatic Asylum (1858 – 1908)[5]

	01 Reg 1858-1873	**02 CB** 1873-1878	**03 CB** 1878-1897	**04 CB** 1901-1908	**05 CB** 1901-1908	**06 CB** 1906-1908	**Total**	**Percentage**
VIC	-	-	1	-	20	24	**45**	10%
English	2	-	2	-	21	14	**39**	8.6%
Colonial	-	1	1	-	31	-	**33**	7.3%
Irish	5	-	1	1	10	13	**30**	6.6%
WA	-	-	1	-	13	13	**27**	6%
SA	-	-	-	-	4	9	**13**	3%
Scottish	1	-	1	1	7	2	**12**	2.7%
NSW	-	-	-	-	4	8	**12**	-
Australian	-	-	-	-	2	3	**5**	1.1%
British	1	-	-	-	4	-	**5**	-
Aboriginal	-	1	1	-	2	1	**5**	-
German	-	-	-	-	4	1	**5**	-
TAS	-	-	-	-	1	2	**3**	0.66%
Japanese	-	-	-	1	1	1	**3**	-
Russian	-	-	-	-	-	2	**2**	0.44%
NZ	-	-	-	-	2	-	**2**	-
QLD	-	-	1	-	-	1	**2**	-
USA	-	-	-	-	1	1	**2**	-
N/A	38	14	92	33	23	3	**203**	45%

[3] This figure does not include the Indigenous Australians admitted as at this time they were not considered part of the colonial Australian identity.
[4] See Table 4.2 for further information on nationalities.
[5] Half-caste, Malay, Italian, and Canadian were also admitted once.

The religion of the women was also varied; however, the biggest single denomination was Roman Catholic (25%). Catholicism in total accounted for 26.3% of all religions, and the various Protestant denominations equalled 40.5%.[6] Therefore, it was mostly women of Protestant faiths that were admitted to Fremantle, with a good percentage of Catholics.

Table 4.3: Religious Denominations of female patients on admission to the Fremantle Lunatic Asylum (1858 – 1908)[7]

	01 Reg 1858-1873	**02 CB** 1873-1878	**03 CB** 1878-1897	**04 CB** 1901-1908	**05 CB** 1901-1908	**06 CB** 1906-1908	**Total**	**Percentage**
Roman Catholic	24	3	8	-	47	32	**114**	25%
Church of England	3	2	3	1	46	4	**59**	13%
Anglican	-	-	1	-	9	28	**38**	8.37%
Protestant	6	7	2	1	5	1	**22**	4.8%
Presbyterian	-	-	-	-	13	5	**18**	4%
Wesleyan	-	-	1	-	8	8	**17**	3.7%
Baptist	-	-	-	-	5	4	**9**	2.2%
Methodist	-	-	1	-	5	4	**10**	-
Catholic	3	-	-	-	2	-	**5**	1.1%
Jewish	1	-	-	-	1	2	**4**	0.88%
Congregational	-	-	-	-	1	3	**4**	-
Church of Christ	-	-	-	-	2	-	**2**	0.44%
Salvation Army	-	-	1	-	-	1	**2**	-
N/A							**145**	32%

Occupations for the female patients varied, with four women having two occupations listed, resulting in 457 occupations from 1858 to 1908.[8] Domestic work was the most frequent profession (23.6%). Of the 108 women in domestic jobs, 84.3% were listed under the general term 'domestic' or 'domestic servant'; the variations are listed in Table 4.4. Interestingly, household-related duties were mentioned in the occupation section and were also significant with ninety-six references (21%) such as: 'housework', 'housewife', 'housekeeper' or 'home duties'. However, 214 women (47.3%) did not have any occupation listed and thus can be assumed to have not worked in paid employment, or the physician did not record the information. Some of these professions would have required literacy,

[6] See Table 4.3 for further information on religious denominations.
[7] Shinto, Lutheran, and Plymouth Brethren were also admitted once.
[8] See Table 4.4 for further information on occupations.

something that was rarely noted in the registers and case books. Dr Attfield made more effort in 1858 to 1872; however, 94% of the women did not have this skill mentioned in their records. Only, ten women were noted to be able to write, eight to read, six for reading and writing, and three were listed as illiterate. Therefore, most women admitted to the asylum were domestic workers or housewives, while the literacy levels were not well-reported and possibly quite low.

Table 4.4: Occupation of female patients on admission to the Fremantle Lunatic Asylum (1858 – 1908)[9]

	01 Reg 1858-1873	**02 CB** 1873-1878	**03 CB** 1878-1897	**04 CB** 1901-1908	**05 CB** 1901-1908	**06 CB** 1906-1908	**Total Number**	**Percentage**
Domestic/Domestic servant	11	1	8	-	39	32	**91**	20.1%
Housework	-	-	1	-	25	23	**49**	10.8%
Housewife	-	-	1	-	37	2	**40**	8.8%
Home duties	-	-	-	-	-	7	**7**	1.5%
Cook	-	-	-	-	3	3	**6**	1.3%
Tailoress	-	-	-	-	4	2	**6**	-
Laundress	-	-	-	-	3	2	**5**	1.1%
Housekeeper	-	-	-	-	-	4	**4**	0.88%
Dressmaker	-	-	1	-	2	1	**4**	-
Washerwoman	-	-	-	-	3	-	**3**	0.66%
Prostitute	-	-	1	-	1	-	**2**	0.44%
Ex-nurse	-	-	1	-	1	-	**2**	-
Palmist	-	-	-	-	1	1	**2**	-
School girl	-	-	-	-	2	-	**2**	-
Teacher	-	-	-	-	2	-	**2**	-
Waitress	-	-	-	-	2	-	**2**	-
N/A							**214**	47.3%

Admission and Discharge

Medical superintendents and medical officers were required to follow specific procedures when admitting patients to the asylum. In Britain, in private and public sectors of asylums medical certificates were required for admission and doctors with interests in the facility were not to sign

[9] One patient was listed with the following occupations: milliner, nurse, ex-school mistress, companion, billiard saloon keeper, shop keeper, draper, chemist's assistant, bookbinder, living at home.

admission forms.[10] In Fremantle, the few physicians available in the colony resulted in medical superintendents sometimes having no alternative but to sign certificates and admit patients. In Britain, families wanted care and control for dependent and violent relatives, and 'although small numbers of inmates were arrested and confined for vagrancy, the majority were admitted by family members'.[11] Wright notes that in England, 'decisions over confinement rested on a delicate negotiation between families, local medical practitioners and Poor Law officers' with an 'interdependence between household and medical authority'.[12] Marriage ownership ideals of a husband over his wife held by nineteenth-century society affected committal, and in Australia, 'Europe, and North America a man had the legal right to lock up his perfectly sane wife or daughter' if he wanted.[13] Eileen Clark writes, of her study of Beechworth Lunatic Asylum in Victoria in the early twentieth century, that families played significant roles in providing evidence to led to patient admission, and were important in taking charge of the patients after discharge.[14]

By the middle of the nineteenth-century British asylum records revealed that women were the majority of patients in public asylums.[15] However, this was not the experience in Western Australia. In the Fremantle asylum, the number of women always stayed below that of the men, except in 1875 when the female population was twice that of the male population (which was one-quarter of the numbers of incarcerated men in 1870).[16] This was due to the end of convict transportation in 1868 and the implementation of the *Lunacy Act 1871*: which required, for the first time, a medical certificate of insanity from a registered medical practitioner before admission.[17] The introduction of this law affected the number of male inmates but not the female.[18] Women were more likely to be deemed insane on the grounds of drunkenness, prostitution, or contraction of venereal disease, than men due to the level of moral transgression attached to these acts.[19] Thus, the measures introduced in the act affected the medical judgement of the male section of society

[10] Peter Bartlett and Ralph Sandland, *Mental Health Law: Policy and Practice*, 4th ed (Oxford: Oxford University Press, 2014), 58.
[11] David Wright, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century," *Social History of Medicine: The Journal of the Society for the Social History of Medicine* 10, no. 1 (1997): 139; 145. https://doi-org.ipacez.nd.edu.au/10.1093/shm/10.1.137.
[12] Wright, "Delusions of Gender?," 152.
[13] Chesler, *Women and Madness*, 4.
[14] Eileen Clark, "Lessons from the Past: Family Involvement in Patient Admission and Discharge, Beechworth Lunatic Asylum, 1900–1912," *International Journal of Mental Health Nursing* 27 (2018): 326. doi: 10.1111/inm.12323.
[15] Showalter, *Female Malady*, 3.
[16] Harman, "Out of Mind, Out of Sight," 104.
[17] *The Lunacy Act*, Section 13-14.
[18] Harman, "Out of Mind, Out of Sight," 105.
[19] Ibid.

but had little effect on the definition of insanity amongst women.[20] Shurlee Swain notes that 'despite the demographic imbalance that marked most of the Australian colonies, women predominated amongst the poor', which meant that women 'came to signify a threat to the social order well beyond individual plight'.[21] Thus, it was not only an issue of gender but one of class and situation. Coleborne argues that 'this "threat" was embodied by the sometimes violent or disruptive female asylum inmate, but also by the physically weak and demoralised figures of the insane woman whose responsibilities to home, husband, and family could not be met'.[22]

In Fremantle, most of the women were classified insane on the information provided by their husbands, which suggests that women were often judged by law enforcement and asylum staff according to their husband's stories.[23] In Fremantle, doctors, Justices of the Peace, and Regional Magistrates accounted for 61.5% of all admissions from 1858 to 1908. Male relatives admitted 19% of female patients, of which husbands accounted for 11.73%. Female relatives accounted for 2.65%, which reveals that admission decisions were left to men.[24]

Table 4.5: Those who admitted female patients to the Fremantle Lunatic Asylum (1858 – 1908)[25]

	Total	Percentage		Total	Percentage
Doctors/RM/JPs	278	61.5%	**Friends**	5	1.1%
Husband	53	11.7%	**Police/Police Magistrate**	5	-
Brother	10	2.2%	**Colonial Hospital**	4	0.88%
Father	10	-	**Colonial Secretary**	4	-
Mother	8	1.77%	**Governor**	2	0.44%
Prison	7	1.55%	**Brother in law**	2	-
Son	7	-	**Sister**	2	-
Medical Board	6	1.3%	**N/A**	57	12.6%

[20] Ibid.
[21] Shurlee Swain, "Writing the History of Women and Welfare," *Australian Feminist Studies* 22, no. 52 (2007): 43, doi: 10.1080/08164640601145046.
[22] Coleborne, "Insanity, Gender and Empire," 84.
[23] Harman, "Out of Mind, Out of Sight," 110.
[24] See Table 4.5 for further information on those who admitted patients.
[25] Nephew, Stepfather, Grandson, son-in-law, sister-in-law and daughter also admitted a patient once. If patient a was admitted more than once by the same person or institution it was only counted once, some were admitted by two different ones.

Similarly, the discharge of patients could be 'precipitated by one of two agents: by order of the medical superintendent or by request of the family'.[26] The asylum superintendents took the opinions and requests of the husband's seriously and were less likely to discharge a woman who did not have the support of a husband, friend, or family.[27] In Britain, 'relatives could request the discharge of a patient', regardless of whether they were improved, which 'required a separate form and personal undertaking'.[28] The medical superintendent had the right to refuse the request for discharge if they felt the patient in question was dangerous and unfit to be released, but a Visiting Committee or government order could overrule them.[29] However, it was often husbands who requested the release of their wives. The prolonged absence of a wife left husbands to fend for themselves and could result in children being sent to poor homes or orphanages.[30] Therefore, repeated requests for discharge were often granted. For example, Bridget McDonald's husband, Pat, admitted her to the Fremantle asylum in March 1879 with religious delusions; however, by April, 'her husband applied for her discharge, stating that he would take care of her. She is quieter and I recommend her discharge to care of the husband. Discharged to care of husband according to Sec 32 Lunacy Act on his written request'.[31] The 1871 act outlined that the 'person who signed order for the reception of a private patient may order his discharge or removal'.[32] In this case, as her husband admitted her, he also had the power to remove her.

In Fremantle, of the 452 patients, 37% were discharged at some point from the asylum; 30.5% were discharged once, and 6.6% were discharged multiple times. The other patients across 1858 to 1908 were those who died in the asylum (24%) and those transferred to Claremont (38.5%). Therefore, there was just as much chance that a patient would be discharged as there was to be transferred to Claremont. However, a bulk of the patients transferred to Claremont were admitted in the twentieth century and had less time to recover and be considered for discharge than women admitted in the nineteenth century.[33]

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[26] David Wright, "The Discharge of Pauper Lunatics from County Asylums in mid-Victorian England: The Case of Buckinghamshire, 1853-1872," in *Insanity, Institution and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, eds. Joseph Melling and Bill Forsythe (Oxon, Routledge, 1999), 98.
[27] Megahey, "More Than a Minor Nuisance," 57.
[28] Wright, "The Discharge of Pauper Lunatics", 98.
[29] Ibid.
[30] Patricia E. Prestwich, "Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914," in *The Confinement of the Insane: International Perspective, 1800-1965*, eds. Roy Porter and David Wright (Cambridge, Cambridge University Press, 2003), 94.
[31] *Case Book Female Patients*, 1878-1897, Folio 36, 6 March; 22 April 1879; Bridget's sister Catherine Hackett was also admitted in 1883.
[32] *The Lunacy Act* 1871, section 32.
[33] See Table 4.6 for further information on discharge, death, and transfer information.

Table 4.6: Female patients discharged, died, or transferred in the Fremantle Lunatic Asylum (1858—90)

	01 Reg 1858-1873	02 CB 1873-1878	03 CB 1878-1897	04 CB 1901-1908	05 CB 1901-1908	06 CB 1906-1908	Total	Percentage
Discharged once	8	7	37	8	49	29	138	**30.5%**
Discharged multiple	4	2	12	1	10	1	30	**6.6%**
Transferred	4	3	30	21	59	57	174	**38.5%**
Died	32	4	22	6	34	11	109	**24%**
N/A	-	-	1	-	-	-	1	**0.2%**

Of the seventy-one patients who were readmitted at least once, there were those who were discharged again (42.3%), died in the asylum (26.7%), and transferred to Claremont (30%). Therefore, if a patient was readmitted, they were likely to be discharged again. Of the 209 patients that were discharged, most were discharged to male relatives (24.4%, including husbands, which alone accounted for 17.7%) and female relatives (11.5%).[34] Therefore, if a patient was discharged, it was most likely to a male relative. The female patients were more likely to be discharged to a female relative than admitted by one, which suggests that although having less control over committal the female relatives could often be responsible for post-incarceration care. However, of the patients discharged, 59% did not have whom they were discharged to noted in their records.

Table 4.7: Female patients discharged to family from the Fremantle Lunatic Asylum (1858 – 1908)[35]

	Total	Percentage		Total	Percentage
Husband	37	17.7%	**Relatives**	3	1.4%
Mother	12	5.7%	**Son**	2	0.95%
Friends	11	5.3%	**Employment**	2	-
Sister	10	4.8%	**Father in Law**	1	0.48%
Brother	6	3%	**Parents in Law**	1	-
Father	4	2%	**Poor Home**	1	-
Daughter	4	-	**N/A discharged**	123	59%

[34] See Table 4.7 for further information on who the patients were discharged to.
[35] Some of the patients who were discharged were readmitted and later died or were transferred. Therefore 209 patients were discharged. Some were discharged to multiple people. If they were discharged to their husband multiple times, it was only counted once.

Classification and Diagnosis

As explored in Chapter One, there were several types of 'insanity' that a patient could be diagnosed with, such as mania, melancholia, monomania, delusional insanity, imbecility or idiocy (intellectual disability), and moral insanity. The 'early practitioners of psychiatry were men of science and classification came readily to them'.[36] Classification was 'attractive to medical superintendents of asylums' who observed insanity within a closed system; however, they sometimes failed to take on complexities.[37] The value of classification was seen in ensuring the correct therapeutic approach was implemented.[38] Early attempts were rudimentary with convalescents separated from incurables and the noisy from the quiet; these relatively crude categories became more refined over time.[39] Tuke also believed in classification and separation; organising patients into smaller groups ("little families") and proposed classification on the extent of the disease rather than the diagnosis itself.[40]

In Australia, the classification and separation of patients were also encouraged. In New South Wales imbeciles and idiots, acute cases, and chronic patients were all housed in different institutions in Newcastle, Gladesville, and Parramatta Asylums.[41] In Victoria, Ballarat housed idiots and imbeciles, while the more chronic cases were accommodated at Yarra Bend Asylum; leaving Kew, Beechworth, and Ararat, for further categorisation.[42] Fremantle compared unfavourably; in 1879, Dr Frederic Norton Manning, the Inspector General of the Insane in New South Wales noted that Fremantle was a 'well-ordered establishment, standing in extensive grounds, and possessing abundant cubic space per inmate. Its chief drawback, inherent in almost all small asylums, is want of classification'.[43] Manning did note that 'the convict patients are, however, kept in a separate ward, and are subject to the visitation and treatment of a separate medical officer' and that the 'rate of recovery is very high'.[44] Dr Barnett continually addressed this issue; in his 1882 Annual Report, he stated 'once more respectfully urge that the needful steps should be taken to enable me to effect a separation between the quiet and curable patients and the noisy and incurable cases'.[45] In 1886, he again mentioned 'the crying need which exists for a separation of incurable patients from those

[36] David Pilgrim, *Understanding Mental Health: A Critical Realist Exploration* (Oxon: Routledge, 2015), 9.
[37] Pilgrim, *Understanding Mental Health*, 9.
[38] Shepherd, *Institutionalizing the Insane*, 119.
[39] Ibid.
[40] Ibid.
[41] Harman, "Out of Mind, Out of Sight," 52.
[42] Ibid.
[43] Frederick Manning, "Statistics of Insanity in Australia," *Journal of Mental Science* 25, no. 110 (2018 [1879]): 177. doi: https://doi-org.ipacez.nd.edu.au/10.1192/bjp.25.110.165.
[44] Manning, "Statistics of Insanity in Australia," 177.
[45] Barnett, *Report Upon the Lunatic* Asylum, 3.

whose reason is only for a brief time under a cloud'.[46] Barnett stated, 'at present the want of space and of attendants necessitates that cases of temporary insanity, amendable to treatment and above all things requiring quiet and rest, should be associated and eat their meals with incurable congenital idiots and noisy maniacs'.[47] By 1889, he wrote:

> However wearisome my reiterated complaints may be, I feel compelled to continue to advocate and press for those changes which I know are required. The correctness of my assertions as to the advisability of separating curable from incurable patients has never been questioned, yet I have been left year after year to get on as best I could with unsuitable buildings and overworked attendants.[48]

Despite Barnett's complaints, female patients continued to be placed together at the asylum, and once Claremont was complete in 1908, further classification was implemented. However, 'unsatisfactory separation and differentiation of care for patients' continued in Claremont.[49]

The psychiatric classifications in the mid-nineteenth century were mania, melancholia, dementia, and idiocy and they were often 'applied to men and women using consistent criteria across the genders'.[50] This was also the case for the women admitted in the Fremantle Lunatic Asylum across 1858 to 1908. However, patients in the Fremantle asylum could be admitted with more than one reason for admission; therefore, the data relates to terms used rather than one term per patient.[51] Of the 452 female patients from 1858 to 1908 delusions accounted for 24% of admissions, 19% for mania, 12.4% for dementia, and 10.8% melancholia. However, a gender specific category of puerperal insanity did account for 13.5% of female patient admissions. Further categories reveal that women were admitted for issues with moral insanity (21%), the female body (17.4%), intellectual disability (6.6%), and old age (5%).[52] There were fifty-eight different reasons for admission and although varied and sometimes overlapping, this reveals an attempt from physicians to understand the reason for insanity and to best treat it. However, delusional insanity was a significant proportion of the admissions and may have been used as an umbrella term to cover many variations of mental illness. Puerperal insanity was also significant due to the lack of contraception and domestic pressures on women. To a modern eye, these classifications sometimes seem arbitrary or misdiagnosed. However, they represent a nineteenth and twentieth-century understanding of

[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] David T. Roth, "'Died Today': The Brief Lives of Patients at Claremont Hospital for the Insane, 1909-1919" (Master's Thesis, Australian National University, 2015), 61.
[50] Wright, "Delusions of Gender?," 152.
[51] *Case Book Female Patients Chronic Medical Conditions, 1901-1908* did not list any reasons and as such the diagnosis was assumed from terms used in their reporting.
[52] See Table 4.8 for further details on reasons for admission.

insanity and related symptoms. It also reveals nineteenth-century attitudes towards women, their roles in society, and illnesses, which will be explored in greater detail in Part III. Despite some of the smaller data sets in some categories, there is merit in examining the gender specific diagnoses, as they provide further insights into the women's experiences with the labelling of madness and their interactions with the asylum, their families, or the public.

Table 4.8: Reasons for admission to the Fremantle Lunatic Asylum (1858 – 1908)[53]

	Total	Percentage		Total	Percentage
Delusional	108	24%	**Martial cruelty**	8	1.77%
Mania	86	19%	**Unsound mind**	7	1.54%
Puerperal	62	13.7%	**Violence**	6	1.33%
Dementia	56	12.4%	**Menstruation**	6	-
Melancholia	49	10.8%	**Drugs**	6	-
Alcohol	31	6.85%	**Old age**	5	1.1%
Pruriency	30	6.6%	**Sunstroke**	5	-
Suicidal	22	4.8%	**Hallucinations**	5	-
Imbecile	21	4.6%	**Deranged**	5	-
Epilepsy	19	4.2%	**Brain injury**	4	0.88%
Hysteria	18	4%	**Homicidal mania**	4	-
Religious	18	-	**Depressed**	3	0.66%
Senile dementia	15	3.3%	**Shock**	3	-
Prostitution	15	-	**Domestic trouble**	3	-
General Paralysis (G.P.)	11	2.4%	**Cancer**	2	0.44%
Menopause	11	-	**Sexual assault**	2	-
Idiot	9	2%	**Weak minded**	2	-
Heredity	9	-	**Heart disease**	2	-
Heart broken	9	-	**Congenital syphilis**	2	-
Worry	9	-	**Money**	2	-

[53] The following had one admission: moral insanity, choleric, rheumatic fever, typhoid fever, senile debility, operation, senile mania, delirium tremens (D.T.), optic nerve, fright, defective memory, over study, senile decay, manic-depressive, paralytic stroke, internal trouble, psychosis polyneuritica, deaf and dumb.

Appearance of Insanity

The medical superintendents' aims to categorise and treat patients were reflected in the notes in the patient registers and case books. However, there was a distinct emphasis placed on how the female patients physically appeared, and visual assessments continued to be made from 1858 to 1908. The late nineteenth century saw fears of social degeneration through an emphasis on eugenics and selective breeding.[54] Eugenics practices involved the belief that some human life was more valuable than others, often involving mental state and physical appearance.[55] Victorian studies in physiognomy were also prevalent in asylums, offering a way to make judgements of people's character based on physical appearances or attributes.[56] Physicians in the Fremantle asylum would have been influenced by these practices and theories; thus, comments ranged from favourable, denoting improvements, to negative physical markers of insanity.

The favourable comments on appearance often demonstrated desired mental state, such as Mary Kirtley who was aged sixty-three when admitted in January 1906, 'a stout, well-developed woman of pleasing and intelligent appearance'.[57] Selina Turner was also described favourably in 1874, 'mind is being gradually restored and she looks much plumped and more cheerful'.[58] Anne Smith was aged thirty and single when admitted in June 1874; after admission, she was noted as 'looks more cheerful but will not reply to questions'.[59] These comments emphasise appearance as an indicator of sanity; although perhaps unimproved their appearance was part of the assessment.

The comments on appearance also denoted how "insane" the patients looked, which impacted their assessment and categorisation across the nineteenth century. When Catherine Casey was admitted aged twenty-one with dementia, in July 1862, she was described as having a 'small head, small eyes with a dull stony gaze, still expressionless features'.[60] Such descriptions continued as with Mary Hunter who was aged thirty-seven when she was admitted with dementia in September 1864; she had an 'insane and occasionally vacant expression, small emaciated looking woman'.[61] Charlotte Pidgen was twenty-six years old when admitted with partial dementia in April

[54] Showalter, *Female Malady*, 110.
[55] Alison Bashford and Philippa Levine, eds., *The Oxford Handbook of the History of Eugenics* (Oxford: Oxford University Press, 2010), 3.
[56] Sharrona Pearl, *About Faces: Physiognomy in Nineteenth-Century Britain* (Massachusetts: Harvard University Press, 2010), 3.
[57] *Case Book Female Patients*, 1901-1908, Folio 315, 10-11 January 1906.
[58] *Female Register Case Book*, 1873-1878, Folio 132, 15 June 1874.
[59] *Register of Female Patients*, 1858-1873, Folio 127, 11-15 June 1874.
[60] Ibid, Folio 52, 9 July 1862.
[61] Ibid, Folio 74, 2 September 1864.

1888, Dr Barnett wrote that 'her face is without expression'.[62] Ada Huges was aged twenty-four with homicidal mania in April 1895, and was described as having 'vacuity of expression'.[63] Therefore, vacant expression was indicative of insanity to nineteenth-century physicians.

Expression was also crucial in Sarah Burns' case. Sarah, a twenty-four-year-old maidservant, was admitted in July 1858 described as 'stout, dark with a restless expression' but 'appears in good health'.[64] However, by the end of August, it was noted 'her expression is that of an insane person, she has a blank unintelligent expression when spoken to'.[65] Although Dr Attfield noted she 'appears quite happy and in good health'; but still had 'an insane mischievous look'.[66] The descriptions continued into 1859, as he stated she continued 'to have an insane look and expression and is apt to be mischievous…If it were not for the expression of her eye it would be very difficult to pronounce her insane'.[67] This assessment was compounded in March, with the comment 'her general expression is highly indicative of insanity' and in January 1861, 'she has a very insane and furtive expression of eye'.[68] She also had 'very scanty and irregular' catamenia (menstruation), and she was 'invariably worse' at those times.[69] Therefore, Sarah's expressions were an essential element in Attfield's assessment of her mental state.

Similar descriptions were also used in the early twentieth century. Louisa Scott was noted as 'looks utterly miserable and thinks she is paralysed' in June 1902.[70] Nellie McDonald was a twenty-five-year-old single domestic servant admitted for mania in March 1902; 'she does not seem to have any delusions or hallucinations, but she has the appearance of insanity' and 'smiles insanely'.[71] Hannah Walsh was a thirty-two-year-old single dressmaker with acute mania, noted in November 1902 as 'looks very mad' with 'wild expression'.[72] Margaret June Milne Johnstone, a Scottish twenty-seven-year-old single housemaid with acute melancholia was admitted in April 1903; 'looks very depressed and miserable'.[73] Christina Ward was admitted in May 1903, a thirty-eight-year-old housewife with puerperal mania, 'manner and appearance that of an insane person'.[74] Margaret Henderson was a forty-seven married domestic with melancholia noted in December 1906 to have

[62] *Case Book Female Patients*, 1878-1897, Folio 131, 26 April 1888.
[63] Ibid, Folio 177, 10 April 1895.
[64] *Register of Female Patients*, 1858-1873, Folio 7, 12 July; 4 August 1858.
[65] Ibid, 28 August 1858.
[66] Ibid, 23 October; 27 November 1858.
[67] Ibid, Folio 24, 6 January 1859.
[68] Ibid, Folio 24-36, 9 March 1859; 31 January 1861.
[69] Ibid, Folio 48, 2 February 1864.
[70] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 26, 11 June 1902.
[71] *Case Book Female Patients*, 1901-1908, Folio 25, 20 March 1902.
[72] Ibid, Folio 65-66, 24 November; 1 December 1902; 30 March 1903.
[73] Ibid, Folio 81-82, 3 April 1903.
[74] Ibid, Folio 89, 20 May 1903.

'vacant apathetic expression' and 'vacant expressionless face with occasional appearances of anxiety'.[75] These women reveal the emphasis placed on visual assessments and physical appearance as an indicator of insanity and a tool in diagnosis that was used into the twentieth century.

The use of visual markers, expressions, or eyes, to classify and diagnose the patients was used across 1858 to 1908. These women are few of several other cases in the following chapters where visual comments and assessments are made. Visual assessments would have impacted assessments of improvement relating to admission and discharge; therefore, significantly impacting the lives of the female patients in Fremantle.

Chapter Conclusions

This chapter provided new insights into female patient data at the Fremantle asylum. Based on the data collected across several case books, the female patients ranged in age between twenty and thirty-nine, were Australian, Protestant, married, and probably suffered from delusions. The chapter then identified that most women were admitted by a doctor, Regional Magistrate or Justice of the Peace, but were also likely to be admitted by a male relative or husband. This pattern was also apparent in discharge, as women were most often released to family and unlikely to leave the asylum without a family member. These practices had an impact on female patients as their male relatives provided information about them on admission, controlling the process of committal and discharge. This control could have dire consequences at times, as will be explored in the following chapters. Lastly, this chapter explored the classification and diagnosis of female patients in the asylum. However, due to the overcrowded nature of Fremantle's wards, classification was almost impossible. Although the use of visual diagnosis revealed how physicians used visual markers and descriptions to diagnose insanity or assess improvement. This practice contributed to the growing professionalisation of asylum treatments in the nineteenth and early twentieth centuries.

Thus, this chapter assembled data to provide a general understanding of the women in the asylum while also constructing a range of variations and inferential data. As the female patient experiences at the asylum drive the thesis, this chapter is essential for the following chapters in which their lives, treatments, and experiences are investigated further.

[75] Ibid, Folio 59, 28-29 December 1906.

CHAPTER FIVE

Moral Rehabilitation

The lives of the women admitted to the Fremantle asylum were diverse. As investigated in the previous chapter, they were different ages, at different stages of their lives, and had a variety of mental symptoms and responses. However, they all experienced very similar treatment in the asylum. The nineteenth-century theory of moral treatment greatly impacted how Fremantle ran their asylum, treated, and rehabilitated their patients.

As explored in Chapter One, moral treatment heavily emphasised the idea of work as rehabilitation in asylums. In nineteenth-century Australia, the 'asylum world offered little distancing from the cares of everyday life' for women; something that moral treatment pioneer Conolly encouraged.[1] Conolly also believed that 'ladylike values of silence, decorum, taste, service, piety, and gratitude', were integral parts of the treatment; he claimed to have 'successfully imposed this on even the wildest and most recalcitrant female maniacs'.[2] The 'association of women with domesticity ensured almost constant employment in the asylum laundry, and sewing and knitting'; 'the non-specialised nature of these jobs resulted in ordinary day rooms being used for work, providing little diversification in women's lives'.[3] Contrastingly, male patients were 'rarely employed beyond physical labouring in the grounds of the asylums'; domestic tasks were deemed unsuitable for men and therefore would not contribute to their recovery.[4] In Victoria's Kew Asylum in the 1886 it was reported by Dr William Moore that 'a great number of women find employment in the laundry, and seem quite contented and even happy at their work. Others are engaged in sewing, and a great number of the worst patients, both men and women, are occupied picking oakum'.[5] He stated that 'it is astonishing that so many, who might be expected to be noisy, are wonderfully quiet over their work'.[6] At Kew, and other colonial asylums, 'the medical attendants recognise the importance of employment as a means of furthering recovery, hence all the work about the institution is done by the patients, with the assistance of the ordinary attendants'.[7] In Fremantle,

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[1] Piddock, "Ideal Asylum", 46.
[2] Showalter, *Female Malady*, 79.
[3] Piddock, "Ideal Asylum", 46..
[4] Ibid; Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (New York: Editions Rodopi B.V., 2008), 71.
[5] William Moore, "Notes of a Visit to the Kew Asylum," *Australian Medical Journal* viii, no. 3 (March 1886): 98. http://hdl.handle.net/11343/23150.
[6] Moore, "Notes of a Visit to the Kew Asylum," 98.
[7] Ibid.

work was encouraged, and a reluctance to perform household tasks was punishable, incurring longer stays.[8] In his 1889 Report, Dr Barnett wrote that 'the male patients are occupied in gardening, cutting firewood, pumping water, cooking, cleaning the premises, etc., and the women do all the washing, and make their own clothing'.[9] The emphasis was placed on a willingness to work, rather than the amount of work completed; this paralleled moral treatment ideas since a willingness to be useful was indicative of a healthy mind.[10] It was the activity itself that 'was thought to be therapeutic rather than the end-product'.[11]

Nineteenth-century women would have been very familiar with juggling domestic work. British sociologist Ann Oakley writes that for women 'orientation to the housewife role involves the issues of self-concept, gender identity and sub-cultural norms of feminine role-behaviour'.[12] The standards of this role of housewife were often difficult to meet given the demands on her time, and the impact that, often multiple, children could have.[13] Thus, in the asylum, nineteenth-century physicians reinforced stereotypes of femininity on women who defied their gender roles by forcing them to complete domestic tasks.[14] As Judith Butler states, gender is culturally constructed, and as such women's acceptable ladylike behaviour was also constructed by nineteenth-century society. Butler states that people are only recognised through gender intelligibility; therefore, identity is established through sex and gender, and the very notion of a person is called into question if they do not act as the culturally established norm of that gender.[15] Anne Summers writes that 'femininity is a cultural imposition upon the female sex, an artificial contrivance designed to replace natural conduct and appearance with conventions which make their governing easier'.[16] This theory is apparent in defining mentally ill behaviours for women and men. Jane Ussher writes that women who reject the female role are likely to be labelled mad.[17]

This chapter examines the female patients in the asylum who experienced domestic work as rehabilitation through investigation of the patient records. This treatment involved the assignment of domestic tasks like laundry, cleaning or sewing as a way to "cure" women's insanity by reinforcing "sane" and expected behaviours for women: the ability to care for their family. The women had

[8] Harman, "Out of Mind, Out of Sight," 117.
[9] Barnett, *Report Upon the Lunatic Asylum*, 5.
[10] Harman, "Out of Mind, Out of Sight," 117-118.
[11] Digby, "Moral Treatment", 63.
[12] Ann Oakley, *The Sociology of Housework (Reissue)* (Bristol: The Policy Press, 2018), 73.
[13] Oakley, *The Sociology of Housework*, 55; 159.
[14] Showalter, *Female Malady*, 86.
[15] Butler, *Gender Trouble*, 10-23.
[16] Summers, *Damned Whores and God's Police*, 367.
[17] Ussher, *Women's Madness*, 168.

various responses to the treatment method with some discharged cured after taking on domestic tasks, while others were discharged potentially still unwell, and some women were readmitted. There were also those whose behaviours or illnesses prevented discharge, such as the long-term and violent patients or the intellectually disabled. This chapter reveals that the use of moral treatment through domestic work as rehabilitation on the women in the asylum reinforced nineteenth and early twentieth-century ideas of womanhood.

'Discharged Recovered'

Almost all female patients in the Fremantle asylum were expected to do some form of domestic work. The following women are a selection of the "successful" patients who managed domestic tasks allowing them to be considered well enough for discharge.

As the women had to be discharged to a family member and husbands often desired the return of their wives, married women were often released after reasonably short periods as is the case for Ada, Mary, Katherine, and Sarah. Ada Woodward was admitted by her husband with acute mania in October 1902.[18] Ada was deluded, excited, noisy, and believed Dr Montgomery to be her husband.[19] However, within a few weeks, she was slightly better and began a little sewing.[20] By January, Ada was much better, quiet, orderly, and working well, and so she was discharged recovered after four months.[21] Mary Martin was a thirty-six-year-old housewife admitted with acute mania in April 1904: she was noisy, excited, violent, and destructive.[22] Mary's bad behaviour continued as she tore her clothing, was untidy in her habits, deluded, and incoherent.[23] However, by July, she became quieter and worked well.[24] This improvement was maintained, and Mary was discharged recovered in September.[25] Katherine Stapp was aged thirty-eight when she was admitted in November 1903 with delusional mania.[26] Katherine believed her persecutory hallucinations were visions sent from God; she was quiet, depressed, and nervous.[27] However, she was soon noted as quiet and orderly, worked well and gave little trouble, although she was still deluded.[28] By March, Katherine was less nervous, quiet and industrious; the good behaviour was maintained, and she was

[18] *Case Book Female Patients*, 1901-1908, Folio 63, 25 October 1902.
[19] Ibid.
[20] Ibid, 3-10 November 1902.
[21] Ibid, 14 January; 25 February 1903.
[22] Ibid, Folio 169, 19 April 1904.
[23] Ibid, 28 April; 7 May 1904.
[24] Ibid, 13 July 1904.
[25] Ibid, 3 September 1904.
[26] Ibid, Folio 131, 2 November 1903.
[27] Ibid, 7 November 1903.
[28] Ibid, Folio 132, 14 December 1903.

discharged recovered.[29] Sarah Arnott was a thirty-four-year-old laundress admitted by her husband in July 1904 with religious excitement.[30] Sarah had become manic, had visions, and spoke of offering her only six-year-old son as a sacrifice to God.[31] On admission, she was sensitive to noise, trembled in bed, was filled with terror and very agitated; she also violently resisted having her abdomen examined.[32] Whatever happened to Sarah, she was scared and suffering. Within a week, she made a slow improvement after receiving some medicine.[33] In September, Sarah was 'greatly improved, working well in laundry', and was discharged recovered.[34] Ada, Mary, Katherine, and Sarah were reported as "improved" when they completed domestic work, and this led to the assessment that they were well enough for discharge.

The domestic work as rehabilitation also applied to the single women admitted to the asylum. They were released when deemed able to perform domestic tasks to help their parents, get a husband, or continue work in domestic service; this is evident in the cases of Leonora, Mary Ann, and Elizabeth. Leonora Yandell was single and aged thirty-two when admitted with melancholia caused by sunstroke in December 1902; she suffered from delusions of identity, was violent, and did not sleep or eat.[35] In January, she was still dull and depressed; however, once she started to do some sewing, she was noted as better.[36] By February, Leonora was working well but still depressed; despite this, she was seen to be improving and was discharged in March.[37] Mary Ann Leverman was a single twenty-seven-year-old teacher admitted by her mother, Elizabeth, in November 1903 with acute mania due to overstudy; she was violent, mischievous, destructive, would scream and throw herself around.[38] In March, Mary Ann had improved when she started work; she was then considered convalescent and discharged within three months.[39] Elizabeth Ann Dray was a thirty-three-year-old, single, chemist's assistant admitted by her father in October 1906 with sub-acute mania.[40] Elizabeth had become incoherent and suspicious; she believed her mother had given her chloroform to drink and that she was saved by Jesus Christ.[41] She had been very excited about her father's arrival from England and Dr Blackall believed this was the 'exciting cause of her mental

[29] Ibid, 28 March 1904; 7 June 1904.
[30] Ibid, Folio 181, 19-20 July 1904.
[31] Ibid.
[32] Ibid.
[33] Ibid, 21-27 July 1904.
[34] Ibid, 5-12 September 1904.
[35] *Case Book Female Patients*, 1901-1908, Folio 71, 27 December 1902.
[36] Ibid, 7-14 January 1903.
[37] Ibid, Folio 72, 14 February; 10 March 1903.
[38] Ibid, Folio 135, 5 November 1903.
[39] Ibid, 14-21 November 1903; Folio 136, 28 March; 28 April; 19 June 1904.
[40] *Case Book Female Patients*, 1906-1908, Folio 31, 18-19 October 1906.
[41] Ibid.

condition'.[42] She had poor judgement, but cheerfully worked, which was reported as mental and physical improvement.[43] Within four months, Elizabeth was discharged.[44] Leonora, Mary Ann, and Elizabeth were also expected to meet the standard of ideal womanhood through domestic chores, which led to "improved" mental state and release.

This pattern of domestic work leading to discharge from the asylum is also apparent in Elizabeth "Bessy" Dunn's case. Bessy was a twenty-seven-year-old, single, Protestant admitted on the recommendation of a Perth medical board on 8 July 1862.[45] The history sent with Bessy revealed she was an Irish domestic servant and her family, apart from her father, were all alive and well, although she had an unnatural antipathy to her sister.[46] However, Bessy had left Dublin in March 1862 on the *Mary Harrison* of sound mind and became unmanageable and violent five weeks before arriving in Fremantle; she had since been strange in conduct, suffering from headaches, and frequently violent.[47] On admission, Dr Attfield described Bessy as having a 'depressed look', she often laughed without cause, answered most questions rationally, but her memory was somewhat defective.[48] Attfield also reported that her menstrual period was three months late and that Bessy had been violent and ungovernable on several occasions.[49] In late October, she menstruated, although it was very scanty, and her behaviour had not improved: she was frequently inclined to use personal violence and bad language.[50] Menstruation was a concern for nineteenth-century physicians, and the connection was seemingly made between Bessy's irregular periods and her bad behaviour.[51] In January 1863, Attfield noted that although combative and quarrelsome at times, Bessy was quiet, civil, and hard working.[52] In April, Bessy began to get regular menstrual periods and was in good health, although, she occasionally had pain at the top of her head.[53] By October, she was described as sometimes quite rational, and at others excitable, irrational, and incoherent, but 'as a rule, she is obedient and is a capital workwoman'.[54] In February, the following year, Attfield noted that fits of anger sometimes occurred with Bessy, but otherwise, she was quiet and well behaved; in February 1864, a medical board reviewed her case, and she was considered entirely free

[42] Ibid.
[43] Ibid, 7-14 November 1906.
[44] Ibid, 2 March 1907.
[45] *Register of Female Patients*, 1858-1873, Folio 51, 8 July 1862.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid, 1 August 1862.
[50] Ibid, Folio 53, 25 October 1862.
[51] The connections between behaviour and menstruation are explored further in Chapter Nine.
[52] Ibid, 12 January 1863.
[53] Ibid, 17 April 1863.
[54] Ibid, 20 October 1863.

from any symptom of insanity and, therefore, discharged.[55] Despite Bessy's occasional outbursts, her general quietness and obedience combined with domestic work made her sane enough to re-join society.

Integral to moral treatment, domestic work as rehabilitation allowed the female patients to complete tasks that were required for them to function as "sane" women outside of the asylum. This technique, therefore, reinforced nineteenth and early twentieth-century ideas of women as domestic homemakers. As evidenced in these women's cases, willingness to work and appropriate, ladylike behaviour, could lead to discharge from the asylum. However, the success of the treatment is challenging to measure, as the following patients will illustrate, the women were not necessarily cured of their mental illness when discharged.

As Long as the Dishes are Washed

Mental improvement did not always accompany domestic rehabilitation; however, despite their mental state, completing domestic tasks could lead to the women's discharge as it was seen as an improvement. This pattern was also experienced in modern mental illness facilities: in 1960s America, Dr Shirley Angrist found that women who refused to function "domestically" in terms of cleaning, cooking, and childcare, were often hospitalised and re-hospitalised.[56] Husbands who admitted their wives seemed more willing to tolerate extremely childlike and dependent behaviour as long as the dishes were washed.[57] In the 1970s, Chesler observed that women could be used as unpaid domestics; if they refused these jobs, they were considered "crazy" and "uncooperative", resulting in more drugs, beatings, mockery, and extended hospital stays.[58] However, if these women accepted these jobs, and performed well, hospital staff were reluctant to let them go.[59] This reluctance was not experienced in the overcrowded and overworked Fremantle asylum whose staff reported on domestic chores favourably and associated it with improvement; therefore, they were willing to release women who managed the basic domestic tasks, despite other issues.

This pattern can be observed in the following patients, Maria, Ellen, and Louisa. Maria Anna Louisa Bentley was aged thirty-four when admitted in November 1900; she was quiet although experienced hallucinations of touch and believed she was 'worked on by electricity'.[60] Maria was

[55] Ibid, 2-27 February 1864.
[56] Chesler, *Women and Madness*, 110.
[57] Ibid.
[58] Ibid, 223.
[59] Ibid.
[60] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 72, 5 December 1901.

'demented and silly, but a good worker'.[61] Despite her continued and noted hallucinations, Maria worked well, quiet, and orderly and was therefore discharged recovered in September 1903.[62] Ellen Hanrahan was admitted in October 1905, a delusional, married, thirty-year-old domestic.[63] Ellen suffered from delusions of persecution and had attempted suicide twice by jumping from the hospital window; she was anxious, worried, would not speak, and suffered from boils.[64] By November, Ellen was 'a little brighter mentally', although her physical health impacted her mental state.[65] By March 1906, Ellen was physically better, mentally brighter, and had begun to work.[66] In April, Ellen was released on trial reported as 'quiet but not so well'; despite this, she was discharged in May.[67] Louisa Mary Sforcina was aged twenty-eight when admitted by her husband in August 1907 with grandiose delusions: she believed she was related to the King of England and the Tsar of Russia.[68] Upon admission, Louisa was noisy, excitable, and untidy; however, she worked.[69] Louisa often relapsed but as she maintained some work she was discharged in March 1908.[70] Maria, Ellen, and Louisa were all discharged after completing domestic chores; however, their mental state was not necessarily stable. Another factor was that, while Maria's marital status is unknown, both Ellen and Louisa were married, and their husbands may have required them at home.

Cecelia Hardy was another woman who was discharged but perhaps not recovered. Cecelia was sent from Perth on 10 July 1858, a married sixty-year-old Roman Catholic, who was recorded as having been deranged upwards of six years.[71] On admission, Cecelia stated she had thirty-five children, and five were 'cut out of her' on Christmas Eve; she also believed she was deprived of much property and was in daily expectation of receiving it.[72] Although, Dr Attfield noted 'no reliable information or history of herself can be gleaned from her…very morose, extremely apt to be offended'.[73] Cecelia was 'extremely indignant at being detained in asylum and every day expects to go home or elsewhere'; she complained of hunger and of not having butter and other luxuries.[74] By October, Cecelia had become reconciled to the asylum: although still very obstinate, she no longer

[61] Ibid, 11 December 1902.
[62] Ibid, 11 March; 11 June; 28 September 1903.
[63] Ibid, Folio 297, 21-25 October 1905.
[64] Ibid, 30 October; 6 November 1905.
[65] Ibid, 13-21 November 1905.
[66] Ibid, 15 March; 18 April 1906.
[67] Ibid, 1906.
[68] *Case Book Female Patients*, 1906-1908, Folio 157, 5-7 August 1907.
[69] Ibid, 15-22 August 1907.
[70] Ibid, 1 March 1908.
[71] *Register of Female Patients*, 1858-1873, Folio 3, 10 July 1858.
[72] Ibid, 4 August 1858.
[73] Ibid, 4 August 1858.
[74] Ibid, 28 August 1858.

wore the same morose air.[75] In November, Attfield wrote that she was 'extremely quiet and taciturn as a rule' but was easily provoked.[76] Cecelia referred to the patients and attendants as 'the family' and would often tell them stories about her farm.[77] However, several years passed with her mental state unchanged and she seldom worked: Attfield noted, she 'does not appear at all unhappy, she generally has a smile on her face and I am sure she comprehends what is said but will not speak'.[78] In 1861, Cecelia was generally quiet and had become industrious; however, she occasionally exhibited much temper and irritability, 'she then lets loose her tongue to a great extent'.[79] By June 1862, 'she works very hard especially when there is any washing. She is very presumptuous as to things being done in a proper way'; but she remained taciturn and refused to answer questions.[80] By September 1864, Cecelia was noted as 'very useful in household work, very clean, in good health and cheerful' and as her husband wished to take her home, promising to take good care of her, she was discharged: though, Attfield wrote and the end of her discharge entry that 'she is still, however, suffering from delusions'.[81] Cecelia's improvement in her domestic work and ability to fulfil her role in her marital home outweighed her delusional behaviour.

The moral treatment techniques implemented at the asylum enforced "good" behaviours and rejected the "bad" ones. It was bad to refuse work, be violent, loud, or have a temper. It was good to be willing to do domestic chores, be quiet, and speak when addressed. Those behaviours could lead to release, whether cured or even mentally stable. Therefore, domestic work as rehabilitation did not necessarily cure mental illness but potentially masked the symptoms through perceived improvement by performing the role of a good nineteenth-century woman.

Repeat Offenders

For some of the women at the asylum, their first discharge for good behaviour was not their last. These women were readmitted after recovery was established through good behaviour and willingness to work. Much like the case of Nora Fitzgerald explored in the introduction, the experiences of patients Mary Catherine and Mary Beatrice again demonstrate that despite moral treatment physicians' use of domestic chores as an acknowledged rehabilitation system, it perhaps did not treat the women's deeper psychological problems, resulting in readmission.

[75] Ibid, 22 October 1858.
[76] Ibid, Folio 18, 27 November 1858.
[77] Ibid.
[78] Ibid, Folio 28, 7 April 1861.
[79] Ibid, Folio 40, 25 September 1861.
[80] Ibid, 4 June 1862.
[81] Ibid, Folio 69, 22 September 1864.

Mary Catherine Anthony was a single twenty-nine-year-old domestic worker admitted for mania on 6 May 1903.[82] The constable at Police lockup reported that she had been arrested at the General Post Office where she had, for more than an hour, been writing on telegraph forms and giving them as messages to be sent to various persons.[83] She was 'in an excited condition and labours under delusions about many of her friends being in trouble' and that people are saying things about her; although not explicitly stated, her concerns may have led to the incident at the post office.[84] In the asylum, Mary was noisy, excited, restless, abusive, and would not answer questions.[85] However, within weeks, Mary was quiet and working well; this was not maintained as she would sometimes become violent and destructive, even noted as 'very independent'.[86] In November, she was more troublesome and 'endeavours to keep the other patients from work'; not only was she idle but she was preventing others from their chores, and therefore, recovery.[87] In December, Mary was noted as 'rather more civil' and was discharged recovered in February 1904.[88] However, almost a year later, Mary was readmitted after she 'went to the police station and asked to be arrested as she was out of her mind and wanted to go back to the Asylum': she had auditory hallucinations and believed she would be murdered.[89] Initially depressed, by February, Mary was much brighter and worked well in the laundry and at needle-work.[90] However, her bad behaviour returned, and she often became violent; by December, she was noted as bad-tempered and abusive, although, she was working well again.[91] In the following months, Mary worked in the kitchen and workroom; by July, she was quiet and was given a month's trial, extended to October, and discharged in November 1906.[92] Mary struggled, and while the domestic tasks kept her occupied, they may not have helped in her overall recovery. Her "bad" behaviour often negated her work, but when she maintained her quietness and willingness to work, she was released.

Mary Beatrice Keys was also readmitted to the asylum. Mary was twenty years old when admitted by her father for suicidal acute mania in September 1903.[93] She was 'heavy and depressed in her bearing', heard voices from angels, suffered from hallucinations, and was sometimes violent.[94]

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[82] *Case Book Female Patients*, 1901-1908, Folio 87, 6 May 1903.
[83] Ibid.
[84] Ibid.
[85] Ibid, Folio 88, 6 May 1903.
[86] Ibid, 18-22 May; 1 July 1903.
[87] Ibid, 1 November 1903.
[88] Ibid, 1 December 1903; 28 January; 8 February 1904.
[89] Ibid, Folio 233, 25-26 January 1905.
[90] Ibid, 16 February 1905.
[91] Ibid, Folio 234, 14 June; 11 December 1905.
[92] Ibid, 15 March; 4 November 1906.
[93] Ibid, Folio 119, 7 September 1903.
[94] Ibid.

In the asylum, Mary continued to improve as she began to work, although she was noted as having hysteria.[95] Despite this, she was recovered rapidly; therefore, she was discharged in April.[96] However, two months later, Mary was readmitted with acute mania; she had been discovered on Monument Hill when a call to the Fremantle Police reported that 'a young woman was behaving in an hysterical manner': the police found her 'lying under one of the bushes…she appeared to be very ill and had evidently lost her reason'.[97] On re-admission, Mary remained noisy and violent and was given a sedative which improved her behaviour.[98] However, despite continued prescribed sedatives, she was noisy and troublesome and 'rather worse than on admission'.[99] By mid-November, Mary was quieter but would frequently cry; Dr Blackall believed that 'the melancholic phase has gradually replaced the maniacal' and she was placed on a ticket (suicide watch).[100] However, in the same entry, Blackall noted she was more dejected than acutely melancholic, and that she sewed well.[101] This positive reporting continued, as in March 1905, she was considered 'much improved, brighter, quiet, no trouble, works well' and was allowed leave on Sundays to see her father.[102] Mary was so improved that by May, she was discharged recovered and seen off on a boat to the Eastern States with her family.[103] The combination of sedatives and domestic work seemingly led to a sense of recovery.

Mary Catherine and Mary Beatrice were admitted for different reasons, although they both experienced domestic chores as rehabilitation. This treatment may not have "cured" them as their readmission suggests underlying issues. These women's experiences further illustrate that performing domestic tasks was deemed an improvement in Fremantle. However, there were consequences for those who remained unwilling to undertake domestic rehabilitation.

Utility not Cure: The Long-term Cases

In Fremantle, long-term female patients who were less willing to complete domestic tasks often incurred punishments such as continued incarceration. The patients either remained in the asylum to be transferred to Claremont in 1908 or died. At times female patients would be willing to work; however, if they continued to be overtly violent, it would negate their improvements. Long-

[95] Ibid, Folio 120, 14 December 1903.
[96] Ibid, 28 February; 11 April 1904.
[97] Ibid, Folio 171, 2 June 1904; "News and Notes: On Monument Hill," *The West Australian*, Perth WA, 11 April 1904, 4.
[98] Ibid, 7-14 June; 1 July 1904.
[99] Ibid, 9 August 1904.
[100] Ibid, 15 December 1904.
[101] Ibid.
[102] Ibid, 20 March 1905.
[103] Ibid, 6 May 1905.

term patients could also be intellectually disabled. As will be discussed Chapter Seven, intellectual disability was seen as incurable during the nineteenth and into the twentieth century. Charles Fox notes for that those who were incurable work as therapy was irrelevant, but they were still expected to work if possible and were judged on their proficiency: in this case, work was seen in terms of utility and self-sufficiency, not cure.[104] In 1883, the Medical Society of Victoria noted:

> Employment, under proper supervision, is one of the best means of treatment, and, if possible, it is advisable that all patients should be employed according to their strength. Moreover, it is especially necessary that the recent and curable cases should be constantly employed. There are, however, large numbers of chronic cases in most asylums, persons who have been inmates for a length of time, and have become accustomed to the usual routine work. These patients are so efficient in their different places, that the officers have at times great difficulty in making the attendants interest themselves to find employment for the recent admissions.[105]

In the long-term cases in the asylum, work set for women and it was favourably reported on; however, it did not necessarily lead to release.

Some long-term patients, such as Frances, Bridget, and Anne, had behaviour that was so violent or bad that it negated their domestic work. Frances Clifton was aged fifty and married when sent from Geraldton in January 1894, a 'violent maniac'.[106] She was sometimes very violent, tearing the patients' hair, but at other times worked well.[107] By 1901, Frances had become less violent; described as quiet, industrious, and gave little trouble, although she was still childish and demented.[108] Frances continued the same, 'a hopeless case', but a useful and willing worker.[109] She was transferred in June 1908.[110] Bridget Sharkey was admitted in July 1900 aged forty-six; deluded, idle, obstinate, and claimed to be 'all powerful'.[111] Bridget remained insolent, stubborn, sullen, morose, deluded, and would not work.[112] In late 1905, she became quieter, worried less, and was anxious to go home; however, she still did not work and was delusional regarding her wealth.[113] In 1907, Bridget was reported as quarrelsome, dirty in habits, abusive and 'does no work'; she was

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[104] Charles Fox, "'Forehead Low, Aspect Idiotic': Intellectual Disability in Victorian Asylums, 1870-1887," in *Madness in Australia: Histories, Heritage and the Asylum*, eds. Catharine Coleborne and Dolly MacKinnon (Lucia: University of Queensland Press, 2003), 152.
[105] Medical Society of Victoria, "Ordinary Monthly Meeting, Wednesday, September 5th, 1883," *Australian Medical Journal* v, no. 9 (September 1883):403. http://hdl.handle.net/11343/23147.
[106] *Case Book Female Patients*, 1878-1897, Folio 161, 8 January 1894.
[107] Ibid, 14 February 1894; 10 March 1896.
[108] *Case Book Female (Chronic)*, 1901-1908, Folio 73, 5 December 1901.
[109] Ibid, 11 March 1903.
[110] Ibid, 2 June 1908.
[111] Ibid, Folio 66, 18 July 1900; 5 December 1901.
[112] Ibid, 11 March; 11 December 1902; 11 March 1903.
[113] Ibid, 11 December 1905; 12 October 1906.

transferred in 1908, after eight years.[114] Anne Bree was sixty-one years old when admitted in July 1901, delusional and incoherent.[115] Anne was abusive, noisy, did little work, and stated that she owned the asylum.[116] In June 1904, Anne believed the institution had betrayed her, and this feeling manifested as attacks on Dr Montgomery whenever she had the opportunity.[117] Although quiet, Anne worked well and was good-tempered, but still violent and abusive towards Montgomery about whom she had continued delusions.[118] By 1906, Anne was titled the "queen of the laundry", but her bad behaviour had not changed; as such, she remained in the asylum.[119] Work on domestic tasks was often discounted due to the struggle with violence and temper. It is also possible that as the women in these cases were older than the average admission they may have been considered "old'" or "infirm". However, despite their completed tasks, violence and temper were not characteristics that asylum staff were willing to accept from female patients.

For the intellectually disabled patients, the use of domestic work as rehabilitation was often for utility as their "incurable" mental states prevented major "cure" for release. This attitude is apparent in Anne Casey's experience. Anne was intellectually disabled, single and eighteen years old when admitted to the temporary warehouse asylum on 10 July 1858.[120] Her history reported she had arrived in the colony of unsound mind and gradually became worse: she laughed in an idiotic manner and hung her head when addressed.[121] Anne was noted as almost incapable of doing the most trivial work and never volunteered to do anything; although, she was obedient and docile.[122] A month later, Dr Attfield observed she occasionally did some small jobs but 'in a most listless and slovenly manner'.[123] Anne often 'grins in a cunning meaningless' way with stooping shoulders and slouching gait; she would pick and unpick a little work but took little notice of anything.[124] By January 1859, she was more 'intelligent', appeared to have more capacity for work, and was generally employed in cleaning.[125] However in February, Attfield wrote that 'great trouble is taken by the matrons and attendants to keep this patient tidy in her dress and make her more intelligent, but besides being imbecile she is unfortunately very obstinate'.[126] By December, she was occasionally

[114] Ibid, 19 July 1907; Folio 97, 25 September 1907; 29 May 1908.
[115] Ibid, Folio 81, 18 July 1901; 8 September 1902.
[116] Ibid, 11 December 1902; 11 September 1903.
[117] Ibid, 12 June; 12 December 1904.
[118] Ibid, 20 March 1905.
[119] Ibid, 15 March 1906.
[120] *Register of Female Patients*, 1858-1873, Folio 8, 10-12 July 1858.
[121] Ibid, 4 August 1858.
[122] Ibid, 28 August 1858.
[123] Ibid, 23 September 1858.
[124] Ibid, Folio 21, 27 November 1858.
[125] Ibid, 6 January 1859.
[126] Ibid, 8 February 1859.

spiteful and morose, although generally docile and tractable; she assisted in hemming handkerchiefs, washing clothes, and cleaning.[127] Anne's willingness to work was favourably viewed as she was still employed at house and needlework in May 1860, although only sometimes useful at it.[128] In June 1861, she appeared happy and contented and could now assist with washing and eating.[129] She continued the same once transferred to the new asylum building; however, if any alteration in her routine occurred, she was quite helpless.[130] Anne deteriorated, and in 1871 she could no longer wash or dress and had become much older in appearance, she would now be approximately thirty-one years old.[131] Anne was a long term patient, spending thirty-nine years incarcerated, until her death in 1897, aged seventy-one.[132]

Ellen Markie was another intellectually disabled patient in the asylum, noted as 'semi-imbecile for the want of education and cultivation'.[133] Ellen was twenty-four years old and single when admitted with dementia on 8 April 1865.[134] Her history on admission revealed that since arriving in the colony in 1860, she had worked in domestic service for three months but left for the Perth Poor Home where she had spent the last four years.[135] Ellen was noted to have not communicated with her friends in Britain and while in the poor home she had become 'manifestly insane' with offensive habits, often becoming violent and abusive when interfered with or threatened.[136] Ellen stated 'she came to the Colony as she thought she should do well but is now sorry she came'.[137] On admission, she was described by Dr Attfield as, 'listless, lazy and idle in her habits and dispositions, does very little work, is quietly obstinate in not doing what she is told to perform'.[138] She continued lazy, idle, and indifferent, and would do little or no work.[139] By the end of the year, she had become docile and obedient but was still noted lazy and indolent.[140] In 1870, it was revealed she suffered a good deal with headaches before her menstrual periods, and she had a voracious appetite; she now did a good deal of hard work in scrubbing and washing, but she did no needlework and never read.[141] In early 1871, Ellen was more favourably reported on as although

[127] Ibid, 7 December 1859.
[128] Ibid, 18 May 1860.
[129] Ibid, Folio 35, 18 August 1861.
[130] Ibid, Folio 140, 18 August 1870.
[131] Ibid, 14 January; 15 June 1871.
[132] *Case Book Female Patients*, 1878-1897, Folio 11, 23 June 1897.
[133] *Register of Female Patients*, 1858-1873, Folio 88, 24 May 1866.
[134] Ibid, Folio 79, 8 April 1865.
[135] Ibid.
[136] Ibid.
[137] Ibid.
[138] Ibid, 18 May 1865.
[139] Ibid, Folio 88, 20 March 1866.
[140] Ibid, 17 November 1866.
[141] Ibid, 18 June 1870.

'demented', she was in robust health.[142] She frequently worked hard at washing and scrubbing and would often throw water over herself and others; as it was January in Fremantle, the weather would have been quite hot.[143] In 1872, Dr Dickey noted that even though Ellen did her share of work, she was 'lazy and indolent, would (like a cat) be content to lie down in a sunny corner the greater part of the day if allowed'.[144] By mid-1872, Ellen took a turn for the worse, becoming violent to herself and others: 'beats herself so as to make herself black and blue'.[145] This behaviour continued into 1874; she would beat herself, thinking she was beating someone else.[146] By June 1878, she did more needlework than formerly although she still had fits of temper where she would beat herself.[147] Her behaviour continued until she became ill in the mid-1880s and died in December 1885 of natural causes, having spent twenty years incarcerated.[148]

However, not all intellectually disabled patients remained in the asylum; while not necessarily "cured", some were released to family, as in Helena and Emma's cases. Helena Jean Thompson was aged thirty-seven when admitted by her father in July 1907 with delusional insanity.[149] Helena had been deaf for seventeen years and was 'rather stupid and weak minded' with vague persecutory delusions.[150] On admission, she was dull and depressed, but was no trouble, and did some sewing.[151] By October, Helena was anxious to go home and as she had mentally improved she was released on trial over Christmas and discharged in January 1908.[152] Emma Stranbe, a single thirty-one-year-old German domestic worker, was admitted with mania by her parents in December 1901 after wandering from home.[153] Upon admission, she was quiet and well behaved but was observed as dull and childish in manner.[154] In March 1902, Emma began working steadily, though she still believed she was acted on by spirits.[155] Emma continued 'demented' but was industrious and was discharged recovered in June 1902.[156] Helena and Emma were fortunate to have parents willing to care for them and who accepted industriousness as a good enough reason for discharge.

[142] Ibid, Folio 133, 18 January 1871
[143] Ibid.
[144] Ibid, 20 January 1872.
[145] Ibid, 8-16 October 1872.
[146] *Female Register Case Book*, 1873-1878, Folio 106, 20 May 1874.
[147] Ibid, Folio 281, 1 June 1878.
[148] *Case Book Female Patients*, 1878-1897, Folio 93, 29 December 1885.
[149] *Case Book Female Patients*, 1906-1908, Folio 149, 26-27 July 1907.
[150] Ibid.
[151] Ibid, 2-9 August 1907.
[152] Ibid, 16 August; 16 October; 11 December 1907; 11 January 1908.
[153] *Case Book Female Patients*, 1901-1908, Folio 11, 12 December 1901.
[154] Ibid, Folio 12, 23-30 December 1901.
[155] Ibid, 28 March 1902.
[156] Ibid, 12 May; 24 June 1902.

The long-term cases in Fremantle revealed that bad behaviour or perceived “incurable” states could result in indefinite incarceration, despite occasional willingness for domestic tasks. The domestic duties kept the patients busy, instead of being used as a cure.

Chapter Conclusions

This chapter explored how moral treatment emphasised domestic work as rehabilitation for female patients at the Fremantle asylum. The societal construction of gender, as outlined by Butler, resulted in embedded expectations for a “sane” nineteenth-century woman. The emphasis on domestic chores as appropriate work for female patients reinforced those nineteenth-century gender roles as reluctance to perform the tasks incurred prolonged incarceration. However, the actual mental state of the patients did not negate release, meaning women who were still mentally unwell could be released to family if they maintained their chores.

This chapter illustrates how aspects of moral treatment were implemented in the asylum. It demonstrates the appropriate and inappropriate behaviours for nineteenth and early twentieth-century women in Fremantle by revealing what behaviours resulted in asylum admission and what behaviours were enforced in treatment that led to release. It also emphasises that moral treatment and domestic rehabilitation, while perhaps improving the lives and mental states of some patients, was not always successful for all women. Thus, the following chapter will expand on discussions of moral treatment with examinations of the punishments and rewards for the female patients.

CHAPTER SIX

Punishments and Rewards

As discussed in the previous chapter, moral treatment aimed to rehabilitate female patients through domestic chores for them to be considered sane and able to function within the nineteenth-century understandings of womanhood. However, there were other aspects of moral treatment that enforced appropriate gendered behaviours, and this operated in the punishments and rewards used in the asylum.

This chapter will explore punishment through theories of non-restraint, seclusion, mechanical restraint, and chemical restraint; revealing that violence or disruptive behaviours most often resulted in seclusion or restraint. It will also explore rewards and amusements provided by the medical superintendents for the patients who were well behaved. As with domestic rehabilitation, punishments and rewards in the asylum reveal the expected behaviours for nineteenth and early twentieth-century women in Fremantle and further demonstrate how moral treatment ideals governed asylum practices and experiences.

Non-restraint and Straitjackets

By the mid-nineteenth century, the non-restraint philosophy evolving within moral treatment 'was a powerful force shaping English asylum practice'; developing less coercive measures to treat violent patients.[1] The theory relied on manual restraint and temporary seclusion for patient violence.[2] As such, when patients became violent, attendants conducted them 'to a padded cell, where they remained until the rage passed'; 'if the violence persisted, various other measures might then be employed' including sedation or "chemical restraint".[3] In 1859 John Conolly reported:

> During the hours of night, especially when the patient is feverish and restless, and perhaps disposed to violence, requiring especial care and every effort to soothe and compose him, the straight-waistcoat is still too often substituted for all the attentions that would, as a matter of course, be paid to him in a well-managed asylum, public or private.[4]

However, while objecting to restraint and preferring non-restraint methods, physicians recognised that each posed disadvantages.[5] Manual restraint could potentially lead to conflicts between

[1] Tomes, "Great Restraint Controversy", 196-198.
[2] Ibid.
[3] Ibid.
[4] John Conolly, "On Residences for the Insane," *Journal of Mental Science* 5, no. 29 (1859): 416. doi: 10.1192/bjp.5.29.411.
[5] Tomes, "Great Restraint Controversy", 196-198.

attendants and patients, rib-fractures and other patient injuries and seclusion could become neglect, if not carefully monitored.[6] Therefore, staffing problems and the management of the asylum could accompany the implementation of non-restraint.[7]

The main basis of justification for restraint was precautionary, in particular, to restrict chances for the patient to harm themselves, other patients, or the attendants.[8] Even in the most liberal and progressive institutions' restraint would be imposed without question for these reasons; authorities were not prepared to tolerate risky or violent behaviour.[9] Violence in the asylum was not a male preserve, and examples of violent women could be found in all asylums.[10] For women, violent behaviour was not acceptable, within or outside of the asylum, and 'women's deviations from ladylike behaviour were severely punished'.[11] At Bethlem, female patients were placed in 'solitary confinement in the basement' for violence or bad language.[12] 'At Colney Hatch, they were sedated, given cold baths, and secluded in padded cells, up to five times as frequently as the male patients'.[13] Robert Gardiner Hill at Lincoln Asylum noted that from 1840 to 1841, the female refractory had the most severe and violent breakdowns of order.[14] However, evidence of female asylum patients being more prone to violence is little more than circumstantial.[15] Perhaps the response to women's violence was heightened as violence was not accepted as part of their character. After all, as Chesler notes, even in the 1970s, excessive anger in women was seen as a sign of a character disorder.[16]

In Fremantle, with the aim of superintendents to engage moral treatment, restraint and confinement were employed inconsistently; the severity of the perceived "crime" sometimes had little to do with the type or severity of the punishment assigned.[17] In 1898, an enquiry into the mistreatment of patients at the asylum was launched and revealed some of the potential problems in underfunded and understaffed asylums. The enquiry stated that 'Nurse McCormack says she only gave this patient some knocks on her shins with a stick, but that had she had sufficient assistance to control the patient she would not have touched her with the stick'; 'the Matron, who saw what took

[6] Ibid.
[7] Smith, *Cure, Comfort and Safe Custody*, 273.
[8] Ibid, 250.
[9] Ibid.
[10] Ibid, 121.
[11] Showalter, *Female Malady*, 81.
[12] Ibid.
[13] Ibid.
[14] Smith, *Cure, Comfort and Safe Custody*, 122.
[15] Ibid.
[16] Chesler, *Women and Madness*, 11.
[17] Harman, "Out of Mind, Out of Sight," 112.

place, said she did not consider the beating serious at all'.[18] The implementation of non-restraint and moral treatment practices also appear to have encountered issues in Fremantle.

Data was collated from what remains in the asylum patient records and case books, of the 452 patients, fifty-eight experienced either or both restraint or seclusion (12.8% of the total female patient population from 1858 to 1908).[19] There were seventy-six instances which were counted once per patient. Fourteen patients experienced both seclusion and restraint, and four patients experienced more than one type of restraint. While a small data set, they are real female patient experiences that reveal what kinds of behaviours were punished in the asylum.

Table 6.1: Restraint and seclusion on female patients at the Fremantle Lunatic Asylum (1858 – 1908)

	01 Reg 1858-1873	**02 CB** 1873-1878	**03 CB** 1878-1897	**04 CB** 1901-1908	**05 CB** 1901-1908	**06 CB** 1906-1908	**Total**	**Percentage**
Straitjacket	1	1	7	-	6	3	**18**	4%
Padded Room	5	3	9	-	-	-	**17**	3.8%
Chemical Restraint	2	2	-	1	6	4	**15**	3.3%
Seclusion	1	3	4	1	3	2	**14**	3.1%
Hand Restraint	1	-	5	-	1	2	**9**	2%
Restraint	-	-	1	-	-	2	**3**	0.66%

Another reason for the small data collection was the lack of consistency in recording the incidents and types of repercussions in the asylum registers and case books. For example, in 1874, the case book refers to an Assault Book, in which details of assaults were logged. Rosanna McMahon struck Mrs Manning twice on 13 to 14 March 1874, recorded 'in Assault Book'.[20] A day later, in Anne Hawkins entry, it also stated 'she struck and injured the matron as recorded in Assault Book'.[21] There are no other references to this book, and it has not been preserved; the details of these assaults are lost to history. These inconsistencies could be due to changes in asylum management and the re-establishing of procedures and records. Therefore, patients like Margaret and Mary, who were as equally difficult and violent as the patients who received a punishment, either had inconsistent or no recorded consequences. Margaret Durant attacked one of the assistant matrons, scratched and tried to strangle her in April 1879.[22] In this entry, she was noted as 'one of the most troublesome'

[18] Harman, "Out of Mind, Out of Sight," 111.
[19] See Table 6.1 for further details.
[20] *Female Register Case Book*, 1873-1878, Folio 85, 13-14 March 1874.
[21] Ibid, Folio 80, 15 March 1874.
[22] *Case Book Female Patients*, 1878-1897, Folio 34, 10 April 1879.

patients, but no punishment was recorded for the incident.[23] Mary Harris had, in November 1883, 'interrupted the bathing and was so violent that for a few minutes, it was needful to place her in the padded room'.[24] However, in August 1886, Mary attacked two patients and no punishment was recorded, despite the second incident being more serious than the one for which she was punished.[25] These women were often as violent as the women with recorded consequences, who will be explored in the following section. However, their cases reveal the potential issues with colonial asylum records as it cannot be known with certainty if incidents were or were not recorded, or if the archives did not survive.

However, in Fremantle, when female patients behaved badly or violently, they could experience mechanical restraint such as straitjackets or hand-muffs. The origins of the straitjacket date to the second half of the eighteenth century; unlike ropes or chains, the straitjacket allowed the patient to walk and was considered more humane and progressive than traditional restraints.[26] Straitjackets were frequently made of canvas or leather; it was typically a closed jacket, equipped with buttons or strings at the back, with long sleeves tied to the back of the wearer.[27] Some straitjackets also covered the head or immobilised the legs.[28] Other restraints employed were hand-muffs, locked gloves, or mittens, which allowed the movement of hands but protected them. Hand-muffs were made of canvas or leather, with air holes for ventilation, secured at the wrists with a screw unlocked with a key.[29] In Fremantle, mechanical restraint occurred with at least thirty patients (6.6% of the total female asylum population).[30] The most frequently used mechanical restraint in Fremantle was the straitjacket, used at least once on eighteen patients.

The straitjacket featured in Elizabeth, Katherine, Maria, and Mary's cases, in response to their violence. Elizabeth Hyde was a twenty-nine-year-old dressmaker, on probation from Kew Asylum where she had been incarcerated seven months previously; when Elizabeth was admitted to Fremantle in September 1896 she was 'so violent that she had to have jacket on'.[31] Katherine Hiscox was sixty years old when admitted in March 1897; 'the patient on admission presents all the symptoms of acute mania and is so violent and noisy that it has been necessary to have her confined

[23] Ibid.
[24] Ibid, Folio 75, 3 November 1883.
[25] Ibid, 28 September 1886.
[26] Benoit Majerus, "The Straitjacket, the Bed, and the Pill: Material Culture and Madness," in *The Routledge History of Madness and Mental Health*, ed. Greg Eghigian (Oxon: Routledge, 2017), 264.
[27] Majerus, "Straitjacket", 265.
[28] Ibid.
[29] Mary De Young, *Encyclopedia of Asylum Therapeutics, 1750-1950s* (North Carolina: McFarland & Company, Inc., Publishers, 2015), 227.
[30] See Table 6.1.
[31] *Case Book Female Patients*, 1878-1897, Folio 192, 24 September; 5 December 1896.

in a strait jacket'.[32] Maria Daly was thirty-nine, Irish, and married when admitted with delusional insanity in October 1906; 'mischievous and violent requiring almost constant restraint in jacket'.[33] Mary Ellen Shaw was aged thirty-six when admitted as delusional in July 1903.[34] She often tried to match or steal keys to escape the asylum, and in March 1905, she was placed in the straitjacket after an assault on the night nurse while trying to obtain keys.[35] In June, Dr Blackall noted, that Mary had 'been wearing jacket every night up to one week ago, seems mentally unchanged'.[36] It had been three months between the two entries and as such was one of the longest recorded sustained periods of restraint in the straitjacket. Elizabeth, Katherine, Maria, and Mary were all violent on admission and required mechanical restraint to control them.

Mary (Margaret) Montgomery was also subject to repeated and sustained mechanical restraint. Mary was fifty-five years old when admitted on 10 November 1886 with mania after taking 'too much spirit of late'.[37] The mother of a 'large family of grown up son and daughters' she had become melancholic, dull, and stupid.[38] On admission, Mary became 'very dangerously violent and the matron is hereby directed to use the straight waistcoat for four-hour intervals when necessary. This is for her own safety and that of others around'.[39] Two days later, Dr Barnett noted, that 'the vest has had to be used' which made her 'more quiet'.[40] Three days after this, it was reported, 'she is not to be managed, tears everything and hurts her attendants who try to wash and dress her. To have a glove with wrist band to prevent her striking the others. She kicks all round viciously and the other patients would destroy her if allowed'.[41] While dramatic, it is not insignificant as Mary's actions could have provoked or hurt other patients. In April 1887, she was once again restrained: 'she behaves in the most foul and dirty manner, spreads her excrement over the walls and tears her clothing. To have wristbands on when needful for her preservation'.[42] In July, Mary still 'kicks and strikes at all about her at times—her hands to be confined when she is dangerous—she tears her clothing to pieces when her hands are free'; however, 'the hands are so arranged as to increase her comfort but prevent her from tearing her clothing'.[43] Therefore, her comfort was considered and

[32] Ibid, Folio 199, 8 March 1897; It is suspected that Katherine's daughter, Mary, was also admitted to the asylum in 1893.
[33] *Case Book Female Patients*, 1906-1908, Folio 23, 2 October; 27 December 1906.
[34] *Case Book Female Patients*, 1901-1908, Folio 105, 7 July 1903.
[35] Ibid, Folio 106, 15 December 1904; 20 March 1905.
[36] Ibid, 7 June 1905.
[37] *Case Book Female Patients*, 1878-1897, Folio 116, 10 November 1886.
[38] Ibid.
[39] Ibid, 9 December 1886.
[40] Ibid, 11 December 1886.
[41] Ibid, 14 December 1886.
[42] Ibid, 22 December 1886; 6 April 1887.
[43] Ibid, 28-30 July 1887.

noted, although it is doubtful that she was comfortable. Two months later, Mary was still 'very troublesome' and 'exceedingly violent', 'has to have arms confined to prevent injury to herself and others'.[44] Described as 'savage looking' in December, she had 'the sleeves put on to prevent her from tearing her clothing, but she does so with her teeth'.[45] When Mary was transferred to Claremont in June 1908, she was aged seventy-seven, 'feebler and more senile' but 'very noisy, troublesome and destructive'.[46] Mary had been incarcerated for twenty-two years, and her experience was dominated by mechanical restraint.

Another patient, Caroline Wilkins, was also subject to restraint, and her case reveals the attempted integration of seclusion instead of restraint in late nineteenth-century Fremantle. Caroline was thirty-six years old when admitted by her husband, Jacob, a farmer from Toodyay.[47] Her history revealed she had a nine-month-old child, and that her breasts had 'dried up'.[48] On admission, Caroline tried to 'hurt herself and has to wear gloves to prevent it'.[49] Three days later, she was no better, she tore her clothing and tried to hurt herself, once again had 'to have hands fastened for her safety'.[50] Caroline was discharged and readmitted to her sister Mrs Paton and her children several times; in 1884, it was noted that her husband was also in the asylum, on the male side.[51] In March 1889, Dr Barnett stated that Caroline was great trouble, 'tears her clothing and all she can get hold of. Has to wear a muff'.[52] In 1893, Barnett reported, 'her children are afraid of her and will not receive her' or 'care for her'; despite this, her sister took her home once again.[53] Caroline was readmitted in 1895, for the fifth time, and had 'to have her hands tied to prevent her from stripping herself'; she also 'struck Sarah Burns in the eye—most violent'.[54] In 1896, she was, for the first recorded time, placed in a separate room: Barnett wrote 'there is great need for rooms for such patients when they would be secure without being able to reach windows and injure themselves'.[55] Here, Barnett seemed to aim to use seclusion as a substitute for restraint but required further infrastructure. However, Caroline remained in the asylum until her death in February 1903.[56]

[44] Ibid, 28-30 September 1887.
[45] Ibid, 6 November; 5 December 1887.
[46] *Case Book Female (Chronic)*, 1901-1908, Folio 86, 24 October 1907; 24 February; 12 June 1908.
[47] *Case Book Female Patients*, 1878-1897, Folio 66, 2 January 1882.
[48] Ibid.
[49] Ibid, 5 January 1882.
[50] Ibid, 7 January 1882.
[51] Ibid, Folio 84, 25 September 1884.
[52] Ibid, 21 March 1889.
[53] Ibid, Folio 144, 3 March; 23 April; 21 September 1893.
[54] Ibid, 24-28 December 1895.
[55] Ibid, 7 February 1896.
[56] *Case Book Female (Chronic)*, 1901-1908, Folio 37, 4 February 1903.

Mechanical restraint, while only noted in a small number of cases in the remaining archival records, had profound impacts on the women who experienced it. Their incarceration in the asylum was dominated by restraint, and it may have impacted their mental state. Thus, seclusion in padded cells was implemented in Fremantle to reduce the use of restraint. Most non-restraint advocates preferred such measures to restraint, on both moral and medical grounds; believing that restraint only worsened the diseased state of the nervous system, as it irritated and disordered the body.[57]

'Placed in padded room': Seclusion and Isolation

Seclusion was advocated as a humane form of treatment for the violent or extremely agitated and each ward was allocated a padded cell; the use of which was to be signed off by the medical superintendent.[58] Although seclusion was no new remedy, as it had been standard practice in the old regime, the 'therapeutic rationale was to limit external stimulation as well as to reduce the scope for destructive behaviour'.[59] James Bucknill, Medical Superintendent of Exeter Asylum, stated that seclusion was but merely one in a range of more enlightened treatments.[60]

Padded rooms are believed to have been first invented in Germany in the early nineteenth century and were first introduced to Britain when installed at Bethlem in 1844.[61] Conolly wrote that 'the great advantage of a padded room in all these cases, is that it renders both mechanical restraints and muscular force unnecessary for the control of even the most violent patients'.[62] In Hanwell Asylum, the thick, soft padding of coir was enclosed and fastened to wooden frames which were attached to the walls of the room, extending to above the reach of a patient.[63] Piddock notes that when the Fremantle asylum was constructed in 1864, the female side had three cells, compared to the men's eight; however, by 1884, the female cells were reduced to two.[64] The isolation cells at the asylum were used frequently to subdue and confine troublesome and violent patients.[65]

Seclusion in Fremantle could also be combined with mechanical restraint but was often used to calm violent or noisy patients, as evidenced in Susan, Frances, and Annie's cases. Susan Coppin was thirty-one years old when admitted from Victoria Plains by her policeman husband in November

[57] Tomes, "Great Restraint Controversy", 198.
[58] Anne Alty, "History of the use of Seclusion," in *Seclusion and Mental Health: A Break with the Past*, eds. Ann Alty and Tom Mason (Dordrecht: Springer Science and Business Media, 1994), 28.
[59] Smith, *Cure, Comfort and Safe Custody*, 272.
[60] Phil Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (Oxen: Routledge, 1996), 26.
[61] De Young, *Encyclopedia of Asylum Therapeutics*, 200.
[62] Conolly, *Treatment of the Insane*, 44.
[63] Ibid.
[64] Piddock, "Place for Convicts," 566-567.
[65] Hall, *May They Rest in Peace*, 8.

1874.[66] On admission, Susan was so noisy that she prevented the other patients from sleeping and was, therefore 'placed in separate room at night'.[67] Her hair was also deemed too long and was cut to half its length.[68] A few days later, Susan was 'so violent that she could not be managed by matrons and they had to get assistance'; Principal Warder Paisley then 'placed her in the padded room for two hours—for her own safety and the comfort of the other patients she is to sleep in padded room each night till she is more calm'.[69] In November 1904, thirty-two-year-old Frances Edith Davidson barricaded herself in one of the bedrooms, she pushed the beds against the door and refused to come out; the door had to be broken in, and she was placed on a suicide watch ticket and put in seclusion for two subsequent days.[70] In March 1905, she attacked a night nurse, persuading another patient Mary Ellen Shaw to assist; they stole the nurse's keys, and Frances barricaded herself in the stock room.[71] Frances was removed to a single room, placed in a straitjacket, and received large doses of paraldehyde to help with sleep.[72] Annie Facey was a thirty-two-year-old Wesleyan housewife from Wagin admitted in November 1903 with acute melancholia.[73] In January 1905, she made a 'violent attack on Dr Montgomery' and was 'put in a cell for a few days'.[74] Therefore, attacking the Medical Superintendent resulted in prolonged seclusion. Susan, Frances, and Annie reveal that the destruction of property, bad behaviour, or violence towards the patients and staff would incur punishment, and occasionally further mechanical restraint.

Another patient who was placed in seclusion was Maria. In February 1878, a thirty-year-old Aboriginal woman identified only as 'Maria (Native)', was admitted after having been in Dr Barnett's care in police lock-up.[75] 'The early psychologists in Britain and Europe were fascinated by the "native" peoples in the colonies since they were thought to be relics or vestiges of earlier stages in human development and hence gave insights into the prehistory of Western people'.[76] The life expectations and experiences of Aboriginal women were significantly different from those of non-

[66] *Female Register Case Book*, 1873-1878, Folio 202, 27 November 1874.
[67] Ibid, 28 November 1874.
[68] Ibid.
[69] Ibid, 30 November 1874.
[70] *Case Book Female Patients*, 1901-1908, 30 November 1904.
[71] Ibid, 13 March 1905.
[72] Ibid, 23 March 1905.
[73] Ibid, Folio 133, 2 November 1903.
[74] Ibid, 20 March 1905.
[75] *Female Register Case Book*, 1873-1878, Folio 270, 27 February 1878.
[76] Rob Ranzijn, Keith McConnnochie, and Wendy Nolan, "Steps Along a Journey: The Growth of Interest in the Relations of Between Psychology and Indigenous Australians," in *Psychology and Indigenous Australians: Effective Teaching and Practice*, ed. Rob Ranzijn, Keithe McConnochie and Wendy Nolan (Newcastle upon Tyne: Cambridge Scholars Publishing, 2008), 11.

Aboriginal women, whether Australian born or immigrant.[77] Indigenous Australian's cultural, physical, and mental trauma from the experience of invasion would also have been a factor in their mental state. Phillipa Martyr, in her study of Western Australian Indigenous contact with asylums in the nineteenth and early-twentieth century states that Indigenous Australian lunacy has 'painful dimensions of police rule, poverty, disease and institutionalised humiliation with which to contend'.[78] The day Barnett went to admit Maria, she was 'in a state of mania, this morning when I saw her at local jail was dancing a wild corroboree and exposing her person'.[79] However, this behaviour may not have been deemed manic within her culture. On admission, she climbed onto the roof of the asylum and long resisted efforts to get her down; she was then placed in a 'straight waistcoat on loosely for a short time' until Barnett could recommend 'that she should, whilst violent, be kept in the padded room—the waistcoat being removed'.[80] She remained in violent mania, and Barnett reported she was too violent to allow her in the yard and 'even when she had waistcoat on she reached at an idiot ([Alice] Halliday) to injure her'; he added, 'confinement to padded room at present, both for the safety of herself and of other patients'.[81] She was then directed 'to be kept in the garden as much as possible and closely watched'.[82] Maria's husband, George, and her sister visited in March and wished to take charge of her; they stated 'she will be all right in bush' and she was then behaving quietly and was anxious to go with them.[83] However, she continued to roam about in the yard in an excited state, talked wildly, exposed her person, and 'frequently indulges in a corroboree'.[84] Barnett noted that Maria no longer seemed dangerous but that the other patients excited her: 'will be well to let her go with her relatives to the bush as soon as there seems to be decided improvement as she excited all the other patients'.[85] On 15 March, Maria was discharged on trial into the care of her husband who readmitted her within three days as he could not manage her: he stated he would 'go to the Murray and return to see her after the races'.[86] As Martyr notes, the 1871 Lunacy Act of Western Australia provided a kind of solution for problematic Indigenous individuals who defied other forms of legal control, and who were seen as troublesome by white

[77] Jill Julius Matthews, *Good and Mad Women: The Historical Construction of Femininity in Twentieth Century Australia* (North Sydney, NSW: George Allen & Unwin Publishers, 1984), 30.
[78] Martyr, "'Behaving Wildly'," 319.
[79] *Female Register Case Book*, 1873-1878, Folio 270, 27 February 1878; Corroboree was first used by early Europeans to describe Aboriginal ceremonies involving singing and dancing. Corroboree was the English version of the Aboriginal word Caribberie. See: http://www.indigenousaustralia.info/index.htm.
[80] Ibid.
[81] Ibid, 1 March 1878.
[82] Ibid, 4 March 1878.
[83] Ibid, 6 March 1878.
[84] Ibid, 7 March 1878; Folio 271, 9 March 1878.
[85] Ibid.
[86] Ibid, 15-18 March 1878.

authorities and their own communities.[87] In the asylum, Maria was still inclined to be violent and so as punishment 'diet to be reduced to half for two days'.[88] In April, her husband called on Barnett and informed him he was going to Murray and, if she were better, would come to get her in six months and a fortnight.[89] In August, Maria was visited by her sister and brother-in-law and was recommended for discharge into her sister's care.[90] However, Maria's sister left town without taking her; in mid-September, they came back for her, and she was discharged 'to take her into bush'.[91] Six years later, in June 1884, Maria was readmitted via police lockup, occasionally noisy, troublesome, delusional, and behaved in a distraught way 'holding her hand up and crying out loudly without cause'.[92] However, her behaviour quickly improved, and she was discharged to the care of her husband in July.[93] Maria was placed in restraints and seclusion, and she also had her food reduced as a punishment for what was deemed bad behaviour, most of which was a clash of culture. As Caitlin Murray writes, racial hierarchies were maintained in Indigenous contact with white asylums.[94]

Anne Hawkins was a notorious patient readmitted across 1869 to 1902, frequently requiring restraint and seclusion in the padded room. The first instance of restraint was in 1869, after the birth of her baby in the asylum; Dr Attfield noted that she was in a complete state of dementia, very noisy, restless, and required constant supervision and restraint.[95] In November 1870, it was 'necessary to confine her hands to prevent her tearing her clothes'.[96] She was also given opium to help her sleep; however, she was so 'extremely noisy and mischievous' it was 'absolutely necessary to restrain her hands by mufflers'.[97] However, Anne was discharged in May 1871; but 'was subsequently so violent and unmanageable that her husband was obliged to bring her back again'.[98] She was readmitted again in June 1872, in a 'very violent condition'; she was filthy in her habits, spat and soiled her bed, and as such 'mufflers needed'.[99] In September, she bit patient Catherine McCormick on the arm; a month later she was 'getting quieter', and the records noted that the jacket was removed; thus this

[87] Martyr, "'Behaving Wildly'," 331.
[88] *Female Register Case Book*, 1873-1878, Folio 270, 21 March 1878.
[89] Ibid, 30 April 1878.
[90] Ibid, Folio 283, 29 August; 1-17 September 1878.
[91] Ibid.
[92] *Case Book Female Patients*, 1878-1897, Folio 81, 9 June 1884.
[93] Ibid, 6-7 July 1884.
[94] Caitlin Murray, "The 'Colouring of the Psychosis': Interpreting Insanity in the Primitive Mind," *Health and History* 9, no. 2 (2007): 19. https://www.jstor.org/stable/40111573.
[95] *Register of Female Patients*, 1858-1873, Folio 105, 20 November 1869; The details of this and Anne's continued story is in Chapter Nine.
[96] Ibid, Folio 125, 19 November 1870.
[97] Ibid, 28 November 1870.
[98] Ibid, Folio 147, 30 May; 7 June 1871.
[99] Ibid, Folio 153; 170, 28 June; 5-25 July 1872.

was the assumed punishment for the bite.[100] In January 1874, Anne was admitted for the seventh time 'symptoms worse than ever', 'raving wildly and dangerous to herself and others so that confining her hands (in the absence of a padded room) is absolutely necessary'.[101] Barnett reported that due to the 'shameful delay in completing the padded room' Anne had to be 'tied to prevent her injuring herself', and Matron Pyke was 'directed to confine Mrs Hawkins in the jacket if that seems to be more comfortable to her than binding her hands'.[102] On 22 February, Anne was inspected by Visitor Mr Barlee who directed the removal of bandages and requested a report on her.[103] Matron Pyke and Assistant Matron Fay reported that when Barlee arrived, Anne was tied to the bench to feed her: 'this cannot be done without fastening her as she jerks herself about and spits the victuals in the face of the nurse'.[104] Barnett added:

> With regard to her confinement in padded room this is only practicable for a very short time as the room gets insupportably warm at this time of year. It is needful for the poor creature's health and comfort that she should be frequently in the open air and she cannot be allowed to have her arms at liberty for she assaults those about her.[105]

Fifteen minutes after Barlee left, Anne 'made a fierce attack on Mrs Fay, without provocation, and attempted to bite and kick her'.[106] Three days later, it was noted she was occasionally quiet and obedient but that 'the violent attacks come over without any warning'.[107] Barnett wrote that the jacket was to be removed 'and only used when there is no possibility of restraining her by hand. It will be advisable to call in a warder to assist in holding her if the nurses find they cannot do so without assistance'.[108] Later that day, she 'kicked and injured two of the matrons' and in consequence damaged her healing leg ulcer.[109] Barnett noted, 'the jacket is to be used only when absolutely necessary and always removed when it can be done with safety, it is not to be used without first obtaining the surgeons permission'.[110] This comment identifies the regulations of restraint; matrons needed permission from the superintendent to use it on the patients. However, Barnett was also aware of the visitor's recent inspection and may have made this note with that in mind. Anne's violence did not abate; in March she threw items at patients and 'pulled off Mrs Fay's hat and assaulted her': 'she must be confined in the padded room for two hours whenever she

[100] Ibid, Folio 170, 8 September; 3 October 1872.
[101] *Female Register Case Book*, 1873-1878, Folio 68, 2 January 1874.
[102] Ibid, 5 January 1874.
[103] Ibid, Folio 69, 22 February 1874.
[104] Ibid.
[105] Ibid.
[106] Ibid.
[107] Ibid, Folio 77, 25 February 1874.
[108] Ibid.
[109] Ibid.
[110] Ibid.

attacks others', and the instances were to be reported to Barnett.[111] A few days later, she struck and injured the matron; this was recorded in the Assault Book that was not preserved.[112] Two days afterwards, she 'threw the matron on the ground, scratched her arm and tore her dress—hands to be put in mufflers until she becomes less violent'.[113] In May, she was 'placed in a separate room at night to give the other patients a chance of sleep'.[114] Anne was released and readmitted over the next few years, but it was not until 1881 that she was restrained again; in January she was violent and troublesome, so her 'hands have to be tied sometimes to prevent her from hurting herself'.[115] In February 1882, her husband sent her a letter 'complaining of being left alone', he was anxious to take her out, but Barnett stated that he knew it 'would only end in her return to Asylum', and she would 'return in manic'; however, due to her husband's insistence, she was discharged in July 1882.[116] Anne was readmitted three years later in February 1885; she had 'torn the padded room to pieces, throws stones at patients and has had to have the jacket put on her', 'the padded room had been rendered useless by her violence' and was also given a 'chloral draught caused twelve hours sleep'.[117] In July 1894, Anne's daughter Elizabeth Mary Donovan was admitted, Elizabeth also had 'to be put in the padded room for her safety'.[118] Anne spent the rest of her life in the asylum, dying of old age at seventy-seven in March 1902.[119] Anne was readmitted nine times across thirty-three years, and her violent behaviour resulted in considerable time in seclusion and restraints. Her case reveals the attendant's procedures for excessively violent patients. Barnett and his staff were, at least in his written account, to only use restraint and seclusion as a last resort. These cases also emphasise the often interchangeable use of mechanical restraint and seclusion.

'Inclined to be Drowsy': Chemical Restraint

Chemical restraint was another aspect of moral treatment and non-restraint measures, as cautious use of sedatives reduced the need for physical restraints.[120] In the nineteenth century, British asylum physicians wanting to implement moral treatment adopted a range of strategic methods such as 'suicide surveillance, protective clothing, force-feeding, and increasingly, drugs'.[121] Sedation was

[111] Ibid, Folio 80, 7-11 March 1874.
[112] Ibid, 15 March 1874.
[113] Ibid, 17 March 1874.
[114] Ibid, Folio 86, 13 May 1874.
[115] *Case Book Female Patients*, 1878-1897, Folio 54, 5 January 1881.
[116] Ibid, 23 February; 16-28 April; 24 July 1882.
[117] Ibid, Folio 87, 19 February; 14-21March 1885.
[118] Ibid, Folio 166, 13 July 1894; Elizabeth Mary Donovan's story is continued in Chapter Nine.
[119] *Case Book Female (Chronic)*, 1901-1908, Folio 21, 29 March 1902.
[120] Fennell, *Treatment Without Consent*, 25.
[121] Anne Shepherd and David Wright, "Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint," *Medical History*, 46 (2002): 179, doi: 10.1017/S0025727300000053.

used to reduce tension and anxiety and induce calm, and hypnotics were used to induce sleep as sleep was essential for resting and repairing the body and mind.[122] In British asylums, during the 1870s and 1880s, 'the use of drugs to restrain patients was extensively debated': there was 'evidence that heavy doses of medicines with unpleasant effects were used to deter patients from misbehaviour' and that many patients were over-sedated.[123] However, potent sedatives were acceptable if the intention was to quieten disturbed or violent patients, and not as a punishment; routine sedation was not permissible to make life easier for attendants.[124] Ann Hardy and Nancy Cushing write that by the twentieth century drug therapies began to be used more extensively within general psychiatry in New South Wales and across Australia.[125] When administered by physicians, common sedatives, like opium and paraldehyde, could be powerfully effective.[126] Both of these drugs were used in Fremantle on violent or suicidal patients. The use of chemical restraint was recorded more in the early twentieth century, which may have been due to access to the drugs and changing attitudes to mechanical restraint. Chemical restraint was also often used alongside mechanical restraint or seclusion.

Chemical restraint featured in Catherine, Edith, and Mary's cases, and it was used in response to bad behaviour. Catherine Reany, the wife of a warden, was forty-three years old when admitted with mania and delusions in November 1871.[127] Three months before admission, Catherine had wandered in mind and assaulted her husband and four children.[128] In the asylum, she remained violent and was ordered to take a draught, administered with great difficulty, she then slept for five hours and was much quieter the next day.[129] That evening, Catherine was again instructed to take chloral but remained restless all night.[130] In January 1872, she 'continued to take the chloral draught each night since December 17th, has slept well but has not improved in mind except that she is quiet and easily managed'.[131] Catherine was easier to deal with when she was taking the chloral. Edith Barker was a twenty-eight-year-old single draper admitted in October 1906 with acute mania caused

[122] Kathryn Burtinshaw and John R.F. Burt, *Lunatics, Imbeciles and Idiots: A History of Insanity in Nineteenth-Century Britain and Ireland* (South Yorkshire: Pen and Sword Books Ltd, 2017), 288.
[123] Fennell, *Treatment Without Consent*, 37.
[124] Ibid.
[125] Hardy, Ann and Nancy Cushing, "A Sensory History of the Newcastle Asylum for Imbeciles and Idiots, 1871-1900," *Journal of Australian Colonial History* 19 (2017): 160. https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=303747455486639;res=IELAPA.
[126] Fennell, *Treatment Without Consent*, 37-47.
[127] *Register of Female Patients*, 1858-1873, Folio 159, 15 November 1871.
[128] Ibid.
[129] Ibid, 16 November 1871.
[130] Ibid, 17 November 1871; Chloral is an organic compound that when combined with water forms chloral hydrate and was used a sedative and hypnotic.
[131] Ibid, Folio 160, 17 January 1872.

by influenza.[132] Edith was 'excited requiring restraint' and also needed 'paraldehyde to obtain sleep which however is always of short duration'; 'cold baths reduce the temp and soothe her for only a short time'.[133] However, she still required 'large doses of paraldehyde alternated with veronal to get sleep'.[134] Edith was then 'much quieter and inclined to be drowsy', due to the sedatives; in 1907 she was still prescribed veronal.[135] Mary Naughton was first admitted in August 1899, and by 1903 she was noted as 'more like a wild beast than a woman'.[136] Mary continually fought and attacked other patients and injured several nurses.[137] In December 1904, she was noisy and violent and 'requires seclusion at times'.[138] However, in March 1905, Dr Blackall reported that she was 'noisy and very violent, makes unprovoked attacks on people, is having paraldehyde with good effect'.[139] Mary continued as 'the most violent woman in the asylum', and in 1907, had to be 'confined in a single room every now and then for violent assaults on nurses'.[140] Blackall claimed she 'fears no one'. [141] Catherine, Edith, and Mary all received chemical restraint in an attempt to improve their behaviour and possibly to make them easier to manage.

Another patient who experienced chemical restraint was Rosanna McMahon, a woman who was frequently violent and who required restraint and seclusion. Rosanna was twenty-five years old when first admitted with mania and delusions on 23 May 1867; she had a 'restless expression' and 'an insane look'.[142] A married mother, the youngest of her children just six months old and 'at breast', she had accused her 'husband [James] of leading an irregular life' and had signs of deranged intellect two months after her confinement.[143] Rosanna was discharged in August but was readmitted in October possibly due to her seven-month-old baby James' death.[144] In November 1870, Rosanna was 'generally good humoured and willing to do what she is told', however, she was 'very excitable and passionate' and did not 'appear to have desired any benefit (with regard to her excitability) from the opium'.[145] The sedative is the first instance of Rosanna's recorded chemical restraint. In January 1871, she was 'extremely mischievous in tearing up her clothes. She is always at

[132] *Case Book Female Patients*, 1906-1908, Folio 27, 15 October 1906.
[133] Ibid, 16 October 1906.
[134] Ibid, 6 November 1906; Veronal was a hypnotic barbital used as a sleeping aid from 1903 to 1950s.
[135] Ibid, Folio 27, 27 December 1906.
[136] *Case Book Female (Chronic)*, 1901-1908, Folio 55, 11 March 1903.
[137] Ibid, 11 December 1902; 11 September 1903.
[138] Ibid, 12 December 1904.
[139] Ibid, 20 March 1905.
[140] Ibid, 15 June 1906; 20 March 1907.
[141] Ibid, Folio 96, 25 September 1907.
[142] *Register of Female Patients*, 1858-1873, Folio 99, 23 May 1867.
[143] Ibid; BDMWA: *Certificate of Birth*: Ann (1859), Ellen (6233/1862), Mary (7626/1864), James (9506/1866).
[144] Ibid, 3 August; 18 October, 1867; BDMWA: *Certificate of Death:* James Mcmahon (3501/1867).
[145] Ibid, Folio 117, 2 November 1870.

her worst immediately after catamenial period'.[146] In 1874, she assaulted Matilda Manning twice, the details of which are lost in the Assault Book.[147] The next day, she raved violently and addressed Dr Barnett as Napoleon.[148] By May, she prevented the other patients from sleeping and was 'placed in a room by herself at night, till the noisy period passes away'.[149] A week later, she was 'exceedingly violent and troublesome', and continuously teased patient Selina Turner, so Barnett 'had to order her seclusion in padded room for two hours and if needful, two hours more'.[150] She was 'so troublesome to other patients that she must be placed in a separate room at night'.[151] Rosanna continued as 'excessively noisy, violent and foul tongued, wearies and troubles all about her and uses horrible language' with 'the eye always an insane expression'.[152] In January 1875, 'she struck the matron, hurting her much, had to be secluded one and a half hours'.[153] In July 1899, a 'crochet hook went into the palm of her hand, is very painful', she went to the hospital and when her hand did not improve the 'amputation of right hand by Drs Hope and White' was undertaken in August.[154] Rosanna remained without change, and in September 1906, she was still noted as troublesome and used 'her amputated arm to advantage'.[155] In March 1907, she died aged sixty-five; a violent and frequently restrained, sedated, and secluded patient across forty years.[156]

Chemical restraint could also be administered for suicidal patients. In Britain, sedatives and strict surveillance were crucial for suicidal patients, and this was increasingly combined with sedatives in the late nineteenth and early twentieth century.[157] In Fremantle, from the late 1870s, sedatives for suicidal patients were used to calm them and procure sleep, as seen in Sarah, Laura, and Annie's cases. Sarah Catherine Langsford was single and aged thirty-two when admitted by her father with suicidal mania in July 1878.[158] The morning of her admission she had 'tried to drown herself in a tub'; she was given a 'chloral mixture', 'to be carefully watched and locked in a separate room at night'.[159] Laura Vernon was a thirty-nine-year-old married domestic from London, admitted with acute delirium and delusions in July 1906.[160] She had 'tried to choke herself' by 'ramming sheet

[146] Ibid, 23 January 1871.
[147] *Female Register Case Book*, 1873-1878, Folio 85, 13-14 March 1874.
[148] Ibid, 15 March 1874.
[149] Ibid, 11 May 1874.
[150] Ibid, Folio 102, 17 May 1874.
[151] Ibid, 26 July 1874.
[152] Ibid, Folio 121; 160, 6 June; 4 August 1874.
[153] Ibid, Folio 196, 8 January 1875.
[154] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 504; 506; 520, 8-13 July; 17 August 1899.
[155] *Case Book Female (Chronic)*, 1901-1908, Folio 6, 15 September 1906.
[156] Ibid, 4 March 1907.
[157] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 201; Shepherd, *Institutionalizing the Insane*, 165.
[158] *Female Register Case Book*, 1873-1878, Folio 286, 11-12 July 1878.
[159] Ibid.
[160] *Case Book Female Patients*, 1906-1908, Folio 5, 21 July 1906.

down her throat'.[161] On admission, 'it was discovered that her head was infested with vermin so hair was cut very short and soft', she was given a warm bath but was restless in the night so was given 'repeated paraldehyde'.[162] Laura continued to take sedatives as it was the only thing that affected her mental state.[163] Annie May Canter was a single tailoress admitted in March 1907 with melancholia agitate; previously an inmate in Kew Asylum twenty years ago, she had since threatened 'self-destruction' and attempted to 'destroy her sister's children'.[164] In the asylum, Annie was 'exceedingly restless, constantly repeating "what have I done" all day long', and 'requires much paraldehyde'.[165] After no improvement within the week, the 'opium treatment' was continued.[166] In early April, Annie still had not improved and 'requires paraldehyde constantly in large doses to procure sleep'.[167] She briefly improved in July; however, by November, she was unwell again and 'frequently requires sleeping draught'.[168] The use of chemical restraint was seemingly used to suppress the suicidal tendencies of these patients.

As evidenced by the examples of the female patients in Fremantle, seclusion and mechanical or chemical restraint could be employed for violent behaviour towards themselves, other patients, or asylum staff. Therefore, punishments were used to enforce nineteenth, and early twentieth-century ideas of womanhood, violence and bad behaviour was not accepted. Although seemingly only used when there were no other options, the reality for Fremantle was that attendants would use whatever resources they had to deal with troublesome patients. Following this investigation of punishment is an equally important aspect of moral treatment, an examination of the entertainment supplied for the patients as rewards.

Fremantle Asylum Amusements

Another aspect of moral treatment was the entertainment and amusement of the patients. In nineteenth-century Britain, a wide variety of recreations were available for asylum patients and their guests.[169] In the best asylums, Conolly argued, 'the patients are now often recreated by excursions in the neighbourhood, pic-nic parties, and visits to public exhibitions; care being taken both in the selection of patients and places'.[170] He stated that 'evening parties, concerts, and dances are found

[161] Ibid.
[162] Ibid.
[163] Ibid, 25-31 July 1906.
[164] Ibid, Folio 81, 14-15 March 1907.
[165] Ibid, 21 March 1907.
[166] Ibid, 27 March 1907.
[167] Ibid, 3 April 1907.
[168] Ibid, 13 July; 20 November 1907.
[169] Showalter, *Female Malady*, 37.
[170] Conolly, *Treatment of the Insane*, 88.

to be practicable and useful. In some public asylums even dramatic performances are ventured upon. All these things have been found to be compatible with the order and mild discipline necessary to be maintained in asylums'.[171] Thus, Australian practices of recreation and amusement also developed from moral treatment theories in nineteenth-century Britain.[172]

Entertainment covered a vast range of activities; there were various forms of physical exercise, including dances and balls, walks, boat rides, indoor and outdoor sports.[173] Entertainment might involve patients, staff and visitors as either spectators or participants; family and friends also provided informal entertainment in the form of parcels of reading material, as well as fruit and tobacco.[174] The provision of recreational activities for asylum inmates came from three main sources: paid professional groups, volunteers (from both inside and outside the asylum), and the asylum band.[175] The economic imperative for Australian asylums was to only pay for services that could not be obtained through voluntary work by individuals, community groups, or staff and patient labour.[176] In more isolated asylums, the provision of recreation fell solely to the staff and patients, who had to rely upon their resources to entertain themselves.[177] Like every other aspect of the asylum, entertainment was gendered, activities such as music were considered appropriate for women and outdoor sports for men.[178] Recreation was another means of "improving" select inmates' chances of recovery through the provision of appropriate sights and sounds that either reinforced or instilled moral values and gender roles.[179]

In Fremantle, the emphasis on morality , combined with a staple diet, exercise, religious instruction, amusements, and a lack of punishment and restraint was the treatment most likely to lead to the recovery of the insane.[180] Dr Attfield emphasised the human nature of care for the mentally ill, ensuring that all possible amusement was supplied such as books and ball games.[181] One such patient he cared for was Sarah Burns, admitted in 1858, she was generally indifferent and

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[171] Ibid, 88-89.
[172] Dolly MacKinnon, "'Amusements are Provided': Asylum Entertainment and Recreation in Australia and New Zealand c.1860-c.1945," in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, eds. Graham Mooney and Jonathan Reinarz (Amsterdam: Editions Rodopi B.V., 2009), 268.
[173] MacKinnon, "Amusements are Provided", 267.
[174] Ibid, 267-268.
[175] Ibid.
[176] Ibid.
[177] Ibid.
[178] Ibid.
[179] Dolly MacKinnon, "'Jolly Fond of Singing': The Gendered Nature of Musical Entertainment in Queensland Mental Institutions c1870-c1937," in *'Madness' in Australia: Histories, Heritage and the Asylum*, eds. Catharine Coleborne and Dolly MacKinnon, (St Lucia: The University of Queensland Press, 2003), 158.
[180] Harman, "Out of Mind, Out of Sight," 110-111.
[181] Maude, "Treatment of WA's Mentally Ill," 400-401.

slothful and with difficulty could be induced to work, she was, however, 'fond of reading' and was encouraged to do so.[182] Sarah Harding's sister sometimes brought her books and paper in June 1871; however, she would not use them at the time.[183] Dr Barnett also ensured entertainment for the patients. Barnett's 1888 Annual Report stated that a 'small annual grant of £20 allowed to me for supply of books, pictures, and games has been expended to the best advantage, and proves a source of comfort and pleasure to the patients'.[184] Barnett noted, 'when it becomes practicable to make the necessary additions to the Asylum, a large hall for concerts and similar entertainments may be included in the plan. At present the only available room is the dining room on the female side: it is quite unsuitable to the purpose, and cannot be used without much inconvenience'.[185] In 1889 he wrote, 'occasional breaks in the monotony of the lives of the patients are very beneficial, and on all occasions, when practicable, I endeavour to get up entertainments'.[186] In 1894, the government, for no apparent reason, terminated a grant to the asylum for the purchase of games, books, music, and pictures.[187] Thus, in 1896, Barnett complained that the staff had tried cricket, with little success; he noted that the patients sometimes played draughts, more often cards, but that the musical instruments were broken and in need of repair.[188] The instruments must have been fixed, as in May 1905, Elizabeth Hamilton was 'found playing the piano'.[189]

The following sections in this chapter expand on these patient examples with analysis of the kinds of amusement provided and the impact it had on patient experience. Some such amusements at Fremantle were extras like food, religious instruction, exercise, and daily leave. These extras were also integral parts of treatment. In 1903, Australian asylum superintendent William Beattie Smith noted that 'active open air exercise and athletic games for both sexes, morning shower bath, simple diet of milk, fish, fowl, and eggs, no stimulants, tonics, and cod liver oil' was needed for patient recovery.[190] However, he also stated that 'much flesh eating, which induces masturbation, and tobacco should be avoided'.[191] In the Kew Asylum in Victoria, 'unless the weather is persistently wet,

[182] *Register of Female Patients*, 1858-1873, Folio 7, 23 September 1858.
[183] Ibid, Folio 146, 14 June 1871.
[184] "The Fremantle Lunatic Asylum," *The West Australian*, Perth WA, 27 March 1888, 3.
[185] "Fremantle Lunatic Asylum," *The West Australian*, 3.
[186] Barnett, *Report Upon the Lunatic Asylum,* 5.
[187] Harman, "Out of Mind, Out of Sight," 119.
[188] Ibid.
[189] *Case Book Female Patients*, 1901-1908, Folio 229, 21 May 1905.
[190] William Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," *Intercolonial Medical Journal of Australia,* viii, no. 2 (1903), 65. http://hdl.handle.net/11343/23169; Beattie Smith (1854-1921) was an asylum physician, trained in Scotland by Clouston, and employed at the Ararat Asylum in Victoria and the Yarra Bend Lunatic Asylum from 1881-1899. In 1899 he became Superintendent at Kew Asylum until 1903. He was involved in revising the Victorian Lunacy Act 1903.
[191] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 65.

the patients are kept in the open air throughout the day'.[192] Dr William Moore reported that 'many [patients] are engaged about the farm; and those who are unfit, or who cannot be induced to work, are allowed to wander about in the yards under the charge of a few attendants'.[193] This was deemed an important part of colonial treatment. These activities and extras provided opportunities for potential improvement while also operating as a reward for good behaviour. However, they could also be rescinded due to bad behaviour.

A staple diet was crucial for patients as it aided in mental improvement, and therefore, extra food was allowed in Fremantle.[194] Regularly consumed foods at the asylum included bread, milk, oatmeal, tea, and vegetables that were grown on-premises.[195] Harman notes that patients rarely ate meat and were offered little variety in their diet, which was possibly an economy measure.[196] Friends and relatives of patients were permitted to bring gifts such as cakes, jams, or tea, on the condition that the patient had been "good", and that their diet allowed consumption of the items brought.[197] They did not always receive these, as Cecelia Hardy would complain in 1858 of a lack of 'butter or other luxuries'.[198] However, Alice Theodoria Hester's brother sent 'one pound to the matron to buy fruit for her' first in January 1893 and six times after that; her father also sent one pound in January 1894.[199] Although, extras could have adverse effects: Sarah Gaisford's husband 'brought her a cake which made her ill' and so she was 'not to be allowed to have anything he brings in future'.[200] Therefore, the staff controlled the extras and used them as rewards for good behaviour.

The practice of allowing patients personal items also provided another possible form of punishment; in these cases, extras were banned if the patient was seen to misbehave.[201] When Matilda Manning was admitted in March 1873 she was permitted to 'wear her own clothing and to have her own tea, sugar and oatmeal; such favours being conditional on her behaving well'.[202] However, when Matilda escaped from the asylum two days after her admission, made violent threats, and bit a nurse, she was 'confined to a cell' with 'all extras forbidden and temporary exclusion enforced'.[203] Although in April, Matilda was 'behaving better has former favours allowed'

[192] Moore, "Notes of a Visit to the Kew Asylum," 98.
[193] Ibid.
[194] Harman, "Out of Mind, Out of Sight," 111.
[195] Ibid.
[196] Ibid.
[197] Ibid.
[198] *Register of Female Patients*, 1858-1873, Folio 3, 28 August 1858.
[199] *Case Book Female Patients*, 1878-1897, Folio 199, 24 January 1893; 17 January; 27 February; 30 November 1894; 19 April; 24 October 1895; 22 January; 1 July 1896.
[200] Ibid, Folio 170, 8 October 1894.
[201] Harman, "Out of Mind, Out of Sight," 113.
[202] *Register of Female Patients*, 1858-1873, Folio 176, 24 March 1873.
[203] Ibid, 26-29 March; 1 April 1873.

once again.[204] Mary Taylor also had 'extra tea and sugar stopped' in June 1874 after she was 'very noisy and troublesome'.[205] Susanna Bowron applied for tobacco in August 1889, but it was 'not to be given till she behaves quietly'.[206] Consequently, behaviour also dictated the extras provided.

Religious instruction was also provided for the patients in the asylum. Patients could attend services or have priests, ministers, or nuns visit them. In most asylums, including Fremantle, the religion of the patient was often specified in their records as an identifying attribute. Conolly wrote that 'the introduction of regular religious observances, and all the consolations of religion, among the inmates of asylums' was a significant change introduced just before the abolishment of restraint, and is therefore associated with moral treatment reforms.[207] In Hanwell, 'it was required that the patients should attend the chapel neatly dressed. Prayer-books and hymn-books were furnished to them; psalmody was encouraged; and, by the appointment of a chaplain, two services were established on Sundays'.[208] Conolly noted, women who were 'quiet, decorous in manners and language, attentive to their dress, disposed to useful activity, and able to preserve their good behaviour in the chapel' were recovering.[209] Dolly MacKinnon writes that hymn singing was considered especially beneficial for women.[210] Medical and religious perceptions of the power of music to heal were based on beliefs from the Middle Ages: the success of music as treatment lay in its ability to enter through the ear and affect the mind, body, and soul of the recipient.[211] Therefore, music and singing's healing powers could restore a disordered mind.[212] In Fremantle, it seemed the religious services were one of the few voluntary activities at the asylum, although some patients may have attended all the sermons, regardless of religious belief because of the company of someone from "outside".[213]

Services for patients run by a priest or chaplain were recorded regularly in the *Female Occurrence and Daily Strength Book 1895 – 1900*. Other examples include Ruth Goode, who was 'taken to church by nurses' in November 1895 upon request.[214] An ill patient could also request a priest or minister, especially if there were a possibility of death.[215] Roman Catholic Joanne Sylvester

[204] Ibid, 5 April 1873.
[205] *Female Register Case Book*, 1873-1878, Folio 118, 1 June 1874.
[206] *Case Book Female Patients*, 1878-1897, Folio 99, 17 August 1889.
[207] Conolly, *Treatment of the Insane*, 104.
[208] Ibid, 185.
[209] Ibid, 128.
[210] MacKinnon, "Amusements are Provided", 269.
[211] MacKinnon, "Jolly Fond of Singing", 160.
[212] Ibid.
[213] Harman, "Out of Mind, Out of Sight," 117.
[214] *Case Book Female Patients*, 1878-1897, Folio 176, 24 November 1895.
[215] Harman, "Out of Mind, Out of Sight," 117.

was sixty-one when 'visited by the priest—Rev Father O'Reilly' in March 1879, after she had an apoplectic attack in the yard where she fell and hit her head.[216] Seventy-four-year-old Elizabeth Rampling was also Roman Catholic when in January 1894, she entered an excited stated and 'said she would not eat till she made her confession. Priest was sent for but she refuses to eat. Promises that she will take milk'.[217] The next day, Elizabeth saw the priest 'but she still refuses to eat until she gets the sacrament'; however, she ate a little porridge and milk that morning.[218] Jane Earle was another Roman Catholic who at sixty-four became 'dangerously weak' and was visited by 'the priest and also her husband'; she 'died from debility' due to natural causes in April 1878.[219] All of the women who had noted instances of religious instruction were over sixty years old (which was considered elderly in the nineteenth century) and were all Roman Catholic. As seen in Chapter Four, Roman Catholics were the single biggest denomination (25%) in the asylum; however, Protestant denominations accounted for 40.5% of the patients.[220] Therefore the representation of Roman Catholics in this section could be due to the Catholic tradition of confession, as a complete confession of all "mortal sins" to a priest was necessary for valid absolution.[221] Religious services may not have been explicitly used as a reward, but in moral treatment, it was considered helpful in the patient's recovery.

Another critical factor in the moral treatment regime was exercise. Almost all asylums offered exercise yards or courts where patients could get fresh air. Cherry and Munting argue this was considered a 'counter-measure to the miasmas then associated with infection and overcrowding linked with fevers in gaols, barracks, ships, or hospitals'.[222] 'Outdoor activities were increasingly linked with more positive benefits'; although it was possible 'such exercise was restrictive, monotonous', and could lead to 'fights, disorder, and escape attempts'.[223] In 1813, Samuel Tuke wrote, 'every means is taken to seduce the mind from its favourite but unhappy musings, by bodily exercise, walks, conversations, reading, and other innocent recreations. The good effects of exercise, and of variety of objects has been very striking'.[224] Conolly expressed that 'bodily exercise in the open air cannot be estimated too highly'.[225] In 1847, he stated 'the patients must be taken out for

[216] *Case Book Female Patients*, 1878-1897, Folio 10, 14 March 1879.
[217] Ibid, Folio 15, 9 January 1894.
[218] Ibid, 10 January 1894.
[219] *Female Register Case Book*, 1873-1878, Folio 269, 22-28 April 1878.
[220] See Table 4.3.
[221] John Cornwell, *The Dark Box: A Secret History of Confession* (London: Profile Books, 2014): https://books.google.com.au/books?id=MRolAwAAQBAJ.
[222] Steven Cherry and Roger Munting, "'Exercise is the Thing'? Sport and the Asylum *c.*1850-1950," *The International Journal of the History of Sport* 22, no. 1 (2005): 47, doi:10.1080/0952336052000314629
[223] Cherry and Munting, "Exercise is the Thing?," 47.
[224] Tuke, *Description of the Retreat*, 96.
[225] Conolly, *Treatment of the Insane*, 68.

exercise; even violent patients must not always be kept shut up in small rooms but be allowed to walk where they can do no mischief, or accompanied by one or two attendants'.[226] Even 'those patients who were unable, or even unwilling, to be employed, were regularly taken out for daily exercise'.[227] In Fremantle, exercise was usually on the afternoon schedule and limited to the yard.[228] Patients were encouraged to play games, chat, or garden; however, those unwilling to take part were seen as uncooperative and rejecting curative measures.[229] The yard and the garden in the male section were larger than the area on the female side, although there were more male patients than females.[230] Another aspect was that female recreation was often tied to domestic chores, as explored previously, which were often indoors.

In some cases, exercise was a reward for good behaviours, such as walks outside of the asylum.[231] Catherine Hescons' good behaviour in January 1873 meant she was allowed to go on a walk with the matron and she behaved well.[232] Agnes McGee was improving in July 1886 and so 'when the matron can afford time for it, she may take Agnes McGee out for a short walk, making all needful arrangements for care of Asylum during short absences'.[233] Elizabeth Ann Drown was allowed 'out walking with her mother' in July 1894, which went so well she was discharged to her mother on a fortnight's trial eight days later.[234] Mary Denehy had not shown much mental improvement in the asylum, although she was happy and worked; however, when she went 'out for a walk with daughter' in August 1906, she became a 'little better and brighter and cheerful'.[235] Although, despite the exercise, the patients could still relapse. Charlotte Prinsep was 'permitted to take a short walk with matron' in January 1881; however, two days later she was noted 'not to be taken out for the present' as she was somewhat delusional and 'has had too many visitors of late. Not to be visited by any one for the present, except Mr Prinsep'.[236] Despite the possible issues, exercise was generally encouraged for the female patients, and extra walks with staff or family could be beneficial and used as a reward for good behaviour.

Periods of leave from the asylum were also considered beneficial for the patients. However, it was usually patients considered well on their way to recovery that were granted leave for an hour,

[226] Conolly, *Construction*, 92.
[227] Conolly, *Treatment of the Insane*, 184.
[228] Harman, "Out of Mind, Out of Sight," 117.
[229] Ibid.
[230] Ibid.
[231] Ibid.
[232] *Register of Female Patients*, 1858-1873, Folio 174, 7 January 1873.
[233] *Case Book Female Patients*, 1878-1897, Folio 98, 2 July 1886.
[234] Ibid, Folio 163, 4-12 July 1894.
[235] *Case Book Female Patients*, 1906-1908, Folio 1, 13-20 August 1906.
[236] *Case Book Female Patients*, 1878-1897, Folio 55, 29-31 January 1881.

day, or weekend.[237] In Fremantle, the women who were granted leave had generally shown some improvement, but it did not necessarily precipitate discharge. Emma Schneider was given 'three days leave with her son', Rudolph, in May 1906, after which she felt it was imperative to be discharged.[238] Sarah Ann Jarvis was 'allowed to go home for a few days' in April 1905, 'but returned very much worse'.[239] Charlotte Campbell was 'discharged on daily leave' in May 1907, but returned 'relapsed, quiet, restless, very worried, often praying, not taking food well'.[240] In April 1907 Ida Gerschow was sent out 'in care of mother and husband on daily leave'; however, she returned eight days later 'considerably worse mentally'.[241] In May her 'friends have been forbidden to see her', but she was improving steadily both physically and medically.[242] Therefore in August, she was allowed 'out driving with husband most days' and was 'shortly to be discharged in care of friends to the other side'; she was finally discharged in August 1907.[243] Daily leave, like the other extras, was a privilege that could be granted and rescinded due to behaviour and mental state.

The use of amusements in Fremantle was perceived as beneficial for the patients. The extras were often used as rewards for improved behaviour and would have enhanced the patients' quality of life. However, bad behaviour would result in the loss of such extras. Therefore, the amusements became incentives for continued "good" behaviour. However, extras would have been a potentially exciting and anticipated part of the patient experience.

'The treat so kindly afforded them': Asylum Events and Shows

In England, weekly entertainment of readings, concerts, conjuring shows, marionettes, or pantomimes were enacted, and on alternate weeks, balls were held.[244] Local newspapers frequently emphasised the notion of amusement as therapy and supported involving the "outside" worlds: the *London Advertiser* wrote in 1877 that 'what most patients require is amusement—something to cause them to forget their sad condition'.[245] The importance of entertainment was a sentiment that was shared by nineteenth and twentieth-century West Australian newspapers, who frequently reported on the events at the asylum. In Fremantle, events were held at various times to amuse the

[237] MacKinnon, "Amusements are Provided", 268.
[238] *Case Book Female Patients*, 1901-1908, Folio 112, 7 May; 2 July 1906.
[239] Ibid, Folio 277, 15 April 1905.
[240] *Case Book Female Patients*, 1906-1908, Folio 55, 22-29 May 1907.
[241] Ibid, 31-30 April 1907.
[242] Ibid, 22 May 1907.
[243] Ibid, 12-24 August 1907.
[244] Shepherd, *Institutionalizing the Insane*, 35.
[245] Janet Miron, *Prisons, Asylums, and the Public: Institutional Visiting in the Nineteenth Century* (Toronto: The University of Toronto Press, 2011), 203.

patients: picnics, variety shows, operas, concerts, and minstrel troupes. However, it was also used as a reward, as badly-behaved patients could not attend the shows.

The first recorded event was a picnic for the female patients at Woodman's Point on Tuesday 4 March 1873. *The Herald* reported:

> Ten of the female patients in the Lunatic Asylum, accompanied by Dr and Mrs Barnett, and by the matron and one assistant matron, passed a most agreeable day in the country. Music was provided and the patients danced vigorously and frequently; at times they collected under a tree and sang together…The drive to Woodman's Point and the exercise of dancing on the grass during a strong sea breeze combined to freshen the appetites of the party, and very full justice was done to an ample and comfortable cold dinner provided…ultimately all returned safely and pleasantly to Fremantle. Not a single unpleasant circumstance occurred during the day which will be marked by a white stone in the memories of the patients, all of whom expressed warmly the gratitude which, they felt for the kindness shown to them, and the enjoyment they had experienced in getting such a pleasant change to the monotony of their usual life.[246]

Only seven of the women who attended the picnic were noted in the case book records. Anne Hawkins 'behaved very well and quietly, did not join in the amusements but expressed herself very grateful for the pleasant day she spent'.[247] Mary Anne Gilmore 'went to picnic and behaved gently'.[248] Sarah Burns was noted as 'quiet at the picnic'.[249] Catherine Hescons 'was one of the picnic party which I [Barnett] made to Woodman's Point. Behaved with perfect quietness and good senses. Spoke and looked as sane as could be wished. Was very grateful for the day's amusement. Joined in the dancing'.[250] Margaret A. Mullins 'behaved well at the picnic' and had since been 'quiet and ready to work'.[251] Catherine Casey 'was the foremost amongst the messy singers and dancers at the picnic'.[252] Catherine McCormick, however, was less easy to manage; 'though rather difficult to keep in bounds did not show any violence. Had to be restrained once or twice when she showed a disposition to strip herself. Danced alone generally'.[253] Barnett deemed the picnic a success. *The Herald* also shared this sentiment: 'this is the first time that a picnic has been attempted from the Asylum, and its complete success ought to serve as an example for similar occasional parties'.[254] 'In other countries it is customary to provide funds for such amusements by public subscription and on future occasions, it is hoped, an appeal to the public will enable the patients to enjoy a little

[246] "The Week: Picnic to the Asylum Patients," *The Herald*, Fremantle WA, 8 March 1873, 2.
[247] *Register of Female Patients*, 1858-1873, Folio 170, 4 March 1873.
[248] Ibid, Folio 135, 4 March 1873.
[249] Ibid, Folio 175, 4 March 1873.
[250] Ibid, Folio 174, 4 March 1873.
[251] Ibid, Folio 171, 1 May 1873.
[252] Ibid, Folio 151, 4 March 1873.
[253] Ibid, Folio 162, 4 March 1873.
[254] "The Week," *The Herald*, 2.

variety'.[255] They argued 'such an excursion as that which they have had is not only a harmless pleasure but a potent means of benefit to them physically and mentally'.[256]

The next event was the following year on 22 June 1874. Sloman & Smith Bijou Variety Troupe performed at the asylum; *The Herald* recorded:

> The performance took place in the large dining hall, where the patients of both sex were assembled, under the care of the warders and matrons attached to the institution. A table formed a temporary stage, and the entertainment, consisting of music, songs, dancing, and legerdemain, was specially selected for the peculiar audience. The utmost delight was manifested by the patients, in everything done, and they applauded the various points of excellence with as much discretion as any ordinary assemblage, and with rather more enthusiasm.[257]

Three of the women at the picnic in 1873 attended the performance. Margaret Mullins 'behaved well at theatrical performance'.[258] Mary Anne Gilmore 'attended the theatrical performance and behaved quietly'.[259] Catherine McCormick, who had been problematic at the picnic, also attended.[260] Other patients in attendance were Sarah Salter, Ann Burns, Margaret Forbes, Anne Smith, Amelia Bishop, Anne Casey, Catherine Stokes, Ellen Markie, Sarah Harding, Judith Butler, Margaret Kane, Selina Turner, and Mary Thompson.[261] *The Herald* stated 'the proprietors of the Bijou Troupe deserve great credit for affording this treat to the unfortunate inmates of the Asylum'.[262]

The following year a concert was held on 3 May 1875; however, it was not reported on in the papers. The six women who had previously attended the picnic in 1873 and the performance in 1874, Anne Hawkins, Catherine McCormick, Catherine Casey, Margaret Mullins, Mary Anne Gilmore, and Sarah Burns were present, all of them behaving well.[263] Six of the patients who had attended the 1874 performance also attended the concert: Mary Thompson, Amelia Bishop, Sarah Harding, and Ann Smith, all behaved quietly: while Sarah Salter and Ellen Markie behaved well.[264] Other attendees were Mary Taylor, Alice Halliday, Anne Tippet, Clementina O'Byrne, Ann Casey, Martha Rogers, Catherine Reany, Sarah Jane Bell, and Mary Ann Connerton.[265] However, Joanna Lloyd 'was noisy and had to be removed from concert'.[266] Dr Barnett also noted that Rosanna McMahon 'was not at

[255] Ibid.
[256] Ibid.
[257] "Lunatic Asylum," *The Herald*, Fremantle WA, 27 June 1874, 2.
[258] *Female Register Case Book*, 1873-1878, Folio 133, 22 June 1874.
[259] Ibid, Folio 137, 22 June 1874.
[260] Ibid, Folio 108, 22 June 1874.
[261] Ibid, 22 June 1874.
[262] "Lunatic Asylum," *The Herald*, 2.
[263] *Female Register Case Book*, 1873-1878, 3 May 1875.
[264] Ibid.
[265] Ibid.
[266] Ibid, Folio 214, 3 May 1875.

concert' possibly due to her noisy and violent behaviour; and that Mary Ann Rogers 'did not attend the concert as she would probably have been noisy'.[267] These examples further highlight that the performances were rewards; Rosanna and Mary Ann were not well behaved enough to attend.

On 9 October 1885, the Stanley Opera Company 'gave a gratuitous entertainment to the afflicted inmates of the Lunatic Asylum'.[268] *The Inquirer* reported 'the performance, which consisted of singing, dancing, and character representations was immensely enjoyed by the unfortunate spectators', 'this is the first time such a pleasant break has occurred in the depressing monotony of the patients' ordinary daily routine of life for about eight years'.[269] However, it is more likely ten years as there is no reference to any other concerts since 1875. The opera was not mentioned in the patient records, so attendance and behaviour remain unknown. However, *The Inquirer* reported that Harry Stanley received a letter from Dr Barnett thanking them, 'the patients would benefit in many ways from the treat so kindly afforded them'.[270] Two years later, on Wednesday 21 September 1887, 'Messrs. Farmer & Imray's Minstrel Troupe gave an entertainment'.[271] The *Western Mail* reported that 'the programme was composed of songs, nigger jokes, and other pleasantries pertaining to Christy Minstrel performances, and was evidently keenly relished by the inmates'.[272] Interestingly the only recorded attendee was Rosanna McMahon, who was prevented from attending the 1875 concert; this performance was a reward for her improved behaviour.[273] The *Western Mail* added Barnett thanked the performers and said 'he hoped it would not be the last time he would have the pleasure of witnessing their successful efforts to amuse the inmates of the Asylum'.[274]

After 1887, there are no further entries in the female patient records in regards to attendance at performances; however, the newspapers continued to report on them. On 23 November 1889, 'Mr Roachhock, a well known athlete from the other colonies…gave an exhibition of his powers to the inmates' and various songs were performed.[275] Amongst those present were the Mayor of Fremantle, Mr E. Solomon, Dr and Mrs Barnett, Mrs Bird, Mr D. Thomas, and Mr F. Hart.[276] The *Western Mail* reported that the stage was composed of three dining tables placed into one corner of the large room, the female inmates were seated on the right side of the platform, and the

[267] Ibid, Folio 209; 211, 15 February; 3 May 1875.
[268] "General News," *The Inquirer and Commercial News*, Perth WA, 14 October 1885, 3.
[269] "General News," *The Inquirer and Commercial News*, 3.
[270] Ibid.
[271] "News of the Week," *Western Mail,* Perth WA, 24 September 1887, 25.
[272] "News of the Week," *Western Mail,* 25.
[273] *Case Book Female Patients*, 1878-1897, Folio 16, 23 September 1887.
[274] "News of the Week," *Western Mail,* 25.
[275] "Entertainment at the Fremantle Lunatic Asylum," *Western Mail*, Perth WA, 23 November 1889, 36.
[276] "Entertainment," *Western Mail,* 36.

men on the left, with the visitors between them.[277] The local papers continued to record asylum events, such as, on 23 September 1891, the asylum had a 'unique treat by a visit from the Western Liedertafel'; 'a programme consisting of part songs and solos was rendered, the rapt attention paid by the inmates to each item being a sure index of the pleasure experienced'.[278] Amongst those present were Dr Hope, acting Medical Superintendent, and Mrs Hope, Mr Fairbairn, R.M., and Mrs Fairbairn.[279] In the end, Dr Hope 'thanked the Liedertafel for their kindness in giving the concert, which had been greatly appreciated by all, and the occasion would be pleasant food for reflection, to the inmates as well an agreeable break in the monotony of their existence'.[280] On 23 January 1892, *The Inquirer* reported a Fremantle town band, organised by Mr Ready, 'kindly gave an instrumental performance' for two hours and 'supplied a great amount of pleasure to the inmates'.[281] Seven years later, on 12 April 1899, the patients 'were provided with a treat...when an entertainment organised by Mr W. O. Mason was given expressly for their delectation by a number of ladies and gentlemen at the port'.[282] *The West Australia* reported 'every item was enthusiastically applauded'.[283]

Upon entering the twentieth century the concerts and performances became a monthly occurrence and were often noted, with minimal detail, in the *Female Occurrence and Daily Strength Book, 1895 – 1901*. On 19 September 1900, *The Daily News* reported the thirtieth monthly concert in connection with the asylum; 'the occasion, marking the close of the third year of Dr Hope's management of the Asylum, drew a larger than ordinary attendance of visitors'.[284] The concert closed with thanks to Mr Mason, the musical director of the monthly concerts, for the 'praiseworthy efforts to brighten the lives of the mentally afflicted'.[285] On 7 November 1900, the patients 'were treated to a gramophone entertainment, provided by Miss Haga and Captain G. Waage…the gramophone selections, which were quite novel to many of the patients, were greatly appreciated': they returned to play more selections on the 16 November.[286] On 10 September 1902, a concert was held at the new theatre in the asylum and 'among the large and interested audience' were Mr Briggs, M.L.A., with Mr and Mrs John.[287] *The Daily News* reported 'the new theatre marks another stage in the evolution of the institution towards higher and better things, and the superintendent, Dr

[277] Ibid.
[278] "General News," *The Inquirer and Commercial News*, Perth WA, 25 September 1891, 4.
[279] "General News," *The Inquirer and Commercial News*, 4.
[280] Ibid.
[281] "General News," *The Inquirer and Commercial News*, Perth WA, 29 January 1892, 4.
[282] "News and Notes: Concert at the Lunatic Asylum," *The West Australia*, Perth WA, 13 April 1899, 4.
[283] "News and Notes," *The West Australia*, 4.
[284] "Lunatic Asylum: Monthly Concert," *The Daily News*, Perth WA, 20 September 1900, 2.
[285] "Lunatic Asylum," *The Daily News*, 2.
[286] "News and Notes," *The West Australian*, Perth WA, 8 November 1900, 4; *Female Occurrence and Daily Strength Book,* 1895-1901, Folio 698, 16 November 1900.
[287] "Fremantle Asylum Concert," *The Daily News*, Perth WA, 12 September 1902, 3.

Montgomery, is much to be congratulated on the result of his efforts'.[288] On 16 November 1904, a party of twenty-five from Perth paid their monthly visit to the asylum and 'gave a very enjoyable entertainment, which was greatly appreciated, not only by the inmates of the hospital, but by a number of visitors' who had a 'very pleasant evening'.[289] These articles reveal the interest of the general public and society members who attended the concerts, as well as patient involvement.

The Daily News reported on the last concert on record held on 23 March 1905; 'several members of the West Perth Glee Club' visited the asylum, 'and contributed a programme of vocal and instrumental numbers'.[290] The paper noted, 'some of the audience were rather eccentric in their methods of expressing appreciation, but that they thoroughly enjoyed the concert was apparent and they joined heartily in the choruses'.[291] They also observed 'the event had evidently been well advertised, for there was a large attendance'.[292] They concluded 'the performers returned to Perth thoroughly pleased with their outing, a pleasure, enhanced possibly by the consciousness of having done a good and charitable act'.[293] The attitudes displayed in the reporting of entertainment at the Fremantle asylum, are similar to their English counterparts: the kindness and charitability of the people to amuse and hopefully help the unfortunate patients. What is also apparent is the social event the concerts became: visitors would come to not only see inside the asylum but for the free entertainment. It would also have been viewed favourably to be charitable towards the "unfortunate". The names of those who contributed were usually included in the newspaper's report, which is perhaps why regional magistrates and local politicians attended the events.

Stephen Garton notes, that the existence of picnics and extras 'does not necessarily undermine representations of asylums as overcrowded, institutional, and custodial in operation'; 'all the dances and musical performances…did not prevent a steady accumulation of chronic patients, overcrowding, and routines geared more to discipline than cure'.[294] However, asylum physicians were 'very committed to improving conditions, making institutions more effective, and of course, trumpeting these successes'.[295] It is clear that the use of these performances was to reward good behaviour, and attendance could be restricted if the patients misbehaved. As with the other extras provided, these concerts would have been enjoyable and anticipated events for patients.

[288] "Fremantle Asylum Concert," *The Daily News*, 3.
[289] "Fremantle Lunatic Asylum: Concert to the Inmates," *The Daily News*, Perth WA, 19 November 1904, 1.
[290] "Fremantle Lunatic Asylum: Concert to the Inmates," *The Daily News*, Perth WA, 24 March 1905, 5.
[291] "Fremantle Lunatic Asylum," *The Daily News*, 5.
[292] Ibid.
[293] Ibid.
[294] Garton, "Seeking Refuge," 34.
[295] Ibid.

Chapter Conclusions

Moral treatment was the nineteenth-century physicians' attempt to provide more humane solutions for asylum and patient management. Therefore, punishments and rewards were crucial components of the moral regime in Fremantle. Combined with the domestic chores as rehabilitation, punishments and rewards also enforced nineteenth-century gender roles; punishing "bad" behaviour and rewarding "good".

With the introduction of the non-restraint movement within moral treatment, asylums attempted to treat their patients without mechanical restraints and with seclusion or chemical restraint which was seen to be more humane. However, as this chapter revealed, mechanical restraint was used for almost the entire time the asylum was in operation. The use of these practices was particularly apparent with violent patients who were often restrained and placed in the padded cell. However, the understaffed, underfunded, and overcrowded asylum resulted in attendants using any means available to maintain order in the asylum. Rewarding patients for good behaviour was also implemented in the moral treatment regime. The provision of entertainment was an essential aspect of moral treatment that aimed to promote recovery by keeping the patients occupied and active. It also became an avenue for rewarding patients who displayed good behaviour or improvements. Although these amusements did provide entertainment for the well-behaved patients, even if only temporarily, it could be stopped if patients misbehaved.

The staff at the asylum, with the best intentions and influenced by moral treatment, used all available resources to aid in the care, amusement, and containment of the female patients. This chapter further emphasises that gender roles were intrinsically linked to moral treatment theories and practices. Nineteenth-century ladylike behaviour was enforced, and deviations were punished. This section determined how moral treatment was implemented and experienced by female patients in the asylum. Thus, the following chapters in Part III provide further insights into moral treatment techniques and patient experiences by examining the categories and diagnoses with which the female patients were labelled in the Fremantle asylum.

PART III

Female Patient Experiences

CHAPTER SEVEN

Nowhere Else to Go: The Chronic and Incurable

Part III provides greater insight into the female patient experiences in Fremantle. These chapters further deliver the aims of the thesis through an investigation of patient records to determine the provision of care and moral treatment methods. This part also expands on the kinds of diagnoses women received in Fremantle and how this was influenced by preconceived notions of womanhood. The categorisation of madness, as discussed in previous chapters, was seen to improve treatment and women's experiences in asylums. However, Part III will reveal that Fremantle physicians, in treatment and diagnosis, were impacted by the nineteenth and twentieth-century social and moral theories about women, their bodies, and their place in society.

This section of the thesis begins with an investigation into the women admitted to the asylum who were considered chronic or incurable and who were at the mercy of their families when it came to admission and release. As discussed in Chapter Four, the impact of a family's influence (or lack thereof) could affect when and why a patient was admitted, her length of stay, and discharge. Therefore, Chapter Seven examines the women this impacted the most: the elderly, epileptics, and the intellectually disabled.

'Asylums were established to confine individuals for a variety of reasons: to keep them safe, to "cure" them, and sometimes to relieve relatives of difficult household situations, thus separating the insane from the rest of the world'.[1] Thus, asylums may have offered 'respite to society rather than the patients', "insane" people could be 'removed from communities and deposited within an institution where unusual behaviour would find a home'.[2] However, as Mark Finnane argues, the asylum was not just a "dumping ground", 'although it became that to an important degree: its custodial functions were undeniable and alarming to asylum and state authorities from an early period'.[3] Asylum case histories construct a spectrum of familial relationships; 'at one end, families are represented as close-knit, loving, and healthy', while 'at the other end, families were brutal,

[1] Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World 1860-1914* (New York; Palgrave Macmillan, 2010), 3.
[2] Stevens, *Life in the Victorian Asylum*, 148.
[3] Mark Finnane, "Asylums, Families and the State," *History Workshop*, no. 20 (1985): 141. https://www.jstor.org/stable/4288653.

abusive, and dangerously unhealthy'.[4] Therefore, 'poverty and disappointed expectations put pressure on even the most caring of families'.[5]

The nineteenth-century asylum 'operated as a particular type of intervention in family life'. 'That intervention was moulded and changed by the operations of an array of agents': doctors, police, magistrates, and families; but also by state policy, legislation, institutional arrangements, and financial provision.[6] However, by the end of the century, relatives began to choose to place unmanageable family members in asylums under professional care and control, a response to the pressures of industrialisation and social change.[7] In Britain, at Brookwood Asylum in 1871, Superintendent Brushfield expressed concerns that many of his patients, particularly the elderly, had been sent to the asylum by their family and friends, to get them out of the way.[8] He viewed such actions as indicative of a lack of compassion amongst communities; but also as medically damaging, these patients occupied places that could be better filled by more medically deserving cases.[9] However, Anna Shepherd argues that evidence provided by family members to doctors was crucial in obtaining an accurate assessment of the patient's insanity, and suggests a level of mutual co-operation; although the full extent of family collusion in committal is challenging to discern.[10] It is, therefore, overly simplistic to suggest that relatives used asylums to dispose of unwanted individuals such as the elderly or unmarried women; it must be remembered that often families, of all classes, cared deeply about their unwell relatives, sought custodial care as a last resort, and wanted only reassurance and guidance from the asylum staff.[11]

Although the attitudes towards institutional care were shifting, the stigma attached to asylums did not disappear; hence, the name changes for institutions.[12] In Western Australia, the Fremantle Lunatic Asylum was replaced in 1908 by the Claremont Hospital for the Insane. At the time, the word hospital held connotations of cure and health, rather than the negative associations with asylum or lunatic. Australian convicts and early migrants had left their families behind in Britain and were obliged to confront illness, destitution, and death without the crucial support of family

[4] Marjorie Levine-Clark, "Dysfunctional Domesticity: Female Insanity and Family Relationships among the West Riding Poor in the Mid-Nineteenth Century," *Journal of Family History* 25, no. 3 (2000): 346, doi: 10.1177/036319900002500305.
[5] Levine-Clark, "Dysfunctional Domesticity," 346.
[6] Finnane, "Asylums, Families and the State," 146.
[7] Shepherd, *Institutionalizing the Insane*, 4.
[8] Ibid, 71.
[9] Ibid.
[10] Ibid, 71-79.
[11] Ibid, 79.
[12] Ibid, 4.

networks or traditional communities until new family formation took place over generations.[13] Due to often small families in the colonies, relatives sometimes struggled with in-home patient care, and family members who needed extra attention were sent to the asylum. Therefore, some of the women admitted to Fremantle had nowhere else to go, and this chapter will examine how families impacted incarceration and release.

'Demented from Old Age': Elderly Women in Fremantle

As in Britain, the trend of institutionalisation of the elderly poor was well underway in colonial Australia from the mid-nineteenth century.[14] Families were not always able, or willing, to provide ongoing care for older people with conditions such as dementia and its associated challenging behaviours.[15] These problematic behaviours also meant that other institutions, such as general hospitals and invalid depots, were often unwilling to provide ongoing care for older people.[16] Many sick and incurable elderly in colonial Australia spent their last years in asylums, where conditions varied from inhumane in Queensland and Tasmania to more tolerable in South Australia and Victoria.[17] The removal of the elderly poor from home to asylums was a fundamental social change, reflecting a growing tolerance for large institutions treating the elderly, destitute, and insane.[18] Despite both genders suffering health problems associated with aging, men were more likely to have supportive, often younger, wives or unmarried daughters to care for them.[19] However, women were also more likely to develop supportive networks to assist them, and families often found it easier to cope with dependent older women.[20] It was when they had no families, or their families could not cope, that they were admitted to the asylum.

The elderly women with no apparent family or marital support were admitted to Fremantle with little hope of leaving, as demonstrated in Margaret Haggerty's case. Margaret was stated to have 'no appearance of insanity about her' when first admitted in 1868, and in July 1870, was noted as 'being free from any symptoms of insanity and being only childish and somewhat imbecile she has today on the recommendation of a medical board been taken away by her friends'.[21] However, she

[13] Pat Jalland, *Old Age in Australia: A History* (Carlton: Melbourne University Press, 2015): https://books.google.com.au/books?id=cbQtBgAAQBAJ.
[14] Jalland, *Old Age in Australia*, n.p.; In the nineteenth century sixty and over was generally considered elderly.
[15] Anthea Vreugdenhil, "'Incoherent and Violent if Crossed': The Admission of Older People to the New Norfolk Lunatic Asylum in the Nineteenth Century," *Health and History* 14, no. 2 (2012): 107. https://www.jstor.org/stable/10.5401/healthhist.14.2.0091.
[16] Vreugdenhil, "Incoherent and Violent if Crossed," 107.
[17] Jalland, *Old Age in Australia*, n.p.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] *Register of Female Patients*, 1858-1873, Folio 109-124, 1868; 13 July 1870.

was readmitted in February 1871, 'suffering from dangerous delusions and to be unfit to take care of herself'.[22] Dr Dickey reported, that 'I cannot discover any delusions whatever. She is now 61 years old, looks 70. Is anaemic and feeble. Has no sign of insanity proper about her she is simply somewhat demented from old age'.[23] Margaret remained in the asylum dying of natural causes in December 1872.[24] Her situation also became more apparent when a memo stated 'rings and some clothing belonging to deceased have been put aside until her husband's address is discovered. He is believed to be in Melbourne'; he was not located as a note in September 1873 stated to auction the items.[25] Whether she was separated or deserted in unknown, but Margaret was alone.

Similar situations occurred in nineteenth-century Fremantle with other elderly women without family, including Mary, Johanna, and Mary. Mary Maley was a seventy-year-old former hospital nurse admitted in August 1891 via the Perth Police Magistrate; she had 'tried to commit suicide by opening veins in arms'.[26] Mary remained in the asylum and by 1901 was 'very feeble' and confined to bed with an 'ulcer on her left foot'; she died in December.[27] Johanna Dewar was aged sixty when admitted in June 1898; by 1903 she was a 'feeble, objectionable old woman' who 'wanders about all day causing trouble'.[28] In 1907 Johanna was 'quite blind, very weak and feeble' and would sit quietly in the infirmary all day.[29] In June 1908 Johanna was transferred to Claremont where she died in 1910 aged seventy-two.[30] Mary McGregor was a sixty-seven-year-old Irish widow and laundress admitted with senile dementia in December 1906.[31] She was 'white haired with distinct arcis senilis…irritable, and bad tempered, restless, difficult to keep in bed, obstinate and resistive, refuses to answer questions replying "oh don't bother me, I won't answer these"'.[32] In January 1907, Mary was less irritable with 'fairly advanced dementia senilis'.[33] Mary was transferred to Claremont in June 1908 and where she died in 1912, aged seventy-three. These women spent the rest of their lives incarcerated in the asylum.

Early twentieth-century admissions also resulted in elderly women admitted to the asylum as they had nowhere else to go, including, Ann, Mary, and Hannah. Ann Unity Adams was a seventy-

[22] Ibid, Folio 124, 27 February 1871.
[23] Ibid.
[24] Ibid, Folio 165, 14-15 December 1872.
[25] Ibid, 3 September 1873.
[26] *Case Book Female Patients*, 1878-1897, Folio 149, 7 August 1891; 23 February 1893.
[27] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 30, 5-23 December 1901.
[28] Ibid, Folio 48, 3 June 1898; 11 June; 11 December 1903.
[29] Ibid, Folio 91, 20 June; 17 December 1907.
[30] Ibid, 9 June 1908; BDMWA: *Certificate of Death:* Johanna Dewar (81/1910).
[31] *Case Book Female Patients*, 1906-1908, Folio 53, 10 December 1906.
[32] Ibid, 11 December 1906; Arcis senilis is a white, blue, or grey ring around the iris of eye found in the elderly.
[33] Ibid, 4 January 1907.

year-old widow admitted with senile dementia in October 1904; 'a very old feeble woman bearing all the usual signs of senile decay'.[34] Ann had become 'unable to look after natural wants', lost her memory, spoke to imaginary people, and mistook others for old friends.[35] However, Ann's health was weak with troublesome bronchitis, by November, she was 'confined to bed in hospital' with a failing heart and impeded breathing, dying a month after admission.[36] Mary Tracey was a sixty-eight-year-old Irish single housekeeper admitted with senile dementia caused by 'old age' in November 1906.[37] The medical certificate stated that Mary 'lived alone for a long time till taken into the Sacred Heart Convent' where she developed delusions regarding poisons.[38] In December, Mary was noted as 'helpless, always anxious to see a priest, thinks she is very ill,' and a week later was 'weak and evidently slowly sinking, has troublesome cough'.[39] In January 1907, Mary 'quietly died'.[40] Hannah Skrimski was an eighty-five-year-old 'white haired old lady in excellent condition for her years'.[41] A widowed German 'Jewess' with senile decay, Hannah was admitted in November 1905 with delusions, loss of memory, and auditory hallucinations.[42] Hannah was 'cheerful and happy, very kindly and polite, denies all delusions and hallucinations…no mental impairment beyond that expected from her years'.[43] Hannah continued 'quiet and happy' but stated 'she has never forgiven her son and does not wish to speak or have anything to do with him because he married a Christian woman'; her estrangement from her son may account for her admission.[44] In 1907, Dr Blackall noted she was a 'placid old dame to speak to', but she would 'often sit and cry, unable to give a coherent reason'; in May 1908, Hannah died aged eighty-eight.[45] These women had no family to care for them and nowhere else to live out the rest of their lives, resulting in incarceration.

However, it was not uncommon that elderly women had family, but that they were too difficult to care for at home. Bridget O'Cairn was once such case. Admitted in December 1902, Bridget was a 60-year-old Irish widowed housewife, with dangerous mania who had previously been in a Victorian asylum.[46] Bridget was 'a healthy old lady, grey hair, teeth bad', she had used abusive and incoherent language and thrown stones at her son and daughter-in-law; she also believed her

[34] *Case Book Female Patients*, 1901-1908, Folio 197, 7-10 October 1904.
[35] Ibid.
[36] Ibid, 27 October; 1-11 November 1904.
[37] *Case Book Female Patients*, 1906-1908, Folio 43, 26-27 November 1906.
[38] Ibid, 26-27 November 1906.
[39] Ibid, 4-11 December 1906.
[40] Ibid, 9 January 1907.
[41] *Case Book Female Patients*, 1901-1908, Folio 303, 1-2 November 1905.
[42] Ibid.
[43] Ibid.
[44] Ibid, 9-14 November 1905.
[45] Ibid, 17 April; 19 July 1907; 25 May 1908.
[46] Ibid, Folio 73, 31 December 1902

daughter-in-law wanted to poison her due to jealousy.[47] Within a month, Bridget acknowledged the incident with her family, stating 'it was only to frighten them and not to hurt them'.[48] By July, she had improved, becoming quiet, orderly and more sensible; she was discharged on trial in August and discharged recovered in September.[49] Bridget was fortunate that her son was willing to receive her again as she was one of the few elderly patients to be released back into family care.

The other patients, such as Maria, Mary, and Elizabeth, with known relatives, remained in the asylum or were transferred to Claremont where they died. Maria Jane Bull was a sixty-one-year-old British housewife admitted in May 1902, with senile dementia caused by paternal heredity.[50] Physically she was 'a feeble old woman in a filthy condition, emaciated, grey hair, blue eyes, teeth bad'.[51] She had delusions, was 'in a filthy condition', and thought 'her husband has designs against her life'.[52] Her husband must have struggled with her behaviour, as this was the primary motivation for her admission. Maria was transferred in May 1908, and died in Claremont that same year, aged sixty-seven.[53] Mary Warren was aged approximately sixty-five to seventy, Irish, and married when admitted in December 1906, with senile dementia.[54] The medical certificate reported: 'imagines she is being chased by evil spirits, no memory for time, place or people, wanders about in night clothes, refuses food, screams without reason, at times inclined to be violent'.[55] However, in the asylum, she was quiet, contented, 'cheerful and full of smiles, friends with everybody'.[56] This behaviour was maintained, and she was allowed daily leave with friends in May 1907, which made her 'quite cheerful'.[57] Mary remained cheerful, but was transferred to Claremont in June 1908 and died the following year.[58] However, although married, Mary's friends were the ones who took her on daily leave, suggesting issues within her marriage. Elizabeth Hollingsworth was a seventy-one-year-old housewife with senile mania when admitted in June 1903; 'a healthy old woman, very stout', she was 'very deluded, says that her husband who is 80 years of age is unfaithful' and in the asylum on the male side.[59] By 1907, Elizabeth was 'periodically very abusive, believes she is very ill,' and still had 'delusions about her husband speaking to her from the male side'; she was 'always complaining

[47] Ibid.
[48] Ibid, Folio 74, 21 January 1903.
[49] Ibid, 1 July; 21 September 1903.
[50] Ibid, Folio 31, 26 May 1902.
[51] Ibid.
[52] Ibid.
[53] Ibid, Folio 364, 16 May 1908; BDMWA: *Certificate of Death:* Maria J Bull (87/1908).
[54] *Case Book Female Patients*, 1906-1908, Folio 51, 8 December 1906.
[55] Ibid, 10 December 1906.
[56] Ibid, 16-21 December 1906.
[57] Ibid, 22 May 1907.
[58] Ibid, 11 June 1908; BDMWA: *Certificate of Death:* Mary Warren (62/1909).
[59] *Case Book Female Patients*, 1901-1908, Folio 93, 11 June 1903.

of her health and the quality of the food, both of which are good'.[60] In June 1908, Elizabeth was transferred where she died in 1911 aged seventy-nine.[61] These women were not noted to have ever been visited by their husbands or family while in the asylum.

Some patients were admitted by their children, who must have struggled with the needs of their mothers, apparent in Elizabeth and Mary's cases. Elizabeth Day was a seventy-eight-year-old widow with senile dementia admitted by her son Owen in January 1904 after her behaviour became difficult; she was 'unable to give her own or her son's name', appeared dazed and 'does not know where or when her husband died'.[62] She was a 'very feeble old woman', who 'if left for a moment she wanders from home, does not know how to dress'.[63] In the asylum she was a 'feeble, childish old woman, is very restless and depressed'.[64] However, she became very ill with bronchitis and died in December 1904.[65] Mary Elizabeth Irving was a sixty-seven-year-old Irish widow with senile dementia caused by brain fever and grief, when admitted by her daughter Jessie Crocker in March 1907.[66] Mary was an 'old lady in fairly good condition; right breast has been amputated with excellent result'.[67] She had 'to be constantly watched else she gets lost, cannot dress herself', which would have been difficult for her daughter.[68] She was also loquacious, joyful, and would break 'out into laughter at her jokes'.[69] Mary was a 'typical senile dement, memory very poor' and was transferred in June 1908, dying that year aged sixty-eight.[70] Elizabeth and Mary's families could no longer cope with their mothers' troublesome behaviour.

The difficulties families faced with elderly relatives is further evidenced in the case of Ann and Emma, whose delusions centred on their family members. Ann Ross was a seventy-five-year-old Scottish widow admitted by her grandson with senile dementia in November 1904; it was noted she 'does not look as old as 75 years, is delicate and ill in appearance'.[71] Ann 'tears off her clothes and refuses to be dressed' and 'believes her daughter put poison in her drinking water…she will not give her reason for suspecting her daughter but adopts a mysterious manner. Has not been getting on very well with the family there are several young children'.[72] In 1905 she often became worried; 'is

[60] Ibid, Folio 94, 11 January 1907.
[61] Ibid, 12 June 1908; BDMWA: *Certificate of Death:* Elizabeth Hollingsworth (24/1911).
[62] Ibid, Folio 149, 8 January 1904.
[63] Ibid.
[64] Ibid, Folio 150, 14 March 1904.
[65] Ibid, 20 November; 10 December 1904.
[66] *Case Book Female Patients*, 1906-1908, Folio 93, 26-27 March 1907.
[67] Ibid; there was no reference for the amputation but it was possibly breast cancer.
[68] Ibid.
[69] Ibid.
[70] Ibid, 23 April 1907; 12 June 1908; BDMWA: *Certificate of Death:* Mary E Irving (75/1908).
[71] *Case Book Female Patients*, 1901-1908, Folio 209, 12-14 November 1904.
[72] Ibid.

very afraid of doing wrong, troublesome to get her to eat because she is afraid of eating somebody else's dinner' and delusions of 'her own worthlessness'.[73] In 1907 she began 'taking more kindly to her daughter', was 'more cheerful than formerly' and noted as a 'typical senile dement'.[74] However, in August, she accidentally fell in the airing court fracturing her left femur; she developed pneumonia that 'steadily advanced' and she died three days later.[75] Ann's daughter could not continue to care for her mother and family, which resulted in committal as the delusions potentially endangered her children. Emma Hoare was a seventy-six-year-old English widow admitted by her son-in-law in September 1907 with senile dementia caused by 'old age'.[76] The medical certificate stated: 'talks continuously and incoherently to imaginary people, does not recognise her near relatives, dirty in habits, denies herself food saying that she could not afford it which is not true, accuses her relatives of robbing her'.[77] Emma's physical examination revealed she was 'in remarkably good condition for her years, hair white, well-marked arcus senilis…is very deaf, has a curious harsh voice very similar to the Jewess Mrs [Hannah] Skrimski whom she closely resembles in face' and 'has had fourteen children'.[78] She was 'very reluctant to give up a bag of money she brought along with her, is inclined to be suspicious'.[79] In October, her wrist was bruised, and her thumb partially dislocated after struggling against going to bed.[80] Emma remained senile but 'as a rule cheerful'; she was transferred in June 1908 and died in 1912, aged eighty-one.[81] Emma's delusions centred on her family and combined with her resistive behaviour made it difficult to handle her care.

The elderly women admitted to Fremantle asylum with senile dementia had nowhere else to go. These women often had families who struggled with care at home due to their behaviours, and although the asylum was perhaps not ideal for palliative care, it was the beginning of a cultural shift to the professional care of the elderly.

'Imbecile' and 'Idiot': Intellectual Disability

The modern term intellectual disability was not used in the nineteenth century; imbecile and idiot were common labels for these patients admitted to asylums. By the fifteenth century, 'idiot' became preferred for someone who had a congenital incapacity with no intervals of sanity; the category

[73] Ibid, 5 January; 23 March 1905.
[74] Ibid, Folio 210, 11 January; 17 April 1907.
[75] Ibid, 14-17 August 1907.
[76] *Case Book Female Patients*, 1906-1908, Folio 171, 26-27 September 1907.
[77] Ibid.
[78] Ibid.
[79] Ibid.
[80] Ibid, 10 October 1907.
[81] Ibid, 19 November; 16 December 1907; 8 June 1908; BDMWA: *Certificate of Death:* Emma Hoare (36/1912).

'imbecile' was also developed for people who had acquired permanent cognitive impairment after birth, such as brain injury or illness.[82] The disabilities of an imbecile, although permanent, were generally not considered as profound as those of idiots; there was less social stigma having a child who was mentally disabled at birth, than a family member who became mentally deranged in adolescence or adulthood.[83] Scottish physician Arthur Mitchell noted in his study that 'amongst idiots and imbeciles there are more males than females' and reported that 'the heads of idiots, as a rule, are abnormally small, but that a small head is not an essential in idiocy'.[84] Thus, there was an emphasis on studying the physical differences as well as mental. However, by the beginning of the nineteenth century the distinction between mental illness and intellectual disability was blurred: '"idiocy" and "insanity" were aspects of the same kind of disorder'.[85]

Up until the mid-nineteenth century, imbeciles and idiots were cared for by families or local communities.[86] However, there was consensus during this period that intellectually disabled children were better cared for in institutions that could cater for their needs, rather than care from their families, where they could become neglected and hidden away.[87] For the working class, a child with a disability was a drain on resources, and therefore, the poorhouse or asylum were possible options.[88] Indeed, some parents had their intellectually disabled children admitted to forget them.[89] Ann Hardy and Nancy Cushing write that in late-nineteenth and early twentieth century Australia, influenced by eugenics, asylum care for the intellectually disabled was isolating, with many kept in institutions located on islands and coastal peninsulas.[90] Importantly, they were away from the gaze of the general public.[91] Ultimately, intellectual disability was considered incurable, an attitude that continued well into the twentieth century.[92]

Authorities in nineteenth-century Western Australia often failed to 'distinguish accurately and consistently between mental illness and intellectual disability'; Megahey argues that the confusion continued into the twentieth century due to a lack of medical and psychological knowledge on the topic.[93] The Victorian Inspector Edward Paley regarded the intellectually disabled

[82] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 170.
[83] Ibid, 170-174.
[84] Arthur Mitchell, "Some Statistics of Idiocy," *Journal of Mental Science* 12, no. 57 (1866): 140-142. doi: 10.1192/bjp.12.57.140.
[85] Megahey, "Living in Fremantle", 17.
[86] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 170.
[87] Ibid, 174.
[88] Ibid.
[89] Fox, "'Forehead Low, Aspect Idiotic'", 150.
[90] Hardy and Cushing, "A Sensory History of the Newcastle Asylum," 160.
[91] Ibid.
[92] Megahey, "Living in Fremantle Asylum", 15.
[93] Ibid, 26; 29.

as burdens on the asylum system; thus, idiots and imbeciles became defined as problems in a different way to curable patients.[94] The Medical Society of Victoria noted in 1883:

> There is a danger to imbecile young women, as well as of allowing an insane husband to cohabit with his wife, or an insane wife with her husband, and so increasing the insane population. Idiots of either sex should not be allowed to leave an asylum, which should be specially adapted for them.[95]

This idea of permeant incarceration and the fact that patient case notes for imbeciles and idiots were often sparse and suggested physicians saw them as long-term and less worthy of careful observation.[96] Society seemed to offer no hope beyond life-long incarceration for the intellectually disabled; they were hidden away so as not to disturb an emerging community, which needed social stability.[97] Some of the women in Fremantle were discharged to their family, but most of them remained institutionalised, with or without family contact.

However, two intellectually disabled women, Alice and Jessie, were discharged to family members. Alice Cousins, was fifteen years old when she was admitted semi-imbecile in July 1878 and although at first 'very dull' she soon looked 'less unearthly in expression' and by the end of July 'looks greatly better'.[98] In August Alice was deemed well enough for her parents to take her and she was discharged to her sister in October.[99] Jessie Chipper was eighteen years old when admitted by her mother in April 1888 with partial imbecility; she had 'from birth suffered from malformation of head and impaired intellect...of late her mother finds it difficult to handle and hopes that a short stay in Asylum will so impress her as to render her more manageable at home'.[100] At first, Jessie was 'behaving well and controlling herself'; however, after three days in the asylum Barnett reported she became 'very noisy, trying to kick me and will not behave herself', 'requires to have her hands fastened, as formerly at her home, as she is violent and destructive at times. Spoke to her, she is more quiet, but not to be trusted'.[101] Two weeks after admission, Jessie's mother visited her, she came again twice in April and expressed a wish to remove Jessie.[102] Thus, Jessie was discharged to her mother 'somewhat improved' in May, a month after her admission; however, in August her mother readmitted Jessie as she was 'very violent and uncontrollable and cannot be managed at

[94] Fox, "'Forehead Low, Aspect Idiotic'", 147.
[95] Medical Society of Victoria, "Ordinary Monthly Meeting," 403.
[96] Coleborne, *Madness in the Family*, 55.
[97] Megahey, "Living in Fremantle Asylum", 14.
[98] *Female Register Case Book*, 1873-1878, Folio 285, 3-22 July 1878.
[99] Ibid, 22 July; 26-29 August; 1 September; 1 October 1878.
[100] *Case Book Female Patients*, 1878-1897, Folio 130, 2 April 1888.
[101] Ibid, 3-8 April 1888.
[102] Ibid, 15-24 April 1888.

home'.[103] Jessie continued 'as usual, partial imbecility' and had 'attempted suicide before she was brought here'.[104] By December she 'had some violent attacks acting like a wild beast and using hideous language'.[105] Despite her behaviour, Jessie was once again 'removed to care of her mother' in April 1889.[106] Both Alice and Jessie were lucky to have female relatives willing to care for them at home.

The more chronic or long-term cases of intellectual disability did not mean total isolation from their families; Ann and Grace both had some contact while incarcerated. Ann Hayes was fifteen years old when she was admitted in October 1879; 'she has been imbecile and idiotic from birth'.[107] On admission she was 'very troublesome and causes much mischief in the place, throwing stones at other patients'.[108] However, Ann's mother visited her just eight days after her admission; perhaps Ann's violent tendencies were too difficult for her mother to manage at home.[109] In 1880, Ann complained of abdominal pain and was 'feverish and flushed' which was believed to be due to menstruation approaching for the first time; eight days later her menstruation commenced, and she became much less troublesome.[110] Ann remained in the asylum without much change, and in 1886 she was again noted as 'a chronic case—idiotic from birth'.[111] In April and December 1899, Ann's mother and sister visited her, and in October 1899 and December 1900 friends visited her; these were the only other recorded visits.[112] Ann was transferred to Claremont in June 1908, dying in 1914, aged fifty; she had been incarcerated for thirty-five years.[113] Grace Chitty was twenty years old when admitted by her mother in July 1881; she was 'sullen, stupid and silent. Has been so for years—no cause known'.[114] Grace's mother Johana remained in contact with Dr Barnett via telegraph and received updates on her health and mental state from August to December; her mother also wrote to her; however, Grace 'remains imbecile'.[115] By February 1886, Barnett reported: 'her mother writes to me, is very anxious to take her out, she is not sane, but I am willing that she

[103] Ibid, 1 May; 25 August 1888.
[104] Ibid, 27 August; 2 September 1888.
[105] Ibid, 26 December 1888.
[106] Ibid, 12 April 1889.
[107] *Case Book Female Patients*, 1878-1897, Folio 45, 21 October 1879.
[108] Ibid.
[109] Ibid, 29 October 1879.
[110] Ibid, 13-21 October 1880.
[111] Ibid, Folio 112, 8 August 1886.
[112] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 476; 538; 570; 710, 28 April; 1 October; 20 December 1899; 21 December 1900.
[113] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 15, 12 June 1908; BDMWA: *Certificate of Death:* Ann Hayes (32/1914).
[114] *Case Book Female Patients*, 1878-1897, Folio 60, 30 July 1881.
[115] Ibid, 9-12 August; 15 September; 8 December 1881.

should take her out on trial and try what a change will do'.[116] Across 1898 to 1901, Grace was visited by friends at least once a month; her mother visited occasionally, and Mrs Gilchrist regularly visited from March 1900.[117] She was fortunate to receive consistent visitation, as Grace had the most frequently noted visitations of any female patient in the asylum during this period. Grace was transferred to Claremont in May 1908.[118] While Ann and Grace had some form of contact at points in their incarceration, they were often inconsistently contacted and reported.

Other intellectually disabled patients had no mention of family contact after admission, as demonstrated in Eliza, Pollie, and Minnie's cases. Eliza Lockyer was a thirty-three-year-old domestic admitted for the third time in March 1907 with chronic dementia caused by 'abscesses in head' and has been "insane" since she was two years old.[119] She was a 'well developed and well-nourished woman with extensive stigmata of degeneracy e.g. ears placed far back with no lobule, small, flat head, asymmetrical face, high palate'; 'face is devoid of expression and all emotions appear lost'.[120] Two weeks after admission, Eliza's mother attempted suicide 'she set fire to her house and then threw herself down a well, injuring both legs sufficiently to require amputation'.[121] In this case, Eliza's mother was in no state to care for her intellectually disabled adult daughter. Eliza remained 'a chronic dement' and was transferred to Claremont in June 1908.[122] Pollie Hembry Cox was seventeen years old when she was admitted in July 1907, an imbecile who was 'subject to fits of hysteron-epileptic type' with 'an idiotic and degenerate type of face with irregular much decayed teeth'.[123] Pollie's mother stated that she 'was a delicate child but commenced to walk and talk at a normal time and showed normal mental abilities' and it was not until '15 years of age she commenced to have fits of crying and became very nervous', becoming progressively worse.[124] However, Dr Blackall found her mother's statement 'very doubtful' and suspected 'a very strong possibility of the presence of congenital syphilis'.[125] Pollie was a 'typical imbecile' and was put 'on mercury' treatment; she was generally quiet and never had a fit in the asylum.[126] Pollie was transferred to Claremont in May 1908 and eventually died in 1927 aged thirty-seven.[127] Minnie Bee was a twenty-four-year-old single houseworker admitted as a 'typical imbecile of high grade type' in

[116] Ibid, 21 February 1886.
[117] *Female Occurrence and Daily Strength Book*, 1895-1901, SROWA.
[118] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 18, 29 May 1908.
[119] *Case Book Female Patients*, 1906-1908, Folio 79, 8 March 1907.
[120] Ibid, 9 March 1907.
[121] Ibid, 21 March 1907.
[122] Ibid, 3 April; 15 May; 20 June 1907; 2 June 1908.
[123] Ibid, Folio 141, 10 July 1907.
[124] Ibid.
[125] Ibid, 17 July 1907
[126] Ibid, 24 July; 14 August; 14 September 1907.
[127] Ibid, 27 May 1908; BDMWA: *Certificate of Death:* Pollie H Cox (428/1927).

January 1908.[128] She was noted as of 'imbecile appearance, is mute though not deaf, was well up till a fall when 18 years old when she developed fits and has been getting worse mentally although the fits seem to have ceased' she then developed 'sudden and unprovoked tempers'.[129] Minnie also had 'very typical Hutchinson's teeth' which was a symptom of congenital syphilis.[130] In the asylum, she worked and was 'bright and cheerful' and was eventually transferred to Claremont in May.[131] All three women were left in the asylum with no noted contact from their families; however, they were possibly visited in Claremont. In Pollie and Minnie's case, the congenital syphilis factor may have levied a sense of shame or guilt on their parents and could account for their absence.

The female patients admitted to Fremantle could be abandoned by their family or be discharged to them; this depended on their families' financial situation and what they could manage. The visual assessments of these patient's physical and mental disabilities also impacted their assessment of imbecility and idiocy, with references to appearance and expression. The terms recorded by physicians also reveal there was often little distinction between "imbecile" or "idiot"; nor did it affect their care or treatment. However, there was also a high instance of intellectually disabled patients with epilepsy as will be explored in the following section.

'Fits Frequent': Epileptic Patients

In the Victorian era, epilepsy was a common diagnosis in asylums.[132] From the thirteen to seventeenth-century, epilepsy had associations with witchcraft and demonic possession, particularly if accompanied by tremors or convulsions.[133] Nineteenth-century European physicians understood epilepsy as a brain condition, though it was widely regarded as incurable.[134] In the research trying to understand epilepsy alcohol is sometimes blamed as a cause or exacerbation. In 1881 it was reported that alcohol consumption had an effect regarding epilepsy; 'intemperance may appear as a hurtful habit of the individual favouring the development of the spasmodic neurosis, or again, as a constitutional tendency entailed by parent on offspring with similar dreadful consequences'.[135] However, the asylum was deemed the best place for people with epilepsy regardless of mental

[128] Ibid, Folio 197, 3-4 January 1908.
[129] Ibid.
[130] Ibid.
[131] Ibid, 11 January; 16 May 1908.
[132] Ennapadam S. Krishnamoorthy and Rema Reghu, "The Psychoses of Epilepsy," in *Psychiatric Issues in Epilepsy: A Practical Guide to Diagnosis and Treatment*, 2nd ed, eds. Alan B. Ettinger and Andres M. Kanner, (Philadelphia: Wolters Kluwer, 2007), 264.
[133] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 182-183.
[134] Ibid, 183.
[135] M.G. Echeverria, "Alcoholic Epilepsy," *Journal of Mental Science* 26, no. 116 (1881): 489. doi: 10.1017/S0368315X00001614.

capacity or class.[136] Epileptic patients were occasionally admitted to for a cure; however, many became long term inmates with little distinction in asylum facilities for non-insane epileptics, despite the classification of epileptic-imbecile and epileptic-insane.[137]

The treatment for epileptic patients was often sedatives. In 1857, Sir Charles Locock discovered the anticonvulsant and sedative qualities of potassium bromide, which was used regularly until the discovery of phenobarbital in 1912.[138] During the 1888 Victorian branch meeting of the British Medical Association, J.W. Springthorpe's paper on epilepsy was discussed; Springthorpe suggested that 'the removal of peripheral and other sources of nerve irritation is as important in the relief of epilepsy as the continued use of a specific nerve sedative such as bromide of potassium'.[139] Thus, a diagnosis of epilepsy extends beyond the physical and biological impact on the body and brain of an individual and also affects economic, psychological, and social aspects of life; this impact would have been more significant in the nineteenth century when the medication was limited, and the prospects for those with uncontrollable epilepsy were bleak.[140] In asylums, epileptics were always identified on admission as their fits could cause injury to themselves or others; they could also be issued with padded clothing.[141] In Fremantle, some of the women with epilepsy were discharged, but others were long-term cases, some dying due to the affliction.

Margaret Atkinson was one of the few epileptic patients discharged from the asylum. Margaret was eleven years old when admitted with dementia in November 1889; 'epileptic and has lost memory—wanders into bush and gets lost. Is noisy and troublesome'.[142] Two days after admission, Margaret was visited by her mother and was noted after as 'less troublesome'.[143] In January to March 1890, she had 'frequent fits', and by April, she had 'congestion of brain and the fits become worse and more frequent'.[144] In May, Dr Barnett reported: 'fits follow one another incessantly…all care is taken of her but she gets more and more dangerously ill'; 'has screaming fits at times. Probably a tumour pressing on brain'.[145] In June, Margaret's 'mother wishes to take her out' which Barnett agreed to 'giving her two days notice and come for her daughter'.[146] Whether her

[136] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 183.
[137] Ibid, 183-184.
[138] Ibid.
[139] J.W. Springthorpe, "Notes on Fifty Cases of Epilepsy," *Australian Medical Journal* x, no. 1 (January 1888): 4. http://hdl.handle.net/11343/23152.
[140] Burtinshaw and Burt, *Lunatics, Imbeciles and Idiots*, 83-84.
[141] Stevens, *Life in the Victorian Asylum*, 98-99.
[142] *Case Book Female Patients*, 1878-1897, Folio 139, 14 November 1889.
[143] Ibid, 16-19 November 1889.
[144] Ibid, 21 January; 10 February; 28 April 1890.
[145] Ibid, 3-5 May 1890.
[146] Ibid, 4 June 1890.

mother came is not recorded, and it is not until November that she was reported as having 'had a succession of severe epileptic attacks'; 'the fits are exceedingly bad—am writing to her parents'.[147] In January 1893, Barnett wrote 'this poor child has been now confined to bed for two months with frequent epileptic fits. Begins to eat a little better. Is a sad tax on the overworked matrons, who take every care of her'.[148] By mid-January, her fits were less frequent, but she was in constant need of nursing, the matron, Mary Thompson, attended her.[149] In February Matron Thompson wrote to Margaret's mother requesting she take charge of her: 'she has now got over the last attack of epilepsy and is really a case for home treatment more than for an Asylum'; Margaret was 'removed by her mother. Much improved' in February 1893, then aged fifteen.[150] Margaret's severe condition would have been challenging to manage, but her slight improvement and young age may have contributed to her mother's willingness to care for her at home.

However, most of the epileptic women admitted to the asylum remained for long periods and were transferred to Claremont in 1908. Due to difficulties with their families, Eliza, Jane, and Frances became long-term patients. Eliza Ann Bottomley was twenty-three years old with epileptic mania admitted via the Albany lockup in December 1894; she 'suffers from epileptics fits. Has assaulted her mother violently—tears her clothing'.[151] Eliza had frequent fits, and by 1896, she was 'losing health and strength' and 'lying in a semi-comatose condition'.[152] From 1898 to 1901, her mother, brother, and friends visited her regularly, and she often had fits during the night.[153] By 1907, Eliza 'shows usual epileptic obstinacy' and was transferred to Claremont in June 1908 where she died in 1914 aged forty-three.[154] Jane Smith was a thirty-six-year-old housewife admitted with epileptic mania in April 1905; she had experienced epileptic fits since the shock of her father's death ten years previously.[155] Jane's medical certificate noted: 'screams and has to be held down to prevent her injuring her children at times, roams aimlessly about'.[156] Jane had a 'scar of severe burn on left side of face, neck and shoulder, the left ear having much deformed, due to falling in fire 5 years ago whilst in a fit…her face is immobile and lacks expression.[157] Dr Blackall noted that 'she has not had a fit since admission, her appearance and speech suggest that epileptic dementia is setting

[147] Ibid, 19-26 November 1890.
[148] Ibid, 12 January 1893.
[149] Ibid, 18 January 1893.
[150] Ibid, 13-24 February 1893.
[151] Ibid, Folio 174, 27 December 1894.
[152] Ibid, 12 November; 9 December 1896.
[153] *Female Occurrence and Daily Strength Book*, 1895-1901, SROWA.
[154] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 35; 95, 20 June 1907; 5 June 1908; BDMWA: *Certificate of Death:* Eliza A Bottomley (243/1914).
[155] *Case Book Female Patients*, 1901-1908, Folio 243, 8-10 April 1905.
[156] Ibid.
[157] Ibid.

in'.[158] However, weeks later Jane had 'one or two petit mal seizures characterised by sudden loss of consciousness, no initial cry, no convulsions, she becomes limp and very pale and recovers consciousness in about 3 minutes', she had 'on average 4 petit mal seizures a week'.[159] In 1908, it was noted, 'fits as frequent as ever, no mental change, quiet', and Jane was transferred to Claremont in June.[160] Frances O'Brien was a thirty-year-old single domestic worker admitted with epilepsy in August 1907.[161] Frances had been in the Old Women's Home in Perth where she became violent, irritable, and pulled other women out of their beds and then got into them.[162] She had 'fits of great regularity and fair frequency since 12 years of age' with 'cerebration slow and deliberate, very characteristically epileptic, memory good, well oriented, fairly intelligent, some evidence of commencing epileptic dementia'.[163] Frances was quiet on admission with 'occasional grand mal seizures'.[164] Frances was generally 'cheerful, is docile and easily managed', though she continued to have fits, and was transferred in June 1908.[165] Both Eliza and Jane were proving difficult and dangerous for family members, while Frances was troublesome in the women's home; all three women caused issues with carers, which resulted in asylum committal.

Ada Jane Gilham also remained in the asylum due to family issues. Ada was a twenty-four-year-old single houseworker admitted with epileptic mania by her mother, Annie Taylor, on 3 December 1906.[166] Ada was reported as 'at times violent and difficult to control, had made a dangerous attack on her mother of which she has no recollection'.[167] However, the admitting Coolgardie physician, Dr Mitchell, claimed he did not believe Ada a 'true epileptic' as the fits 'were capable of being controlled by suggestion of disagreeable treatment'.[168] Despite this assessment, she was still treated for epilepsy as she had a 'rash on chest and back probably due to bromides, she says she has had a lot of medicine but not for last six months, her hair has been cut short'.[169] Ada's history on admission noted that at age seventeen she contracted a disease, possibly scarlet fever, and afterwards the fits commenced.[170] Dr Blackall observed that she was 'fairly normal apart from

[158] Ibid.
[159] Ibid, 28 April 1905; Petit mal are smaller spells of unconsciousness without seizure and Grand mal involves a loss of consciousness and violent muscle contractions.
[160] Ibid, Folio 248, 24 January; 5 June 1908.
[161] *Case Book Female Patients*, 1906-1908, Folio 161, 23-24 August 1907.
[162] Ibid.
[163] Ibid.
[164] Ibid, 29 August 1907.
[165] Ibid, 21 October; 19 November 1907; 5 June 1908.
[166] Ibid, Folio 45, 3-4 December 1906.
[167] Ibid.
[168] Ibid.
[169] Ibid.
[170] Ibid.

fits and the pre and post epileptic periods'.[171] She had 'genuine fits…but on more than one occasion has run about the ward fussing saying "oh am I going to have a fit, am I going to have a fit" ad lib, she was laid down on bed and no fit took place'.[172] Ada was 'irritable and bad tempered', had 'about 1-2 fits per week' and 'fabricates many lies of ill-treatment to her friends'.[173] In June 1908, she had 'hallucination of hearing, has been hearing her mother's voice in ward' and was transferred to Claremont the same day.[174] Ada's hallucinations and attacks were centred on her mother, making her difficult to control; however, there were no recorded visits from her family.

Some of the women in Fremantle that had epilepsy died as a result of it, such as the cases of Christina and Julia. Christina Laura Stirling was fifty-seven years old when she was admitted in September 1900; she was a 'very acute melancholic, shivers and shakes when spoken to, says destruction is about to fall on the world'.[175] Christina was consistently visited by her daughter from 1900 to 1901, and occasionally, her son and husband.[176] In October 1904, Christina 'had a series of epileptic form seizures after which she was partially paralysed in left arm and leg, the left pupil is dilated and the eye quite blind…there was left facial paralysis for a short time after fits'.[177] By early November, she had 'recovered from seizures, but the right leg is cold, and there is very slight pulsation in the femoral in groin'; the leg then became gangrenous, she 'is in considerable pain, the right leg is dead to middle of thigh, left leg is dead to the knee…receiving opium to relieve pain, amputation is out of the question'.[178] Christina died in November 1904 as a direct consequence of her seizure. Julia Kerr was a thirty-six-year-old single domestic worker admitted in June 1906; she stated she had had epilepsy all her life.[179] Julia had attempted to escape from the Old Woman's Home, which Dr Blackall believed was 'probably post-epileptic' attack as she 'appeared quite sane at present'.[180] In July, Julia had a fit but afterwards seemed sensible and wished to leave; however, she was 'bad tempered after the fits'.[181] She was 'violent at times, worries patients, abuses nurses…cries a good deal, a typical case of epileptic insanity'.[182] In October, Julia was 'very anxious to get back to Old Woman's Depo' but 'has fits and is often bad tempered'.[183] In April 1907, Julia passed 'into a

[171] Ibid.
[172] Ibid.
[173] Ibid, 11-27 December 1906.
[174] Ibid, Folio 46, 5 June 1908.
[175] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 69, 13 September 1900; 11 March 1903.
[176] *Female Occurrence and Daily Strength Book*, 1895-1901, SROWA.
[177] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 69, 28 October 1904.
[178] Ibid, 3-14 November 1904.
[179] *Case Book Female Patients*, 1901-1908, Folio 353, 18 June 1906.
[180] Ibid.
[181] Ibid, 9-16 July 1906.
[182] Ibid, 13 August 1906.
[183] Ibid, 10 October 1906.

condition of status epilepticus having 80 fits during the night', she did not regain consciousness between the fits.[184] Blackall stated that 'nothing would check the fits but chloroform; rectal enemata of chloral and bromide could not be retained under chloroform, to relieve congestion she was bled; the fits, however, continued unless under very deep chloroform anaesthesia; she died of heart failure'.[185] The epileptic fits experienced by Christina and Julia had severe impacts on their health.

There were also a significant number of intellectually disabled patients that had epilepsy. Lucy Matilda Duff also died due to her condition. Lucy was only six years old when she was admitted with epileptic amentia on 10 April 1905; she 'was perfectly healthy until three and a half years of age when the fits commenced apparently without cause'.[186] Lucy was 'of intelligent but vacant appearance, there is nothing suggestive of congenital idiocy', although 'unable to understand any simple questions put to her, talks in a very stupid, rambling manner, calls all male persons "dada" and female "mama", very dirty in habits and very mischievous'.[187] Her mother's statement also revealed that after Lucy's birth her parents were no longer living together and her mother had since 'taken to drink', although there was no family history of insanity or epilepsy.[188] On admission, Lucy usually had two fits every night but was 'quiet and easily managed'.[189] A month later, Lucy 'fits frequently and fairly regularly, they are more of the petit than the grand mal type, she utters a cry and falls heavily but is not convulsed and recovers consciousness in about two minutes'.[190] In June, Lucy was ill, 'owing to increase of fits', thus, she was placed on an ordinary diet, but the fits worsened and reached as many as thirty fits every twenty-four hours; 'she was treated with chloral and bromide'.[191] Following this Lucy had 'weakness of the right arm and leg, no wasting is noticeable as yet, it is difficult to say whether this is an exhaustion paralysis or acute anterior poliomyelitis (her younger sister is crippled with the latter)'.[192] Lucy's 'fits passed from the grand mal to the petit mal type during height of her attacks, she is averaging about ten fits in the twenty-four hours still and grand mal seizures are reappearing, but she is physically much brighter and better'.[193] Lucy was 'restless, dirty, self-abusive, becomes demented' and remained in the asylum, transferred in June 1908 dying in 1912, at only thirteen years old.[194]

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[184] Ibid, Folio 354, 29 April 1907.
[185] Ibid.
[186] Ibid, Folio 249, 10-29 April 1905.
[187] Ibid, 10-12 April 1905.
[188] Ibid 29 April 1905.
[189] Ibid, 21 April 1905.
[190] Ibid, 4 May 1905.
[191] Ibid, 14 June 1905.
[192] Ibid; Poliomyelitis, commonly polio or infantile paralysis, is an infectious disease caused by poliovirus.
[193] Ibid.
[194] Ibid, Folio 250, 11 December 1905; 11 June 1908; BDMWA: *Certificate of Death:* Lucy M. Duff (261/1912).

However, when epilepsy and intellectual disability were combined, it could result in long-term incarceration, as evidenced in Eliza and Alice's cases. Elizabeth "Eliza" Rosamund (Rosanna) Edwards was only thirteen years old when admitted in November 1869; 'has been semi-imbecile from birth, is dwarfed and crooked in figure. Intellect very weak…sometimes shouts and curses, has an awkward shambling gait'.[195] In June 1870, she was noted as 'perfectly imbecile…eyes oscillating and squinting apparently is unable to discern anything more than a foot or two from her eyes, feels about, as if quite blind, when she walks', she could not dress, wash or feed herself, 'she is as dwarfed in body as she is in mind'.[196] However, by 1871, Eliza began to have strong epileptic fits lasting for ten to fifteen minutes.[197] In June 1874, she continued to have a 'succession of severe epileptic fits…constant attendance by the nurses and care given'.[198] It was also reported that her fits were 'always worse when menstruating'.[199] Eliza continued a 'hopeless imbecile can detect no change, pokes her tongue out of her mouth and depicts the hopeless degradation of imbecility'.[200] However in October 1904, she had a 'succession of fits which rendered her unconscious for some days, semi-paralysed, she had marked twitchings on left side'.[201] In September 1905, Eliza was 'exceedingly weak and emaciated, she lies in bed helpless and just alive', she died two days later, having been incarcerated for thirty-six years.[202] Alice Halliday was in her twenties when she was admitted as an imbecile with epilepsy in September 1868, noted as 'insane from childhood'.[203] She was 'dwarfed in figure, but very muscular and strong—completely irrational in talk and behaviour but understands what is said to her. Is prone to be mischievous and requires constant watching' and 'subject to epileptic fits from which however she speedily recovers'.[204] In March 1869, Alice had 'on an average a fit about once a week, but they do not appear to affect her mental condition or health'.[205] In June 1870, Alice had an epileptic fit that lasted ten minutes: 'suffers apparently from much headache at the menstrual period, cannot be persuaded and scarcely forced to take any medicine'.[206] In December, Alice had 'as many as twenty epileptic seizures in the last forty-eight hours' but was getting better.[207] By April 1871, she was 'much more free from strong fits but is frequently subject to

[195] *Register of Female Patients*, 1858-1873, Folio 119, 2 November 1869.
[196] Ibid, 14 June 1870.
[197] Ibid, Folio 119; 154, 24 August; 24 September; 20 December 1871; 4 March 1872.
[198] *Female Register Case Book*, 1873-1878, Folio 125, 14 June 1874.
[199] Ibid, Folio 91, 9 May 1874.
[200] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 7, 10 June 1902.
[201] Ibid, 12 December 1904.
[202] Ibid, 20 March; 11-13 September 1905.
[203] *Register of Female Patients*, 1858-1873, Folio 108, 1 September 1868.
[204] Ibid, 12 January 1869.
[205] Ibid, 1 March 1869.
[206] Ibid, Folio 123, 15 June 1870.
[207] Ibid, 10-14 December 1870.

attacks of "petit mal"'.[208] However, in May 1872, Alice's mother complained of Alice's ill-use in the asylum; Dr Barnett examined her finding no evidence, and Assistant Matron Mahoney refuted the claim which Barnett ultimately deemed unfounded.[209] Although, there was 'no alteration in the case of this poor creature…Mind—a perfect blank'; 'this chronic of idiotic imbecility remains unchanged'.[210] Alice died in 1899 aged fifty-one; most of her life was spent institutionalised.[211]

Epilepsy was a difficult condition to treat and manage in the nineteenth century, and families often admitted their relatives they could no longer handle, especially those who were also intellectually disabled. Epilepsy affected all aspects of life; it could even lead to death. As such, some of these women were institutionalised for long periods, if not indefinitely.

Chapter Conclusions

This chapter examined the patients admitted to the Fremantle asylum that had nowhere else to go, in particular, those considered chronic or incurable: elderly women, the intellectually disabled, and epileptics. It also revealed the impact of family on admission as having no one to provide care could result in incarceration. The elderly women admitted to the asylum could have had no family support, and thus, were left to live out their lives incarcerated. Another aspect was that children found their aging parents too challenging to care for, especially if they were violent. This sentiment reveals a growing cultural shift in the nineteenth and early twentieth centuries toward the professional care of the elderly. Similar experiences were had by the intellectually disabled patients in the asylum. Blurred distinctions between idiocy and imbecility were seen as incurable and resulted in often long-term incarceration. Intellectual disability filtered into many sections of the thesis and is also apparent in epileptic patients. Epilepsy was also seen as incurable in the nineteenth century, and long-term cases faced sedatives as treatment and often endured multiple fits.

This chapter further explored the lives of the women admitted to Fremantle with particular reference to the impact of family and how this impacted treatment and patient experience. This chapter revealed that chronic or incurable patients were often left in the asylum for extended periods of time. However, this did not mean total abandonment and families often visited their incarcerated loved ones. The following chapter, however, explores the darker impacts that, in particular, men and husbands, could have on the women admitted to the asylum.

[208] Ibid, Folio 145, 8 April 1871.
[209] Ibid, Folio 145; 167, 17 May 1872.
[210] *Female Register Case Book*, 1873-1878, Folio 115; 145, 25 May; 25 June 1874.
[211] BDMWA: *Certificate of Death:* Alice Halliday (1052/1899).

CHAPTER EIGHT

The Impact of Men and Marriage

As previously discussed, families had significant control over asylum committal and discharge. However, due to the control men had in marriage, women were also often at the mercy of their husbands; which could impact their sanity and incarceration. This chapter will explore the particular impacts that men and marriage had on women admitted to the Fremantle asylum. Exploration of widowhood, desertion, separation, heartbreak, sexual assault, and marital cruelty, reveals the trauma experienced by the women and the power that men held through nineteenth-century social norms concerning marriage. Thus, this chapter provides greater understandings of moral treatment and ideal nineteenth-century womanhood, and how it impacted the female patient experience.

'Marriage was the most important social institution' for the vast majority of Victorian women.[1] Every woman should wish to be a wife and marriage was seen as the cornerstone of femininity.[2] Young girls were sold the idea of marriage through the benefits of matrimony and the risks of being unwed: such as the social stigmas attached to old maids and widows.[3] Marriage was to bring women identity and a promising future: a husband, home, family, security, and stability.[4] However, in Britain during the late eighteenth and early nineteenth centuries, the controls surrounding the institution of marriage demonstrated male dominance in all areas of public life and the same system was set up in what would become Australia and Western Australia.[5] Therefore, laws were designed to keep marriage under the control of the dominant males in the community to establish the legitimacy of children born into families through the male line.[6] Generally, economically and legally, women had less power than their husbands in their marriage.

Ussher argues that 'the institution of marriage has been fundamentally connected to women's experience of distress'.[7] This distress is revealed in the case of Minnie Louise Forster. Minnie, 'a noisy brown-haired blue-eyed girl', was nineteen when she was admitted to Fremantle in April 1906 with acute mania; 'her fiancé stayed away longer than expected and this upset her'.[8] By

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[1] Pat Jalland, *Women, Marriage and Politics 1860-1914* (Oxford: Clarendon Press, 1986), 45.
[2] Matthews, *Good and Mad Women,* 112.
[3] Jennifer C. Kelsey, *Changing the Rules: Women and Victorian Marriage* (Leicestershire: Matador, 2016), 9; Jennifer Phegley, *Courtship and Marriage in Victorian England* (Santa Barbara: Praeger, ABC-CLIO, 2012), 17.
[4] Kelsey, *Changing the Rules*, 9.
[5] Hetherington, *Marriage Knot*, 6-32.
[6] Ibid, 6.
[7] Ussher, *Women's Madness*, 263.
[8] *Case Book Female Patients*, 1901-1908, Folio 341, 26 April 1906.

May, she was improving, so she was given a month's trial in June and was discharged in July.[9] This story has a reasonably happy ending, as Minnie married Henry O'Donnell in 1907.[10] Pat Jalland notes that 'sincere affections could be killed by the restraints and irritations of long engagements'; thus, shorter engagements were advised.[11] Minnie's stress and mental instability concerning her fiancé reveal the importance placed on marriage, with its link to identity and purpose for women; if her engagement was unfulfilled, she might have been in a precarious position. In the nineteenth century 'emotional causes of insanity, notably bereavement, were more likely to be cited as an explanation of a female's descent into madness'.[12] Therefore, the link with emotion, women, and madness was well established. Other precarious positions affected some of the female patients in Fremantle.

'Death of Husband': Widowhood

Nineteenth-century widowhood 'was a devastating experience, entailing the loss of the central role of wife, which defined the identity and sense of worth of many women'.[13] 'Middle- and upper-class widows generally had a tougher time than widowers, with no paid occupation to divert their time, more practical and financial hurdles to overcome, and little expectation of remarriage, except for the youngest and prettiest'.[14] However, a widow was 'stigmatized less than that of spinster, but it was considerably inferior to that of wife', and 'it signified the probable end of the social recognition and responsibilities from the husband's work, wealth, and status'.[15] In the early years of the Swan River Colony, the loss of husbands and children was a common occurrence for women, whether through illness, accident or misfortune; the death rate in the first three years of the colony was high, as at least 12% of the first British arrivals were dead by 1832.[16] Therefore, by 1868 in Western Australia, nearly 30% of marriages were remarriages and many people lost at least one parent by the time they became an adult, with a large proportion acquiring a step-parent.[17] While not uncommon for the women of Fremantle, the emotional trauma from the death of a husband could impact women psychologically, socially, and economically, resulting in committal to the asylum.

[9] Ibid, 7 May; 26 June; 16 July 1906.
[10] BDMWA: *Certificate of Marriage:* Minnie L Forster and Henry P.W. Odonnell (40/1907).
[11] Jalland, *Women, Marriage and Politics*, 27.
[12] R.A. Houston, "Madness and Gender in the Long Eighteenth Century," *Social History* 27, no. 3 (2002): 320. https://www-jstor-org.ipacez.nd.edu.au/stable/4286909.
[13] Pat Jalland, *Death in the Victorian Family* (Oxford: Oxford University Press, 1999), 230.
[14] Jalland, *Death in the Victorian Family*, 230.
[15] Ibid, 230-231.
[16] Gare, "In The Beginning", 17.
[17] Susan Hart, "Widowhood and Remarriage in Colonial Australia," (PhD thesis; University of Western Australia, 2009), 1.

Widowhood directly impacted the admissions of Emma, Amelia, and Jane. Emma Stephens was sixty-two years old when she was admitted by her son Harry in April 1903 with delusional insanity, the cause 'death of husband'.[18] Emma was melancholic and 'sits with folded hands in perfect silence weeping…like to break her heart, without any apparent cause'; which seems insensitive considering her husband's death.[19] Emma also thought 'that her husband, who she says she saw dead, is alone again, that she has been told he is alone by a voice'.[20] However, Emma became ill with dysentery, dying in December 1903; not long outliving her husband she feared was alone.[21] Amelia Valentine Payne was a fifty-five-year-old widowed laundress with melancholia, admitted in July 1905.[22] Amelia made 'wild statements as to being struck in the heart by lightning', had an 'anxious, worried expression', and was 'hypochondriacal, dwells a lot on the death of her husband years ago'; perhaps the strike in the heart was a veiled reference to grief.[23] Amelia remained in the asylum and was transferred to Claremont in June 1908.[24] Jane Cameron was a Scottish, Presbyterian, forty-five-year-old office cleaner, admitted by her son with acute melancholia due to 'worry over loss of husband' and 'religious worry' in July 1907.[25] Jane stated that 'her family have all been murdered and their bones hidden; that she has committed such terrible sins that God will not forgive her, has threatened to kill herself'.[26] Jane's delusions could be linked to grief as she was so melancholic that she refused food and had to be tube-fed.[27] However, Jane improved and was discharged within three months.[28] Emma, Amelia, and Jane's stories had different outcomes, but they were all admitted to the asylum due to the grief over their husband's deaths.

Another woman who was impacted by her husband's death was Mary Fahey. Mary was fifty-five years old when she was first admitted on 24 May 1879, married to Darby, a Pensioner Guard.[29] Mary was observed as of unsound mind, incapable of taking care of herself, violent in conduct, used incoherent language, and broke wind.[30] In just over a month, Mary had improved and was discharged into the care of her husband, who was reported to be anxious to have her home again.[31]

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[18] *Case Book Female Patients*, 1901-1908, Folio 83, 15 April 1903.
[19] Ibid.
[20] Ibid.
[21] Ibid, Folio 357, 11 December 1903.
[22] Ibid, Folio 263, 19 July 1905.
[23] Ibid, 20 July 1905.
[24] Ibid, Folio 264, 2 June 1908.
[25] *Case Book Female Patients*, 1906-1908, Folio 155, 31 July 1907.
[26] Ibid, 1 August 1907.
[27] Ibid, 6 August 1907.
[28] Ibid, 16 October 1907.
[29] *Case Book Female Patients*, 1878-1897, Folio 39, 24 May 1879.
[30] Ibid.
[31] Ibid, 2-8 July 1879.

However, in under a month, Mary was readmitted the same as before.[32] By December, she was behaving well and was recommended for discharge, although this was postponed for four days as her husband 'being under punishment' was unable to receive her.[33] Within two months, Mary was readmitted, and Dr Barnett noted that she had been 'subject to many delusions since her husband's death by suicide'.[34] Darby had committed suicide after he was confined for drunkenness and neglect of duties.[35] His death would have caused significant stress to Mary as her two daughters were placed in the Fremantle Convent of St. Joseph of Apparition.[36] After her third admission, Mary remained in the asylum in a chronic state of delusion and mental aberration.[37] In July, she grieved loudly over 'fancied wrongs', but perhaps she was merely grieving in general.[38] In 1882, she had a 'fit of refusing food', and Barnett noted she was 'again trying to starve herself': however, she eventually began to eat again.[39] In October 1899 and January 1900, her daughter visited her, and so she was reunited with some of her children.[40] However, Mary was transferred to Claremont in 1908 and died in May 1913 aged eighty-nine.[41] The impact of Mary's husband's suicide was apparent on an already fragile woman; she lost her identity, her children, and faced long-term incarceration.

Widowhood was a precarious situation for nineteenth-century women who were often dependent on their husbands economically and socially. The loss of the role of wife and the genuine grief that came with a husband's death could lead to "insane" symptoms and result in admission to the asylum. The impacts of these men and marriage were clear; this will be explored further as the disappointment of an engagement or separation could also have severe effects on colonial women.

'Disappointment in Love': Desertion, Separation, and Heartbreak

As with death, desertion by a husband, fiancé, or lover could also cause psychological issues for women. Abandoned women could spend money to follow or find defaulting husbands or fiancé's, but would often be left alone in precarious situations.[42] In Britain, the *Matrimonial Causes Act* of 1878 'empowered women to summon their husbands before magistrates for separation with

[32] Ibid, 28 August 1879.
[33] Ibid, 20 November-24 December 1879.
[34] Ibid, 14-27 February 1880.
[35] Erickson, "Bicentennial Dictionary,": F, 1001.
[36] Ibid.
[37] *Case Book Female Patients*, 1878-1897, Folio 52, 15-22 May 1880.
[38] Ibid, 26 July 1880.
[39] Ibid, 11 March; 10-16 June 1882.
[40] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 548; 580, 27 October 1899; 14 January 1900.
[41] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 16, 24 February 1908; Erickson, "Bicentennial Dictionary,": F, 1001.
[42] Henry Alan Finlay, *To Have but Not to Hold: A History of Attitudes to Marriage and Divorce in Australia 1858-1975* (Sydney: The Federation Press, 2005), 301.

maintenance orders on the grounds of domestic violence'; however, 'the high costs and inconveniences of divorce' combined with a 'lack of social and legal support for abused wives' posed issues for women.[43] 'In 1886, the British *Maintenance of Wives (Desertion) Act* gave magistrates the power to grant maintenance orders…to women whose husbands were guilty of desertion and neglect. But the courts were often too ineffective in recovering money for it to be beneficial for working-class wives'.[44] In nineteenth-century Australia, a lack of legal divorce resulted in informal means of ending marriages, with separation and desertion then leading to informal or irregular marriages.[45] Nineteenth-century irregular or cohabitating couples threw the traditional definition of marriage into disarray; however, most of them insisted they were married in all important respects: they fulfilled spousal duties, shared a surname, reared children, and often made lifelong commitments.[46] Frank Bongiorno notes that for both Australian and British working-class society, it was not uncommon for men and women to live out of wedlock.[47]

Some of the women in Fremantle were deserted by their partners, and it directly affected their admission, as evidenced by Mary Ann and Bridget. Mary Ann Galvin (or Harris), was thirty-eight years old when she was admitted 'abnormally depressed and very emotional…unable to take care of herself or children', caused by 'domestic worries'.[48] Mary Ann was, in fact, single but living as married, she had 'been living with Galvin for about ten years as his wife, has four children (youngest twelve months), he has now deserted her, and her children are in homes'.[49] Mary Ann was also living in a non-traditional union, which may have impacted the removal of her children and her admission. Bridget Enrille was thirty-three with acute melancholia admitted in April 1902, she was 'deserted by her husband' and had since 'been living with another man'.[50] Bridget secured some stability with another man although her mental state remained melancholic, potentially due to the desertion.

However, some women left their husbands, and the complications associated also affected mental state, as evidenced in Caroline and Emily's cases. Caroline Inman was a thirty-four-year-old domestic worker admitted with simple mania in January 1905; 'her husband died a year ago, she had

[43] Marjorie Levine-Clark, "From "Relief" to "Justice and Protection": The Maintenance of Deserted Wives, British Masculinity and Imperial Citizenship, 1870–1920," *Gender & History*, 22, no. 2 (2010): 304, doi: 10.1111/j.1468-0424.2010.01592.x.
[44] Joan Perkin, *Women and Marriage in Nineteenth-Century England* (London: Routledge, 1988), 116.
[45] Hart, "Widowhood and Remarriage," 68.
[46] Ginger S. Frost, *Living in Sin: Cohabiting as Husband and Wife in Nineteenth-Century England* (Manchester: Manchester University Press, 2008), 2.
[47] Frank Bongiorno, *The Sex Lives of Australians: A History* (Collingwood: Black Inc, 2012), 23; 40.
[48] *Case Book Female Patients*, 1906-1908, Folio 169, 20-21 September 1907; She was the niece of patient Mary Bufton admitted in 1881.
[49] Ibid.
[50] *Case Book Female Patients*, 1901-1908, Folio 29, 21 April 1902.

separated from him owing to his alcoholic habits, since then she has been in financial difficulties'.[51] Emily Nash was a twenty-two-year-old married domestic admitted with epileptic dementia in September 1906.[52] It was noted that Emily 'was married when just over 16 but left her husband [Harry James Sterling] a year later because he would not contribute to her maintenance'.[53] Both Caroline and Emily reveal the emotional and economic issues that came with separation.

A disappointment in love could also prove detrimental to mental state. Broken engagements or promises could often happen, usually due to class, practical needs, structural issues, or relative's disapproval.[54] It could also have a legal impact as nineteenth-century fiancés could sue for breach of promise, as engagements were 'considered a contract to marry, which was legally binding on both parties'.[55] Women could also use 'their sexuality in courtship, gambling that intimacy would lead to commitment or would push a fiancé to the altar'; 'the risks of pregnancy or desertion' were weighed against 'affection and hopes of marriage'.[56] However, 'when the courtship failed…women had a great deal to lose'; although premarital sex was considered acceptable for working-class engaged couples if the woman became pregnant and the couple did not marry, shame and disgrace followed.[57] Love was also 'an emotion of enormous public consequence, the proper regulation and appropriate expression was entrusted to "respectable" women in their legally sanctioned role as moral guardians of home and society'.[58] Therefore, disappointment in love affected identity. According to Mark Finnane 'disappointment' was a common category of causes of insanity in early asylum statistics: the phrase was 'used commonly to describe the experience of women who had been jilted or cheated by men', but could also summarise the position of 'both men and women who found their lives falling apart through social, emotional, or economic upset'.[59]

Fanny Andrew was among the women disappointed in love. Fanny was twenty-eight years old and suicidal when admitted by her mother in September 1888; Dr Barnett reported: 'this girl has for some time been under my care suffering from melancholia brought on by disappointment in a love affair—latterly she has become worse and several times tried to commit suicide'.[60] She

[51] Ibid, Folio 231, 24-25 January 1905.
[52] *Case Book Female Patients*, 1906-1908, Folio 19, 22 September 1906.
[53] Ibid, 24 September 1906.
[54] Ginger S. Frost, *Promises Broken: Courtship, Class, and Gender in Victorian England* (Charlottesville: University of Virginia Press, 1995), 80.
[55] Ibid, 16.
[56] Ibid, 98.
[57] Ibid.
[58] Simmonds, "Breach of Promise of Marriage," 108.
[59] Finnane, "Asylums, Families and the State," 140.
[60] *Case Book Female Patients*, 1878-1897, Folio 134, 2 September 1888.

improved quickly and within thirteen days was discharged to her mother.[61] However, in 1891, Fanny married William Mann and gave birth to Alfred William in 1893 and Gilbert Tattersall in 1894.[62] Sadly, Gilbert died at eleven months old in 1895, and the mother was listed as unknown, this could be because Fanny had been readmitted to the asylum in 1894 with puerperal mania.[63] In December 1894, Fanny attacked staff and other patients and Barnett reported, 'this vicious, violent woman must be placed in a room by herself when needful'.[64] Fanny's story almost had a happy ending.

For the women in Fremantle the word 'engagement' was not mentioned in the records in the cases of disappointments of love or affairs; whether formally engaged or not the impact of these disappointments was clear in Margaret, Catherine, Kate, Olive, and Ethel's records. Margaret McKay was twenty-six years old with dementia when she was admitted as a pauper in July 1882; 'has been mentally ill about eighteen weeks in consequence of a disappointment in her affections'.[65] Catherine Hackett, 'a delicate, semi-imbecile woman of thirty-five stated to have had a disappointment in love', was admitted with delusions in November 1883.[66] Thirty-five would have been considered quite old for marriage, and a disappointment at that age may have led to her fragile mental state. Kate Ryan was thirty years old when she was admitted in June 1902 with acute melancholia caused by 'love affairs'; 'she was jilted some few weeks ago and has never been the same since. Has become gradually melancholy and attempted to commit suicide'.[67] Olive Edith Caroline Butler was twenty-three, admitted in June 1904, when 'epilepsy set in after love affair'; she had a 'weak emotional face', 'a hysterical girl, at times passionate, often obstinate'.[68] Olive's love affair outcome was not stated, but it can be assumed unsuccessful. Ethel Brooks was a twenty-one-year-old maid in public school admitted in March 1907 due to 'disappointment in love'; she made 'ceaseless incoherent talk about marriage, deaths, funerals and insanity, states that Christ is coming in the afternoon to be present at her own marriage'.[69] Her disappointment impacted her mental state as Ethel's delusions centred on marriage. These women's disappointments in love directly led to their admission.

Desertion, separation, and heartbreak could have mental consequences for women. The impact of marriage on nineteenth-century women's lives revealed that the association of shame or

[61] Ibid, 15 September 1888.
[62] BDMWA: *Certificate of Marriage:* Fanny Andrew and William Mann (393/1891); *Certificate of Birth:* Alfred William (63/1893), Gilbert Tattersall (1055/1894 d. 757/1895).
[63] *Case Book Female Patients*, 1878-1897, Folio 167, 22 July 1894.
[64] Ibid, Folio 134, 2 January 1895.
[65] Ibid, Folio 69, 3 July 1882.
[66] Ibid, Folio 76, 20 November 1883; Catherine was the sister of patient Bridget McDonald admitted in 1879.
[67] *Case Book Female Patients*, 1901-1908, Folio 33, 2 June 1902.
[68] Ibid, Folio 175, 22-24 June 1904.
[69] *Case Book Female Patients*, 1906-1908, Folio 95, 29-30 March 1907.

spinsterhood carried a real fear with real social consequences. This fear could manifest in varying ways: delusions, suicidal actions, melancholia, and hysteria. Although, men could also physically affect women, with sexual assault and marital cruelty also impacting the sanity of the women admitted to Fremantle.

'Driven to Insanity': Sexual Assault and Marital Cruelty

Physical abuse could take many forms and, in Fremantle, sexual assault and marital cruelty impacted the mental state of some of the women admitted. As already explored, husbands could have a tremendous influence on their wives' lives, including assaults that led to "insanity".

In the nineteenth century, the lines between seduction and sexual assault were 'legally blurry', and rape was not classified as a crime unless the woman was underage or kidnapped.[70] Therefore, the public often ignored rape and treated it like other injuries instead of a crime.[71] Rape was also a moral offence; however, the victim was often the sinner, and nineteenth-century social commentators blamed women for seduction.[72] However, by the end of the century, the culture showed a decreasing tolerance to rape; nevertheless, 'doubts about the morality of the victim persisted'.[73] Modern physicians now acknowledge that victims of sexual assault are more likely to develop mental illness disorders as a direct result of the traumatic event.[74] There may have been more women admitted to the asylum that experienced sexual abuse; however, the records do not always reveal all patient information, and nineteenth-century women may not have reported the incidents. A climate of secrecy has existed on this topic with women fearing their stories would not be believed, although modern movements suggest a possible cultural shift.[75] However, the women admitted to the asylum in the nineteenth century reveal the mental consequences of sexual assault.

The cases of Martha Rogers and Emily Dowling are only two of the women identified in the records to have suffered a sexual assault that resulted in committal. Martha Rogers was a seventeen-year-old domestic servant admitted with delusions on 24 April 1875.[76] In May Dr Barnett reported that 'the patient today made a statement to me that her illness was caused in consequence

[70] Rachel G. Fuchs, *Gender and Poverty in Nineteenth-Century Europe* (Cambridge: Cambridge University Press, 2005), 66.
[71] Fuchs, *Gender and Poverty*, 66.
[72] Ibid.
[73] Ibid, 67.
[74] Michele R. Davidson, *A Nurse's Guide to Women's Mental Health* (New York: Springer Publishing Company, 2012), 50.
[75] Beverly Engel, *I'm Saying No!: Standing Up Against Sexual Assault, Sexual Harassment, and Sexual Pressure* (Berkeley: She Writes Press, 2019): https://books.google.com.au/books?id=fnpnDwAAQBAJ&.
[76] *Female Register Case Book*, 1873-1878, Folio 221, 24-25 April 1875.

of her person being violated by a man named Mr Desmolt in Newcastle'.[77] Martha had been 'gradually improving and is now quite sane' and after her statement was considered 'quite convalescent'; she was discharged in May.[78] Martha's confession of her assault seemed to coincide with her perceived mental improvement. However, Emily Dowling's case was less straightforward than Martha's. Emily was eighteen years old with partial dementia and epilepsy when she was admitted by her stepfather Edward James and the Police Constable of Perth on 7 August 1878.[79] Before immigrating, Emily had been a patient in London Hospital and private treatment in Essex for seven years.[80] In Fremantle, Dr Barnett tracked Emily's menstruation noting in September that she had 'not menstruated since she came in' and she was 'to be carefully observed'.[81] By October he seemed more suspicious: 'from present symptoms it is not unlikely that she will soon menstruate. No discharge has taken place since she entered Asylum'.[82] However, in November, he wrote:

> Observing her appearance, as she walked in the yard, and increased stoutness, I examined her in the presence of the Matron and find that she is probably pregnant…on questioning her she acknowledged that some time before she left Perth a man accosted her when she was coming from church and promising to marry her took her into the bush and had connexion with her.[83]

After this conversation, Barnett wrote to Emily's mother and requested she take charge of her daughter, whom he believed was now mentally convalescent.[84] Emily was discharged to her mother in November 1878.[85] She was lucky that her mother was willing to take her home, but the realities of her life there may have been just as harsh. Whatever happened to Emily's baby is unknown, however, in 1883 she married Isaac Walter Clements and in 1884 gave birth to daughter Florence.[86] In May 1900, now in her forties, Emily was readmitted 'dull and demented, fits frequent, has little mental power'.[87] Emily was transferred to Claremont in June 1908 and died in 1912 aged fifty-two.[88] Martha and Emily suffered a sexual assault, and both were young and initially discharged after short stays. The trauma of the event dramatically affected their mental state and may have impacted the

[77] Ibid, 12 May 1875.
[78] Ibid, 12-13 May 1875.
[79] Ibid, Folio 290, 7-8 August 1878.
[80] Ibid.
[81] *Case Book Female Patients*, 1878-1897, Folio 4, 28 September 1878.
[82] Ibid, 19 October 1878.
[83] Ibid, 2 November 1878.
[84] Ibid.
[85] Ibid, 5 November 1878.
[86] BDMWA: *Certificate of Marriage:* Emily Dowling and Isaac Walter Clements (5591/1883); *Certificate of Birth:* Florence (25458/1884).
[87] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 63, 9 May 1900; 5 December 1901.
[88] Ibid, Folio 108, 5 June 1908; BDMWA: *Certificate of Death:* Emily Clements (69/1912).

rest of their lives. As in the case of Emily, although not confirmed to be related to her subsequent readmission, the effects of her past may have contributed.

However, the female patients in Fremantle could experience abuse from their husbands, and marital cruelty was a contributing factor for several women's admissions. In the centuries before and during the nineteenth century, the husband was head of the household and women were responsible for housework and childcare.[89] Therefore, wives and children were held in law to be possessions of the husband or father and acts of violence committed against them by these men were not punishable by criminal law.[90] Historian Alana Piper writes that in the late nineteenth century women in Australia who alleged that their husbands were violent, revealed that they also withheld money, food or other goods.[91] Piper states that alcohol or drunkenness was often blamed by wives, courts, the media, and of course temperance societies, as the cause of marital violence.[92] However, by the early nineteenth-century wife-beating was generally out of favour and families no longer approved of the abuse of female relatives.[93] Despite this, magistrates and the police were reluctant to interfere in cases of marital cruelty, believing that most cases settled themselves.[94] Judith Allen writes that nineteenth-century Australian women had little to gain by prosecuting their husband's for violence; unless the violence resulted in death, it generally remained in secret or unpunished.[95] Due to their 'large families and financial dependence', relatively few battered wives took such action.[96] Australian historian Kay Saunders notes 'her husband's home was not a woman's haven but her entire life's work which ultimately she could not control'.[97]

Emphasis was often placed on the physical effects of marital cruelty; in 1790, English lawyer Sir William Scott defined cruel violence within marriage as something that endangered life and 'evidence of physical violence that caused harm to physical health'.[98] However, misery and harm due to marital cruelty could manifest as mental illness, and many women's mental responses to marital

[89] Del Martin, *Battered Wives, Revised, Updated* (Volcano CA: Volcano Press, 1981), 37.
[90] Jocelynne A Scutt, *The Sexual Gerrymander: Women and the Economics of Power* (North Melbourne, Spinifex Press, 1994), 107.
[91] Alana Piper, "Understanding Economic Abuse as Domestic Violence," in *Gender Violence in Australia: Historical Perspectives*, eds. Alana Piper and Ana Stevenson (Clayton: Moniash University Publishing, 2019), 41.
[92] Piper, "Understanding Economic Abuse as Domestic Violence," 41.
[93] Perkin, *Women and Marriage*, 107.
[94] Scutt, *Sexual Gerrymander*, 174; 107.
[95] Judith A. Allen, *Sex and Secrets: Crimes Involving Australian Women Since 1880* (Melbourne: Oxford University Press Australia, 1990), 46-51.
[96] Allen, *Sex and Secrets*, 51.
[97] Kay Saunders, "The Study of Domestic Violence in Colonial Queensland, Sources and Problems," *Historical Studies* 21, no. 82 (1984): 68. doi: 10.1080/10314618408595693.
[98] Elizabeth Foyster, *Marital Violence: An English Family History, 1660-1857*, (Cambridge: Cambridge University Press, 2005), 42.

cruelty remained hidden.[99] However, nineteenth-century Britain saw a steady intake of female patients to asylums who admitted 'ill-treatment' by their husbands, and marital problems as causes of mental illness were only attributed to women.[100] Although, awareness of marital violence did not always translate to sympathetic or effective treatment; often, opium was prescribed as a way to help women endure their violent partners.[101] However, modern counsellors and psychologists are now aware that domestic violence can be severely traumatising.[102] Symptoms such as anxiety, depression, substance misuse, and suicidality are now seen as responses to trauma.[103] Trauma is also cumulative, and repeated exposure to victimisation potentially increases levels of mental illness.[104]

Marital cruelty, combined with other issues like alcohol, was the principal cause of insanity for some of the women in Fremantle.[105] Mary Carrotts was thirty-five years old when she was admitted in November 1879 with delusions that people were trying to kill her; she was 'driven to insanity by cruelty of husband'.[106] Mary Walsh, a fifty-year-old pensioner's wife, was admitted via prison in January 1880, with delusions of being poisoned.[107] In 1882 Dr Barnett noted: 'very badly treated at home by her husband and is thereby weaker in mind'.[108] Barnett wrote that her illness had been due mainly to her husband's bad treatment and that he had not acknowledged Barnett's letters' on the subject; despite this, she was discharged into his care in March 1886.[109] Mary Kelly was aged thirty-two when she was admitted in November 1894 with her four-week-old infant; described as a homicidal maniac, melancholic, emaciated, and 'sad looking', she had attempted to cut her throat.[110] Mary's infant was not admitted and was sent back to York, and after her admission, a memo stated that she was not to be discharged without first communicating with the Police as her husband 'intends to murder her'.[111] Mary Kitson was forty-two years old when she was admitted in September 1905; described as having simple mania, she threatened suicide, and gave a history of 'cruelty by husband who is repeatedly drunk'.[112] Mary Ann Paynting was fifty years old

[99] Foyster, *Marital Violence*, 102.
[100] Ibid, 99.
[101] Ibid.
[102] Christine Sanderson, *Counselling Survivors of Domestic Abuse* (London, Jessica Kingsley Publishers, 2008), 9-10.
[103] Sanderson, *Counselling Survivors*, 9-10.
[104] Susan L. Miller, *Victims as Offender: The Paradox of Women's Violence in Relationships* (New Brunswick, Rutgers University Press, 2005), 26.
[105] These case studies are explored in greater detail in Alexandra Wallis, "Driven to Insanity: Marital Cruelty and the Female Patients at the Fremantle Lunatic Asylum, 1858-1908" forthcoming 2019.
[106] *Case Book Female Patients*, 1878-1897, Folio 46, 1 November 1879.
[107] Ibid, Folio 49, 30 January 1880.
[108] Ibid, Folio 70, 13 July 1882.
[109] Ibid, 16-17 March 1886.
[110] Ibid, Folio 172, 21 November 1894.
[111] Ibid, 7 December 1894.
[112] *Case Book Female Patients*, 1901-1908, Folio 291, 27-28 September 1905.

when she was admitted in January 1908 with General Paralysis, she was unable to look after herself and was violent.[113] She had been married twice and 'her present husband was formerly a patient in this institution and is now in Cue Asylum [sic], he was cruel to her'.[114] All of the women who had experienced marital cruelty were suffering from a trauma that manifested in various ways: suicidality, alcoholism, violence, or delusions. They all had different reasons for incarceration, but the cruelty of their husbands was a significant factor in their sanity and committal.

A common pattern in the records was the repeated discharge of the women into the care of their abusive husbands. As previously discussed, women in the asylum were classified insane on the information provided by their husbands or families and were judged from their husband's accounts. As husbands relied on their wives domestically, repeated requests for discharges were often granted. However, this was also the case when the staff were aware of the violence at home. This pattern affected three patients quite significantly as Annie Cummings, Rachel Hamilton, and Hannah "Annie" Weir were all subject to their husband's violence and discharged into their "care".

Annie Cummings was twenty-five years old when she was admitted in January 1886, a married woman from Geraldton with 'puerperal mania' the 'supposed cause, confinement', in a 'weak dirty state…wild and distraught'.[115] In March, Annie's husband visited her and seven days after she had 'improved but not enough to warrant her discharge'.[116] Regardless, just nine days later, she was discharged on trial to the care of her husband.[117] After only two days, Annie was 'brought back covered with bruises and foully ill-used. Mind gone'.[118] A month later, her head still bore the marks of bruises, and she was no better.[119] In May, there was a slight improvement, but Annie's mind was still blank.[120] By July, Annie was slowly improving; however, in August, her husband visited and informed the matron that her baby had died in Perth; the matron was to break the news at a 'suitable time'.[121] The records do not indicate Annie's reaction, only that she had 'greatly improved' and was discharged to the care of her husband once more.[122] Annie's struggle after the birth of her baby resulted in her inability to function at home. However, her presence at home was desired due to the responsibilities of a newborn. The ensuing violence when she was still unable to perform sent

[113] *Case Book Female Patients*, 1906-1908, Folio 195, 2-3 January 1908; General Paralysis was a condition that nineteenth century physicians believed could have resulted from alcohol or a venereal disease.
[114] Ibid.
[115] *Case Book Female Patients*, 1878-1897, Folio 100, 15-18 January 1886.
[116] Ibid, 6-11 March 1886.
[117] Ibid, 20-22 March 1886.
[118] Ibid, 24 March 1886.
[119] Ibid. 5-18 April 1886.
[120] Ibid, 10-29 May 1886.
[121] Ibid, Folio 100; 110, 16-22 July; 10 August 1886.
[122] *Case Book Female Patients*, 1878-1897, Folio 110, 16-21 August 1886.

her to the asylum. Annie was not admitted again and what became of her is lost to history, but she suffered the consequences of her husband's violence.

Rachel Hamilton was another case of marital cruelty. Rachel was twenty-six years old and seven months pregnant when she was admitted in May 1876.[123] The wife of a mechanic, she had twice attempted to strangle herself and tried to stab her husband.[124] When Rachel's husband visited her in the asylum, she could 'scarcely speak civilly', however, she had not used bad language at other times.[125] Rachel disliked the idea of returning home stating 'her husband "knows what is going on" and that "it is no use two Devils living together"'; Dr Barnett noted that 'her husband and she herself have both bad tempers'.[126] Rachel's husband visited again and afterwards, she was 'unwilling to go home, sulky looking and with unsteady eye', but it was noted that she felt 'her child moving'.[127] Barnett decided he did not 'think it safe' to allow her to leave; perhaps Rachel also felt it was unsafe.[128] In early June, her husband visited again, and for the first time Rachel expressed a wish to go home; her husband requested to 'take care of her at home', and she was discharged to him in June 1876.[129] Merely eight days later, she was readmitted in a similar mental state as her first admission.[130] Her husband visited in July and was 'excessively rude' to Barnett when told he needed an order from the surgeon to see his wife, he used 'abusive language and said he would go to the Governor'; however, the incident was not referred to again.[131] This action was potentially Barnett's attempt to prevent Rachel's husband access to her. On 11 July 1876, Rachel gave birth to a boy.[132] Ten days after the birth, her husband was anxious to discharge her; as she was attending to the baby carefully, and both were doing well, Rachel was released.[133] However, five days later, she was readmitted with 'fresh delusions, great excitement and threats of taking her husband's life. The baby was removed from her and placed in charge of a nurse'.[134] In August, Rachel was visited by her husband and 'as usual quarrelled with him', she was anxious 'to get out to her children' and wished to be with them 'but not with her husband'; however, Barnett noted she was unfit to have charge of her children.[135] By September, Rachel had improved, she stated that if released, her husband would

[123] *Female Register Case Book*, 1873-1878, Folio 240, 17 May 1876.
[124] Ibid.
[125] Ibid.
[126] Ibid, 27-29 May 1876.
[127] Ibid, 31 May 1876.
[128] Ibid.
[129] Ibid, 4-19 June 1876.
[130] Ibid, Folio 242, 29 June 1876.
[131] Ibid, 2 July 1876.
[132] Ibid, 11 July 1876.
[133] Ibid, 22 July 1876.
[134] Ibid, 27 July 1876.
[135] Ibid, 27 August 1876.

let her have a separate room; though Barnett doubted this was true.[136] In early October, Rachel was deemed 'quite sane' and was recommended for discharge: 'if properly treated by her husband she will remain sane, if he ill-treats her he ought to be punished'.[137] This entry was the only instance that Barnett suggested punishment for the violent husband; his underlining of 'he' suggests a genuine frustration. However, Rachel was still discharged on trial for two weeks into her husband's care in October 1876.[138] Three years later, Rachel was readmitted 'described as dangerous' and had given birth weeks before admission; she had 'had puerperal mania before' and was 'now quiet but distraught'.[139] In May, she was 'somewhat better', and her husband made a 'written application promising to have all care taken of her'; she was discharged to her husband in June for the last time.[140] Rachel was another case of continued release to her abusive husband, and their unhappy, violent relationship strained her mental health and ability to care for her children. It is also possible that she used violence and bad behaviour to influence admission and discharge. Rachel's continued exposure to violence in her home resulted in repeat victimisation and violent responses.

Hannah "Annie" Weir was continually released to her husband William; although Annie was not identified as having suffered marital cruelty, it was clear from Dr Barnett's reports that she was impacted by her abusive husband. Annie was thirty years old when she was admitted with homicidal mania in June 1876.[141] At first troublesome, she quickly became well behaved; however, when her family visited her, she was 'rather vexed with her husband'.[142] Due to good behaviour, Annie was discharged on trial to her husband in August but was cautioned to 'refrain from drink'.[143] However, Annie was arrested and readmitted within the fortnight after being found in the street with a tomahawk in her hand.[144] It was reported that 'her husband has given her drink and took her to a public house'; William was deemed 'unfit to have charge of her', and Barnett noted 'some marks of bruises or kicks upon her, arms, legs and body'.[145] Despite this, she was 'tolerably sensible' on admission and 'anxious to get to her children again'.[146] Within a month she 'quite sane' and discharged on trial.[147] Three years later, Annie was readmitted 'flighty and verbose', troublesome,

[136] Ibid, 9 September 1876.
[137] Ibid, Folio 244, 2 October 1876.
[138] Ibid, 4 October 1876.
[139] *Case Book Female Patients*, 1878-1897, Folio 51, 6-8 March 1880.
[140] Ibid, 24 May; 19 June 1880.
[141] *Female Register Case Book*, 1873-1878, Folio 241, 25 June 1876.
[142] Ibid, 4 July 1876; Folio 241; 243, 24-27 July 1876.
[143] Ibid, Folio 243, 27-29 July 1876.
[144] Ibid, 9 September 1876.
[145] Ibid.
[146] Ibid.
[147] Ibid, 2-4 October 1876.

and violent.[148] However, by January 1880, she was again improved and discharged to her husband.[149] In October, Annie was back for the fourth time after having 'had another quarrel with her husband and has used obscene and threatening language'.[150] Annie was also noted to be two and a half months pregnant, and Barnett added: 'ever since admission she has been perfectly quiet and well behaved…much inclined to think that her husband should not have sent her'; she was discharged in November 1880.[151] It was during this period that Annie lost her tenth child, a stillborn male, which would have been a traumatic experience.[152] Within two months, she was readmitted in February 1881, this time 'a criminal lunatic' with a five-month sentence terminating in July 1881.[153] Annie was arrested at Williams River on 28 January for drunk and disorderly, she received six months hard labour, and an extra month for using threatening language and assaulting police.[154] In July 1881, two days before Annie's criminal sentence was due to end, Barnett applied to the Colonial Secretary for a warrant to retain her, which was granted in August.[155] Annie remained in the asylum 'a hopeless case' and was transferred in 1908.[156] The violence and alcohol in Annie's life was the cause of her mental illness; her continual release to her abusive husband did not help her situation. Another aspect of Annie's case was that of suspected self-medication; 'the social context of women's depression and alcohol use, including social histories of trauma lends support to the notion that women use alcohol as a form of self-medication for depression'.[157] Annie's entire family must have suffered as both her son and daughter (Matilda Bovell) were admitted to the asylum while she was still incarcerated; the violence, alcohol, and institutionalisation caused generational trauma.[158]

While it is evident from the examples provided that Dr Barnett was concerned for his patients and aware of some of the violence perpetrated by their husbands, he was also a product of his time. During their divorce proceedings 'Ann Barnett claimed that her husband had mistreated her for years' claiming that when he discovered her affair, Barnett hit her with his crutches and

[148] *Case Book Female Patients*, 1878-1897, Folio 43, 1 October 1879; 2 January 1880.
[149] Ibid, 22-32 January 1880.
[150] Ibid, Folio 53, 1 October 1880.
[151] Ibid, 31 October; 1 November 1880.
[152] BDMWA: *Certificate of Birth:* Stillborn M Weir (21608/1880); *Certificate of Death*: Annie had also lost her first-born fifteen-day-old George (2388/1863) and her second born one-year-old Emily (3431/1867); she had seven other children: Sarah Elizabeth (9443/1866), Annie (10808/1868), Matilda (12821/1870), Minnie (14159/1872), May (1874/1874), William James (16956/1876), John Lewis (18189/1877).
[153] *Case Book Female Patients*, 1878-1897, Folio 56, 5 February 1881.
[154] State Library of Western Australia (SLWA): "Police Gazette," February 1881, 7.
[155] *Case Book Female Patients*, 1878-1897, Folio 56, 26 July; 8 August 1881.
[156] *Case Book Female Patients (Chronic),* 1901-1908, Folio 17, 1 December 1902.
[157] Catrina G Brown and Sherry H Stewart, "Exploring Perceptions of Alcohol Use as Self-Medication for Depression Among Women Receiving Community-Based Treatment for Alcohol Problems," in *Women and Depression: Antecedents, Consequences, and Interventions*, ed. Peter Horvath (Oxon: Routledge, 2009), 34.
[158] *Case Book Female Patients (Chronic),* 1901-1908, Folio 17, 12 December 1905.

threw a mustard poultice at her head.[159] Barnett denied the charges. There are difficulties in reading Barnett through the records. He was progressive and implemented new techniques to aid in patient treatment and was seemingly attempting to do his best for his patients. However, he was bound by the established parameters of society; if a husband requested the release of his wife, and there were no medical reasons to retain her, he had to discharge her. Therefore, Barnett and the asylum staff, willingly or not, contributed to the trauma of the women who experienced marital cruelty.

Chapter Conclusions

The traumas of domestic life were significant factors in the committal of women to the Fremantle Lunatic Asylum; complete reliance on husbands for support and the rearing of large families contributed to strains on their mental health.[160] The issues in these chapters often intersect with other patient lives in other chapters, with more women who were heartbroken, affected by their family, or husband's treatment. Indeed, some of the women in the asylum may not have been "insane", but seen as such; Chesler's theory is 'that what we call madness can also be caused or exacerbated by injustice and cruelty within the family and society'.[161] This chapter explored how men and marriage impacted and traumatised the women admitted to Fremantle. The emphasis nineteenth-century society placed on marriage and how crucial it was in women's identity reveals why the loss of marriage could be so impactful. The goal of nineteenth-century womanhood was to marry and produce children, being unable to fulfil the desire was distressing. Violence was also a factor in the lives of the women admitted to the asylum. The physical and mental trauma from sexual assault resulted in a committal and was also a factor for the women who suffered marital cruelty. Women generally had less power in their marriage, and this was most apparent when the marriage was violent, as husbands controlled admission and discharge. Asylum staff, despite occasional awareness, contributed to trauma by discharging women to their abusive husbands.

This chapter reveals that nineteenth-century women's mental states could be affected by outside sources through analysis of the impacts of men and marriage on the women admitted to the asylum. Thus, furthering understandings of the female patient experience and treatment methods. However, the other primary goal for nineteenth-century women was producing and raising children, and the female reproductive system was also believed to be psychologically dangerous. The following chapters will explore nineteenth-century concerns surrounding women's bodies through the stories of the asylum patients.

[159] Martyr, "Unlikely Reformer," 498.
[160] Megahey, "More Than a Minor Nuisance", 56.
[161] Chesler, *Women and Madness*, 27.

CHAPTER NINE

Madness and The Female Body

Women's lives and behaviours were believed to be linked to and controlled by their reproductive organs. In 1871, G. Fielding Blandford stated that 'women become insane during pregnancy, after parturition, during lactation; at the age when catamenia first appear and when they disappear...the sympathetic connection existing between the brain and the uterus is plainly seen by the most casual observer'.[1] Scull notes that 'the [perceived] instability of women's bodies…profoundly affected female health and formed the perceived physiological foundation of her greater delicacy and fragility'.[2] Thus, across history, women's perceived higher propensity to madness was attributed to reproduction as women's reproductive organs were 'deemed to be "pre-eminent" in all aspects of the psyche and physical well-being'.[3] Therefore, Ussher asserts, 'the female reproductive body is positioned as abject, other, as the site of deficiency and disease'.[4] 'Women gave life, but at the cost of menstruation, emotional dependency, nervous weakness, and a world view restricted to the family'.[5]

In this chapter, the female patient's experiences with their bodies and the perceived links to insanity will be explored through the connections between the menstrual cycle and menopause on women's mental states, the impact of pregnancy on women's sanity, and puerperal insanity. However, some of the terms are used interchangeably across cases, and this chapter is arranged to allow for more in-depth case analysis. Chapter Nine reveals the nineteenth-century connections between women's bodies and insanity and provides further insights into the experiences of diagnoses and moral treatment for the women in the asylum.

Menstrual Madness

Menstruation was the earliest experience for women with their reproductive systems. Eighteenth and nineteenth-century 'doctors regarded puberty as the most psychologically dangerous of the female life-cycle' believing that 'menstrual discharge in itself predisposed women to insanity'.[6] For

[1] George Fielding Blandford, *Insanity and its Treatment: Lectures on the Treatment, Medical and Legal of Insane Patients* (Philadelphia: H.C. Lea, 1871), 68.
[2] Scull, *Hysteria*, 72.
[3] Jane M. Ussher, *The Madness of Women: Myth and Experience* (London: Routledge, 2011), 18.
[4] Ussher, *Madness of Women*, 153.
[5] David J. Vaughan, *Mad or Bad: Crime and Insanity in Victorian Britain* (South Yorkshire: Pen & Sword Books Ltd, 2017): https://books.google.com.au/books?id=b4ATDgAAQBAJ&printsec.
[6] Showalter, *Female Malady*, 56.

girls, puberty was viewed as a period of stress and crisis; the entire female organism was thrown into turmoil: 'girls must be carefully protected during this period; they must be treated as invalids'.[7] In 1835, Prichard wrote that 'dysmenorrhoeal affections' would result in some women undergoing 'a considerable degree of nervous excitement'.[8] He stated that during menstruation, 'morbid dispositions of mind are displayed…at these times, a wayward and capricious temper, excitability in the feelings, moroseness in disposition, a proneness to quarrel with their dearest relatives, and sometimes a dejection of mind approaching to melancholia'.[9] According to the theory, any deviation such as an 'abnormal quantity or quality of blood' could affect the brain.[10] In 1873, Henry Maudsley wrote that most women during menstruation 'are susceptible, irritable, and capricious, any cause of vexation affecting them more seriously than usual; and some who have the insane neurosis exhibit a disturbance of mind which amounts to a disease'.[11] Therefore, he argued, 'a sudden suppression of the menses has produced a direct explosion of insanity'.[12] Thus, even 'late, irregular, or "suppressed" menstruation was regarded as a dangerous condition', which, in Britain, 'was treated with purgatives, forcing medicines, hip baths, and leeches applied to the thighs'.[13] It was believed that the menstrual process was the 'only bodily function in relation to which the organ of the mind somewhat loses the remarkable stability of its equilibrium'.[14] Australian physician, William Beattie Smith states that 'catamenial periods must be watched with regard to irregularity, suppression, or anaemia. The return of the flow does not, in itself, reinstate the brain. It is the improved condition of the blood bringing up the nutrition of the brain'.[15] He also reiterated the idea that 'Puberty, then, is the first really dangerous period of life in the occurrence of insanity, and all its manifestations are intensified at the further period of adolescence, and all treatment must be based on physiological considerations'.[16] For female asylum patients, menstruation was perceived to worsen their symptoms; it was argued that in 'periodically insane women, the condition of insanity tends to occur at the menstrual periods; or just preceding it'.[17] All the women in Fremantle would have menstruated in some form, unless pregnant or postmenopausal. This section will investigate some of

[7] Lorna Duffin, "The Conspicuous Consumptive: Woman as an Invalid," in *The Nineteenth Century Woman: Her Cultural and Physical World*, eds. Sara Delamont and Lorna Duffin (Oxon: Routledge, 2013), 32.
[8] Prichard, *Treatise on Insanity*, 207.
[9] Ibid.
[10] Showalter, *Female Malady*, 56.
[11] Henry Maudsley, *Body and Mind* (London: Macmillian, 1873), 87; Maudsley (1835-1918) was a pioneering British psychiatrist.
[12] Maudsley, *Body and Mind*, 87.
[13] Showalter, *Female* Malady, 56.
[14] Raymond Bernard, *The Physiological Enigma of Woman: The Mystery of Menstruation* (Pomeroy: Health Research Books, 1999), 173.
[15] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 65.
[16] Ibid, 65.
[17] Hilton Hotema, *Secret of Regeneration* (Pomeroy: Health Research Books, 1998), 270.

the women these theories impacted and reveal the connections the staff made between their behaviour, madness, menstruation, and menopause.

Bad and unladylike behaviour was typical in the asylum, and often the reason for initial incarceration; however, links between menstruation and behaviour were made by the staff, who paid close attention to their patients' menstrual cycles. The links are clear in Sarah and Judith's patient notes. Sarah Harding, the widow of the late Harbour Master, James Harding, was admitted by her sister, Mrs Eray, in December 1869.[18] Sarah was in a 'state of high indignation at her confinement', but by July 1870, her sister requested her discharge, which was granted.[19] However, Sarah was readmitted in January 1871, just as bad as before, but with regular menses.[20] By June 1874, Dr Barnett reported Sarah was excited and violent in language, and looked somewhat maniacal, but was 'generally subject to fits of excitement at termination of menstruation'.[21] Sarah was discharged into the care of her sister in January 1878 and left for England.[22] It was believed that she was not likely to improve mentally at the asylum but that she might have had 'a chance of doing so in an asylum where separation of noisy patients from the quiet ones in a practicable matter'.[23] Judith Butler was also reported to be subject to menstruation affecting her behaviour. Judith was a thirty-seven-year-old farmer's wife, admitted with delusions in May 1874.[24] Barnett noted that Judith seemed 'a quiet and respectable woman' and was to be 'kept as much apart from the noisy patients as may be practicable'.[25] However, Judith became violent in conduct, offensive in language, and 'exceedingly maniacal'.[26] Barnett tracked her menstruation across the case books. In October 1874, Judith escaped over the garden wall to the priest's house and was immediately brought back by the matron and warden.[27] The note preceding the account of her escape stated that Judith was 'near the time for menstruating'; this was deemed a contributing factor for her behaviour as two days later she began menstruation.[28] This theory is apparent in January 1875, when Barnett wrote 'menstruation quite regular but always becomes worse mentally after catamenia ceases'.[29] The staff

[18] *Register of Female Patients*, 1858-1873, Folio 120, 20 December 1869.
[19] Ibid, 21 July 1870.
[20] Ibid, 1 January 1871.
[21] *Female Register Case Book*, 1873-1878, Folio 131, 12 June 1874.
[22] Ibid, Folio 258, 17 December 1877; 4-8 January 1878.
[23] Ibid, 4-8 January 1878.
[24] Ibid, Folio 117, 28 May 1874.
[25] Ibid.
[26] Ibid, Folio 199, 30 October 1874.
[27] Ibid.
[28] Ibid, 1 November 1874.
[29] Ibid, Folio 207, 6 January 1875.

identified menstruation as a contributing factor in both Sarah and Judith's bad behaviour and mental states.

Another aspect monitored by the staff was anything unusual surrounding menstruation; irregularity, too heavy, late, or even atypical discharge, was reported. This pattern is apparent in Bridget, Clementina, and Emma's case notes. Bridget Mackie was a single twenty-two-year-old who had 'arrived in the colony mad upwards of six years since', possibly due to separating from her brother during the journey.[30] In May 1860, she was noted to have 'menses too profuse at times but otherwise her health is very good'.[31] Despite this, Bridget remained in the asylum and in January 1882, Dr Barnett reported she had a discoloured and hardened left breast; she died aged sixty in December 1882.[32] Clementina O'Byrne was first admitted in December 1867, with melancholy; although on her second admission in January 1870, she was noted as 'semi-imbecile'.[33] In June, the matron reported that Clementina constantly suffered 'in a slight degree from leucorrhoea with a faint sanguineous stain', (mucus discharge with spots of blood from the vagina).[34] She was stated as previously very dirty in her habits but was now clean.[35] The staff tracked her unusual discharge, which she was free from four months later.[36] Clementina remained in the asylum, dying of 'natural causes' in July 1878.[37] Emma Elizabeth Harold was a single, twenty-five-year-old, domestic admitted with hysteria in January 1906.[38] Emma was always 'quite regular and normal in menstrual period except for the last two occasions when she has lost nothing'; she also had ill-defined and transient tenderness, especially in the region of her ovaries.[39] However, Emma quickly improved and was discharged in June.[40] Mental state and menstruation were linked in Bridget, Clementina, and Emma's cases due to their catamenial irregularities. Healthy and regular menstruation were connected to a healthy condition; the fragility of the normal menstrual cycle reflected the weakness of women's health and sanity as any irregularities could affect the entire body.[41]

[30] *Register of Female Patients*, 1858-1873, Folio 4, 12 July 1858
[31] Ibid, Folio 31, 16 May 1860.
[32] *Case Book Female Patients*, 1878-1897, Folio 30, 2 January; 16 December 1882.
[33] *Register of Female Patients*, 1858-1873, Folio 103, 2 December 1867; 4 January 1870.
[34] Ibid, Folio 103, 15 June 1870.
[35] Ibid.
[36] Ibid, 31 October 1870.
[37] *Female Register Case Book*, 1873-1878, Folio 280, 1 July 1878.
[38] *Case Book Female Patients*, 1901-1908, Folio 317, 19-20 January 1906.
[39] Ibid.
[40] Ibid, 18 June 1906.
[41] Marjorie Levine-Clark, *Beyond the Reproductive Body: The Politics of Women's Health and Work in Early Victorian England* (Columbus: Ohio State University Press, 2004), 116.

This attitude was further displayed in the cases of Margaret and Minnie whom both had amenorrhea, a condition where several periods in a row are missed.[42] Margaret Curley was the first woman in the records admitted to the warehouse asylum on 12 July 1858; she was a twenty-three-year-old maidservant.[43] Her history stated she arrived from England in 1857 and went into service for eight months when she was admitted to the hospital due to headaches and haemorrhoids: 'sundry indication of mental derangement followed' and she was sent to the asylum.[44] After admission, Margaret was noted as extremely docile and well behaved, though she complained of 'vague ill-defined pains'.[45] However, in October 1858, Dr Attfield wrote: 'menstrual function out of order. Amenorrhea for six months'.[46] Perhaps this was the cause of her previously mentioned pains. Two weeks later, Margaret attributed her illness 'to want for her precaution when in domestic service, in not avoiding the heat of the steam'.[47] This admission was deemed an improvement and Margaret was discharged in October 1858.[48] Minerva "Minnie" Jane Tabitha Owen was a twenty-one-year-old single domestic worker admitted with primary dementia in September 1904.[49] Minnie was very emotional, rambled chiefly about her lover, Tom, and that she was 'a bad girl and has not been churched, that she loves her baby'.[50] However, as Dr Blackall noted, her 'breasts are those of a virgin, the abdomen was also consistent with virginity', with no present or past signs of pregnancy.[51] On admission, Minnie's mother stated that Minnie had amenorrhea for most of her life, especially two months before admission as she had only menstruated for one day in September.[52] The abnormality and absence of menstruation was seen as a significant factor in Minnie's mental state. Amenorrhea impacted both Margaret and Minnie, and it also influenced the physician diagnosis.

Menstruation also affected the epileptic patients. The connections between epilepsy and menstruation made by medical professionals stemmed from the ancient Hippocratic belief that 'seizures in women were caused by the uterus rising from its proper position in the pelvis into the abdomen or thorax causing symptoms of smothering'.[53] As discussed in previous chapters, ovariotomies became a treatment for epilepsy as nineteenth-century physicians associated the

[42] Amenorrhea could also include a failure to menstruate by fifteen years of age.
[43] *Register of Female Patients*, 1858-1873, Folio 1, 12 July 1858.
[44] Ibid.
[45] Ibid, 3 August 1858.
[46] Ibid, Folio 10, 6 October 1858.
[47] Ibid, 19 October 1858.
[48] Ibid, 30 October 1858.
[49] *Case Book Female Patients*, 1901-1908, Folio 195, 17-19 September 1904.
[50] Ibid.
[51] Ibid.
[52] Ibid, 22-23 September 1904.
[53] Timothy Betts and Lyn Greenhill, *Managing Epilepsy with Women in Mind* (Oxon: Taylor & Francis, 2005), 90.

frequency of seizures with the waxing and waning of the menstrual cycle.[54] In 1868, Baker Brown attributed 'excessive or too frequent menstruation' as one of the causes of cystic disease or ovarian dropsy.[55] However, there is no evidence of ovariotomy in cases of epileptic women in Fremantle's asylum, but epilepsy was associated with reproductive illnesses well into the twentieth century. This association is particularly apparent in Sarah Salter's case. Sarah was thirty-nine years old when she was admitted by her husband in July 1858; she had an 'insane restless expression', suffered from epileptic fits, and abnormally heavy bleeding during menstruation.[56] It was reported Sarah had seven children (four of whom were still living), and showed symptoms of irrationality and derangement, indicated by melancholy and apprehension.[57] Dr Attfield also noted, 'her first question to me is invariably whether I have any castor oil or laudanum'; possibly to relieve her pain.[58] By May 1860, it was noted that Sarah had 'occasionally a tendency to menorrhagia' (abnormally heavy bleeding at menstruation).[59] In October, she was 'now larger round the abdomen by two inches than she was but does not suffer in health'.[60] In February 1864, Dr Attfield wrote that she had 'ovarian disease' which was slowly increasing as she was four inches larger around the abdomen.[61] Sarah's menorrhagia continued for four months and when it ceased Attfield noted that the 'ovarian dropsy' had discharged through the vagina and a considerable quantity of colourful fluid had passed which lessened her size and allowed her to be more active.[62] For Sarah, there was no reported return of ovarian dropsy, but her menstruation remained irregular with some menorrhagia. Sarah remained in the asylum for twenty-two years, and in March 1880, during one of her epileptic fits which lasted an hour and a half 'she expired', the cause of death was recorded as epilepsy.[63] Sarah's menstrual cycle affected her epilepsy and her diagnosis of insanity.

Therefore, nineteenth-century physicians saw the menstrual cycle as a potential cause for madness in women; however, menopause was also deemed as a psychologically dangerous process. Nineteenth-century medical and psychiatric views on menopause developed from the pathologising of women's bodies and the idealisation of motherhood. Showalter writes that 'menopausal women were more harshly discussed, more openly ridiculed, and more punitively treated than any other

[54] Betts and Greenhill, *Managing Epilepsy*, 90.
[55] Isaac Baker Brown, *On Ovarian Dropsy: Its Nature, Diagnosis and Treatment*, 2nd ed. (London: Robert Hardwicke, Piccadilly, 1868), 19.
[56] *Register of Female Patients*, 1858-1873, Folio 9, 10 July 1858.
[57] Ibid.
[58] Ibid, Folio 13, 22 October 1858.
[59] May 1860.
[60] Ibid, Folio 47, 20 October 1863.
[61] Ibid, Folio 68, 2 February 1864.
[62] Ibid, 15 November 1864.
[63] *Case Book Female Patients*, 1878-1897, Folio 18, 25 March 1880.

female group, especially if they were unmarried'.[64] Nineteenth-century physicians often 'ignored the psychological and social impact of aging and stressed feminine biology to explain insanity in older women'.[65] 'They claimed that the end of women's reproductive lives was a profound mental upheaval' due to an altered and diminished sexual status.[66] 'Expressions of sexual desire were considered ludicrous or tragic, and husbands of menopausal women were advised to withhold "sexual stimulus"'.[67] Despite this, there were also suggestions that some hysterical women, who had been afflicted by their uterine functions, were given a new lease on life when menopause began.[68] However, the consensus was that menopause rendered women vulnerable to depression and increased chances of illness.[69] Louise Foxcroft argues that fear of menopause was learned by society and grew out of a general male and medical distaste due to the end of viability, fertility, beauty, desirability, and therefore, worth.[70] Angela Saini adds that the physical and hormonal changes related to menopause impacted their mental health due to the shift in their life and status: 'If fertility represented youth and health, society assumed then, that infertility was the exact opposite. It wiped out the entire point of being female'.[71] Women in Fremantle could be admitted to the asylum due to experiences with menopause.

Women admitted to the asylum with menopausal symptoms could show suicidal and violent tendencies towards their husbands, as evidenced in Clara, Louisa, and Elizabeth's cases. Clara Crudace was fifty years old with 'mania of menopause' when her son admitted her in October 1905; she had 'taken a violent dislike to her husband'.[72] Although troublesome, violent, and noisy on admission, she quickly improved and was discharged in February 1906.[73] Louisa Matilda Hicks was a forty-one-year-old American admitted by her husband in October 1904 for religious excitement and 'mania of climacteric'.[74] Louisa had been 'violent, threatening lives of children and husband, intensely excited, constantly praying in loud voice, various hallucinations'.[75] She was 'of demented

[64] Showalter, *Female Malady*, 75.
[65] Ibid, 59.
[66] Ibid, 59.
[67] Ibid, 75.
[68] Ruth Formanek, "Continuity and Change and 'The Change of Life': Premodern Views of the Menopause," in *The Meaning of Menopause: Historical, Medical, and Cultural Perspectives*, ed. Ruth Formanek (Hillsdale, NJ: The Analytic Press, 1990), 10.
[69] Ruth Formanek, *The Meaning of Menopause: Historical, Medical, and Cultural Perspectives* (Hillsdale, NJ: The Analytic Press, 1990), xvi.
[70] Louise Foxcroft, *Hot Flushes, Cold Science: A History of the Modern Menopause* (London, Granta Books, 2011), https://books.google.com.au/books?id=TQ8_lWAZBPwC&printsec.
[71] Angela Saini, *Inferior: How Science Got Women Wrong and the New Research that's Rewriting the Story* (London: 4th estate, 2017), 207-209.
[72] *Case Book Female Patients*, 1901-1908, Folio 293, 17-19 October 1905.
[73] Ibid, 25 October 1905; 1 February 1905.
[74] Ibid, Folio 201, 7-10 October 1904.
[75] Ibid.

appearance', but by March 1905, she became 'a little quieter, not so troublesome'.[76] However, Louisa's health declined, and she died two months later due to complications with diarrhoea.[77] Elizabeth Maria Roberson was forty-three years old when she was admitted by her husband, William, in June 1907, due to 'menopause'.[78] Elizabeth's medical certificate stated she had 'threatened her husband's life several times, has an uncontrollable temper, has attacked her husband'.[79] Dr Blackall noted that five years previously, one of Elizabeth's ovaries was removed due to ovarian pain that developed after a horse kick.[80] Elizabeth's menstruation had ceased four years after the operation, and she still suffered from 'flushes'.[81] In the asylum, she was noted as quiet and admitted to a hasty temper; she stated she had 'no remembrance of having threatened her husband "I must have been mad in my head to have done such a thing because he has always been a good husband to me"'.[82] Interestingly, Blackall reported she was 'improving rapidly; to be watched over next menstrual period', despite her menopause.[83] Elizabeth's improvement was maintained, and she was discharged on a month's trial in August, confirmed in September 1907.[84] Clara, Louisa, and Elizabeth's mental states were linked to their physical reactions to menopause and their violent actions towards their husbands was not tolerated.

Patients Barbara and Maggie also had unusual menopausal reactions, and they influenced mental state and diagnosis. Barbara Annie Young was a forty-two-year-old laundress admitted by her husband in December 1905 after she had become suicidal and attempted to strangle her children.[85] Barbara's periods had ceased twelve months ago 'but since her "hysterical attacks" it has come on again'.[86] She denied drinking alcohol but stated 'that she has had a very rough time of it although doing better of late, has had to work manually very hard and often go short of food'.[87] Barbara remained 'noisy and delusional, no improvement' and was transferred to Claremont in June 1908.[88] Barbara's mental state triggered menstruation after menopause, possibly due to malnutrition. Maggie Darvell was forty years old when her husband admitted her in 1908; she had a large linear scar underneath her jaw, extending almost from ear to ear.[89] Maggie had given birth to

[76] Ibid, 23 March 1905.
[77] Ibid, 9 May 1905.
[78] *Case Book Female Patients*, 1906-1908, Folio 135, 30 June 1907.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] Ibid.
[83] Ibid, 25 July 1907.
[84] Ibid, 1-14 August; 14 September 1907.
[85] *Case Book Female Patients*, 1901-1908, Folio 309, 24-26 December 1905.
[86] Ibid.
[87] Ibid.
[88] Ibid, 24 January; 5 June 1908.
[89] *Case Book Female Patients*, 1906-1908, Folio 203, 10-13 January 1908.

her first child sixteen months previously 'at a time when the menstruation had commenced to become irregular suggesting the menopause, since this time she has been weak in health and mental symptoms of anergic type have set in gradually till her present condition had been arrived at'.[90] Upon admission, her menstruation seemed to have ceased, and she was restless and refused to speak.[91] In March, she began to run a high temperature with bloody diarrhoea and was diagnosed with typhoid; she was given stimulant including strychnine but died in March 1908.[92] In terms of natural selection, menopause ensures that mothers are young enough to survive pregnancy, delivery, and the infancy of their offspring; older mothers are also more severely taxed by the numerous physiological demands on the mother.[93] In this case, Maggie and Barbara's menopause had direct effects on their health and mental state.

Two women in Fremantle underwent surgery to relieve their menopausal symptoms. As explored in Chapter Two, oophorectomy was a relatively new procedure in the nineteenth century, which involved the removal of ostensibly healthy ovaries to alleviate a range of women's mental instabilities. Emma and Jane were such patients. Emma Schneider was a forty-three-year-old widowed German washerwoman admitted in August 1903 with melancholia caused by drink.[94] She had a scar of median laparotomy on the lower part of her abdomen which she stated was 'a double oophorectomy performed apparently to relieve the symptoms of the menopause'.[95] Although she was 'hypochondriacal', she was allowed out on trials with her sister and son and was eventually discharged in December 1906.[96] Jane Brine was forty-one years old when her husband admitted her in September 1906: very delusional of a 'mild sexual type' after issues with confinement.[97] Dr Blackall reported that Jane had a linear scar in the hypogastrium 'probably double oophorectomy' and that she no longer had any menstrual periods.[98] Her recovery from a massive overhaul of her reproductive system took place in the asylum until she was transferred in May 1908.[99] Emma and Jane had surgical interference in their bodies, and it may have impacted their mental recovery.

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[90] Ibid.
[91] Ibid.
[92] Ibid, 17-19 March 1908; Strychnine is a toxic crystalline alkaloid used in the nineteenth century as the convulsant effect was believed to be beneficial in small doses.
[93] Lynnette Leidy Sievert, *Menopause: A Biocultural Perspective* (New Brunswick: Rutgers University Press, 2006), 44.
[94] *Case Book Female Patients*, 1901-1908, Folio 111, 27 August 1903.
[95] Ibid, Folio 112, 5 September 1903.
[96] Ibid, 7 June; 11 December 1905; 7 May; 14 December 1906.
[97] *Case Book Female Patients*, 1906-1908, Folio 21, 26-27 September 1906.
[98] Ibid.
[99] Ibid, 27 May 1908.

The connections made between menstruation and violent, suicidal behaviour was again based on nineteenth-century ideals of women's worth as mothers. As menopause robbed a woman of femininity and invited disease, it was believed to drive them to violence, suicide, or drink.[100] The expectation was that the physical changes in women's bodies, and not the social pressures and expectations on aging women, were causing the undesirable behaviour. Therefore, menstruation, or the lack of it, was treated as pathological; women were deemed mentally weak and vulnerable while menstruating and risked damaging their health by excessive mental activity during the menstrual period.[101] Showalter argues that the Victorians' views on menstruation furnished a remarkable example of 'how scientific knowledge reflects, rather than determines, the moral biases of an era'.[102]

Baby Brain: Pregnancy, Miscarriage, and Lunacy

The primary goal for Victorian women was to provide children for her family. American sociologist Barbara Katz Rothman writes that 'women were mothers. Mothering was not something women *did*, it was something women *were*…Motherhood was in fact a master status, and everything women did as seen in terms of our motherhood, or our potential motherhood. Motherhood and its demands, babies and children and their demands, defined women'.[103] Nineteenth-century pregnancy was potentially perilous, and death in childbirth was a common danger for Australian women.[104] In 1844, British obstetrician Dr Robert Lee outlined that women were 'exposed to great suffering and danger during pregnancy and child-bearing, and many die from acute disorders following delivery'.[105] Despite this, Dr William Acton believed that wives should conceive every second year; he argued that the nine months of pregnancy would reduce sexual desire in women.[106] It is also possible that the danger of pregnancy influenced women's experience and attitudes toward sex, which was haunted by fear, not just the hope of conception.[107] Michael Durey's research revealed that 'Perth, because of its climate and its flies, and because it was still in many ways a frontier town, retained the doubtful privilege of having the worst IMR [Infant Mortality Rate] in the Commonwealth' and had particularly 'heavy incidence of death in the first six months of life'.[108] Durey found that in late nineteenth century Perth, infants suffered from 'weanling diarrhoea, in which undifferentiated

[100] Foxcroft, *Hot Flushes,* n.p.
[101] Anne E. Walker, *The Menstrual Cycle* (Oxon: Routledge, 2014), 36.
[102] Elaine Showalter and English Showalter, "Victorian Women and Menstruation," in *Suffer and Be Still: Women in the Victorian Age*, ed. Martha Vicinus (Bloomington: Indiana University Press, 1972), 43.
[103] Barbara Katz Rothman, *Recreating Motherhood* (New Jersey: Rutgers University Press, [1989] 2000), 7.
[104] Bongiorno, *Sex Lives*, 64.
[105] Robert Lee, *Lectures on the Theory and Practice of Midwifery, Delivered in the Theatre of St. George's Hospital* (London: John Churchill, 1844), 1.
[106] Muchembled, *Orgasm and the West*, 161.
[107] Bongiorno, *Sex Lives*, 64.
[108] Durey, "Infant Mortality in Perth," 65.

pathogenic micro-organisms eventually cause death'.[109] However, by 1914, increased health practices and action from the government, along with socio-cultural improvements, resulted in reduced infant death which also coincided with a general decline in the west.[110] Thus, women in Western Australia also had very real fears over the loss of children even after surviving pregnancy.

Several women in Fremantle were pregnant while incarcerated; the patient case notes reflect that their pregnancies affected their mental state. The subsequent removal of these children from the asylum would also have affected the mothers. Jill Matthews notes that the status of motherhood was a prize within the gender order; therefore, a baby was a reward, and aside from the love for the child, such removal was a hard punishment for any woman.[111] The experiences of the patients who suffered miscarriages or received abortions and also impacted assessments of insanity. Illegitimate pregnancies contributed to stigmatised labels of shame, and hysterical pregnancies revealed the pressure placed on women to conceive and produce children. This section analyses the critical role pregnancy had in nineteenth-century women's lives and the connections between pregnancy and insanity.

Pregnancy and childbirth were potentially dangerous experiences in the nineteenth century and undergoing them in an asylum would undoubtedly have added to stress and uncertainty. Anne Tippet was among the women who gave birth in the asylum. Anne was already the mother to three children, the youngest four months old when she was first admitted on 16 April 1864.[112] When readmitted with mania and delusions by her husband, Richard, in April 1866, she was seven and a half months 'gone in the family way' with their fourth child.[113] However, a month later, on 23 April, Anne gave birth to a boy she named William.[114] However, by May, Dr Attfield reported: 'the milk failed about ten days ago, she began to show aversion to the baby and the latter, being healthy and feeding well with a spoon, was transferred to the Home, Perth and placed in charge of a nurse'.[115] The baby's transfer to the poor home did improve Anne's mental state; she remained in the asylum, occasionally visited by her other children.[116] By 1883, she experienced severe menorrhagia which continued for two months until her death in August, the verdict was stated as severe menses.[117]

[109] Ibid.
[110] Ibid.
[111] Matthews, *Good and Mad Women*, 180.
[112] *Register of Female Patients*, 1858-1873, Folio 72, 16 April 1864.
[113] Ibid, Folio 87, 15 March 1866.
[114] Ibid, 23 April 1866; BDMWA: *Certificate of Birth:* William (9248/1866).
[115] Ibid, 24 May 1866.
[116] *Female Register Case Book*, 1873-1878, Folio 265, 1 March 1878.
[117] *Case Book Female Patients*, 1878-1897, Folio 22, 30 June; 30 August 1883.

Anne was a long term patient whose pregnancy and medical repercussions affected her continued incarceration until her death.

Often pregnancies and childbirth that took place in the asylum resulted in the separation of mothers and newborns. If the mother had not improved after giving birth, their babies would be removed from the asylum. While not always explicitly stating the babies were removed, their remaining in the asylum would be unlikely; this is evident in Annie, Selina, and Mary's cases. Annie Erskine was admitted by her husband in October 1903 with melancholia.[118] Annie claimed that her husband had attempted to throttle her, although there were 'no marks of any such thing'.[119] She also stated that she was pregnant; however, there were no signs of this on admission, besides a swollen abdomen.[120] Three months later, on 8 January 1904, 'she was delivered of a male child', Harry; Annie recovered well, but the child was noted as small.[121] There is no mention of Annie's son in the records again; therefore, it can be assumed that he was removed as Annie remained in the asylum and was sent to Claremont in June 1908.[122] Selina Teresa Bowen was admitted in July 1904, after voices urged her to kill her children and she had beat them.[123] In October, Selina became stout and 'as pregnancy was suspected examination was made without definite result'; by December she was reported as 'undoubtedly pregnant'.[124] On 4 March 1905, a female child, Gladys, was born with no trouble.[125] A few days later, the child was removed from the asylum by Selina's husband, William; Selina remained and was transferred in 1908.[126] Mary Elizabeth Watson was admitted in a puerperal state in November 1903.[127] She had recently lost her three-month-old daughter, Mary Frances, and had given birth to a stillborn female.[128] Mary's fragile state was further evidenced when it was noted that she was 'hanging to her husband for fear he will leave her'.[129] Three months later, Mary began showing signs of pregnancy, and on 16 April, she delivered a girl, also named Mary.[130] There is no mention of what became of the child, but Mary remained in the asylum and was transferred in

[118] *Case Book Female Patients*, 1901-1908, Folio 126, 16 October 1903
[119] Ibid.
[120] Ibid.
[121] Ibid, 8 January 1904; BDMWA: *Certificate of Birth:* Harry (2404/1904).
[122] Ibid, 2 June 1908.
[123] Ibid, Folio 183, 23-25 July 1904.
[124] Ibid, 17 October; 15 December 1904.
[125] Ibid, 4 March 1905; BDMWA: *Certificate of Birth:* Gladys (2635/1905).
[126] Ibid, 7 March 1905; 11 May 1908.
[127] Ibid, Folio 141, 14 November 1903; BDMWA: *Certificate of Death:* Mary Frances (1560/1903), Stillborn F Watson (1536/1903).
[128] Ibid.
[129] Ibid.
[130] Ibid, Folio 142, 14 February; 16 April 1904.

1908.[131] Annie, Selina, and Mary's pregnancies may have contributed to further mental strain as these women remained incarcerated separated from their infants.

Pregnancy and childbirth were also significant in Anne Hawkins' case; a notorious patient admitted to the asylum nine times from 1868 to 1902.[132] Upon admission in November 1869, aged between forty-four and forty-five, Anne was noted as 'worn and haggard about the face and far advanced in pregnancy'.[133] Five days later, she gave birth to a boy, Joseph; her labour was described as 'easy and quick' while the child was 'small and puny'.[134] The patient records do not state what happened to her son; however, the BDMWA records reveal that Joseph died at eight days old.[135] After behaving quietly Anne was discharged into her husband, Henry's, care in January 1870; however, four days later, she was readmitted incoherent, noisy, violent, and unmanageable: the reason for this was attributed 'to her having been allowed to indulge in drink'.[136] On her eighth admission, in December 1880, Anne was suffering from physical symptoms related to her previous pregnancies; her womb had come down and had to be replaced by the matron.[137] Uterine prolapse occurs when 'a segment of the vagina always gives way, the uterus falls, producing usually undue tension of some of the ligaments, abdominal pain is thus induced, and unless rest in the recumbent posture is employed the bladder falls also'.[138] The condition was believed to be caused by multiple pregnancies and in part by the downward abdominal pressure of corsets.[139] It would often be treated with pessaries, a mechanical device resembling a rubber plug, which was inserted into the vagina.[140] In 1880 Jankins wrote in the *Australian Medical Journal* that he used 'stem pessaries…in the treatment of uterine flexions, versions, and in cases of flabby enlargement, generally following miscarriage or parturition'.[141] This equipment must not have been available to the Fremantle physicians in 1880, as Anne's 'prolapsus uteri' continued into March 1885, and Dr Barnett noted 'it goes back on lying down, but she cannot be kept quiet'.[142] In October 1898, Anne again suffered

[131] Ibid, 11 May 1908.
[132] Anne's story is continued in Chapter Six.
[133] *Register of Female Patients*, 1858-1873, Folio 105, 15 November 1869.
[134] Ibid, 20 November 1869.
[135] Ibid; BDMWA: *Certificate of Death:* Joseph (4435/1869); *Certificate of Birth:* Mary Christina (3049/1855), Francis Henry (3855/1857), William (4622/1859 d. 1779/1861), Anne (5733/1861 d. 1957/1862), Elizabeth (6901/1863), Bridget Susannah (10031/1867).
[136] Ibid, 19 January 1870.
[137] *Case Book Female Patients*, 1878-1897, Folio 54, 24 December 1880.
[138] W.V. Jankins, "Prolapse of the Uterus," *Australian Medical Journal* ii, no. 12 (December 1880): 531. http://hdl.handle.net/11343/23144.
[139] Valerie Steele, *The Corset: A Cultural History* (New Haven: Yale University Press, 2005), 76.
[140] Steele, *The Corset*, 76.
[141] W.V. Jankins, "On Pessaries," *Australian Medical Journal* ii, no. 7 (July 1880): 296. http://hdl.handle.net/11343/23144.
[142] *Case Book Female Patients*, 1878-1897, Folio 87, 21 March 1885.

from a prolapsed uterus and in December had 'pessary inserted'; finally providing a temporary solution.[143] Anne was not discharged again and spent the rest of her life incarcerated, dying in 1902.[144] Anne's postpartum repercussions were an aspect of her perceived insanity and incarceration in the asylum.

Pregnancy in the asylum was not limited to married women. The stigma attached to illegitimate pregnancy lasted well into the 1960s. Jenny Teichman argues that being a single mother was the worst possible shame: 'the disgrace spread to all her immediate kin, who were expected to purge their shame by expelling the guilty woman from the family or by hiding her away somewhere'.[145] In nineteenth-century Australia, to the respectable, there was 'little distinction between a woman who bore an illegitimate child and one who practised prostitution, for each had fallen'.[146] Illegitimate birth itself was enough to make a woman an unfit mother morally and economically.[147] Christina Twomey writes that in the Australian colonies there was a real risk to being a single mother, if mothers further transgressed against femininity with any arrests or indiscretions it could jeopardise the chance of getting magisterial assistance.[148] Two women in the asylum had illegitimate pregnancies and faced social stigmas and incarceration. Margaret Lynch was a twenty-three-year-old 'Jewess' admitted in December 1862 with delusions after having been 'confined prematurely of a seven months child, three weeks ago'.[149] Margaret's history revealed she had arrived in the colony in May 1858 per the *Emma Eugenia* and had been in service.[150] Her marital status was not recorded, and therefore, she was probably single. Margaret's situation was enquired after by Dr Attfield, who stated that 'when questioned as to her former life and connections she talks very incoherently'; perhaps intentionally.[151] By 1870, Margaret entered 'a very weak state' and died on 9 August.[152] What became of Margaret's baby is unknown; however, she was in the colony without family and may have had a disreputable reputation. The bride ships with single women immigrants were occasionally identified as sources of prostitutes as some women acquired unsavoury reputations upon arrival due to allegations of "irregularities" on board; the *Emma Eugenia* was among such ships.[153] This association may have impacted Margaret. Margaret Wood

[143] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 396; 418, 16 October; 4 December 1898.
[144] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 21, 27-29 March 1902.
[145] Jenny Teichman, *Illegitimacy: A Philosophical Examination* (Oxford: Blackwell, 1982), 119.
[146] Bongiorno, *Sex Lives*, 45.
[147] Matthews, *Good and Mad Women*, 180.
[148] Christina Twomey, "Courting Men: Mothers, Magistrates and Welfare in the Australian Colonies," *Women's History Review* 8, no. 2 (1999): 241. doi: 10.1080/09612029900200200.
[149] *Register of Female Patients*, 1858-1873, Folio 58, 1 December 1862
[150] Ibid.
[151] Ibid, 12 January 1863.
[152] Ibid, Folio 138, 8-9 August 1870.
[153] Gothard, *Blue China*, 28.

was another woman who had an illegitimate pregnancy; she was twenty-one years old when her parents admitted her in December 1889.[154] Margaret was reported to be semi-imbecile since childhood and that 'her unfortunate condition has been taken advantage of by a scoundrel who made her pregnant'.[155] Her mother stated that Margaret had 'been delivered' and expressed 'a determination to go back to the man when she can'.[156] Central to the concept of stigma in illegitimate pregnancy is the notion of self-ascription; as the stigmatised woman shares the value system of the wider society, she tends to accept the judgement.[157] To not accept judgement would be abnormal. There is another level to Margaret's case; Section six of the *Criminal Law Amendment Act, 1892* in Western Australia stated that any person that attempted to or had intercourse with 'any female idiot or imbecile woman or girl' would be guilty of a misdemeanour.[158] By modern standards, 'it is considered rape if the woman is incapable of exercising rational judgement because of mental deficiency'.[159] However, the emphasis on Margaret's desire to go back to the father of her child appears the more significant issue for her family and asylum staff. Unfortunately for Margaret, several epileptic fits led to her death in May 1890.[160] Both Margaret's were young and unmarried women who faced the shame attached to their pregnancies, which resulted in asylum admission.

One of the risks with pregnancy is the loss of the baby, and miscarriages could have significant impacts on women. By the twentieth century, a "good" woman would aim to become pregnant and carry those pregnancies to term; any deviation from this pattern was deemed a guilt-inducing failure for women.[161] Trauma and grief from miscarriage impacted some of the women admitted to the asylum, as evidenced by Agnes and Alice. Agnes McDonald was aged forty when she was admitted in September 1902 with acute delusional mania 'owing to death of a child'.[162] Described as an obese woman with a strong suspicion of alcoholic toxicity, Agnes was deluded, filthy, obscene, and so violent she required a camisole and sheet restraint.[163] Agnes's husband, Henry, revealed that the 'first signs of mental affection appeared after exhausting lactation of a sick child which ultimately died' and that she then had 'septicaemia after a miscarriage and after a labour and has been "dropsical"'.[164] These experiences would have been traumatic, and Agnes' ill health

[154] *Case Book Female Patients*, 1878-1897, Folio 141, 7 December 1889.
[155] Ibid.
[156] Ibid.
[157] Shurlee Swain and Renate Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia* (Cambridge: Cambridge University Press, 1995), 61.
[158] *Criminal Law Amendment Act 1892*, Section 6, 2.
[159] Davidson, *A Nurse's Guide*, 205.
[160] *Case Book Female Patients*, 1878-1897, Folio 141, 29 May 1890.
[161] Matthews, *Good and Mad Women*, 177.
[162] *Case Book Female Patients*, 1901-1908, Folio 51, 4-5 September 1902.
[163] Ibid, 7-10 September 1902.
[164] Ibid, 30 September 1902.

prevented her possible mental recovery; she remained in the asylum, dying in May 1904.[165] Alice Kate Hayes was aged twenty-five when she was admitted in March 1907 with acute mania after having 'undergone an operation for misplaced womb'.[166] Her husband stated, 'she had a miscarriage last September and that her disposition has changed since that date, whereas before she was very neat and tidy, she has now become very slovenly and untidy'.[167] Alice remained in the asylum and was transferred in June 1908.[168] Alice's miscarriage impacted her mentally and affected her ability to function domestically, which resulted in asylum committal. The mental toll miscarriages had on these women was profound and resulted in assessments of mental instability.

However, sometimes, the physicians implied that miscarriages allowed the women to mentally recover, as seen in Emily and Mary's cases. Emily Hoeffer was a forty-year-old British domestic worker admitted for delusional insanity caused by epilepsy in September 1902.[169] By the end of the month, Emily 'complained of pains in the back and limbs', and on 25 October, Dr Montgomery reported 'had a miscarriage today, is improving very well'.[170] The month following he stated, she 'has quite recovered from the miscarriage. Is much better mentally' and she was 'discharged recovered'.[171] Montgomery made a clear link between Emily's pregnancy and mental state, with the miscarriage allowing her to improve. Mary Eddy was forty years old when she was admitted in October 1905; her medical certificate stated 'she was going to have a child (is about three months pregnant), but the devils have removed it from her'.[172] In the asylum, Dr Blackall assessed that she was 'in good condition, she is about 4 months pregnant, there are linea albicantes of former pregnancy on abdomen'.[173] In November, Mary was noted as being 'exceedingly restless and often violent' and required paraldehyde every night.[174] On 24 November, Blackall wrote that he 'voided a 4 ½ months foetus this morning; condition good, mentally very restless, frightened and suspicious'.[175] However, it was not until a year later that Mary began to improve; and she was discharged in November 1906.[176] Mary's pregnancy contributed to her asylum admission and her miscarriage, while traumatic, eventually led to seemingly improved behaviour.

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[165] Ibid, Folio 52, 5 May 1904.
[166] *Case Book Female Patients*, 1906-1908, Folio 97, 31 March- 1 April 1907.
[167] Ibid.
[168] Ibid, 2 June 1908.
[169] *Case Book Female Patients*, 1901-1908, Folio 59, 17 September 1902.
[170] Ibid, 29 September; 25 October 1902.
[171] Ibid, 14-28 November 1902.
[172] Ibid, Folio 301, 28-30 October 1905.
[173] Ibid.
[174] Ibid, 14 November 1905.
[175] Ibid, 24 November 1905.
[176] Ibid, 28 November 1906.

Another aspect that affected the women in Fremantle was when they brought on miscarriages or acquired abortions.[177] Up until the 1960s, abortion was illegal in every Australian state.[178] Therefore, Australian women, with no access to legal, safe, or affordable contraception, had to resort to home-made, unsafe, and often illegal methods for contraception and abortion; the consequences of which were potentially fatal.[179] However, it is difficult to ascertain the safety of abortions in the nineteenth and early twentieth centuries as successful operations were invisible; it was when complications occurred that abortions became visible.[180] Women were aware of the risks as abortion deaths were widely publicised in papers; however, the safety of the procedure would depend on the one performing it.[181] In Fremantle, Lydia and Mary experienced intentional miscarriage or abortion. Lydia Agnes Davis was a twenty-six-year-old married woman from New Zealand admitted for epileptic mania and delusions in March 1905.[182] Lydia stated she had 'brought on miscarriage herself with a knitting needle'; before Christmas 'she had a 4 months pregnancy removed from her under abdomen by Dr Swanston on medical advice at Kalgoorlie'.[183] Since then, she had menorrhagia with 'foul' discharge and some pain.[184] In the asylum, Lydia was noted as 'much quieter, more coherent' but had a tender right ovary that was examined 'by specular showed no erosion nor abnormality'.[185] Lydia's improvement continued, and she was discharged; however, almost two weeks later, she was readmitted with fits during her menstrual period.[186] On the 5 June, 'she effected her escape but was discovered at her sister's in Fremantle after an absence of 1 hour'.[187] However, by March 1906, she was 'sensible and rational' and was discharged in July.[188] Lydia's self-induced miscarriage could reflect a potentially desperate and unstable mental state, compounded by incarceration. It also reflects that Lydia may have desired not to be pregnant, and felt trapped by her limited options. Mary Cleasby, a married Roman Catholic, was admitted in June 1905 with puerperal mania.[189] Her medical certificate stated: 'after the birth of her child she continually baptised it' and eighteen months previously she had become 'maniacal after an abortion

[177] The term 'abortion' must be approached cautiously as it could mean induced or criminal abortion, or spontaneous abortion and miscarriage.
[178] Matthews, *Good and Mad Women*, 136; possible exceptions were allowed in the case of preserving the life of the mother. However, by the twentieth century, states increased prosecution of women seeking abortions.
[179] Ibid.
[180] Lisa Featherstone, *Sexuality in Australia from Federation to the Pill* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2011), 27.
[181] Featherstone, *Sexuality in Australia*, 27.
[182] *Case Book Female Patients*, 1901-1908, Folio 239, 1-2 March 1905.
[183] Ibid.
[184] Ibid.
[185] Ibid, 8-15 March 1905.
[186] Ibid, Folio 239-255, 13 April; 13-30 May 1905.
[187] Ibid, 8 June 1905.
[188] Ibid, 15 March; 3 July 1906.
[189] Ibid, Folio 259, 8-9 June 1905.

which was procured'.[190] Mary resented being touched and wildly resisted examination; she was restless and required paraldehyde at night.[191] However, by the end of June, she was 'much quieter and more coherent' but complained of pain in her abdomen, possibly related to her abortion.[192] By early July, Mary was noted as having 'immensely improved, quiet, rational and coherent, and anxious for discharge': which was granted in August.[193] There are no details on Mary's abortion experience, but in this case, it resulted in asylum admission. These women were in fragile and desperate states, and asylum incarceration may not have addressed their deeper concerns.

The importance placed on pregnancy and childrearing for nineteenth-century women resulted in a strong desire for maternity, which could manifest in hysterical pregnancies. Medically referred to as pseudocyesis, it is often referred to as hysterical, false, phantom, or spurious pregnancy.[194] In the nineteenth century, it was believed that women who had hysterical pregnancies were generally newly married, or near menopause, and were eager to be pregnant, feeling societal and familial pressure.[195] Physicians supposed that the mind could affect the body sufficiently to mimic the pregnant condition; which further emphasised the perceived connection between women's minds and reproductive organs.[196] In Fremantle, Elizabeth and Bessy experienced hysterical pregnancies, and this impacted their admission. Elizabeth Mews was admitted by her husband in January 1878; she was reported as aged forty, but she claimed she was fifty-one.[197] Dr Barnett noted, Elizabeth was 'full of fancies and complaints' and was convinced she was 'in the family way' and 'in ludicrous fear of a miscarriage'.[198] Elizabeth also 'affects to be pregnant by wrapping a shawl around her'.[199] Elizabeth had nine children, and her life revolved around pregnancy; thus, her hysterical symptoms could have been a response to her menopausal symptoms.[200] Bessy Mary Marsh was twenty-years-old when she was admitted by her husband in September 1892, with delusions and a 'history of lunacy'.[201] On her second admission, Barnett noted that she was 'probably pregnant', which was a concern as she was violent.[202] Again, in May, he noted that she was

[190] Ibid.
[191] Ibid.
[192] Ibid, 30 June 1905.
[193] Ibid, 3 July-12 August 1905.
[194] Ina May Gaskin, "Has Psedudocyesis Become an Outmoded Diagnosis?," *Birth* 39, no. 1 (2012): 77.
[195] Gaskin, "Psedudocyesis," 77.
[196] Ibid.
[197] *Female Register Case Book*, 1873-1878, Folio 264, 27 January 1878.
[198] Ibid, 4 February 1878.
[199] Ibid, 19 February 1878.
[200] Ibid; BDMWA: *Certificate of Birth*: Mary Elizabeth (1065/1848), John Charles (1276/1849 d. five weeks old), Sarah Jane (1541/1850), William Frederick (2449/1854), Eliza Anne (3319/1856), Martha Rose (3884/1857), John Charles (4995/1859), Walter Andrew (5852/1861), Emily Edith (6372/1862), Agnes Matilda (8403/1865).
[201] *Case Book Female Patients*, 1878-1897, Folio 153, 25 September 1892.
[202] Ibid, 19-23 April 1893.

pregnant and improving.[203] In June, Bessy's father and mother-in-law visited to remove her from the asylum; it was then that Barnett wrote 'examined—not pregnant'.[204] As Bessy was discharged the following day, it is impossible to know how this affected her. These women were at different stages of their life when they experienced hysterical pregnancy; Bessy was married and wanting to fulfil her marital duties, while Elizabeth was likely entering menopause and the end of her fertile years. Hysterical pregnancies represent a strong bodily and mental response, influenced by nineteenth-century ideals of women as mothers.

Pregnancy represented an extreme range of emotion for women with profound highs and lows. These women's cases reflect the social expectations of motherhood during the nineteenth and early twentieth century. However, another possible outcome of pregnancy was puerperal insanity.

Puerperal Insanity

Puerperal insanity, or what might be understood today as a form of postnatal depression, was a prevalent issue among the women of Fremantle. Hilary Marland noted that 'women had long expressed extreme anxiety about their passage through pregnancy and birth'.[205] In 1835, Prichard argued that puerperal madness was a form of mental derangement in women soon after childbirth, and it would often end in death or the quick recovery of reason.[206] Nineteenth-century British physicians supposed that puerperal insanity was attributed to 'the suppression of the lochia, metastasis of the milk, the peculiar condition of the sexual system which occurs after delivery'.[207] It also included, 'local irritation of the mammae, uterus and other parts, disturbances of the vascular system occasioned by delivery, the combined effects of irritation and loss of blood, nervous irritability and excitement'.[208] Physicians recognised puerperal insanity as so common that it was almost an 'anticipated accompaniment of the process of giving birth'.[209] James De Burgh Griffith, medical officer at Yarra Bend Asylum, Victoria, wrote in 1882, 'I do not know anything more alarming to a family circle, or more trying to the medical attendant. All that seemed bright has suddenly become changed, and instead of joy there has come unmeasured trouble'.[210] Therefore, hospitals

[203] Ibid, 7 May 1893.
[204] Ibid, 6-7 June 1893.
[205] Hilary Marland, "Under the Shadow of Maternity: Birth, Death and Puerperal Insanity in Victorian Britain," *History of Psychiatry* 23, no. 1 (2012): 79: doi: 10.1177/0957154X11428573.
[206] Prichard, *Treatise on Insanity*, 306.
[207] Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Hampshire: Palgrave Macmillan, 2004), 42-43.
[208] Marland, *Dangerous Motherhood*, 42-43.
[209] Ibid, 5.
[210] James De Burgh Griffith, "Puerperal Insanity," *Australian Medical Journal* iv, no. 6 (June 1882): 241. http://hdl.handle.net/11343/23146.

did not always have the time or facilities to treat these patients, and they were sent to asylums. However, Griffith added that 'the friends of the patient shrink from the idea of sending her to an asylum for the insane, and indeed, will endure such trouble before they adopt such a course'.[211] Griffith, and others, believed puerperal insanity could be well treated at home, thus those women sent to asylums were very unwell or violent.[212] Matthews argues, in her study of the Glenside Hospital in South Australia during the twentieth century, that case notes revealed some women had 'suffered no illness till after the birth of a child'.[213] Australian physician Beattie Smith in 1903 wrote of puerperal insanity:

> The ordinary so-called puerperal insanity (that is, the insanity of parturition) refers to all cases coming on within six weeks of delivery, and here the practitioner has an anxious time, owing to the absolute sleeplessness, irritability and antagonism of the patient…First, you have the melancholic stage, and sometimes there may only be depression. Next, you have excitement, with increase of temperature if there be septic trouble, but not otherwise, and should there be septic trouble, you will find other bodily symptoms. Then comes the period of exhaustion, so that you observe the three forms of mental disorder—melancholia, mania and dementia—represented in one case. Fears of poisoning and refusal of food are common, and jealousies and suspicions of infidelity of the husband are painful accompaniments. Distrust and suspicion practically represent the condition, and voices or delusional promptings account for the tendency to the murder of the father and child and the suicide of the mother.[214]

The practice of admitting women to asylums for puerperal reasons carried on well into the twentieth century; this was also confirmed in Alison Watts study of Melbourne mental institutions where women were admitted with 'puerperal insanity' as recent as 1936.[215] The following section will examine the cases of the women admitted with puerperal mania and melancholia, lactational insanity, and infanticide.

The most concerning issue with puerperal insanity was that the sufferers 'challenged notions of domesticity and femininity and flouted ideals of maternal conduct and feeling'.[216] Nancy Theriot writes that 'women's indifference or hostility to children and/or husbands', and their 'tendency to obscene expressions' was most shocking: 'they first upset physicians' ideas about women's maternal and wifely devotion, while the second undermined doctors' assumptions about feminine purity'.[217]

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[211] Griffith, "Puerperal Insanity," 241.
[212] Ibid.
[213] Matthews, *Good and Mad Women*, 178.
[214] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 66-67.
[215] Alison C. Watts, "Maternal insanity in Victoria, Australia: 1920-1973," (PhD thesis, Southern Cross University, 2015), 152.
[216] Marland, *Dangerous Motherhood*, 5.
[217] Nancy Theriot, "Diagnosing Unnatural Motherhood: Nineteenth-century Physicians and 'Puerperal Insanity,'" *American Studies* 30, no. 2 (1989): 74: https://www.jstor.org/stable/40642344.

Puerperal symptoms resulted in 'household duties done without interest, sympathy, and affection'.[218] Therefore, as Theriot argues, 'puerperal insanity can be interpreted as a socially-constructed disease, reflecting both nineteenth-century gender constraints and the professional battles accompanying medical specialization'; male physicians and female patients created puerperal insanity, that 'both reflected and contributed to sexual ideology and medical specialization'.[219] She argues that 'whether on a conscious or unconscious level, women who suffered from puerperal insanity were rebelling against the constraints of gender'.[220] Although, modern medical professionals are now aware there are many factors involved in postnatal depression, including hormonal changes, economic and relationship stress, previous traumas, and a genetic predisposition to depression.[221] However, in 1903 Beattie Smith made the point of stating that 'we must not attribute too much to heredity. We must look to expectancy'.[222] He provides an example, that 'a young woman who marries, and for the whole of her pregnancy wonders whether she will break down, and be like her mother. Expectancy prepares the way for a break down'.[223] He stated that 'a woman who has suffered once is liable to another attack, because she thinks of the past and has expectancy' and provided that advice to physicians that they tell husbands '"I think you may encourage your wife to believe she will not break down again"'.[224] This is very different from modern Australian discourse on postnatal depression; a study from 2019 reveals that awareness of postnatal depression has improved.[225]

The women with puerperal insanity would often be "cured" and sent home after a short amount of time. This theory was based on the belief that puerperal insanity was temporary, albeit severe, aberration, and likely to be curable.[226] In 1846, Conolly stated that 'cases of puerperal insanity appear to afford a better prospect of recovery than any other'.[227] In 1903 Beattie Smith stated that 'half the cases recover in four months, and thence onward to the ninth month, with a

[218] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 68.
[219] Theriot, "Diagnosing Unnatural Motherhood," 72.
[220] Ibid, 81.
[221] Chesler, *Women and Madness*, 104.
[222] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 66.
[223] Ibid.
[224] Ibid, 68.
[225] Terri Smith, Alan W. Gemmill and Jeannette Milgrom, "Perinatal Anxiety and Depression: Awareness and Attitudes in Australia," *International Journal of Social Psychiatry* 65, no. 5 (2019): 385. doi: 10.1177/0020764019852656.
[226] Hilary Marland, "'Destined to a Perfect Recovery': The Confinement of Puerperal Insanity in the Nineteenth Century," in *Insanity, Institution and Society, 1800-1914*, eds. Bill Forsythe and Joseph Melling (Oxon: Routledge, 1999), 137.
[227] John Conolly, "Description and Treatment of Puerperal Insanity," *Lecture XIII: Clinical Lectures on the Principle Forms of Insanity, Delivered in the Middlesex Lunatic Asylum at Hanwell*, Lancet 1, March 28, 1846, 349.

few recoveries even as late as a couple of years'.[228] This attitude was displayed in Fremantle with short asylum admissions for women suffering puerperal insanity. However, a speedy turnaround of puerperal patients into their husband's care did not necessarily mean the patients were cured or that they received the help they needed. Griffith advised that for treating puerperal mania the 'most important step is to procure sleep, which may be done by the use of chloral in full doses, and a warm bath and some aperient will much assist the operation of the sedative'.[229] For puerperal melancholia he stated 'the patients almost invariably refuse food, and much tact and skill is needed to overcome this difficulty, tonics and feeding being our sheet anchor'.[230] However, Beattie Smith wrote that once 'the physical state has been restored [menstruation], but the mental does not work so well (and some are always crippled mentally), they should be sent out unless actively dangerous or suicidal'.[231] Therefore, late-nineteenth and early-twentieth-century physicians would discharge puerperal patients who could manage their home life, as long as they were not overtly dangerous or suicidal. For 13.5% of the women admitted to Fremantle, puerperal issues were the primary reason for admission.[232]

Table 9.1 Puerperal related admissions for the female patients at the Fremantle Lunatic Asylum (1858 – 1908)[233]

	01 Reg 1858-1873	**02 CB** 1873-1878	**03 CB** 1878-1897	**04 CB** 1901-1908	**05 CB** 1901-1908	**06 CB** 1906-1908	**Total**	**Percentage**
Puerperal mania	1	1	5	-	12	7	**26**	42%
Pregnancy	2	1	-	-	4	2	**9**	14.5%
Lactation	-	-	1	1	5	1	**8**	13%
Miscarriage	-	-	-	-	4	3	**7**	11.3%
Death of Children	-	-	-	-	2	2	**4**	6.4%
Childbirth	-	-	-	-	2	2	**4**	6.4%
Attempted harm of child	-	-	2	-	1	-	**3**	4.8%
Abortion	-	-	-	-	2	-	**2**	3.2%
Puerperal melancholia	-	-	-	-	2	-	**2**	-

[228] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 67.
[229] Griffith, "Puerperal Insanity", 243.
[230] Ibid.
[231] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State", 67.
[232] See Table 4.8 for further details on reasons for admission and 9.1 for details on puerperal terms.
[233] The percentages are based on terms used in diagnosis in the case book notes, of which there were 73; however, only 62 women were admitted for puerperal reasons, and the terms were used multiple times for the same patients.

Premature baby	1	-	-	-	-	-	**1**	1.6%
Puerperium	-	-	-	-	1	-	**1**	-
Infanticide	1	-	-	-	-	-	**1**	-
Puerperal insanity	-	-	1	-	-	-	**1**	-
Demented after confinement	-	-	1	-	-	-	**1**	-
Neglect of nurse in confinement	-	-	-	-	-	1	**1**	-
Post-partum	-	-	-	-	-	1	**1**	-
Not herself after birth	-	-	-	-	-	1	**1**	-
Total of terms used	**5**	**2**	**10**	**1**	**35**	**20**	**73**	-
Total Number of women admitted for puerperal reasons	**5**	**1**	**10**	**1**	**27**	**18**	**62**	**13.7%**

As seen in Table 9.1, there were seventeen terms under the category of puerperal insanity; however, puerperal mania was most often identified by staff. These terms, including puerperal mania and melancholia, and lactational insanity will be explored in further detail in the following sections.

Puerperal insanity, in the Fremantle asylum, could manifest in differing ways, particularly mania or melancholia. However, puerperal melancholia was more depressed than a manic response from new mothers, as evidenced in the cases of Caroline, Alice, and Charlotte. Caroline Waddingham was a twenty-eight-year-old domestic worker admitted in August 1905 with melancholia; her husband stated that 'she changed after the birth of her last child', their fifth, and became jealous of him.[234] In the asylum, Caroline was 'dull' and 'expressionless', remaining unchanged for a year until she was noted as 'doing very well getting fat for discharge' and was released on a month's trial, confirmed in August 1906.[235] Alice Mary Anderson was a twenty-seven-year-old housewife admitted in December 1901 with 'puerperal melancholia' caused by childbirth and 'general symptoms of puerperal mania'.[236] She had a baby one month before admission and had since been suicidal and attempted to drown herself in a river.[237] In the asylum, Alice was 'very restless and excited, weeps and bemoans all day' and was 'very depressed'.[238] However, by February 1902, Alice was 'improving,

[234] *Case Book Female Patients*, 1901-1908, Folio 267, 14 August; 24 October 1905.
[235] Ibid, 2-3 July; 5 August 1906.
[236] Ibid, Folio 13, 30 December 1901.
[237] Ibid.
[238] Ibid, Folio 14 7 January 1902.

is more cheerful and contented' was considered convalescent and was discharged recovered in March.[239] Charlotte Isabella Lyford was a twenty-six-year-old housewife admitted in January 1904 with puerperal melancholia caused by childbirth.[240] Charlotte was 'melancholic in demeanour', made 'unfounded charges of unfaithfulness against her husband', William, and had to be 'forced to eat'.[241] Initially, she remained 'dull and depressed', but by March, she was 'slightly improved'.[242] Within four months, Charlotte was 'discharged recovered'.[243] Caroline, Alice, and Charlotte experienced melancholic symptoms after childbirth, and it was the primary reason for their incarceration. The short admission to the asylum also emphasises that physicians deemed puerperal insanity "curable".

However, as evidenced in Table 9.1, puerperal mania was the most diagnosed form of postpartum mental instability for the women of Fremantle, constituting 42% of puerperal diagnosis. Catherine, Anna, and Rebecca are some of the women who were admitted with puerperal mania. Catherine Blackmore was a twenty-nine-year-old wife of a York farm labourer when she was admitted with 'puerperal mania' in January 1863.[244] Catherine's 'symptoms of deranged intellect showed themselves soon after her last confinement (about four months ago)'.[245] In the asylum, Catherine was delusional with irregular menstruation for several years until November 1865, when her husband applied to the Governor to 'take his wife home' and she was discharged.[246] Anna Le Herriser was twenty-seven years old when she was admitted with puerperal mania in December 1906, one week postpartum.[247] Both her breasts were noted to be empty of milk, and she had no vaginal discharge.[248] In the asylum, Anna was free from active delusions and hallucinations and quickly became quieter and more coherent; however, she was 'inclined to be insolent and interfering'.[249] By April, Dr Blackall noted she was 'less quarrelsome' and was discharged on trial in May, confirmed in June.[250] Rebecca Matilda Middleton was twenty-four years old when she was admitted with puerperal mania in January 1908 by her husband, Henry, after she had 'taken a great dislike' to him and their three-week-old child; she even claimed her husband would kill her.[251]

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[239] Ibid, 14-28 February; 22 March 1902.
[240] Ibid, Folio 151, 11 January 1904.
[241] Ibid.
[242] Ibid, 14 February; 14 March 1904.
[243] Ibid, Folio 152, 4 May 1904.
[244] *Register of Female Patients*, 1858-1873, Folio 60, 26 January 1863; Catherine's daughter Elizabeth Blackmore was also admitted to the asylum in 1895.
[245] Ibid.
[246] Ibid, Folio 83, 2 November 1865; Thirty years later, in October 1895, Catherine was readmitted in her seventies as 'semi-imbecile', and she died in the asylum in 1899.
[247] *Case Book Female Patients*, 1906-1908, Folio 61, 29-31 December 1906.
[248] Ibid.
[249] Ibid, 8 January 1907.
[250] Ibid, 18 April; 16 May; 16 June 1907.
[251] Ibid, Folio 199, 8-9 January 1908.

Blackall noted that her mother Emily Deer had also become mentally affected with melancholia at each pregnancy and had died in the asylum in 1889.[252] Her mother's experience would have influenced the staff at the asylum as heredity was believed to be a cause of insanity. Rebecca was 'resistive and inclined to be troublesome' although 'very cheerful'; she was deemed 'improved mentally and physically' in April but was transferred to Claremont in June 1908.[253] The patient notes for Catherine, Anna, and Rebecca reveal that puerperal mania resulted in manic behaviour, violence, and even bad language, and was the main reason for their admission. These women also reveal that puerperal patients were not always easily discharged.

Women also became affected by puerperal insanity, or the case worsened when their children died; the trauma of this could result in asylum committal. While not noted in her records as having puerperal insanity, Matilda Maria Crampton suffered the sudden loss of her toddler and postpartum aftereffects. Matilda was admitted on 25 November 1894, a twenty-eight-year-old farmer's wife from the Collie Wellington District.[254] She had recently given birth to her third child, also named Matilda Maria, in 1894.[255] Further details are revealed in the *Bunbury Herald*, who reported on 26 September 1894, that Matilda's son, Thomas, had wandered from their home into the bush and had been missing for a week; the search had been abandoned 'as no hopes are entertained of finding the child alive'.[256] They also noted that 'Mrs Crampton, who has been mentally affected for some time, has been removed to her parents' house in Australind, but Mr Crampton is still on the search for traces of the boy'.[257] It was not reported on again, and he was never found; this strained Matilda's already fragile mental state and she was admitted to the asylum a month later. Upon admission, Dr Barnett wrote that she had been twelve months mentally bad and that she 'exposes herself naked to people'.[258] Matilda was generally quiet, although she was occasionally violent. Matilda's husband visited her and wrote about her possible release; however, her behaviour did not improve enough to discharge her. She continued 'very untrustworthy often becomes violent without slightest warning; a powerful woman'; she was transferred to Claremont in 1908.[259] Matilda's younger sister, Mary Hurst, had also previously spent four months in the asylum when admitted by their father, in August 1893, for religious mania.[260] Mary later married George Withers in 1899, and in December 1901, was readmitted by her husband with puerperal mania after

[252] Ibid; *Case Book Female Patients*, 1878-1897, Folio 137, 21 October 1889.
[253] Ibid, 25 April; 2 June 1908.
[254] *Case Book Female Patients*, 1878-1897, Folio 173, 25 November 1894.
[255] BDMWA: *Certificate of Birth:* Matilda Maria (89/1894).
[256] "Topics of the Week," *Bunbury Herald*, Bunbury WA, 26 September 1894, 2.
[257] "Topics of the Week," *Bunbury Herald*, 2.
[258] Ibid.
[259] *Case Book Female (Chronic)*, 1901-1908, Folio 34, 17 December 1907; 2 June 1908.
[260] *Case Book Female Patients*, 1878-1897, Folio 158, 14 August 1893.

she had taken a dislike to him and their child, Albert: 'on all occasions tries to do much bodily harm by throwing crockery at them'.[261] Mary was 'continually asking for her discharge', and by September, she was 'apparently recovered, works well, orderly, kind to other patients' and was released in January 1903.[262] Puerperal related insanity influenced both Matilda and Mary's asylum admissions. In Matilda's case, although not identified as a puerperal patient, this was a contributing factor and suggested there may be more women admitted to the asylum who were suffering, but not identified by staff or recorded in the case books.

In Fremantle, most of the women who were diagnosed with puerperal insanity were married; however, Sarah J. Helverston was the only unmarried woman diagnosed with puerperal mania. Sarah was twenty-five years old when she was admitted on 1 January 1897.[263] She had been living, as a wife, with her uncle who was the father of her children; the uncle had a wife in Melbourne, and this was the 'supposed cause of the woman's insanity'.[264] The *Criminal Law Amendment Act 1892*, stated 'any person who carnally knows a woman or girl who is to the knowledge of such person his daughter or other lineal descendant, or his sister, shall be guilty of felony'.[265] The act added the condition that 'it shall be no defence to any such charge that such carnal knowledge, or attempt or assault with intent to have carnal knowledge, was or was made with the consent of such woman or girl'.[266] Therefore, Sarah's complicity would not have been considered as the law dictated she could not give consent. Sarah remained in the asylum, 'a very powerful big Norwegian girl' who did some work; although she was occasionally violent, mischievous and would remove her clothes.[267] Sarah was transferred to Claremont in 1908 after eleven years incarcerated.[268] In England, it was believed that 'single women were more likely to suffer from puerperal mania'.[269] However, in Fremantle, Sarah was unique, and the prevalence of puerperal mania among married women could be coincidental or perhaps represents assumptions of single mothers that resulted in different diagnoses.

Another aspect of puerperal insanity was lactational insanity. In 1835, Prichard argued that 'many females likewise become deranged during the advanced period of lactation, especially those

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[261] *Case Book Female Patients*, 1901-1908, Folio 7, 17 December 1901; BDMWA: *Certificate of Marriage*: Mary Isabel Hurst and George Edward Withers (1578/1899); *Certificate of Birth*: Albert Edward (5674/1901).
[262] Ibid, Folio 8, 7 January; 19 September 1902; 1 January 1903.
[263] *Case Book Female Patients*, 1878-1897, Folio 48, 1 January 1897.
[264] Ibid.
[265] *Criminal Law Amendment Act 1892*, Part 2, Section 17.
[266] Ibid.
[267] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 41; 100, 25 September; 17 December 1907.
[268] Ibid, 5 June 1908.
[269] Marland, *Confinement of Puerperal Insanity*, 149.

of irritable temperament'.[270] Lactational insanity, also taking manic or melancholic form, was seen to exhaust the system and thus lead to depression.[271] It was also believed to be curable; 'careful handling and removal of the patient from her home and its associated distress would solve her problems'.[272] Theriot notes that lactational insanity was believed to occur in women with several children, not first-time pregnancies.[273] Beattie Smith wrote that lactational insanity was a 'brain exhaustion' and caused 'an acute nerve storm, with visual and aural delusions, fears, suspicions, loss of self-confidence (with its accompanying ideas of the future being sacrificed, the soul lost, and crimes committed), as well as dreads, intrigues, poisoned food and dangerous impulses'.[274] This theory applied in Fremantle as Rebecca and Agnes were discharged after short admissions. Rebecca Rosanna Thompson was twenty-seven years old when she was first admitted in October 1901.[275] However, in August 1905, Rebecca was admitted for the second time with 'mania of lactation' after her two-month-old baby, Harold was born.[276] Dr Blackall observed that 'both breasts full of milk' and she was 'very emotional, very suspicious and restless' and 'jealous about her husband'.[277] In the asylum, Rebecca was often 'noisy and talkative, inclined to be mischievous'.[278] By November she was improving was 'quieter and more tidy, does a little work in the laundry on occasion'.[279] In January 1906 Rebecca was given a month trial, extended in February, and was confirmed discharged in July.[280] Agnes Maria Faul, a thirty-four-year-old housewife, was also admitted in August 1905 with 'simple melancholia of lactation'.[281] The medical certificate reported Agnes was 'very depressed and wishes she were dead, has taken a great dislike to her three month old baby, suffers from insomnia and constant headache, very restless, has threatened suicide and tried to throw herself from a train whilst in motion'.[282] Blackall noted that Agnes had been married for fifteen months, and three months before admission had given birth, 'labour normal. Both breasts have belladonna plasters on them and are giving no trouble. She weaned her baby about a fortnight ago on the doctor's orders because she was sleeping badly and feeling ill'.[283] On admission, she was 'rather confused, but on

[270] Prichard, *Treatise on Insanity*, 306.
[271] Marland, *Dangerous Motherhood*, 26.
[272] Ibid.
[273] Theriot, "Diagnosing Unnatural Motherhood," 73.
[274] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 68.
[275] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 84, 20 October 1901.
[276] *Case Book Female Patients*, 1901-1908, Folio 271, 17-18 August 1905; BDMWA: *Certificate of Birth*: Harold Lytton (2937/1905).
[277] Ibid.
[278] Ibid, 8 September 1905.
[279] Ibid, 16 November 1905.
[280] Ibid, 25 January; 26 February; 2 July 1906.
[281] Ibid, Folio 269, 15-16 August 1905.
[282] Ibid; BDMWA: *Certificate of Birth:* Agnes Mickle (3985/1905).
[283] Ibid; Belladonna was used as a topical ointment to relieve pain or soreness.

the whole coherent…is anxious to get out and see her baby again'.[284] By June 1906 she had 'very much improved' and was given a month's trial and was 'discharged completely cured' in July.[285] Both Rebecca and Agnes' melancholic and suicidal reactions postpartum was reasoned as an issue with lactation and their treatment for this was to stop breastfeeding and spend a short time in the asylum: deeper psychological issues or other physical health issues that could have impacted lactation were seemingly ignored.

However, not all lactational patients were quickly discharged: as evidenced in Matilda and Rachel's cases. Matilda Bovell was twenty-three years old when she was admitted in March 1897 suffering with 'extreme lactation'.[286] In the asylum, Dr Barnett 'ordered the breasts to be daily relieved by the pump and smeared with belladonna and glycerine'.[287] However, the BDMWA records reveal that Matilda had recently given birth to her second son, Frederick, who had died at seven-months-old in 1897.[288] Another factor was that Matilda's mother was a patient in the asylum. When Matilda was admitted, Hannah "Annie" Weir had already been readmitted for the fifth and final time; therefore, heredity would have been considered in Matilda's case.[289] In 1901, Dr Montgomery noted Matilda was 'changeable and occasionally does a little work'.[290] Like her mother, Matilda remained in the asylum and was transferred in 1908. Rachel Smyth was a thirty-two-year-old from Geraldton admitted by her husband, David, in March 1907 with 'melancholia agitata of lactation' caused by the birth of her daughter, Charlotte.[291] Rachel's medical certificate stated she had 'delusions that her neighbours are saying things about her abuses them violently and has threatened them with a knife…watches her husband very suspiciously and thinks someone wishes to take her baby away from her': this may have been due to her son Alexander David's death at nine-weeks-old in 1905.[292] In the asylum, Dr Blackall reported that 'both breasts are full of milk, has been suckling her 9 months old baby' and she showed signs of 'erotism when abdomen is being palpated'.[293] Mentally, Rachel was restless and worried, 'continually repeats "please bring baby to me"'.[294] A week later, Rachel was noted as 'quieter and more contented, does not worry so much about her

[284] Ibid.
[285] Ibis, 13 June; 30 July 1906.
[286] *Case Book Female Patients*, 1878-1897, Folio 201, 25 March 1897.
[287] Ibid.
[288] BDMWA: *Certificate of Birth*, William James (1417/1894), Frederick John (668/1896 d. 1352/1897).
[289] *Female Register Case Book*, 1873-1878, Folio 241, 25 June 1876.
[290] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 43, 4 December 1901.
[291] *Case Book Female Patients*, 1906-1908, Folio 85, 20-21 March 1907; BDMWA: *Certificate of Birth*, Charlotte (93/1906).
[292] Ibid; BDMWA: *Certificate of Death*, Alexander David (2508/1905).
[293] Ibid.
[294] Ibid.

baby; milk has dried up with belladonna plasters'.[295] By April, Rachel had 'the appearance of being worried' and now 'never complains or talks of her baby'.[296] In May 1908, Rachel was transferred to Claremont.[297] Despite being free from delusions, her instability with work and cleanliness led to continued incarceration. Although both women were transferred to Claremont, Matilda was incarcerated for a much longer period, with heredity issues influencing her admission. However, lactational issues resulted in their committals, and they were unable to be quickly discharged.

The women who suffered from puerperal insanity, be it melancholia or mania, were often admitted due to perceived 'bad' behaviours postpartum. The symptoms of melancholia and mania also seemed blurred with varied categorisation, especially when lactation was also included. All the women struggled with various issues such as dislike towards their husbands, children, even becoming violent, or suicidal. Therefore, the women's removal to the asylum was seen as curative, and they were often discharged after short admissions. However, shorter admissions did not apply to every case as further illness, death, or readmission were possible. The women needed help; however, their time in the asylum may not have treated some of their deeper psychological traumas as nineteenth-century physicians did not have the tools or understanding surrounding this issue. Despite this, it further emphasises nineteenth-century connections between insanity and women's bodies. However, puerperal insanity could have other extreme consequences, with possible violent outcomes, mothers attempting to or harming their children.

Infanticide: Puerperal Extremes

The most violent and morally repugnant form of puerperal insanity was when mothers attempted to or succeeded in harming their child. Matthews writes that the ideology of motherhood proclaimed that mothers must protect their children from all harm and therefore, the notion of women hurting their children is portrayed as unthinkable, even in modern society.[298] Infanticide and postnatal depression are not inextricably linked, but it is a possible outcome of the most severe kind. Chesler notes that modern women have a ten to fifteen per cent chance of developing more significant symptoms of depression and anxiety after pregnancy and about one to two per one thousand women have postnatal psychosis with delusions.[299] However, during the nineteenth-century 'infanticide by married women was considered so shocking and unlikely that the only motive

[295] Ibid, 27 March 1907.
[296] Ibid, 17 April 1907.
[297] Ibid, 24 February; 11 May 1908.
[298] Matthews, *Good and Mad Women*, 179.
[299] Chesler, *Women and Madness*, 105.

assigned was insanity'.[300] This belief was based on the assumption that married women had no motive for committing infanticide as unlike unmarried women, there was no shame attached to their children.[301] Unmarried women were not exempt from blame in infanticide cases, but it was suggested that they were victims of circumstance, betrayed and alone.[302] Although, the general attitude towards infanticide was that it 'represented the antithesis of female nature, a total rejection of maternal ties, duties and feelings'.[303] There is certainly a case to explain these actions as an extreme symptom of puerperal insanity, the result of a mental disorder that has driven the despondent woman to violence.[304] The women at Fremantle that attempted violence against their infants faced incarceration and social shame.

The female patients who attempted to harm their children or became a danger to them would often remain incarcerated with deeper psychological issues unable to be cured. However, this was not always the case, such as Elizabeth Mary Donovan. Elizabeth was a thirty-year-old from Vasse admitted on 13 July 1894, with 'hereditary delusions destructive mania'.[305] Already mother to five children, Elizabeth had threatened 'to destroy her baby', six-month-old Eva.[306] Elizabeth was the daughter of notorious patient Anne Hawkins, who was still incarcerated when Elizabeth arrived; this was noted several times in Elizabeth's records. In the asylum, Dr Barnett observed that Elizabeth was 'violent and throws articles at people. Fancies home on fire. Falls off the bed and has to be put in the padded room for her safety. Can only be fed with much difficulty'.[307] By August, there was a slight improvement in Elizabeth's behaviour, and after a letter from her husband, James, her improvement continued.[308] In September, she was discharged into her husband's care after two months incarcerated.[309] Elizabeth was fortunate her husband wanted her at home as her mother's case was a significant factor in assessing her mental state.

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[300] Dana Rabin, "Bodies of Evidence, State of Mind: Infanticide, Emotion and Sensibility in Eighteenth-century England," in *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000*, ed. Mark Jackson (Aldershot: Ashgate, 2002), 76.
[301] Marisha Caswell, "Mothers, Wives and Killers: Marital Status and Homicide in London, 1674-1790," in *Female Transgressions in Early Modern Britain: Literary and Historical Explorations*, eds. Richard Hillman and Pauline Ruberry-Blanc (Oxon: Routledge, 2016), 114.
[302] Marland, *Dangerous Motherhood*, 154.
[303] Ibid, 171.
[304] Ibid.
[305] *Case Book Female Patients*, 1878-1897, Folio 166, 13 July 1894.
[306] Ibid; BDMWA: *Certificate of Birth*: James Henry (23949/1883), Thomas Michael (25734/1884), Edward Robert (29045/1886), Edith May (110/1889), Laura Elizabeth (1416/1890), Eva Ann Christiana (120/1894), Frank Rees (1728/1895), Alma Ethel (2280/1896), Arthur Joseph (4499/1899), and May Catherine Alice (5496/1902).
[307] Ibid.
[308] Ibid, 14-30 August 1894.
[309] Ibid, 22 September 1894.

Although, as experienced by patients, Jessie, Maggie, and Catherine, there were consequences for violence towards their children. Jessie Basset was a forty-two-year-old 'semi-imbecile' admitted in April 1879, 'her husband is an imbecile in Mount Eliza', and the certificate of insanity stated 'she attempted to kill her child'.[310] Jessie remained in the asylum, and in 1903, Dr Montgomery reported she was 'faulty in her habits, will never improve'.[311] By 1908, she was noted as having 'senile dementia' and was transferred to Claremont in June after twenty-nine years incarcerated.[312] Margaret "Maggie" Law Sinclair Hare, a twenty-five-year-old Scottish 'tailoress', was admitted for 'family trouble' and puerperal mania in July 1902.[313] She had been acting 'strangely towards child, covers it with pins and needles, says it must walk (it is only 14 months old and very weak)'.[314] Though by September, Maggie had 'much improved, normal emotions' and was discharged recovered.[315] However, in August 1904, Maggie was readmitted, she was delusional and had 'painted her son white, walked about city in nightdress, fits of depression alternating with fits of temper'.[316] In her physical exam, it was reported Maggie had bruises on her face, chest, arms and legs, and 'some of the hair at the top of her forehead seems to have been pulled out'.[317] Whatever happened to Maggie before admission was not reported and she remained in the asylum with 'no improvement' and was transferred to Claremont in June 1908.[318] Catherine Kelsall, a married thirty-four-year-old tailoress from Kalgoorlie, was admitted with melancholia of lactation in September 1905.[319] Dr Blackall noted, she had 'weaned her baby about 3 weeks… complains of prolapses uteri'.[320] He stated, 'when addressed firmly and quietly she becomes perfectly coherent and explains how suckling her child combined with a lot of worry has upset her' and 'as she was very much in need of sleep she was not subjected to a very searching examination'.[321] The BDMWA records reveal that Mary was Catherine's fifth child; she had also lost her daughter Ivy at sixteen months in 1902: another possible factor in her mental state.[322] Although 'still lazy and excitable and violent at times, always untidy', Catherine was discharged improved on a month's trial in March 1906.[323] However,

[310] *Case Book Female Patients*, 1878-1897, Folio 38, 4 April 1879.
[311] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 13, 5 March 1903.
[312] Ibid, 24 February; 12 June 1908.
[313] *Case Book Female Patients*, 1901-1908, Folio 45-46, 17 July 1902.
[314] Ibid.
[315] Ibid, 5-19 September 1902.
[316] Ibid, Folio 189, 3-4 August 1904.
[317] Ibid.
[318] Ibid, Folio 190, 12 June 1908.
[319] Ibid, Folio 275, 8 September 1905.
[320] Ibid.
[321] Ibid.
[322] Ibid; BDMWA: *Certificate of Birth:* Francis Murrow Seddon (591/1898), Mary Dorothy Kathleen (699/1899), Ivy Monica (1196/1901 d. 730/1902), Gladys Catherine (1704/1903), Mary Olive Veronica (1808/1905).
[323] Ibid, 15-31 March 1906.

she was readmitted within a month after she endangered her child: 'thought she had learnt surgical nursing and would practice on the baby'.[324] Blackall noted, 'does not show any improvement whatever'; Catherine was transferred to Claremont in May.[325] Jessie, Maggie, and Catherine threatened nineteenth and early twentieth-century ideals of womanhood by rejecting their role as the nurturing mother through violent and dangerous behaviour. The danger these women posed to their children resulted in assessments of insanity and committal in the asylum.

However, the only reported crime of infanticide was in Mary Goodall's case. Mary was a twenty-four-year-old married Roman Catholic admitted for dementia on the recommendation of a Perth medical board on 13 September 1865.[326] Mary Murphy had arrived in the colony via the *West Australian* in October 1859 and married farm labourer and expiree William Goodall in Bunbury on 3 February 1860.[327] In 1863, she gave birth to Elizabeth and in 1864 to son James.[328] However, the main reason for Mary's admission to the asylum in 1865 was that she had 'killed her child [nine-month-old James] about 2 months ago by stabbing it in a most barbarous manner'; it was 'stated that circumstances had occurred which might account for her reason', however, no history was sent with her.[329] Dr Attfield reported, she was 'incoherent in talk, aspect quiet and demure, when spoken to is restless and busy appears to wish to leave the room, wanders in thought and speech when spoken to, memory defective'.[330] Two weeks after admission, she appeared 'to be about three months gone in the family way'.[331] On 4 October 1865, Mary stood trial at Perth Supreme Court; *The Perth Gazette and West Australian Times* reported that Mary was 'charged with the murder of her son James Goodall' and the 'jury was impanelled to decide as to the sanity of the prisoner at the present time'.[332] *The Inquirer and Commercial News* added that 'the prisoner was given the opportunity of recording her plea, and on being questioned, made some confused answer, and it was evident from her manner that she was suffering from a deranged mind'.[333] Therefore, Attfield's 'testimony alone would guide them in arriving at a decision'.[334] Attfield stated:

> I am surgeon at the Lunatic Asylum, Fremantle. I know the prisoner as Mary Goodall since the 13th of last month. She has been in the lunatic asylum; I have seen her there every day. I have considered her perfectly insane from the first time I saw her; in conversation and the

[324] Ibid, 13 April 1906.
[325] Ibid, Folio 276, 11 January; 17 April; 19 July; 24 October 1907; 11 May 1908.
[326] *Register of Female Patients*, 1858-1873, Folio 84, 13 September 1865.
[327] Erickson, "Bicentennial Dictionary,": G, 1225.
[328] BDMWA: *Certificate of Birth*: Elizabeth (7054/1863), James (8170/1864).
[329] Ibid.
[330] Ibid.
[331] Ibid, 26 September 1865.
[332] "Supreme Court: Criminal Side," *The Perth Gazette and West Australian Times*, 6 October 1865, 3.
[333] "Supreme Court: Criminal Side," *The Inquirer and Commercial News*, 11 October 1865, 2.
[334] "Supreme Court," *The Inquirer and Commercial News*, 2.

> answers to questions led me to believe so. She spoke incoherently, and seemed to labor [sic] under delusion. I saw her again this morning, and believe she is still quite insane.[335]

Therefore, 'the jury, after a short deliberation, recorded their opinion that the prisoner was insane' and 'His Honor [sic] the Chief Justice formally pronounced that the prisoner should be kept in strict custody till her Majesty's pleasure was known'.[336] Mary returned to the asylum 'incoherent and partly imbecile' and was 'proved not to be pregnant'.[337] Attfield noted she had 'become very stout and cheerful', she had 'an insane look however and is frequently silly in her actions and manner'.[338] By August, Mary was recommended for discharge by a medical board and was released after a year incarcerated.[339] While out of the asylum, Mary and William had another baby, also named Mary; however, she died within the year.[340] On 15 June 1868, Mary was readmitted from Bunbury, her baby's death a possible contributing factor.[341] After her readmission she was not reported on for a year until July 1869 when she was noted to have 'very much improved, appears to be in every respect quite rational. Often asks to be discharged, appears to be chiefly anxious to see her children'.[342] In August 1869, she was 'discharged and given over to her husband'.[343]

During this period Mary Goodall's life took another dramatic turn: her husband William died on 9 November 1872, and by February 1875, she was 'charged with being destitute and having no visible means of support'.[344] Sergeant McLarty, the arresting officer, 'stated he had known the prisoner for some time, and believed her to be a person of very weak intellect'; the judge in her case 'considered it would only be an act of charity to detain her for the opinion of a medical officer, and sentenced her to 14 days confinement for that purpose'.[345] In February 1877, Mary was identified with Mary Ann Clarke as 'prostitutes' and charged with 'being loose, idle, and disorderly persons': they were both sentenced to one-month hard labour by Perth Police Court.[346] In July 1878, she was again identified as a 'prostitute' and 'being destitute and having no visible means of support'; she received fourteen days hard labour in Perth Gaol, released on 9 August.[347] Mary was readmitted to

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[335] Ibid.
[336] Ibid.
[337] *Register of Female Patients*, 1858-1873, Folio 84, 20 January 1866.
[338] Ibid, 1 August 1866.
[339] Ibid, 20-25 August 1866.
[340] BDMWA: *Certificate of Birth*: Mary (10057/1867); *Certificate of Death*: Mary (3955/1868).
[341] *Register of Female Patients*, 1858-1873, Folio 101, 15 June 1868.
[342] Ibid, 25 July 1869.
[343] Ibid, 9 August 1869.
[344] Erickson, "Bicentennial Dictionary,": G, 1225; "Perth Police Court," *The Western Australian Times*, Perth WA, 16 February 1875, 3.
[345] "Perth Police Court," *The Western Australian Times*, 3.
[346] SLWA: *Police Gazette*: March 1877, 35.
[347] Ibid, July-August 1878, 124; 134.

the asylum a week later on 15 August 1878.[348] Then aged forty, Mary had '3 children at orphanage and has a baby of 10 months old in her arms. The latter is in danger in the midst of the lunatics'.[349] Dr Barnett 'communicated at once with the Colonial Secretary' about the baby, who advised 'to send the baby to Poor House'; Barnett gave Assistant Matron Nugent the task of removing the baby, providing money for return passage to Perth.[350] In the asylum, Barnett reported 'on examination find Mrs Goodall quiet and reasonable in conversation, manner is good—no excitement—she is reported to have behaved quietly and rationally since she came in'.[351] In early 1879, Mary wrote 'absurd' letters and was 'rude and troublesome'; however, by July, she had 'improved is quite quiet and well behaved'.[352] In October, Barnett wrote 'is so quiet and sane that I shall at end of month discharge if there is no relapse meanwhile'; two weeks later, she 'remains perpetually quiet and sane' and was 'discharged convalescent' on 31 October 1879.[353] Mary's life after the asylum did not improve with several arrests for vagrancy, prostitution, and drunkenness. In February 1885, after being charged with vagrancy, Mary stated she had spent two years in the Perth Poor House and left around Christmas where she 'had several times taken a drop of drink, and had nowhere to live'.[354] The Police Magistrate reported, it would be 'an act of humanity to send the wretched creature to gaol for three months, where she would be taken care of…there ought to be some place other than a prison for persons in her unfortunate condition'.[355] Mary was suffering, and her mental state surrounding the murder of her child was seemingly not addressed in-depth, merely punished. Her traumas were further compounded by her husband's death and economic instability, leading to criminal life and further incarceration. Whether Mary's asylum incarceration "cured" her puerperal insanity is unclear as her readmission suggests her susceptibility to the same issue.

The extremes of puerperal insanity resulted in threats or attempts on children's lives by their mothers. These actions were and still are, viewed as an aberration of maternity and femininity, and are almost unthinkable. The women who suffered from puerperal insanity manifested in various ways and required help; however, the asylum was the only place that nineteenth and early-twentieth-century societies could offer.

[348] *Female Register Case Book*, 1873-1878, Folio 291, 15 August 1878.
[349] Ibid.
[350] Ibid, 22 August 1878.
[351] Ibid.
[352] *Case Book Female Patients*, 1878-1897, Folio 13, 13-25 March; 5 July 1879.
[353] Ibid, 14-31 October 1879.
[354] "Perth Police Court," *The West Australian*, Perth WA, 10 February 1885, 3.
[355] "Perth Police Court," *The West Australian*, 3.

Chapter Conclusions

The connection between madness and the female body was well established by nineteenth-century medical professionals, and the female reproductive system was the maddest of all. This chapter examined how the connection affected the women in Fremantle through menstruation, pregnancy, and puerperal insanity.

The first section analysed how menstruation was treated as pathological; menstruation was often tracked and noted during times of bad behaviour, linking the two. Menopause was also deemed to affect women's mental states while they reconciled the end of their fertile years. The desired outcome of menstrual cycles was pregnancy. Women were in constant physical and mental danger in regards to pregnancy and childbirth as the process was thought to make them unstable. Further emphasising the possible ways women suffered during pregnancy and a lack of understanding of trauma by nineteenth-century physicians. Lastly, puerperal insanity was seen as the ultimate in female mental weakness, an inability to handle their role as a mother. This affliction was deemed to be "curable" with short asylum admissions; however, the quick patient turnaround did not necessarily translate into a healthy mental state for the women. Violence towards their children, however, was the worst of all. Further nineteenth-century misunderstandings of trauma and women's postpartum responses resulted in suffering and potentially left the patients untreated and susceptible to the same issues.

The women with these afflictions were incarcerated in the Fremantle asylum due to their biological functions. The nineteenth-century connections made by physicians on women's bodies and mental state reveal that most would have suspected women to be inherently mad. These women's bodies were generally the main reason for admission, and their cycles, pregnancies, and behaviour affected the longevity of their stay and their release. Thus, this chapter provides further insights into the patient experience, management, diagnoses and treatment. The following chapter of the thesis also contributes to the experiences of the female patients in Fremantle with an examination of the deviant women deemed morally insane.

CHAPTER TEN

Moral Insanity: Deviant Women

Moral insanity was an emerging theory in the eighteenth and nineteenth centuries explored in Europe as physicians and psychiatrists began to deal with patient's personal, social, and ethical problems; with a greater focus on moral rather than medical issues.[1] French physician Philippe Pinel noted that insane 'passions were generally considered in connection with morals'.[2] Moral insanity was first described in detail by Prichard in 1835, he stated moral insanity was 'a perversion of natural feelings, and an ungovernable disposition to give way to violent passion'.[3] He stated that 'some [morally] insane persons display their condition by a propensity to commit every species of mischief'.[4] He noted that 'eccentricity of conduct, singular and absurd habits, a propensity to perform the common actions of life in a different way from that usually practised, is a feature in many cases of moral insanity'.[5] However, when 'such phenomena are observed in connexion with a wayward and intractable temper, with a decay of social affections, an aversion to the nearest relatives and friends formerly beloved—In short, with a change in the moral character of the individual, the case becomes tolerably well marked'.[6] Kitching also emphasised the connection between morality and insanity in 1857:

> When disease invades the general structure of the brain, all the faculties, mental, moral, and instinctive, succumb to the devastating plague. With the inability to reason and to judge, the faculty of distinguishing right from wrong may be lessened or destroyed; the nicety of moral perception may be obscured, the control of emotions and the instincts may be more or less lost, and the whole physical life enervated.[7]

Australian physician Griffith noted in 1885 that 'patients suffering from moral insanity are almost invariably immoral sexually, and are the most cunning of liars'.[8] The nineteenth-century emphasis on insanity weakening morality allowed the definition of moral insanity to be stretched to include almost any 'behaviour regarded as abnormal or disruptive by community standards'.[9] It was now possible that traditional categories of madness like' mania, dementia, and melancholia, might be

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[1] Szasz, *Myth of Mental Illness*, 11.
[2] Pinel, *A Treatise on Insanity*, xi.
[3] Prichard, *Treatise on Insanity*, 165.
[4] Ibid, 22.
[5] Ibid, 23-24.
[6] Ibid.
[7] Kitching, *Principles of Moral Insanity*, 23.
[8] James De Burgh Griffith, "Lunatics in Private Practice," *Australian Medical Journal* vii, no. 11 (November 1885): 505. http://hdl.handle.net/11343/23149.
[9] Showalter, *Female Malady*, 29.

brought on by moral causes'.[10] In 1885, Daniel Hack Tuke outlined types of moral insanity. Firstly 'a constitutional defect in the normal balance between the passions and the power of moral control or will'; secondly, 'a wellmarked change of character took place in regard to the disposition and the higher sentiments, whether from moral shock or from fever' which he argued 'would comprise cases of sexual impulse'; the next was when 'the emotional disorder was manifested simply by the feeling of intense depression'; and lastly and most usual 'one in which drink was clearly an important factor in the production of the symptoms, and those whose craving for stimulants really amounts to irresistibility'.[11] These categories themselves could contain many variations. Showalter writes that Victorian doctors believed that in most cases insanity was preventable if individuals 'used their willpower to fight off mental disorder and to avoid excess': 'mental health was to be achieved by a life of moderation and by the energetic exercise of the will'.[12] Foucault noted that the institutions of morality (asylums) were established in which an astonishing synthesis of moral obligation and civil law was affected; therefore moral error had assumed the aspect of a transgression against the written or unwritten laws of the community.[13]

For nineteenth-century women, moral insanity included any behaviour considered deviant. Hack Tuke wrote in 1885:

> When we see a young lady in a family who has had the same advantages of a good education and a moral training as the rest, but who is the demon instead of the angel of the house, is an inveterate liar, a thief, and prone to startling irregularities of conduct; and when, although there is nothing in the degree of intelligence which prevents her taking her place in society like other people, there is in the close connection of the immoral acts with the evolution of the system, in the family history, or in some moral shock or traumatism, significant indications of a physical cause of this moral instability which separates it from mere vice; I say, when such a combination presents itself, we witness what every mental physician must have met with, and what we are bound to regard as abnormal and morbid, by whatever name we choose to call it.[14]

The diagnosis of moral insanity was more often a label of moral judgment that applied to the women who had transgressed nineteenth-century societal expectations of womanhood. The female patients at Fremantle discussed in this chapter were not always noted as diagnosed with moral insanity but fell into some of the categories such as pruriency, alcohol and drug consumption, and prostitution.

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[10] Ibid.
[11] Daniel Hack Tuke, "Moral or Emotional Insanity," *Journal of Mental Science* 31, no. 134 (1885): 181-182. doi: 10.1192/bjp.31.134.174; Hack Tuke (1827-1895) was the son of Samuel Tuke and grandson of William Tuke, the founders of the York Retreat.
[12] Showalter, *Female Malady*, 30.
[13] Foucault, *Madness and Civilisation*, 56.
[14] Hack Tuke, "Moral or Emotional Insanity," 175.

Through analysis of these women, this chapter reveals the morally reprehensible behaviours for nineteenth and early twentieth-century women and the consequences for displaying them publicly.

'Distinctly erotic': Pruriency and the Female Patients

In Fremantle, moral insanity included pruriency (sexual behaviour). Sex in the nineteenth century, 'whether coitus, masturbation, or even "improper excitement of the imagination"', was believed to have created nervous excitement in the uterine organs.[15] This association created moral concerns for physicians who, as previously discussed, were already convinced of the connection between insanity and women's bodies. However, for those in the nineteenth century, sexual desire did not exist independently of women's reproductive function, and as those functions were inextricably linked to madness, sexual behaviours also had this connection. Foucault wrote that 'power is essentially what dictates its law to sex. Which means first of all that sex is placed by power in a binary system: licit and illicit, permitted and forbidden'.[16] He noted that up to the end of the eighteenth century, 'canonical law, the Christian pastoral, and civil law' determined the division between licit and illicit and their attitudes 'centred on matrimonial relations' and marital obligation. [17] By the nineteenth century, 'the legitimate couple, with its regular sexuality, had a right to more discretion', however, the illicit sexualities came under intense scrutiny: the sexuality of children, mad men and women, criminals, homosexuals, reveries, obsessions, and petty manias.[18] Gayle Rubin writes that sex is always political and in the late nineteenth century powerful social movements to eliminate vice, including prostitution and masturbation, 'left a deep imprint on attitudes about sex, medical practice, child-rearing, parental anxieties, police conduct, and sex law'.[19]

Robert Muchembled states that the Victorian system left men space for sexual freedom by confining women within the 'cage of matrimony' and the moderation of the sexual appetite.[20] Baumeister and Twenge argue that the 'suppression of female sexuality is a pattern of cultural influence by which girls and women are induced to avoid sexual desire and refrain from sexual behaviour'.[21] However, the Victorian double standard consisted of judgments that 'specific sexual behaviours are acceptable for men but unacceptable for women'; this was a 'sign that some messages of sexual restraint had been aimed primarily at women'.[22] Therefore, Victorian attitudes to

[15] Scull, *Hysteria*, 74.
[16] Foucault, *History of Sexuality*, 83.
[17] Ibid, 37.
[18] Ibid, 38.
[19] Rubin, *Deviations*, 138.
[20] Muchembled, *Orgasm and the West*, 199.
[21] Roy F. Baumeister and Jean M. Twenge, "Cultural Suppression of Female Sexuality," *Review of General Psychology* 6, no.2 (2002): 167, doi: 10.1037//1089-2680.6.2.166.
[22] Baumeister and Jean M. Twenge, "Cultural Suppression of Female Sexuality", 167.

sex also varied depending on class and gender. The morality of the labouring classes became a public matter in the mid-nineteenth century as concerns grew over illegitimate births.[23] This concern became particularly important for women, as 'an unchaste woman could impose illegitimate children upon her husband, thereby undermining inheritance and paternal fidelity'.[24] Doctors perpetuated this idea by arguing that sexuality expressed in women was unhealthy and unnatural. Prichard noted, that 'sensual vices are frequent causes of insanity'.[25]

Thus, the failure to recognise female sexuality's essential difference from men's, and unsatisfying marital sex combined with discouraged masturbation, resulted in female sexuality asserting itself through hysteroneurasthenic disorders.[26] It was impossible to believe that there was a flaw in the traditional penetration hypothesis; therefore, the fault must be with women.[27] To desire pleasure and not procreation was considered selfish of women, especially married women, and was regarded as one of the main ills of Australia's new colonial society.[28] Coleborne writes that meanings produced around 'formations of sexuality can be traced along imperial routes' and that 'the very politics of colonisation…were deeply implicated in the creation of meanings around sexuality'.[29] Anne Summers suggests that women's sexual satisfaction was sacrificed to the imperatives of reproductive sexuality, as the object of colonisation was to ensure that women reproduced within the approved kinship structure, the target of this process was women's bodies.[30] It is not necessary for women to be aroused to conceive; thus it was in the interest of the colonisers to keep women ignorant about their sexuality to prevent it from erupting as a demanding and consuming force.[31]

In Fremantle, there were several examples of these anxieties surrounding pruriency; for instance, in the reasons for admission for patients Bertha, Margaret, and Frances. Bertha Louisa Ranford was a single eighteen-year-old described as 'distinctly erotic' with 'internal trouble' when her father admitted her in March 1907.[32] Margaret Clarke was a twenty-nine-year-old single domestic worker admitted in February 1905 with hysteria.[33] Her medical certificate noted that

[23] Faramerz Dabhoiwala, *The Origins of Sex: A History of the First Sexual Revolution* (London: Penguin Books, 2013), 118-119.
[24] Dabhoiwala, *Origins of Sex*, 119.
[25] Prichard, *Treatise on Insanity*, 205.
[26] Maines, *Technology of Orgasm*, 3-5.
[27] Ibid, 6.
[28] Bongiorno, *Sex Lives*, 59.
[29] Coleborne, "Insanity, Gender and Empire," 91.
[30] Summers, *Damned Whores*, 344.
[31] Ibid.
[32] *Case Book Female Patients*, 1906-1908, Folio 77, 3-4 March 1907.
[33] *Case Book Female Patients*, 1901-1908, Folio 237, 27 February 1905.

although she was rational at times, she would often sing in a loud voice, become irrational, and 'erotic'.[34] Frances Edith Davidson was aged thirty-two and married when admitted for the second time in October 1904, due to childbirth; however, it was her 'erotic state of mind' that concerned Dr Blackall, as it made a thorough medical examination of her 'impossible'.[35] She was described as erotic with filthy habits and had been discovered drinking her urine.[36] In November, Blackall noted she was always up to mischief, wrote letters full of nonsense, was untidy in her dress, and of an 'erotic tendency'.[37] Bertha, Margaret, and Frances' cases did not specify in what ways their eroticism manifested, but it influenced their admissions and diagnoses.

Pruriency was also a significant factor in Sarah Burns' diagnosis and continued incarceration. Sarah was a twenty-four-year-old single Roman Catholic, and literate maidservant admitted on 12 July 1858.[38] Her history revealed that she had left Dublin and arrived in the colony aboard the *Sabrina* in June 1853.[39] Sarah had gone into service for one year when she left for the Perth Poor Home 'because there was too much work to do'; she remained there until her admission to the asylum.[40] In September 1859, Dr Attfield noted there was an indication that Sarah had a very prurient disposition and had no sense of shame whatsoever.[41] Three months later, he wrote that her pruriency was frequently manifested and required constant watching and stated: 'I am afraid she will never recover her full intellectual power'.[42] Attfield's observation of Sarah's intellect was linked to her pruriency; her sexual tendencies were preventing her mental recovery. In 1862, Attfield reported no alteration in Sarah's case; 'nymphomania is sometimes very manifest, she requires much looking after on account of the latter propensity and also on account of a general inclination for mischief which characterises her'.[43] Later that year, he wrote that Sarah was 'morally insane' which could only be in reference to her pruriency.[44] Her behaviour continued much the same until January 1869, when although she remained irrational, she was cheerful, obedient, with less prurient tendencies.[45] By June 1870, Sarah was working hard at washing, scrubbing, and any housework; she also read a great deal.[46] However, Sarah was frequently excited and noisy, but only at men.[47] The

[34] Ibid, 1 March 1905.
[35] Ibid, Folio 207, 22-24 October 1904.
[36] Ibid.
[37] Ibid, 23 November 1904.
[38] *Register of Female Patients*, 1858-1873, Folio 7, 12 July 1858.
[39] Ibid.
[40] Ibid.
[41] Ibid, Folio 24, 4 September 1859.
[42] Ibid, 7 December 1859.
[43] Ibid, Folio 48, 4 June 1862.
[44] Ibid, 24 October 1862.
[45] Ibid, Folio 82, 10 January 1869.
[46] Ibid, Folio 136, 18 June 1870.
[47] Ibid.

improvement did not last as, by April 1871, Dr Dickey noted her mind was partly fatuous, and she had 'erotic tendencies'.[48] Sarah remained in the asylum without change for forty-six years, until her death on 6 July 1904, estimated to be eighty years old.[49] Her prurient behaviour seemingly prevented her recovery and discharge.

However, indecent exposure was also a common prurient issue. In the nineteenth century, for a woman to exhibit a naked ankle was considered immodest.[50] In Britain and the Australian colonies, 'nudity during sexual relations was regarded as the ultimate in naughtiness', 'total nudity was redolent of the brothel, and virtuous women were ashamed to undress in front of their husbands'.[51] Therefore, any kind of nudity outside of these tight constraints would be morally unacceptable. This attitude was certainly the case for the women in Fremantle who exposed themselves indecently; it was one of the main reasons for admissions. Margaret Sheedy was aged forty when admitted from Coolgardie in March 1897 for sunstroke; her previous occupation was noted as 'sly grog seller'.[52] She was a 'vile' and 'vulgar' woman who was very indecent, abusive and exposed herself whenever possible.[53] Aside from exposing herself, the sale of illegal alcohol was another moral offence for women. Emily Fleay was forty-seven years old when her husband admitted her in August 1905; she had 'degeneration of optic nerve', had used violent language, and indecently exposed herself.[54] Emily was noted as having a 'distinct erotic tendency'.[55] Margaret Emily Frances Muriel North was aged sixteen when her father admitted her in January 1906 for acute mania, general weakness, and for 'trying to take her clothes off'.[56] All of these women were admitted for indecent exposure considered so deviant it warranted asylum incarceration.

Catherine McCormick was also prone to exposing herself. Catherine was a twenty-three-year-old single Irish Roman Catholic, admitted on 15 October 1858.[57] Her history revealed, she had arrived in the colony five months previous to her admission, aboard the *Emma Eugenia* where she had displayed signs of eccentricity.[58] Upon arrival in the colony, Catherine entered domestic service in York but left due to eccentricity and had, for five weeks, been in the Perth Colonial Hospital.[59] In

[48] Ibid, Folio 82, 19 April 1871.
[49] *Case Book Female (Chronic)*, 1901-1908, Folio 1, 6 July 1904.
[50] Phillip Carr-Gomm, *A Brief History of Nakedness* (London: Reaktion Books, Limited, 2012), 241.
[51] Muchembled, *Orgasm and the West*, 162.
[52] *Register of Patients Fremantle Asylum*, 1857-1904; AU WA S4507, Cons 2723 1, 4-5.
[53] *Case Book Female (Chronic)*, 1901-1908, Folio 42, 7 September 1904; 11 December 1905.
[54] *Case Book Female Patients*, 1901-1908, Folio 265, 2 August 1905.
[55] Ibid.
[56] Ibid, Folio 311, 1-3 January 1903.
[57] *Register of Female Patients*, 1858-1873, Folio 16, 15 October 1858.
[58] Ibid.
[59] Ibid.

the asylum, the matron reported that Catherine heard voices accusing her of murder and that she was apt to be choleric.[60] Dr Attfield noted: 'her appearance and demeanour (as indicated by her slovenly attire, her stony and, at the same time, irascible expression of eye, her gestures and postures) and her conduct (as indicated by her incoherent language and occasional passionate outbreaks) both show the highly disordered state of her intellect'.[61] By December 1859, Attfield recorded slow improvement: Catherine had learned to write since her admission; however, she had a bad memory and was at times very irascible.[62] By 1870, it was noted Catherine was the 'most hardworking woman in the asylum at any house or needlework' and that although her memory was defective and her intelligence disordered, she was not as moody, ill-tempered, or violent as previously.[63] However, in March 1873, at the Woodman's Point picnic, Catherine had to be restrained when she revealed a 'disposition to strip herself'.[64] Then, weeks later, she exposed herself in the garden and was punished with an hours confinement and loss of breakfast.[65] This response to Catherine's actions reveals the intolerance the staff had for any indecent exposure. It impeded her improvement considerably as almost a year passed before the physicians made favourable comments on her behaviour. By April 1884, Catherine was much debilitated with no appetite, on a full milk diet with porridge and tea, and her 'usual special comforts'.[66] On 5 July 1886, Catherine died 'without suffering'.[67] Catherine's "bad" behaviour and especially her indecent exposure prevented her discharge, despite her general improvements and willingness to work. It is also important to note that she was in the colony alone and single; therefore, her discharge would have been difficult.

The reporting on the female patients at Fremantle who were prurient, reveal that pruriency and indecent exposure were critical moral issues and compelling factors in admission. Improper sexual conduct especially displayed publicly, had a social backlash in nineteenth-century society. Often the women's moral transgressions would override any other improvements, and they would remain incarcerated for several years for behaving outside of the socially determined feminine ideal.

Self-Abuse: Masturbation in the Asylum

Masturbation was another aspect of unacceptable sexual behaviour, with links to madness for men and women. Masturbatory insanity was 'a staple of early nineteenth-century psychiatric texts and

[60] Ibid.
[61] Ibid, Folio 27, 9 March 1859.
[62] Ibid, Folio 30, 7 December 1859.
[63] Ibid, Folio 137, 18 June 1870.
[64] Ibid, Folio 162, 4 March 1873.
[65] Ibid, 27 March 1873.
[66] *Case Book Female Patients*, 1878-1897, Folio 78, 1 April 1884.
[67] Ibid, 5 July 1886.

had acquired new credibility through the growing emphasis on the importance of the conservation of energy'.[68] 'By the 1850s, Victorian medical and social commentators were asserting that masturbation for both sexes led dangerously to "a spectrum of physically horrible diseases" that finally brought the self-abuser to a state of madness'.[69] Some of the perceived consequences were mutilation, blindness, aggression, kidney disorders, a deformed spine, and madness.[70] Female masturbation was seen as 'unchaste and possibly un-healthful'.[71] In the mid-1800s, Samuel La'mert declared masturbation to be 'the surest, if not the most direct, route towards death'.[72] In 1871, William Acton wrote, that 'it is rather an habitual incontinence eminently productive of disease'.[73] Most importantly, masturbation was seen as a perversion of the primary purpose of sex, reproduction.[74] Thus, 'masturbation by girls was dangerous because it might make the girl selfish in relations with her husband in the future'.[75] Therefore, the shame attached to masturbation carried a substantial social penalty. Clouston argued in 1887 that in female hysterical patients 'the habit of masturbation is common'.[76] Australian colonial doctors also viewed masturbation as a great and serious evil.[77] Therefore, there was a significant amount of medical attention on preventing masturbation; such as clitorectomy. In Fremantle, there was no indication that extreme methods were undertaken and the staff implemented the more popular moral treatment method, that masturbation 'could be prevented only by close and constant supervision; the patient must be watched night and day'.[78]

Self-abuse and insanity were linked in the nineteenth century and evident in the Fremantle asylum. However, masturbation was often not listed in the reasons for incarceration or medical certificates but noted in later entries. Yet, in Mary Daisyletta and Mary Anne's cases, their self-abuse was unusually identified in the medical certificate. Mary Daisyletta Craig was aged eighteen when she was admitted as an imbecile in January 1906; the medical certificate reported 'practices self-

[68] Scull, *Hysteria*, 77-78.
[69] Wolf, *Vagina*, 191.
[70] Mels Van Driel, *With the Hand: A Cultural History of Masturbation*, trans. Paul Vincent (London: Reaktion Books), 100; 127.
[71] Maines, *Technology of Orgasm*, 3.
[72] Muchembled, *Orgasm and the West*, 174.
[73] William Acton, *The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life: Considered in their Physiological, Social and Moral Relations* (Philadelphia, Lindsay & Blakiston, 1871), 89.
[74] Alfred C. Kinsey, et al., eds., *Sexual Behaviour in the Human Female* (Indiana: Indiana University Press, [1953] 1998), 168.
[75] Bongiorno, *Sex Lives*, 220.
[76] Clouston, *Clinical Lectures on Mental Diseases,* 488.
[77] Featherstone, *Sexuality in Australia*, 48.
[78] Showalter, *Female Malady*, 37.

abuse, wanders from home'.[79] Mary Anne Rogers was admitted in March 1906, after being carried out through the garden in a naked state with just a bit of muslin over her.[80] A chronic alcoholic, whose 'husband knocks her about', she was also 'guilty of self abuse in an aggravated form' with 'erotomania', which is a delusional belief that another person, often a stranger, is in love with them.[81] Thus, prurient tendencies led to the incarceration of both women.

However, it was much more likely that self-abuse was observed during the patients' time in the asylum, as evidenced in the following cases. Joanne Sylvester was described as being very dirty in her habits, and one entry merely stated 'disgusting'.[82] In 1881, Dr Barnett wrote, that Joanne committed 'self abuse'.[83] Elizabeth Ann Drown was admitted in June 1894, Barnett noted, she 'confesses masturbation formerly'.[84] Sarah Thompson's records indicated in 1902 that she was 'erotic, very filthy in her language, masturbates'.[85] Charlotte Stacey was one of the noisiest women in the asylum, using very foul language; she was 'filthy in her habits' and in 1903 was noted as a 'masturbator'.[86] Jenny Kelly was admitted in 1904 with sub-acute melancholia related to her husband's absence from the state.[87] While in the asylum, Jenny 'developed several bad habits including self-abuse'; she was 'dirty', 'erotic' and 'exposes herself'.[88] In 1905, Emily Millicent Wansbrough was labelled a 'hysterical type' who was destructive and dirty at times, with 'occasional self-abuse'.[89] In 1902, when Emma Imelda Conway was first admitted she was noted as 'erotic obscene' and blew Dr Montgomery a kiss during her examination.[90] However, in 1908, Emma wrote 'very erotic and incoherent letters; masturbates'.[91] Each woman had differing reasons for admission but they remained due to an expression of sexuality that society deemed unhealthy and immoral.

Matilda Manning was also noted to have practised self-abuse. Matilda was admitted on 24 March 1873, a thirty-six-year-old widow of unsound mind, subject to delusions, and certified as dangerous.[92] Her history revealed she was 'not quite sane for four or five years past', and her

[79] *Case Book Female Patients*, 1901-1908, Folio 321, 25-26 January 1906.
[80] *Case Book Female Patients*, 1906-1908, Folio 335, 29 March 1906.
[81] Ibid; Helen K. Gediman, *Stalker, Hacker, Voyeur, Spy: A Psychoanalytic Study of Erotomania, Voyeurism, Surveillance, and Invasions of Privacy* (London: Karnac, 2017), xv.
[82] *Case Book Female Patients*, 1878-1897, Folio 50, 10 February; 23 December 1880.
[83] Ibid, 9 April, 1881.
[84] Ibid, Folio 163, 15 May; 11 June 1894.
[85] *Case Book Female Patients (Chronic)*, 1901-1908, Folio 74, 11 March 1902.
[86] Ibid, Folio 54, 5 December 1901; 11 March; 11 December 1903.
[87] *Case Book Female Patients*, 1901-1908, Folio 203, 13 October 1904.
[88] Ibid, 7 June-16 October 1905.
[89] Ibid, Folio 217-218, 18 February; 16 October 1905.
[90] Ibid, Folio 41, 7 June 1902.
[91] *Case Book Female Patients*, 1906-1908, Folio 133, 20 February 1908.
[92] *Register of Female Patients*, 1858-1873, Folio 176, 24 March 1873.

'present insanity originated in domestic trouble and has been aggravated by use of stimulants'.[93] Matilda had frequently threatened people and was stated to be 'disposed to commit suicide'.[94] The BDMWA records reveal that Matilda Birkett married Charles, in Fremantle in 1855, and gave birth to six children from 1857 to 1864.[95] Her firstborn, nine-month-old Amy Constance died in 1858, and both her four-year-old son, William, and her husband died in 1869.[96] These deaths would have taken an emotional toll as it was during this period that her mental state deteriorated. By 1878, Matilda's 'filthy habits' were revealed, and Dr Barnett noted she was 'a chronic case of self abuse', she continued 'as she has done for years past the practice'; despite this, he positively noted that she worked at scrubbing and coarse needlework.[97] In 1879, Barnett noted, she had 'groundless complaints—continues masturbation'.[98] In 1882, she was still 'foul' and 'indecent': 'in spite of all care she continues masturbation', described as 'disgusting, filthy and obscene'.[99] In January 1888, Barnett wrote that she was 'a hopeless case' and remained until her transfer in 1908.[100] Despite Matilda's willingness to do domestic work, her continued masturbation was considered so morally repugnant that discharge was never noted as considered.

It was not just the Caucasian colonial women who were admitted for prurient reasons: two Indigenous women were admitted to the asylum for self-abuse. White colonial anxieties and morality were enforced on these women, and again, it must be remembered that Aboriginal women's mental trauma due to invasion would also have been a factor in their mental state. Murray writes that nineteenth and twentieth century Australian medical discourse on Aboriginal insanity was 'characterised by childish reactions, simplicity of thought and absence of reason, as well as often sexual and animal behaviour'.[101] Giety (alias Cranky) was admitted in March 1903, her cause of insanity was listed as 'self abuse'.[102] She was twenty years old, single, identified as Aboriginal and noted as having been 'peculiar' for six years.[103] The Sergeant of Police in Carnarvon communicated: Giety 'continually practices self abuse and throws all her clothes off in public, frequently stands on her head and places things of various sorts in her vagina, accuses everybody of having had sexual

[93] Ibid.
[94] Ibid.
[95] BDMWA: *Certificate of Marriage:* Matilda Birkett and Charles Alexander Manning (856/1855); *Certificate of Birth:* Amy Constance (3751/1857), Henry Earnest (4601/1858), Inez Amelia (5410/1860), Arthur Nelson (5975/1861), Emily Constance Maud (6912/1863), William Edwin (8128/1864).
[96] BDMWA: *Certificate of Death:* Amy Constance Manning (1127/1858); William Edwin Manning (4378/1869); Charles Alexander Manning (4115/1869).
[97] *Case Book Female Patients*, 1878-1897, Folio 2, 14 October 1878.
[98] Ibid, 20 February 1879.
[99] Ibid, 7 September 1882.
[100] Ibid, 12 January 1888; *Case Book Female (Chronic)*, 1901-1908, Folio 101, 9 June 1908.
[101] Murray, "The 'Colouring of the Psychosis'," 19.
[102] *Case Book Female Patients*, 1901-1908, Folio 79, 13 March 1903.
[103] Ibid.

connection with her'.[104] In the asylum, Dr Montgomery noted Giety would move continually, burst into fits of laughter, hit herself on the chin, and 'shouts and screams without a cause at times tears her clothes off and tries to destroy them'.[105] She eventually started to do a little work in the laundry, but this was inconsistent.[106] In 1907, it was noted Giety was quieter and less violent, but that she had 'defective habits'.[107] In April, Giety developed a mitral regurgitation, oedema of the face and body, and bloody diarrhoea; on 30 May 1907, she died.[108] Giety spent the last years of her life institutionalised for affronting colonial morality. The second Indigenous woman admitted for pruriency was Cannering (alias Darkie).[109] Cannering was admitted on 13 July 1906, with little information, although she was stated to be a widow, an 'aboriginal native', dangerous, and epileptic.[110] The cause of Cannering's insanity was attributed to a skull injury; however, her medical certificate stated that she had an 'erotic manner', threatened to kill the doctors, and would 'jabber' in her native language in what were 'chiefly filthy expressions'.[111] She was noted as 'filthy in habits, abuses herself and would do it [masturbate] openly if not controlled'.[112] In the asylum, Cannering would expectorate, was noisy and dirty, but not overly troublesome.[113] She suffered from phthisis (pulmonary tuberculosis), which would keep her quite low, and she soon became quiet.[114] Her health continued to trouble her, although, she was transferred to Claremont in 1908.[115] Nineteenth-century psychiatrists, across the world, often believed that the more Aboriginal blood an individual had, the less likely they would be to respond to treatments, other than long term incarceration.[116] Massive misunderstandings of cultural beliefs at the root of Indigenous people's lives, such as communications with spirits, were labelled as signs of madness; as well as misunderstandings of their "state of undress" as immodest and immoral. Thus, Giety and Cannering spent long periods institutionalised.

[104] Ibid.
[105] Ibid.
[106] Ibid, Folio 80, 1 June 1903.
[107] Ibid, 11 January 1907.
[108] Ibid, 17 April; 30 May 1907; Mitral regurgitation is a heart disorder where the mitral valve does not close properly when the heart pumps blood.
[109] This alias has a racist tone and the names provided for all Indigenous women may be incorrect or misspelled.
[110] *Case Book Female Patients*, 1906-1908, Folio 3, 13 July 1906.
[111] Ibid.
[112] Ibid.
[113] Ibid, 23-31 July 1906.
[114] Ibid, 6-27 August 1906.
[115] Ibid, 20 February 1908.
[116] Alvin Finkel, Sarah Carter and Peter Fortna, eds., *The West and Beyond: New Perspectives on an Imagined Region* (Edmonton: AU Press, 2010), xx.

Female sexuality in the nineteenth century was viewed as morally dangerous and led to hysteria and madness if unchecked.[117] Any prurient behaviour, including indecent exposure, or masturbation were signs of insanity. Indeed, the women identified as self-abusers in Fremantle often had that behaviour linked to their perceived insanity. Although, masturbation was not the only moral concern for nineteenth-century society and asylums; alcohol and drug use were also perceived as morally reprehensible with serious consequences for women who drank or used drugs publicly.

Temporary Relief: Alcohol and Insanity

Victorian women who drank alcohol were perceived as offensive to the cultural expectations of female behaviour.[118] However, in the colonies, alcohol consumption was generally higher than in Europe as colonial populations during early settlement were primarily composed of men, the heaviest drinking demographic.[119] In the Swan River Colony, drunkenness was prevalent across all classes during the first eighteen months of settlement, reflecting the severe problems of dislocation and adjustment to a new environment.[120] In 1856, Reverend Joseph Johnston remarked that there were more drunkards in proportion to the population in the colony than in any country in the world.[121] Fremantle certainly did not have a good reputation; in 1876, visitor Taunton described it as 'a city of public-houses, flies, sand, limestone, convicts, and stacks of sandalwood'.[122] However, 'by the 1890s, alcohol consumption in Australia had fallen…[to] about half the levels it had attained in earlier colonial days'.[123] Robin Room argues this was partly caused by 'a shift in the demographics of the population', as there were more women and children.[124] Although, it also reflected the rise of strong temperance movements entwined with the late nineteenth-century campaign for women's suffrage.[125] The WCTU, founded in the late nineteenth century, 'attracted large numbers' of women in Australia as moral 'guardians of the home, to protect themselves and their children from the harms associated with excessive alcohol consumption—violence, sexual abuse, and poverty'.[126] By

[117] Ussher, *Madness of Women*, 19.
[118] Paula Roth, ed., *Alcohol and Drugs are Women's Issues: A Review of the Issues* (Michigan: Women's Action Alliance, 1991), 2.
[119] Rod Phillips, *Alcohol: A History* (Chapel Hill, University of North Carolina Press, 2014), 133.
[120] Bob Reece, "Eating and Drinking at Early Swan River Colony," *Early Days: Journal of the Royal Western Australian Historical Society*, 13, no. 4 (2010): 463.
[121] Reece and Pascoe, *A Place of Consequence*, 27.
[122] Cindy Lane, *Myths and Memories: (Re)viewing Colonial Western Australia through Travellers' Imaginings, 1850-1914* (London: Cambridge Scholars Publishing, 2015), 123.
[123] Robin Room, "The Long Reaction Against the Wowser: The Prehistory of Alcohol Deregulation in Australia", *Health Sociology Review*, 19, no. 2, (2010): 151-152. doi: 10.5172/hesr.2010.19.2.151.
[124] Room, "Long Reaction," 152.
[125] Ibid, 151.
[126] Lake, *Getting Equal*, 24.

'the early twentieth century, drinking, particularly public drinking, was differentiated by social class and particularly by gender'.[127]

In Australia, 'debates about women and drunkenness emphasised the frailty of women's bodies'.[128] It was believed that drunkenness would prevent women from attending to their children and husband, and from setting a good moral example.[129] The 'availability of cheap gin in eighteenth-century England led to its widespread use by poverty-stricken women in London and to disgust towards those who became addicted'.[130] By the nineteenth century, things had not improved; in 1835, Prichard wrote, that 'among physical causes of madness, one of the most frequent is the immoderate use of intoxicating liquors...Ardent spirits are perhaps, of all, the most injurious in their effects, particularly on the lower classes in the northern countries of Europe and America'.[131] In 1875, Dr John Haddon wrote that the principal cause of intemperance in women of all classes was due to domestic problems: 'this evil is on the increase'.[132] In 1903 Beattie Smith stated that alcoholic insanity was common and the symptoms were: 'delirium tremens, a typically excited motor melancholia with hallucinations, suicidal tendencies, confusion, and perhaps unconsciousness, and you also have motor restlessness, tremulousness, paralysis of food appetite, digestive disorders and sleeplessness'.[133] Beattie Smith also noted that there was 'chronic alcoholism, the result of long soaking and sober intervals' as well as 'heredity, excessive use in youth, nervous temperament, head injuries, convalescence from debilitating disease…exciting occupations, and the want of normal stimulants, such as amusements and family life'.[134]

Thus, the treatment of alcoholic insanity in Australia was noted to be 'the total withdrawal of all the alcohol', Beattie Smith noted that 'there is no danger—and you ought not to temporise; cutting off liquor gradually has great disadvantages'.[135] He added that 'Bromide of potassium is regarded as the mainstay, from its general calmative effect…it wards off the tendency to epileptiform convulsions, and relieves the distressing vomiting which interferes with the taking of

[127] Room, "Long Reaction," 152.
[128] Peter Kelly, Jenny Advocat, Lyn Harrison, Christopher Hickey, *Smashed: The Many Meanings of Intoxication and Drunkenness* (Melbourne: Monash University Publishing, 2011), 7.
[129] Ben Killingsworth, ""Drinking Stories" from a Playgroup: Alcohol in the Lives of Middle-class Mothers in Australia," *Ethnography* 7 (2006): 357.
[130] Shulamith Straussner, Lala Ashenberg and Patricia Rose Attia, "Women's Addiction and Treatment Through a Historical Lens," in *The Handbook of Addiction Treatment for Women: Theory and Practice*, eds. Shulamith Lala Ashenberg Straussner and Stephanie Brown (San Francisco: Jossey Bass Wiley, 2001), 4.
[131] Prichard, *Treatise on Insanity*, 204.
[132] John Haddon, "On Intemperance in Women, With Special Reference to its Effects on the Reproductive System," *The British Medical Journal* 1, no. 807 (1876): 748.
[133] Beattie Smith, "Insanity in its Relations to the Practioner, the Patient, and the State," 62.
[134] Ibid, 62-63.
[135] Ibid, 63.

the necessary amount of food'.[136] Of course, in Fremantle, moral treatment was also emphasised, and willingness to complete domestic chores was also a measure of improvement. Concerning alcohol, 'the lunatic asylum is, indeed, the most successful, when the symptoms justify the certificates, because you give a good moral shock to the individual who recognises his position and his prospects, and that he is in compulsory confinement, under rigid regimen'.[137] Moral education was important when it came to insanity associated with vice.

As Jennifer Wallis writes, the muddying of the moral and medical discussions on drunkenness positioned it as both disease and vice.[138] It was a moral issue; these women lacked self-control and were on par with other "fallen" women; therefore, they required reform or treatment.[139] Self-medication was also a possible outcome of alcohol use; Chesler argues that trauma victims, of varying degrees, sometimes attempt to mask their symptoms with alcohol or drugs, so it is not unfounded to suggest unhappy women would have taken to temporary relief in intoxicating substances.[140] For nineteenth-century women, public drunkenness placed them at the bottom of the social scale along with prostitutes.[141] However, as Ellis reported, asylums in Western Australia were 'never really successful in rehabilitation because alcoholics needed different treatment from the insane'.[142] Therefore, a lack of understanding surrounding alcoholism contributed to the treatment of these women as insane.

Alcohol use filtered into many other cases in Fremantle and was often seen as the primary cause of madness. Elizabeth Souper was the thirty-four-year-old wife of a clerk in the Colonial office when she was admitted in July 1858; she had been mentally disordered for six and a half years, having been under partial restraint for that time, and 'a habit of drinking has been partly the cause'.[143] Lola Wright was thirty-five years old when she was admitted in July 1892, a violent patient with 'drink supposed to be the cause of her mental aberration' and bad behaviour.[144] Emma Londer was a thirty-two-year-old tailoress from Coolgardie admitted in November 1903 for general paralysis caused by alcohol and worry; she was described as 'faulty in her habits'.[145] General paralysis (G.P.), was a disease of the nervous system and brain; in 1880, William Julius Mickle noted that 'in my own

[136] Ibid.
[137] Ibid.
[138] Jennifer Wallis, "A Home or a Gaol? Scandal, Secrecy, and the St James's Inebriate Home for Women," *Social History of Medicine* 31, no. 4 (2018): 785. doi:10.1093/shm/hky020.
[139] Wallis, "A Home or a Gaol?", 785.
[140] Chesler, *Women and Madness*, 35.
[141] Killingsworth, "Drinking Stories," 357.
[142] Ellis, *Eloquent Testimony*, 56.
[143] *Register of Female Patients*, 1858-1873, Folio 2, 10-12 July 1858.
[144] *Case Book Female Patients*, 1878-1897, Folio 152, 9 July 1892.
[145] *Case Book Female Patients,* 1901-1908, Folio 143-144, 24 November-7 December 1903.

cases alcohol, though perhaps rarely acting alone, has appeared to be by far the most frequent and efficacious cause of general paralysis'.[146] Maree O'Connor notes in her study of Auckland Mental Hospital in New Zealand, colonial physicians debated the causes of general paralysis; alcohol was believed to be the cause of the condition, but syphilis was also associated with the disease.[147] All of the women who drank alcohol would have been considered faulty. The prevalence of general paralysis also reveals that it was perhaps long-term drinking rather than occasional indulgences that resulted in asylum committal.

Catherine Stokes also had a predilection for alcohol. Catherine was a sixty-year-old, widowed Roman Catholic when she was admitted from Perth in July 1858.[148] Catherine had arrived in the colony on the *Scindian* in 1850 with her pensioner guard husband, Michael Stokes, and their son.[149] On admission, she stated she had always been in good health, but that her husband had died a year earlier, and for the last six months, she had been in partial restraint in her home.[150] By September, Attfield reported that Catherine sometimes worked hard at washing but she appeared to 'have a most unfortunately sour temper with dogged obstinacy'; he concluded that Catherine had 'moral insanity'.[151] In 1874, the impact of her alcohol consumption was reported. Dr Barnett wrote that Catherine was 'fluent and foul in language', and that her body was weakening; however, her 'health was improved by wine'.[152] In June, Barnett stopped giving Catherine wine, though this led to her acting 'sulky and strange'.[153] In July it was noted that Catherine was 'always anxious to have a drink of Kerosine [sic], under belief that it is whiskey'.[154] Barnett observed that 'age is telling upon her' and prescribed a stimulant in the form of wine, four ounces each day, commencing at the start of August.[155] However, Barnett noted she 'may fail any day', and that while she was changeable in taking her food, she always took her wine.[156] However, on 8 September, when Barnett returned from a work trip to Rottnest, he found that Catherine had died that morning: 'verdict natural causes'.[157] Catherine had been a patient in the asylum for sixteen years. Her inability to cope with her husband's death meant that she struggled to care for herself and her family and, therefore, she

[146] William Julius Mickle, *General Paralysis of the Insane* (London: H.K. Lewis, Gower Street, W.C., 1880), 104.
[147] Maree O'Connor, "Mobilizing Clouston in the Colonies? General Paralysis of the Insane at the Auckland Mental Hospital, 1868–99," *History of Psychiatry* 26, no. 1 (2015): 77. doi: 10.1177/0957154X14542729.
[148] *Register of Female Patients*, 1858-1873, Folio 6, 12 July 1858.
[149] Ibid; Private Michael Stokes had served in the East India Company Royal Artillery and was discharged to the Enrolled Pensioner Force in 1849. On 21 February 1858, Michael died aged fifty-eight.
[150] Ibid.
[151] Ibid, 23 September 1858.
[152] *Female Register Case Book*, 1873-1878, Folio 83, 30 March; 4 May 1874.
[153] Ibid, 1-3 June 1874.
[154] Ibid, 144, 13 July 1874.
[155] Ibid, Folio 185, 26-31 July; 1 August 1874.
[156] Ibid, 22-24 August 1874.
[157] Ibid, 8 September 1874.

could no longer function as a "sane" woman; combined with her desire for alcohol this led to her diagnosis of moral insanity.

However, alcohol-related insanity was believed to be one of the most easily cured. Prichard wrote: 'when the exciting cause is removed, the effect begins to lessen, and eventually ceases. When these patients are prevented from obtaining stimulating liquors and are treated with sedative remedies, they quickly show signs of amelioration and of the subsidence of disease'.[158] Therefore, the cure lay in preventing the patients from obtaining liquor; In 1874, Bucknill and Tuke wrote, that chronic forms of alcoholic insanity could lead to melancholia or mania and as such physicians looked to remove the exciting causes of alcohol from their patients.[159] In Britain, the removal method played out in reform homes and refuges where they could get repeat offenders off the streets and away from liquid temptation.[160] This method was also used in Fremantle with women like Annette and Maud, "drying out" in the asylum. Annette Lefroy was forty years old when her husband admitted her with partial dementia, the result of dipsomania (alcoholism), in February 1879.[161] She had 'been for a long time addicted to excessive drinking and frequently treated her husband and children with great violence—so much so as to force her daughters to sleep in the bush all night to escape from her'.[162] In the asylum, Annette was also allowed to 'use her own clothing and have as much separation from the other patients as may be practicable'.[163] Very quickly, Annette's behaviour improved: she was quiet, rational, less excited, and was so much better that her children visited her.[164] She was discharged after eleven days incarcerated.[165] Maud Martin was aged thirty-five and single when admitted in October 1905 for drinking alcohol after the death of her father.[166] Maud had been treated 'for nerves' when her father died, and 'the shock has been too much for her'.[167] Maud had a history of alcoholism, but as she was useful and cheerful in the kitchen during her chores, she was discharged recovered by February 1906.[168] Annette and Maud, improved in behaviour as being free from alcohol in the asylum allowed them to regain some sense of "sanity".

Rose Anna Hodge was also admitted for alcohol-related reasons; however, she was not so easily discharged. Admitted by her husband, John, for 'drink' on 5 February 1904, Rose was a

[158] Prichard, *Treatise on Insanity*, 204-205.
[159] Bucknill and Tuke, *Psychological Medicine*, 362.
[160] Wallis, "A Home or a Gaol?," 776.
[161] *Case Book Female Patients*, 1878-1897, Folio 35, 7-8 February 1879.
[162] Ibid.
[163] Ibid.
[164] Ibid, 10-15 February 1879.
[165] Ibid, 18 February 1879.
[166] *Case Book Female Patients*, 1901-1908, Folio 295, 18 October 1905.
[167] Ibid.
[168] Ibid, 11 December 1905; 1 February 1906.

twenty-eight-year-old housewife, described as dangerous with delusions about the death of her children, who were still alive.[169] Her history revealed she had been 'drinking heavy of late' and that her mother, Lizzie, had died from alcohol consumption.[170] Upon admission, Rose was noisy, violent, excitable, destructive, and faulty in her habits.[171] In December, Dr Blackall noted she had distinctly improved and was discharged into her husband's care in February 1905.[172] Rose's time in the asylum, free from alcohol, led to her improved behaviour. However, in November 1907, Rose was readmitted; she had been wandering away from home, 'gradually getting drunk and accosting strange men in streets for money for drink'.[173] The medical certificate also reported she neglected her home and children and made 'all sorts of false charges against her husband'.[174] Blackall added, Rose had a 'history of periodic alcoholic excess often at menstrual periods'.[175] It is possible that Rose used alcohol to numb the pain during menstruation. However, Rose confessed her excessive alcoholism and stated she only accused her husband of things when she was drunk.[176] Blackall noted her judgement was not very good, and she had a great tendency to minimise her faults; however, she was quiet and industrious.[177] Rose was reported to be anxious for discharge to see her friends and continued to be quiet and well conducted with no active delusions, although she still denied her bad behaviour.[178] In January 1908, Rose was discharged on a month's trial 'for special treatment', which was confirmed in February.[179] Rose's alcoholism was also seen to be cured by her abstinence from alcohol; the asylum functioned as a way for her to detoxify and return to her family.

As in Rose's case, there is a possible self-medication aspect to alcoholism. In a modern context, 'women are more likely than men to drink in response to depression and are more likely to use alcohol in response to both severe and less severe depression than men'.[180] Therefore self-medication with alcohol can be understood as a method to reduce or manage emotional pain and suffering.[181] Elizabeth Foyster writes that nineteenth-century women drank, not necessarily for contentment, comfort, or reassurance but to numb the senses and mental anguish of their lives.[182]

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[169] Ibid, Folio 157, 5 February 1904; BDMWA: *Certificate of Birth*: Dorothy Edith Rose (3889/1902) and Florence Amelia (5412/1903) were still very young at Rose's admission.
[170] Ibid.
[171] Ibid, 14-21 February 1904.
[172] Ibid, Folio 158, 15 December 1904; 10 February 1905.
[173] *Case Book Female Patients*, 1906-1908, Folio 183, 28 November 1907.
[174] Ibid.
[175] Ibid.
[176] Ibid.
[177] Ibid, 6 December 1907.
[178] Ibid, 6-20 December 1907.
[179] Ibid, 26 January; 26 February 1908.
[180] Brown and Stewart "Perceptions of Alcohol Use", 34.
[181] Ibid.
[182] Foyster, *Marital Violence*, 101.

While the connection between trauma and alcohol was not always identified by the Fremantle asylum staff outright, it can often be deduced; such as in Margaret, Alice and Eliza's cases. Margaret Barry was a married thirty-eight-year-old admitted in December 1904: she had 'been drinking heavily of late'.[183] It was noted that Margaret had suffered two miscarriages and one still-born before having three healthy children.[184] On admission, Margaret stated a man had 'immoral connexion with her by means of "electrification"' and claimed that a local policeman seduced her with 'an apparatus (electrical) like a human penis'.[185] Dr Blackall wrote that she gave details with great readiness and in this, as well as in other ways, 'does not exhibit any shame'.[186] These were dismissed as delusions to which she admitted to as 'purely imaginary' after ten days in the asylum.[187] The deaths of Margaret's children would have taken a mental toll and combined with worrying delusions were possible reasons for her excessive drinking. Alice Hilder was admitted in May 1908, a forty-eight-year-old melancholic widow who stated she had lived a 'sinful wicked life'.[188] Alice claimed she had been 'annoyed by a man forcing his attentions on her' and that 'on the occasion of his visits she has been upset and indulged in drink'.[189] While this information was recorded without much detail, it suggests that Alice was drinking alcohol in response to the trauma she had experienced. Eliza Weir was thirty-five years old when she was admitted with alcoholic delusional insanity in February 1907.[190] Blackall reported:

> Gives her history as follows: went to the Goldfields as a bar maid, was there "forced" by the manager who entered her room at night, subsequently lived with him for five years as his wife and bore him twins, he refused to marry her and married another woman, this "broke her heart" and she took to drink, since then she has been earning a precarious livelihood as a general servant and cook, but has been in constant trouble as result of drink, she denies being "a common prostitute" but admits "occasional" lapses from the path of virtue.[191]

Blackall added that on admission Eliza was 'anxious to prove her sanity' although she had pronounced delusions of persecution.[192] Eliza 'attributes all her trouble to drink', and as the delusions rapidly disappeared and she continued to work well, she was discharged in July 1907.[193] Although Eliza blamed alcohol for her problems, she "indulged" in it after being "forced" into an unconventional relationship which broke down and left her alone with two children. Therefore,

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[183] *Case Book Female Patients*, 1901-1908, Folio 213, 6 December 1904.
[184] Ibid.
[185] Ibid.
[186] Ibid.
[187] Ibid, 16 December 1904.
[188] *Case Book Female Patients*, 1906-1908, Folio 229, 29 May 1908.
[189] Ibid.
[190] Ibid, Folio 71, 18-19 February 1907.
[191] Ibid.
[192] Ibid.
[193] Ibid, 12 March-15 July 1907.

Eliza's trauma was possibly self-medicated. Margaret, Alice, and Eliza had experienced trauma, and this could have contributed to their alcohol consumption.

Another woman who potentially used alcohol to self-medicate was Jane Earle. Jane was a fifty-eight-year-old Roman Catholic admitted with mania on 1 May 1872, after a 'determined attempt to commit suicide'.[194] The history obtained from her pensioner guard husband recounted she had 'frequently given way to drink and many times attempted suicide'.[195] Jane had recovered and remained well until the week before her admission when 'after drinking for some days; she seized a razor and inflicted a severe wound on her throat laying base, but not dividing, the external carotid'.[196] At the Perth Hospital, the wound was 'stitched and dressed and constant watching resorted to'; however, she escaped the staff's notice and 'attempted to drown herself in the well', she was then sent to the asylum.[197] By June, Jane was decidedly better, and when her husband requested her release, she was discharged.[198] However, a year later, in April 1873, Jane found Dr Barnett in the street and asked to be readmitted as she 'felt the disposition to commit suicide again'; he handed her to the police, and she was transferred to the asylum.[199] A few weeks later, she had made great improvements but had 'an unjust craving for snuff'.[200] Jane must have been discharged again, although there are no notes for this, as the next entry in the case book was her readmission in September 1874.[201] She had arrived at Barnett's home 'in a state of mania declaring that the people were after her wanting to throw her into the river—she begged me [Barnett] to take her again into Asylum' and was admitted that day.[202] However, a similar pattern emerged, Jane improved, replying sanely and clearly to questions, and within a month she was again discharged, convalescent.[203] Over a year later, in January 1876, Jane again appeared at Barnett's home begging to be admitted, claiming 'she would do herself a mischief', 'she was quite insane and in a very excited state'.[204] Jane stated that a man from Perth was following her with a gun trying to shoot her, and so Barnett took her to the police, and she was admitted for the fourth time.[205] Jane was now aged sixty-two and noted as looking 'haggard and worn'; Barnett noted that she was quiet and harmless, 'if humoured

[194] *Register of Female Patients*, 1858-1873, Folio 164, 1 May 1872.
[195] Ibid.
[196] Ibid.
[197] Ibid.
[198] Ibid, Folio 169, 2-9 June 1872.
[199] Ibid, Folio 179, 24 April 1873.
[200] Ibid, 5 May 1873.
[201] *Female Register Case Book*, 1873-1878, Folio 197, 19-20 September 1874.
[202] Ibid.
[203] Ibid, 26 September; 14-21 October 1874.
[204] Ibid, Folio 236, 14-15 January 1876.
[205] Ibid.

will probably remain so'.[206] Jane was discharged at the request of her husband six months after admission; however, in September 1877, she was admitted for the fifth time, 'quite demented but harmless'.[207] In December, Anne Hawkins pushed Jane, she fell and 'dislocated her right hip with a probable fracture of neck femur'.[208] After this incident Jane's health deteriorated; on 28 April 1878, she 'died from debility', the coroner's jury found the verdict to be natural causes.[209] Unlike some of the other patients, who refrained from alcohol and regained some mental stability, Jane Earle was unable to handle her situation, several times begging for treatment. Alcohol was perhaps merely an escape from her potential struggle with depression and suicidality. Alcohol, although seen as a cause for her insanity, was seemingly a form of self-medication.

In Fremantle, women could be admitted purely for reasons relating to alcohol consumption. The treatment of women admitted for drinking alcohol, followed similar moral treatment techniques, with a focus on removing the patient from the addiction. However, other potential factors such as trauma were often not considered and reveal that the nineteenth and early twentieth-century asylum was not yet equipped to handle the complexities of addiction. Another aspect apparent for the female patients was the criminal associations for publicly drunk women.

'Drunk and disorderly': Criminal Drunken Women

Alcohol became the focal point for many nineteenth-century anxieties and was deemed responsible for insanity, suicide, prostitution, and other criminal behaviours.[210] Women's indulgence in alcohol was perceived as a moral failure, and as such, it was policed heavily. In 1892, the British Medical Journal reported an appalling increase in drunkenness among women from all classes and conditions of society; noting that the number of women convicted had doubled in ten years in 1884, from an estimated 5,000 to 10,000.[211] They labelled female alcoholism a 'national shame'.[212] In Western Australia, the *Police Act 1892* was introduced to consolidate previous drunkenness legislation in the colony; this allowed the police to arrest a person for public drunk and disorderly behaviour, with increasing penalties for subsequent offences.[213] Publicly drunk women were harshly treated as they

[206] Ibid, 29 January; 22 July 1876.
[207] Ibid, 24 July 1876; 19 September 1877.
[208] Ibid, 5 December 1877.
[209] Ibid, Folio 269, 26-28 April 1878.
[210] Phillips, *Alcohol*, 173.
[211] Ann M. Manzardo et al., eds., *Alcoholism*, 4th ed. (Oxford: Oxford University Press, 2008), 66.
[212] Manzardo et al., eds., *Alcoholism*, 66.
[213] Greg Swensen, "The Management of Public Drunkenness in Western Australia: Policing the Unpoliceable?" *Limina* 23, no. 1 (2017): 9-10; Consolidated legislation: *Ordinance to Provide a More Suitable Mode of Inflicting Punishment for Drunkenness;* the *Ordinance for the More Effectual Suppression of Drunkenness;* and the *Police Ordinance* 1861.

transgressed the social rules for acceptable public behaviour and respectable female demeanour. Therefore, as Leigh Straw writes, by the early twentieth century, 'women who were loud, drunk, loitering or generally leading idle lives' could face up to six months in the Fremantle Prison.[214]

In asylums, criminal activity and moral insanity were associated as Prichard noted: 'many instances are upon record of individuals noted for a propensity to steal'.[215] In Australian psychiatric circles, there was a concern that criminal persons could pass intellectual tests but were degenerate and morally defective.[216] The idea of degeneracy was taken to indicate those who had weakened their constitution through drink and moral dissipation, and this was believed to be curable.[217] They also agreed that prison was no place for inebriates or the insane, and they required separate institutional treatment.[218] Therefore, nineteenth and early twentieth century connections between crime and insanity could result in committal to the asylum.

Arrests for drunkenness could often result in asylum committal, as evidenced in Ann and Sarah's cases. Ann Dunn was aged 'about sixty' when she came under the care of Dr Barnett at Fremantle Prison; a 'frequent criminal offender' she was serving a three-month sentence for being a loose, idle, drunken, disorderly person, wandering about without any place of abode, or means of subsistence.[219] Barnett observed that her weak mind was to be better treated in the asylum until her three-month sentence had finished and so she was transferred to the asylum in August 1881.[220] In November, when Ann's sentence was over, she was discharged.[221] However, later that day, she was found wandering about Fremantle of unsound mind and was arrested and readmitted to the asylum.[222] Barnett recorded that Ann had 'immediately got drunk', 'her mind has again become mastered by excitement and drink'.[223] Ann remained in the asylum until February 1898 when she was sent with Nurse Lace to the Female Poor Home on Goderich Street, Perth.[224] Sarah Jane Noble was a forty-three-year-old widow with 'alcoholic mania' and a 'bad prison record' when admitted in

[214] Leigh Straw, *Drunks, Pests and Harlots: Criminal Women in Perth and Fremantle, 1900-1939* (Kilkerran: Humming Earth, 2013), 5.
[215] Prichard, *Treatise on Insanity*, 23.
[216] Stephen Garton, "Crime, Prisons and Psychiatry: Reconsidering Problem Populations in Australia, 1890-1930," in *Criminals and their Scientists: The History of Criminology in International Perspective*, eds. Peter Becker and Richard F. Wetzell (New York: Cambridge University Press, 2006), 239.
[217] Garton, "Crime, Prisons and Psychiatry", 239.
[218] Ibid.
[219] SLWA: "Police Gazette," September 1881, 153.
[220] Ibid; *Case Book Female Patients*, 1878-1897, Folio 61, 1 September 1881.
[221] Ibid, 26 November 1881.
[222] Ibid; SLWA: "Police Gazette," December 1881, 204.
[223] Ibid, Folio 61, 1 December 1881.
[224] *Female Occurrence and Daily Strength Book, 1895-1901*, Folio 290, 9 February 1898; Goderich St is now Murray St.

November 1907.[225] A five-foot-one, 'ill-developed, degraded, red-haired woman', Sarah had 'been drinking very heavily' before her admission.[226] Dr Blackall noted, her 'right arm is much scarred from burn received some years ago when drunk' and that she had 'strong auditory hallucinations of unpleasant character' and was 'in great fear of impending doom "Oh! My God, my God, what is going to happen to me"'.[227] Sarah was transferred to Claremont the following May.[228] Sarah and Ann's addiction to alcohol and criminal associations kept them in and out of institutions. Their removal from alcohol while in the asylum or prison often led to release but did not treat any deeper psychological issues or addiction.

Another woman, who had alcohol-related criminal sentences that resulted in asylum incarceration, was Rose Jenkins (alias Jones). Rose was a thirty-one-year-old palmist from Perth who went by the name Gipsy Lee, when she was admitted to the asylum on 14 March 1902 after being arrested at Government House for being drunk.[229] Rose was a 'well made woman, brown hair, false teeth' who had been 'drinking heavily', with delusions she was Queen Alexandra of England and was stolen from her mother when one day old.[230] In the asylum, she was sullen, morose, deluded, and would not employ herself.[231] Although, in April, she became quiet and well behaved; but, was still idle and 'very peculiar in manner'.[232] By June, she had improved enough to be 'allowed out on a fortnight trail' and was 'discharged recovered' in July.[233] Rose's asylum records ended with her discharge; however, *The Daily News* reported in May 1903, that Gipsy Lee, a 'well known character' was charged with having been drunk.[234] A dialogue between Rose and a Mr Brown was detailed:

> Mr Brown: Do you think there's any chance of your reforming?
> The Gipsy: I hope so.
> Mr Brown: So do we; will you go to the Salvation Army?
> The Gipsy hesitated.
> Mr Brown: Well, we want to give you a chance to turn over a new leaf. We won't send you to gaol this time, although you are known. You are given another chance.
> "Away with the thought—I am free! I am free!"[235]

[225] *Case Book Female Patients*, 1906-1908, Folio 177, 4-5 November 1907.
[226] Ibid.
[227] Ibid.
[228] Ibid, 27 May 1908.
[229] *Case Book Female Patients*, 1901-1908, Folio 23, 14 March 1902; "Police Court," *Great Southern Herald*, Katanning WA, 16 May 1903, 3.
[230] Ibid.
[231] Ibid, 21 March 1902.
[232] Ibid, Folio 24, 28 April 1902.
[233] Ibid, 21 June; 14 July 1902.
[234] "Gipsy Lee," *The Daily News*, Perth WA, 1 May 1903, 3.
[235] "Gipsy Lee," *The Daily News*, 3.

Although handed an opportunity to escape incarceration, Rose does not seem overly confident about her ability to turn over a new leaf, she seemed reluctant to accept the help, although grateful to avoid prison. Like Ann and Sarah, Rose's behaviour was seen to be improved after her removal from alcohol, but this did not mean she was cured.[236]

However, no other patient's life, mental state, and incarceration in both prison and the asylum, was more affected by alcohol than Susanna Bowron.[237] Susanna was sent to the asylum from York on 5 August 1879; she was forty years old, married, and had 'occasional mania'.[238] The BDMWA records reveal that Susanna had six children between 1861 to 1877 and had two stillborn boys in 1872 and 1876.[239] In the asylum, Susanna was troublesome but soon behaved quietly and was discharged to her husband, Jonathan, in March 1880.[240] In November 1880, Jonathan posted a notice in the *Eastern Districts Chronicle* stating: 'I hereby give notice that I will not be answerable for any debts contracted by my wife Susanna Bowron in my name after this date'.[241] Susanna had been cut off from the financial support of her husband. Thus, in July 1881, Susanna was arrested for drunk and disorderly and served one month in York Gaol.[242] On 25 January 1882, she was again arrested at York for drunk and disorderly and sentenced to three months hard labour.[243] In March 1882, Susanna was readmitted to the asylum under court order to serve three months; she was described as being violent at home; however, she was quiet on admission.[244] After Susanna's sentence was served, it was noted she had 'a good report made of her by the matrons', and she was therefore discharged convalescent into the care of her husband.[245] In November 1882, Susanna was again arrested in York for drunk and disorderly conduct and was this time sentenced to six months hard labour, to be discharged from York Gaol in May 1883.[246] However, a month after her release, she was arrested in York for having 'no means subsistence' or vagrancy and was sentenced to three months; this time she was sent to Perth Gaol.[247] In August and December 1884, Susanna served two

[236] There is also the palmist element to Rose's story; palmists were mistrusted, as will be further explored in the case of Lizzie Basford in the following section.
[237] Susanna's name has been spelt in a number of different ways across many records; Susannah, Bowran, Bowrin, Bowram. Her maiden name, McGovern, has also been continuously misspelt.
[238] *Case Book Female Patients*, 1878-1897, Folio 41, 5 August 1879.
[239] BDMWA: *Certificate of Birth:* Thomas (6138/1861), Robert (7389/1863), Jonathan (8643/1865), Joseph (11488/1869), Unnamed M Bowron (13702/1872), Sarah Jane (15159/1873), Stillborn M Bowron (8928/1876), Susannah (18180/1877).
[240] *Case Book Female Patients*, 1878-1897, Folio 41, 8 March 1880.
[241] "Advertising: Notice." *Eastern Districts Chronicle*, York, WA, 3 December 1880, 4.
[242] SLWA: "Police Gazette," September 1881, 141.
[243] SLWA: "Police Gazette," February 1882, 18.
[244] *Case Book Female Patients*, 1878-1897, Folio 68, 5-9 March 1882.
[245] Ibid, 12-26 April 1882.
[246] SLWA: "Police Gazette," November 1882, 197; May 1883, 93.
[247] Ibid, June 1883, 103; September 1883, 151.

three month sentences at York Gaol for vagrancy and 'wandering about destitute'.[248] In September 1885, she was again arrested in York for disorderly conduct and sentenced to six months hard labour and was sent to the asylum on 21 December to finish her sentence.[249] Upon readmission, Susanna was noted as 'talkative and weak minded', but behaved quietly, and was discharged when her sentence ended in February 1886.[250] Almost as soon as she was released from the asylum, she was arrested and served a two-month sentence for disorderly conduct.[251] A frequent offender in York, Susanna must have moved to a new area, as in May 1887, she was arrested at Beverley for disorderly conduct, fined one shilling and given six months hard labour.[252] Three months into this sentence, she was again transferred to the asylum for the remaining three months.[253] On her fifth admission to the asylum, Susanna behaved quietly and was discharged convalescent when her sentence was over; seemingly knowing how to behave to ensure she only spent the court-ordered amount of time in the asylum.[254] However, Dr Barnett added at the end of her discharge entry, 'no doubt to resume her dissipation and have the consequences'.[255] Just as Barnett had suspected, Susanna the 'wretched woman' was readmitted to the asylum in August 1889, sent from the Fremantle Prison as a 'criminal lunatic'.[256] She had 'lately endeavoured to wreck a train at Beverley' and stated she would do so again when discharged.[257] *The West Australian* reported that the police found the tracks of a woman and asserted them to be those of Susanna, whom they suspected to be the perpetrator:

> She is alleged to have told a person residing near Dale Bridge that she placed the stones and other obstructions on the railway line, and has been promised five shillings for doing it. She also seems to have visited the camp of the ganger Stone during the day, and the persons there were unable to get rid of her. When the obstructions were mentioned to her, she said she had passed them on the way to the camp. She has a husband and several sons, all of whom are very respectable farmers living near Beverley. It is stated that she is addicted to drink, and has been confined in the Lunatic Asylum on account of her insanity, which was brought on by intemperance. As we have already said, the police suspect her to be the guilty person, though when the weight of some of the stones is considered it seems extremely difficult to believe that a woman could have lifted them. On the other hand, it seems the work of a lunatic.[258]

[248] Ibid, August 1884, 150; December 1884, 202.
[249] Ibid, September 1885, 138; December 1885, 213.
[250] *Case Book Female Patients*, 1878-1897, Folio 99, 22 December 1885; 3 January; 19 February 1886.
[251] SLWA: "Police Gazette," April 1887, 78.
[252] Ibid, May 1887, 90.
[253] Ibid, September 1887, 169.
[254] *Case Book Female Patients*, 1878-1897, Folio 99, 16 September; 8 November 1887.
[255] Ibid; Dissipation was an overindulgence in sensual pleasures which included alcohol and even sex.
[256] Ibid, 12 August 1889.
[257] Ibid.
[258] "Extraordinary Occurence Near Beverley," *The West Australian*, Perth WA, 1 July 1889, 3.

When arrested, Susanna denied the charges claiming it must have been the work of a man, Mr Ford, who was also arrested in connection with the crime.[259] However, on 8 July 1889, at the York Police Court Susanna was fined fifty pounds or in default, six months imprisonment with hard labour at the Fremantle Prison.[260] With the suggestion that she committed the crime for five shillings, Susanna was in default and was sent to prison after which she was again transferred to the asylum. On admission, Barnett noted that she threatened to burn down the asylum and all care was taken to prevent her from doing so; he added 'this is the sixth time of admission and I do not think it will be right to permit her freedom again', receiving the 'warrant for her detention' in October.[261] Susanna remained in the asylum without change until she was transferred in 1908.[262] Susanna's economic and social vulnerability after her husband's abandonment led to further drinking and criminal convictions. Caught in a cycle of vagrancy, she was unable to break her alcohol addiction and repeated incarcerations. Susanna was punished for her social and legal transgressions.

Alcohol consumption in the nineteenth and early twentieth century had severe consequences for women. The criminal associations with public drinking resulted in prison and asylum incarcerations where removal from alcohol was seen to "cure" immediate issues. However, this was not always overly effective. Another aspect of addiction that was encountered in the asylum, although considerably less than alcohol, was drug addiction.

Morphinomaniacs: Drug Addiction

Drug addiction also contributed to the labelling of insanity in Fremantle. In colonial Australia, faced with a harsh climate and environment, settlers developed a desire for stimulants and analgesics.[263] Nineteenth-century pharmacies could provide over-the-counter "quack" medicines, many of which contained opium; this was based on physicians' beliefs that morphine and cocaine were not addictive.[264] Louise Foxcroft notes that in the nineteenth century, a persistently prejudicial theory about the weakness of the female will resulted in womanhood becoming peculiarly susceptible to opium addiction.[265] In 1889, Playfair wrote that female addicts could not resist temptation; 'I have even come across more than one instance in which a medical man has actually taught a patient the use of the hypodermic needle, and placed in her hands a bottle of morphia solution to use at her

[259] "Extraordinary Occurence," *The West Australian*, 3.
[260] "News of the Day," The Daily News, Perth WA, 16 July 1889, 3.
[261] *Case Book Female Patients*, 1878-1897, Folio 99, 16 August; 18 October 1889.
[262] *Case Book Female (Chronic)*, 1901-1908, Folio 28, 29 May 1908.
[263] Andrew Campbell, *The Australian Illicit Drug Guide: Every Person's Guide to Illicit Drugs – Their Use, Effects and History, Treatment Options and Legal Penalties* (Melbourne: Black, Inc., 2001), 428.
[264] Campbell, *Australian Illicit Drug Guide*, 428.
[265] Louise Foxcroft, *The Making of Addiction: The 'Use and Abuse' of Opium in Nineteenth Century Britain* (Aldershot: Ashgate Publishing, 2007), 43.

own discretion. Anything more reprehensible it would be difficult to conceive'.[266] While Playfair admitted some prescribed opiates could influence addiction, he maintained a connection between biologically innate secrecy and neuroses that led to female addiction.[267] Therefore, at least for women, like alcohol, drug addiction and insanity were linked.

In the Fremantle asylum, the connections between drug addiction and insanity were also made in the following cases of Emma and Caroline. Emma Elizabeth Harold was twenty-five years old when she was admitted in September 1906, with suicidal mania; she was peculiar in her manner, 'sulks a great deal', and took 'chloral hydrate to excess'.[268] It was reported, that 'she has never yet committed suicide. She seems to confine herself to threatening. Her "attempt" consisted in wading into the water at a fairly frequented part of Swan River near Swan Brewery'.[269] Emma was described as 'hysterical' and 'very untruthful and is a fine example of mental instability'.[270] In October, Dr Blackall noted that Emma was 'quiet and industrious, inclined to be emotional' and by January 1907, was 'much improved, useful, anxious to go home'.[271] Her improvement was maintained, and in December, she was discharged on a month trial, confirmed in January 1908.[272] Caroline Fletcher was a widowed seventy-one-year-old nurse from Tasmania admitted in November 1906 for 'drug-taking (opium)' and 'senile dementia'.[273] Caroline had been in the Old Women's Home in Perth where she developed persecutory delusions: she 'tells a long rambling story about a supposed jewel robbery where a man in a boat came to the Old Woman's Home (not near any water) and had dropped jewels in the yard'.[274] On admission, during her physical exam, Blackall reported: 'has a rather alcoholic fascies but strenuously denies alcoholism, admits taking large amounts of opium for the last 12 years in the "lungs form dissolved in water", has discontinued the habit for the last 3 months'.[275] Her time in the home may have prevented her access to opium. In the asylum, she 'recognises the other patients as insane, is indignant at her incarceration in an asylum' but quickly became 'bright and cheerful, has not been actively delusional since admission'.[276] By December, she 'does not seem anxious for drugs, contented'.[277] Caroline's improvement was maintained, and in

[266] William Smoult Playfair, "On the Cure of the Morphia and Alcoholic Habit." *Journal of Mental Science* 35, no. 150 (1889): 181. doi: 10.1192/bjp.35.150.179.
[267] Foxcroft, *Making of Addiction*, 128.
[268] *Case Book Female Patients*, 1906-1908, Folio 15, 4 September 1906.
[269] Ibid.
[270] Ibid.
[271] Ibid, 10 October 1906; 3 January 1907.
[272] Ibid, 12 December 1907; 12 January 1908.
[273] Ibid, Folio 39, 17-19 November 1906.
[274] Ibid.
[275] Ibid.
[276] Ibid, 26 November 1906.
[277] Ibid, 17 December 1906.

November 1907, she was given a month trial and was discharged in December.[278] Emma and Caroline's mental instability was linked to their drug-taking, and it impacted their incarceration. As with the women admitted for alcohol consumption, removal from the source of addiction was seen to enable the patients to be "cured".

Another woman admitted with drug addiction was Elizabeth "Lizzie" Basford. Lizzie was a thirty-eight-year-old Coolgardie palmist, by the name of Madam Adele, admitted on 23 March 1907 for 'morphinomania' caused by 'morphine injections'.[279] In Lizzie's physical exam, Dr Blackall noted, she was a 'large woman, well developed and well nourished, looks pale and ill, with heavy eyelids as though requiring sleep. Both arms are much scarred by hypodermic injections, only few scars on forearms'.[280] Lizzie's medical certificate noted: 'accuses the nurses of spreading reports about her saying she is a man and not a woman, that she has had 7 abortions when she has only had one'.[281] This claim may have concerned Lizzie as similar accusations had plagued her career as a palmist. In 1899, her husband, John, wrote to *The Sun* refuting claims made against her profession:

> In reference to certain paragraphs that appeared in the Sun of 2nd inst. re the palmists of Coolgardie being harpies, vultures, prostitutes, procuresses, or abortionists, I desire to state that all palmists should not be vilified and placed in the same boat. I am well that there are women in Coolgardie and Kalgoorlie carrying on illegal practices under the cloak of palmistry, and I am sorry that such is the case, as the persons in question do considerable harm to those who know their work, and do it honestly and straightforward. My wife, Mrs Bosford (professionally known as Madame Adele), has studied palmistry for the past 14 years, but never had occasion to practice publicly until I became ill 18 months ago, and since then she has had to earn the living instead of me. I am not aware of Madame Adele ever having caused unpleasantness in any home or of committing any indiscretion which could possibly bring the slightest shame on herself or husband. The leading people of both Kalgoorlie and Coolgardie (ladies and gentlemen) have visited her professionally, and she can give the highest references if required, and I may state in conclusion that the local police authorities are fully cognisant of my wife's business, and how it is carried on, and I cordially invite them to make the necessary inquiries as to her work at any time they may think fit.[282]

Interestingly the editor of *The Sun* added their response after John's notice:

> We permit Mr Bosford to advertise his wife's "profession" free of charge for the purpose of making an explanation. We did not say that all "palmists" were prostitutes, procuresses, or abortionists, but we did and do say that many of them are. And we further say that all of them, without exception, are impostors, and should be punished as practitioners of imposture. Some of them may be self-deceived impostors, but none the less they make their living by practicing upon the silly credulity of the public.[283]

[278] Ibid, Folio 40, 8 November; 8 December 1907.
[279] Ibid, Folio 91, 23-25 March 1907.
[280] Ibid.
[281] Ibid.
[282] "Palmistry," *The Sun*, Kalgoorlie WA, 9 April 1899, 4.
[283] "Palmistry," *The Sun*, 4.

Palmistry was seemingly mistrusted, at least from the editor's perspective. Although, as Alana Jayne Piper states, the Australian media typically distrusted and counselled against fortune-telling.[284] However, Madame Adele was quite famous and successful; she went to Bunbury in 1902, and the *Southern Times* reported that 'the celebrated palmist' had to extend her stay by a week as 'every day Madam Adele has been kept busy, and her clients have been very numerous and have in many cases expressed surprise at the accuracy of the hand reading'.[285] Although, palmistry still had negative connotations, which were potentially worsened when Lizzie was implicated in a criminal case in 1905.[286] Cribb, an Aboriginal man, stated that he had paid Madam Adele to buy them beer; supplying drink for Aboriginal people was an offence at the time.[287] Although the claim against Lizzie was never substantiated. However, in September 1905, Lizzie was back in the papers when she told *The Sun* she was being evicted from her house at short notice so the landlord, a Justice of the Peace, could live there; however, on the eviction day a French prostitute arrived.[288] Lizzie's character as a witness had to be addressed due to her profession:

> The narrator of this account of the conversion of an ordinary dwelling in Sylvester-street into a demi-monde den is an old resident of Coolgardie, and notwithstanding that she is a "palmist" and therefore a suspicious character to many, we can say this, after making enquiries: She has conducted her home respectably, and the police, certainly, have nothing against her. When she had been treated so badly, she asked the sergeant of police had there been any complaint against her: "No," replied the Sergeant, "neither about you nor your house".[289]

Perhaps the editor at *The Sun* had a particular issue with palmists, but the general mistrust of fortune-tellers was not a new concept. Fortune-telling was a criminal offence in many jurisdictions of Britain throughout the eighteenth to the twentieth century, especially due to its associations with witchcraft, gypsies or Romani, and its perception as a form of fraud.[290] In the nineteenth century, fortune-telling was associated with the criminal class; as the "cunning folk" had traditionally performed divination and offered reproductive advice; the long-standing correlation meant that some continued to act as intermediaries for women and abortionists into the twentieth century.[291] In Australia, Piper notes that attempts to suppress fortune-telling in the early twentieth century

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[284] Alana Jayne Piper, "'A menace and an evil' Fortune-telling in Australia, 1900-1918," *History Australia* 11, no. 3 (2014): 56-66, doi: 10.1080/14490854.2014.11668531.
[285] "News and Notes: Palmistry," *Southern Times*, Bunbury WA, 12 April 1902, 5.
[286] "Police Court," *Coolgardie Miner*, Coolgardie WA, 21 March 1905, 1.
[287] "Police Court," *Coolgardie Miner*, 1.
[288] "Magistrate and Messalina: Palmist Evicted for Prostitute: A Disgrace to the Bench," *The Sun*, Kalgoorlie WA, 10 September 1905, 9.
[289] "Magistrate and Messalina," *The Sun*, 9.
[290] Jo Turner, et al., eds., *A Companion to the History of Crime and Criminal Justice* (Bristol: Policy Press, 2017), 92.
[291] Turner, et al., *History of Crime*, 92.

were part of an effort to construct a national image defined around rational, forward-thinking white men.[292] Piper argues that the perception that both the clientele and practitioners of fortune-telling were drawn from these allegedly backward elements in society (women, the working-class, and non-British races) led the practice to be labelled as evil.[293] These prejudices would have followed Lizzie and informed her experience. While in the asylum, Lizzie was noted to talk 'incoherently and continuously in husky voice, wanders from topic to topic, her attention is attracted by the slightest occurrence which immediately forms the subject of her conversation...no sustained mental operation is possible.[294] On her first night, Lizzie became ill, her temperature increased and her pulse was rapid but weakened; Blackall noted she 'improved considerably after hypodermic of strychnine and cold water sponging'.[295] It is possible this was a side-effect of being cut off from morphine, which was then treated with another drug. The next day, Lizzie was 'quieter, temp down almost to normal'.[296] In May, Lizzie 'made a rather sudden and pronounced improvement; delusions and hallucinations have disappeared' and by the end of the month it was noted, 'mental recovery complete'.[297] Although, during this period, 'she was anaesthetised and skin removed from right thigh was grafted on to the ulcer on leg which has been steadily healing'.[298] In July, it was noted 'the thigh from which the grafts were obtained is still causing some trouble and gives her considerable pain, does not bear pain very well', but she was discharged on a month's trial in August, confirmed in September.[299] Interestingly, Lizzie's run-ins with the law did not end there, in 1909, at the Kalgoorlie Police Court, Lizzie and Jennie Wagner had charged each other with assault; the incident occurred due to an unpaid loan.[300] Jennie claimed that police had warned her about Lizzie 'because she is the worst woman in Kalgoorlie'.[301] Ultimately, the Regional Magistrate dismissed all charges; however, it reveals that Lizzie continued to face accusations. Similar to the other cases, Lizzie's addiction was her reason for incarceration, and her removal from morphine allowed her to be perceived as sane after six months incarcerated, despite her questionable profession.

In Fremantle, drug-taking was treated similarly to alcohol, removal from the addiction, combined with displayed good behaviour led to release, although possibly not cure. The nineteenth-century moral indignation attached to women consuming alcohol or drugs influenced the medical

[292] Piper, "'A menace and an evil'," 54.
[293] Ibid.
[294] *Case Book Female Patients*, 1906-1908, Folio 91, 25 March 1907.
[295] Ibid, 26 March 1907.
[296] Ibid, 27 March 1907.
[297] Ibid, 2-24 May 1907.
[298] Ibid, 24 May 1907.
[299] Ibid, Folio 92, 13 July; 6 August; 6 September 1907.
[300] "Women in Court," *Kalgoorlie Western Argus*, Kalgoorlie WA, 21 September 1909, 42.
[301] "Women in Court," *Kalgoorlie Western Argus*, 42.

perspectives of staff at the asylum and the actions of those who incarcerated them. Alcohol and other intoxicating substances continued to be involved in the following section on another aspect of moral insanity, as it also contributed to other moral failings for women, in particular, prostitution.

In the Moral Gutter: Prostitution and Insanity

Prostitution has a long history in almost every society in the world; in the nineteenth century it was the "Great Social Evil", and Victorians feared it would pollute respectable society, wreck marriages, break up the family home, and destroy the very fabric of the nation.[302] In Australia, prostitution began with the First Fleet; Anne Summers argues that from 1788 to the 1840s, almost all convict women in Australian colonies were categorised as "whores".[303] However, 'colonial authorities regarded prostitution as inevitable': seen by many as beneficial to society, especially one where men outnumbered women.[304] Convict and non-convict men 'operated within a culture that placed few restraints on illicit sexual behaviour for men'.[305] However, by the mid-nineteenth century, 'the ideal of respectability, associated with sobriety, and the restriction of sex to marriage', had taken hold of most of the working class.[306] These attitudes were reflected in the evolving Australian legislation regarding prostitution. Virtually every British colony was subject to contagious diseases regulations that identified female prostitutes as the principal source of contagion.[307] However, as Elaine McKewon notes, prostitution is not illegal in Western Australia, although, 'prostitution-related activities, such as soliciting and keeping premises for the purpose of prostitution, were criminal offences under the WA *Police Act 1892'*.[308] Police used containment policies to enforce unofficial restrictions to the areas prostitutes could solicit, or arrested women on other related charges like idle and disorderly, vagrancy, and drunkenness.[309] Therefore, prostitutes were immoral public women and a serious social problem.[310]

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[302] Drew D. Gray, *London's Shadows: The Dark Side of the Victorian City* (London: Bloomsbury Publishing, 2010), 149.
[303] Summers, *Damned Whores*, 399-400.
[304] Bongiorno, *Sex Lives*, 44-45.
[305] Raelene Frances, *Selling Sex: A Hidden History of Prostitution* (Sydney: The University of New South Wales Press, 2007), 10.
[306] Bongiorno, *Sex Lives*, 47.
[307] Philippa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire* (New York: Routledge, 2013); In Queensland and Tasmania, the acts enforced compulsory medical inspections of female prostitutes, however, it applied to the population more generally instead of being confined to garrison towns, like in England.
[308] Elaine McKewon, "The Historical Geography of Prostitution in Perth, Western Australia," *Australian Geographer* 34, no. 3 (2003): 300-301, doi: 10.1080/0004918032000152393.
[309] McKewon, "The Historical Geography of Prostitution in Perth", 300-301.
[310] Straw, *Drunks, Pests and Harlots*, 106.

The dominant view held by Australian society was that 'women engaged in prostitution due to defects of character…or addiction to drink; but not because they had no alternative'.[311] This attitude was displayed in institutions like the poor and rescue homes that viewed prostitution as a moral failure, exacerbated by deprived home environments and the seduction of young girls by men who abandoned them.[312] Their solution was to raise the women's sense of morality by awakening shame and a desire to repent and reform, combined with a strategy to place them in wholesome family situations where they completed domestic tasks.[313] Kerry Wimshurst notes, in her study of prostitution in nineteenth-century Queensland, that asylums were among these number of reform institutions for those who were deemed prostitutes; the aims of such institutions was to remove 'deviant' women from contaminating environments and 're-socialise them into 'respectable' womanhood through domestic labour'.[314] However, given the limited opportunities for women in Australia to earn a living wage and their economic dependence on men, prostitution appeared to some women as an opportunity, initially more exciting and certainly more remunerative than most other unskilled female work.[315] Therefore, prostitutes were and continue to be women who are simultaneously rewarded and punished for choosing to earn their living through patterns of behaviour that are unacceptable for their gender.[316]

In 1835, Prichard observed, that prostitutes were frequent inmates at asylums, 'these unhappy creatures, after abandoning themselves to excesses of all kinds, and partly through the effect of misery and despair, fall into dementia, and often into that kind of the disease which is complicated with general paralysis'.[317] Chesler writes, that 'impoverished and prostituted women must have been the victims of extraordinary chronic violence both sexually and physically'; due to their moral transgressions, 'their eventual breakdowns were not understood as normal human responses to persecution and trauma'.[318] The Fremantle asylum held prostitutes or suspected prostitutes, and their admission was usually due to their moral failing. Prostitution was also linked with drunkenness and was often combined in these cases as causes for insanity.

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[311] Bongiorno, *Sex Lives*, 45.
[312] Frances, *Selling Sex*, 165.
[313] Ibid.
[314] Kerry Wimshurst, "Age, Prostitution and Punishment in the Late Nineteenth Century," *Australian and New Zealand Journal of Criminology* 47, no. 1 (2014): 106. doi: 10.1177/0004865813497208.
[315] Matthews, *Good and Mad Women*, 126.
[316] Jennifer James, "The Prostitute as a Victim," in *Women's Sexual Experience: Explorations of the Dark Continent*, ed. Martha Kirkpartrick (London: Plenum Press, 1982), 274.
[317] Prichard, *Treatise on Insanity*, 206.
[318] Chesler, *Women and Madness*, 93.

Coleborne writes that colonial mental hospitals rarely used 'the explicit label of "prostitute"'; when the label was used, 'it highlights not only colonial worlds of female dependency and need, but also concerns over the identities of women in social spaces'.[319] Thus, prostitution was often not clearly stated in the Fremantle asylum patient records; however, it can be inferred by the words the staff recorded and from the women's stories. Illegitimate children, excessive drinking, prison convictions, and having aliases were suspicious to nineteenth-century physicians. This pattern is clear in the following cases of Margaret, Caroline, and Mary. Margaret Forbes was sent from Perth Gaol stating she arrived in the colony on the *Emma Eugeina* in 1858 and soon after married a farmer near York, but separated from him after a year and went into service.[320] Margaret then 'got into trouble and into prison'; she was then sent to the Colonial Hospital for three months and confined in a straight waistcoat before she was placed in the asylum.[321] Caroline Mayes was twenty-seven years old when she was admitted in July 1891, with delusions and 'subject to sudden paroxysm of passion'.[322] She had been imprisoned for vagrancy and had 'more than one father for her illegitimate child' which she had 'often threatened the life of'.[323] Mary Richards was suggested as 'possibly a prostitute' when she was admitted in April 1908, for alcoholism.[324] Mary was thirty-six years old and married; she admitted to having been imprisoned for drinking and was noted as 'inclined to be of the alcoholic type (Korsakoff's syndrome)'.[325] Again, the claim against Mary was unsubstantiated, but her excessive drinking led to the belief that it was certainly possible, if not likely. The ways that the physicians recorded these women's lives on admission suggests they were seen as "fallen" women.

Another woman who was suspected to be a prostitute due to her alcoholism, illegitimate child, and aliases, was Ada. Adelaide "Ada" Alberta Koskey, who also went by Regan or Kanowna Kate, was admitted for 'worry' on 21 March 1907.[326] She was a single twenty-eight-year-old with a seven-year-old child, and described as having 'a rather alcoholic and degraded appearance (? Prostitute)'.[327] Dr Blackall noted in her history, that she had 'been much upset at the death of her sister last January and that she has had trouble with her head since'.[328] Ada stated:

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[319] Coleborne, "Insanity, Gender and Empire", 91-92.
[320] *Register of Female Patients*, 1858-1873, Folio 71, 1 March 1864.
[321] Ibid.
[322] *Case Book Female Patients*, 1878-1897, Folio 148, 1 July 1891.
[323] Ibid.
[324] *Case Book Female Patients,* 1906-1908, Folio 219, 8 April 1908.
[325] Ibid; Korsakoff's syndrome is a chronic memory disorder due to vitamin deficiency most commonly caused by alcohol abuse.
[326] Ibid, Folio 87, 21-22 March 1907.
[327] Ibid.
[328] Ibid.

> That a person came into her room and made her inhale something the smell of which is still on her clothes; that a man comes to the window of the cell and threatens to cut out her eyes and ears; that a woman stands outside the cell and sharpens a pair of scissors in order to cut her up; that she hears people whispering and threatening her.[329]

Blackall noted that her delusions were prominent and dominant, and she also gave 'a history of a mysterious recent assault upon her when she got badly injured about the head (this appears to be a delusion)'.[330] Ada denied alcoholism but admitted to 'taking brandy occasionally for her heart and also of having once or twice been drunk'; she was also 'very much on the qui vive and is prepared to deny anything derogatory to her honour; does not give a clear reason for her aliases and is very indignant at "the impudence of Kanowna Kate"'.[331] Ada remained in the asylum and was transferred in May 1908.[332] While never substantiating the prostitution claim, her status as an unwed mother with several aliases and public drinking were all condemning signs in nineteenth-century eyes.

Venereal disease was also a sign of moral wrongdoing and was associated with prostitution, especially if the women were unmarried. Venereal disease in the nineteenth century was linked to overindulgence in alcohol and sex and was deemed a social threat; producing intellectual and moral deprivation.[333] The association with prostitution was implied in Mary, Sarah, and Edith's cases. Mary (Maria) Anne Rogers was a single twenty-eight-year-old admitted in February 1864; she stated she was in service at the Bishop's residence up until a week before her admission when she left at short notice, was taken to the lock-up, and afterwards, she was sent to the asylum.[334] It was quickly discovered that Mary had 'condylomata and a gonorrhoeal discharge'; these discharges were symptoms of secondary phase syphilis, a condition characterised by wart-like lesions on the genitals.[335] However, six days later, Mary was entirely free from visible symptoms.[336] Sarah Jane Bell was a single twenty-two-year-old suffering from venereal disease, when admitted with dementia in June 1874.[337] It was reported, she had 'for years been wandering about the streets in an imbecile state, attributed to a sunstroke received in childhood'.[338] She had 'many sores' on her person, and her clothing was so 'filthy and ragged' that Dr Barnett ordered them burned.[339] Barnett also noted, that 'the sores over person are very numerous and as they are probably of secondary syphilitic

[329] Ibid.
[330] Ibid.
[331] Ibid.
[332] Ibid, 11 May 1908.
[333] Wallis, *Investigating the Body*, 39; 149.
[334] *Register of Female Patients*, 1858-1873, Folio 70, 20 February 1864.
[335] Ibid, 23 February 1865; William Acton, *Prostitution Considered in its Moral, Social and Sanitary Aspects, in London and Other Large Cities* (London: J. Churchill, 1857), 33.
[336] Ibid, 1 March 1864.
[337] *Female Register Case Book*, 1873-1878, Folio 128, 11 June 1874.
[338] Ibid.
[339] Ibid.

character she must be kept apart from other patients at night'.[340] By July, her skin was almost free from the syphilitic symptoms.[341] Sarah was also intellectually disabled, which adds further concern regarding exploitation. Edith Hall was admitted in February 1908, a single thirty-five-year-old with chronic mania, and a sister in Adelaide Asylum.[342] Edith had been in Yarra Bend Asylum in Victoria for several years; however, after her release, she set out to return to England, and while sailing home she was removed from the ship at the port in Albany owing to her drunken and mad habits.[343] In the asylum, Edith was noted as 'absolutely shameless' and had 'suspicious' venereal scars on her legs.[344] Edith admitted excessive alcoholism and was described as a 'low degenerate in morals'.[345] Mary, Sarah, and Edith had venereal diseases that were reported with suspicion, and the attached shame was closely linked with prostitution.

Although these patient records do not explicitly state that the women were prostitutes the words used represent the staff's suspicions: 'got into trouble', 'vagrancy', 'illegitimate child', 'wandering about the streets', were all associated with prostitution. Aliases and venereal diseases were also suggestive of immoral behaviours. This section further reveals that alcohol, as well as prostitution, contributed to moral transgression and mental illnesses. It is important to note that these women may not have been prostitutes; however, they were perceived as "fallen" women.

Prostitutes: The Worst Women in Western Australia

There were cases of more obvious accusations or convictions for prostitution in the asylum records and none more so than Mary Jane Hayes, a repeat offender who was frequently in and out of the prison and asylum.[346] Mary Jane Gallagher was a single eighteen-year-old when she arrived in the colony in 1867, on the bride ship *Palestine*.[347] Her first recorded arrest was in February 1871, when she and Agnes Arbuckle, "two notorious prostitutes were charged by P.C. Moan, with using obscene language, and creating a disturbance in their house, on the night of the 11th instant".[348] Although this was the first remaining reference of Mary Jane's exploits, she was already "notorious". By 1878, Mary Jane had married twice, her second husband, ex-convict Henry Hayes, did not help her

[340] Ibid, 12 June 1874.
[341] Ibid, Folio 175, 23 July 1874.
[342] *Case Book Female Patients*, 1906-1908, Folio 209, 3-4 February 1908.
[343] Ibid.
[344] Ibid.
[345] Ibid.
[346] Mary Jane Hayes' story is explored in greater detail in Alexandra Wallis, "The Disorderly Female: Alcohol, Prostitution and Moral Insanity in 19th-Century Fremantle," *Journal of Australian Studies*, (2019). doi: 10.1080/14443058.2019.1638815.
[347] *Fremantle Passenger Arrivals Index, 1829-1890*. SROWA. ACC115/98A.
[348] "Police News: Fremantle Police Court," *The Herald*, Fremantle WA, 18 February 1871, 3.

situation as he also had criminal convictions.[349] On 16 February 1881, Mary Jane, then thirty-two years old, was first admitted to the asylum: a 'drunken and violent woman' whose mind was 'affected by drink'.[350] At the asylum, Mary Jane was violent, and she was placed in the padded room: she then tore the padding off the walls and had to have her arms fastened in a 'waistcoat', which was removed after she promised to be quiet.[351] By the end of February, she had 'much improved' and was discharged, convalescent.[352] However, four months later, Mary Jane was readmitted 'a drunken prostitute' who was subject to delusions respecting religious matters and occasionally violent.[353] She gradually improved and was discharged in July, but 'cautioned not to drink'.[354] It was another eight years before Mary Jane was readmitted to the asylum, although, she had a series of larceny and drunk and disorderly charges that kept her in and out of prison. However, it was in May 1889, that she was arrested in Fremantle, identified as a lunatic, and sent to the asylum.[355] This time Dr Barnett noted, she 'had led a dissipated life' and had been under his care at Police Lockup 'threatened with D.T.', 'very delusional and violent at times'.[356] Delirium tremens (D.T.) was a severe form of alcohol withdrawal; a combination of both physical and mental symptoms, D.T. would result in tremors of the limbs and terrifying hallucinations.[357] In 1831, American Dr John Ware wrote, that D.T. could be 'occasioned by abstinence from ardent spirits, whether this abstinence be forced or voluntary' or 'frequently ensue shortly after a course of excessive indulgence'.[358] Therefore, Mary Jane's time in prison can be assumed to have led to her developing D.T. due to withdrawal. However, once again, Mary Jane began to improve, and by early June, she was discharged.[359] Two months later, Mary Jane was readmitted for the fourth time, after she had 'again been drinking and as usual her brain is affected'; initially treated in lockup, she was removed to the asylum with her 'customary symptoms'.[360] Unsurprisingly, Mary Jane behaved well and was discharged again.[361] However, while serving a four-month sentence in Fremantle Prison for drunkenness and vagrancy,

[349] On 31 October 1871 Mary Jane Gallagher married Charles Berry, a seaman in the Port of Fremantle; by 1878 she was noted as widowed and on 26 December 1878 married Henry Hayes, a sawyer, drunk, and ex-convict.
[350] *Case Book Female Patients*, 1878-1897, Folio 57, 16 February 1881.
[351] Ibid, 18 February 1881.
[352] Ibid, 22-28 February 1881.
[353] Ibid, Folio 59, 14 June 1881.
[354] Ibid, 6-14 July 1881.
[355] SLWA: "Police Gazette," May 1889, 83; 126.
[356] *Case Book Female Patients*, 1878-1897, Folio 136, 22 May 1889.
[357] Kostas Makras, ""The Poison that Upsets my Reason": Men, Madness and Drunkenness in the Victorian Period," in *Insanity and the Lunatic Asylum in the Nineteenth Century*, eds. Thomas Knowles and Serena Trowbridge (Oxon: Routledge, 2016), 143.
[358] John Ware, *Remarks on the History and Treatment of Delirium Tremens* (Boston: N. Hale's Steam Power Press, 1831), 7.
[359] Ibid, 31 May; 1-7 June 1889.
[360] Ibid, 10 August 1889.
[361] Ibid, 10-25 September 1889.

Mary Jane was admitted for the fifth and final time in November 1898, now aged fifty-three.[362] Dr Montgomery noted, she was a demented woman but worked well and gave little trouble.[363] She was 'fat and very coarse, awfully dirty and untidy', wanted whiskey, and was 'fond of liquor'.[364] Mary Jane was eventually transferred to Claremont in 1908. Mary Jane's drinking and prostitution eventuated in a cycle of incarceration due to her public moral transgressions.

From the 1900s onwards, the staff were more explicit in their labelling of prostitution in the patient records. This labelling could be the result of significant changes to the sex industry in Western Australia; as Raelene Frances notes, it was not until after 1900, that "respectable" women arrived in places like the goldfields and so discretion became encouraged and prostitution more heavily controlled.[365] Therefore, increased labelling of prostitution in the asylum during the early twentieth century could reflect the initiative to control and punish public women. Mary Ann Clayton was a fifty-five-year-old Irish widow admitted in November 1905; her delusional insanity was noted as caused by 'prostitution'.[366] Mary Ann had been serving a twelve-month sentence for drunk and disorderly when she was transferred to the asylum.[367] Margaret "Maggie" Moore, alias Mrs Ah Sing, was twenty-four years old when she was admitted in February 1906, with symptoms of brain and spinal cord disease of general paralysis; her occupation was listed as 'prostitute'.[368] In Maggie's mental condition examination, it was noted she 'denies obvious truths such as immorality, drink and disease'.[369] Alice Squires was a thirty-four-year-old single 'imbecile' admitted to the asylum in April 1906, after escaping from Perth Public Hospital twice; Alice 'was on remand on a charge of vagrancy, and had been sent to the hospital for medical treatment'.[370] On admission to the asylum, it was noted that Alice 'says she has been married very often but has not a husband at present. Woman gives one the idea of very a weak minded prostitute' and that she was a 'sullen woman of criminal type'.[371] Alice's mental capacity as an imbecile would have affected her admission as well as her moral transgressions. Emily Maria Scarlett was twenty-eight years old and single when she was admitted for alcoholic mania and epilepsy in April 1906.[372] She confessed to drinking beer but stated

[362] *Register Female Prisoners*, 1897-1913; AU WA S678, Cons 41861, 74; *Case Book Female Patients (Chronic),* 1901-1908, Folio 51, 18 November 1898.
[363] Ibid, 11 March 1903.
[364] Ibid, 20 March 1905; 15 March; 12 December 1907.
[365] Frances, *Selling Sex*, 64-71.
[366] *Case Book Female Patients*, 1901-1908, Folio 305, 11 November 1905.
[367] Ibid.
[368] Ibid, Folio 323, 10 February 1906.
[369] Ibid.
[370] Ibid, Folio 343, 30 April 1906; "Escaped in her Nightdress, from Perth Hospital, a Woman Bolts," *The Daily News*, Perth WA, 19 April 1906, 4.
[371] Ibid, 30 April; 9 July 1906.
[372] Ibid, Folio 339, 7 April 1906.

that she was 'under the influence and effects of alcohol when she was considered insane'.[373] In the asylum, Emily had no delusions, was quiet and wanted to work; she continued sensible, quiet, worked well, and was discharged after two months.[374] However, she was readmitted in April 1907; she confessed 'heavy alcoholism' and was 'an occasional prostitute on the fields' in Kalgoorlie, although it was noted she had 'no signs of present or past syphilis on her'.[375] Evelyn Secombe was admitted in February 1907, an American from New York, she was twenty-eight and already a widow.[376] Evelyn denied prostitution but admitted 'excessive alcoholism although she has "always been able to walk home"'.[377] It was later noted that Evelyn had 'been a "superior" prostitute'.[378] These women were explicitly labelled prostitutes, and it contributed to the diagnosis of their mental illness; as with Mary Jane, they publicly transgressed nineteenth-century morality.

Mary Nicholls was another case of alcoholism and prostitution with a notorious reputation in Perth and Kalgoorlie before her admission to the asylum in 1907. In January 1905, Mary had been charged in Perth 'with having, at 62 Aberdeen-street, solicited for immoral purposes'.[379] The following year, she was reported as 'a flashly dressed but dissipated looking young woman' who pleaded guilty when charged at the Kalgoorlie Police Court with 'being of evil fame'.[380] However, it was a case in September 1906, that led to her asylum incarceration; *The Evening Star* reported that Mary and two other women, Dorothy Ivory and Jessie Duncan, were charged with having been idle and disorderly persons.[381] Detective Pearce stated that the 'three of them were absolutely the worst women in Kalgoorlie. They were responsible for a lot of crime, and their habits made them a nuisance to the place'; he also saw Mary 'with nothing on but a sort of shirt. She was an abandoned woman, and it seemed impossible to do any good for her'.[382] Detective Dungey deposed that Mary was 'one of the most notorious women in Kalgoorlie'.[383] Mary defended herself stating she had been living at Kanowna with a "boy" who had been keeping her; she had come to Kalgoorlie on Saturday night, and had a return ticket, but missed the train home.[384] She then met a gentleman friend who said that he would give up his bed for her and sleep on the floor, but she had 'got in' with

[373] Ibid.
[374] Ibid, 17 April-21 June 1906.
[375] *Case Book Female Patients*, 1906-1908, Folio 101, 10-16 April 1907.
[376] Ibid, Folio 73, 27 February 1907.
[377] Ibid.
[378] Ibid, 1 July 1907.
[379] "A Charge of Soliciting," *The Daily News*, Perth WA, 18 January 1905, 10.
[380] "Bound Over," *The Evening Star*, Boulder WA, 9 January 1906, 4.
[381] "Fallen Women, The Worst Women in Kalgoorlie, a Young Girl Given a Chance," *The Evening Star*, Boulder WA, 18 September 1906, 3.
[382] "Fallen Women," *The Evening Star*, 3.
[383] Ibid.
[384] Ibid.

some woman who had pulled the clothes off her and kicked her out of the camp into the street; she then had nowhere to go but the Shamrock Hotel.[385] This story did not convince the court and Mary was sentenced to four months' imprisonment.[386] Interestingly, a Salvation Army Rescue Home officer requested to take Mary, but the bench said that due to her bad character, they felt compelled to send her to gaol.[387] After all three women were tried and removed from the court, Jessie Duncan 'called out a cheery "Good-bye, boys," and waved a farewell to the numerous occupants of the court'.[388] On 23 September, both Mary and Jessie were sent under escort by express train to Fremantle to undergo their sentences.[389] Mary was reported on again the following year, in April, in *Truth's* expose on the separation of patients in Perth Public Hospital.[390] Mary was one of three women on the female fever ward who had been arrested on suspicion of being of unsound mind and were remanded to the hospital for medical treatment.[391] *Truth* argued that it was disgraceful there was not 'a separate place in the hospital in which to place the mentally deranged'.[392] Mary, described as 'a well-known convicted prostitute', was placed in the bed opposite a fever patient from Victoria Park; Mary's 'by no means choice language', wild ravings, and 'repeated attempts to get out of bed, naturally greatly alarmed the fever patient'.[393] *Truth* emphasised that 'in most cases, bad grog and disease are at the root of the trouble' for unsound mind cases sent from the police court.[394] Mary was eventually admitted to the asylum in April 1907, where Dr Blackall recorded that she admitted 'excessive alcoholism' and has been living apparently by prostitution.[395] She would sing noisily at night, was mischievous, interfered with other patients, threw crockery about, and wore a 'worried expression'.[396] Mary's mental state did not improve, and she was 'becoming a chronic' patient; she remained in the asylum and was transferred to Claremont in 1908.[397] Mary's life of alcoholism and prostitution led to incarceration and the label of insanity.

The fall of a woman into prostitution in the nineteenth century was believed to inevitably lead to disease, destitution, madness, and death.[398] Despite this, the Victorian attitude that it was a necessary evil prevailed into the twentieth century. Thus, society deemed them necessary while

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[385] Ibid.
[386] Ibid.
[387] Ibid.
[388] Ibid.
[389] "News of the Day," *Coolgardie Miner*, WA, 24 September 1906, 2.
[390] "Perth Public Hospital, a Sanatorium for the Acquirement of Phthisis," *Truth*, Perth WA, 20 April 1907, 5.
[391] "Perth Public Hospital," *Truth*, 5.
[392] Ibid.
[393] Ibid.
[394] Ibid.
[395] *Case Book Female Patients*, 1906-1908, Folio 103, 11-15 April 1907.
[396] Ibid.
[397] Ibid, 12 August 1907; 24 February 1908.
[398] Dabhoiwala, *Origins of Sex*, 271.

condemning them for that service.[399] The labelling of prostitution in the asylum also reflected Western Australia's restriction on prostitution in goldfields areas and reveals that asylum admissions may have been used to control or punish their "unsavoury" behaviour. Female prostitutes were subject to physical danger, alcoholism, venereal disease, police harassment, and social stigmas; the psychological toll must have been profound.[400]

Chapter Conclusions

This chapter examined moral insanity in Fremantle. Pruriency, alcohol and drug use and prostitution constituted the main moral transgressions that led to assessments of insanity. Nineteenth-century society believed that the feminine disposition made women prone to lascivious behaviour, and hence, they were a danger to themselves and the men around them, in the temporal world and the afterlife.[401] As mothers and wives, women were the moral guides of the family, and by extension society, therefore, their moral transgressions were unacceptable.

The first section of this chapter examined nineteenth-century connections between madness and women's sexuality. Expressions of female sexuality were considered morally dangerous, and excessive prurient behaviour was deemed deviant and abnormal. For the women in the asylum, erotic behaviours, indecent exposure, and masturbation led to longer sentences. Despite their inclination to do domestic tasks, their sexual moral transgressions rendered them incapable of returning to normal, chaste, and virtuous society. Therefore, displayed behaviour outside the confines of what was deemed socially good and respectable in the nineteenth and early twentieth century could have serious consequences for women.

Alcohol and drug use were also examined in this chapter. Women who drank publicly could not be moral representatives for their family and as such police or families could admit them to the asylum. Removal from access to alcohol was a crucial part of asylum tactics, combined with moral treatment domestic tasks. However, these cases often resulted in further arrests or readmission following discharge and thus, potentially leaving women untreated. Another factor was the use of alcohol as self-medication for trauma, something that was often overlooked by the asylum physicians. Criminal associations with alcohol also resulted in women struggling through cycles of addiction and incarceration in prison and the asylum. The use of drugs like morphine or opium had

[399] Kathleen Barry, *Female Sexual Slavery* (New York: New York University Press, 1979), 134.
[400] Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1982), 31.
[401] Killingsworth, "Drinking Stories," 362.

similar consequences for women. This section reveals that nineteenth-century physicians did not yet understand addiction and the impacts this had on women socially and economically.

Lastly, the women admitted to the Fremantle either suspected to be or labelled as prostitutes further contributed to nineteenth-century anxieties regarding female sexuality. Female prostitutes were the ultimate morally insane patients as they represented the bottom of the social scale. They publicly solicited, contracted and spread venereal diseases, and often drank alcohol. These women were also caught in cycles of addiction and incarceration in prison and the asylum. This section also reflects that the labelling of women as prostitutes in the asylum coincided with a twentieth-century initiative to contain and control prostitution, particularly in the goldfields; revealing that asylum admission was a punishment for that moral transgression.

Much as moral treatment revealed, moral insanity reported in the female patient records in the asylum was also related to nineteenth and early twentieth-century ideas on respectable, sane behaviours for women. Public indecency could receive prison and asylum sentences; these deviances were perceived as insanity and thus treated with “cures” like domestic tasks to return them to the ideal Victorian woman. Moral transgressions such as pruriency, alcohol and drug use, and prostitution, were unacceptable behaviours and as such, they were locked away in the asylum, separate from regular society.

CONCLUSION

Insights into the Asylum

On Friday 5 October 1900, *The Daily News*, *The West Australian*, *The Coolgardie Miner* and *Herald*, and *The Albany Advertiser*, reported on the suspicious death of patient Catherine Clifford at the Fremantle Lunatic Asylum. Catherine Clifford (née Richardson) was forty-two years old when she was admitted to the asylum on 11 May 1900.[1] Earlier in the year Catherine, 'who lived in the bush some distance from Perth, went out and lost herself, and was wandering for some time in the bush. As a result of shock and exposure, she incurred a mild form of madness'; the police admitted her after she became a nuisance to her neighbours.[2] The *Female Occurrence and Daily Strength Book, 1895 – 1901*, stated that Catherine was initially restless and noisy, and within weeks of her admission her husband, Edward visited her twice.[3] However, Catherine remained 'noisy' and at the end of the month was given a draught to help her sleep.[4] On 15 June Edward visited Catherine, but this did little to alter her behaviour as it was reported the same as before.[5] Despite this, on 22 June Catherine was 'discharged to care of her husband'.[6]

However, Catherine was readmitted on 2 July, noted as 'noisy at intervals'.[7] The *West Australian Sunday Times* reported that Edward claimed Catherine 'was taken from my abode and conveyed to the Lunatic Asylum, Fremantle, being of unsound mind' and that Dr Hope reported her to be 'very quiet, but stupid'.[8] On 7 July, it was noted that 'Mrs Clifford seems very feeble and helpless in hospital'.[9] By 17 July, Catherine was stated to be 'troublesome', and the matron found her 'sitting on the stairs' at eleven o'clock at night.[10] In August, Catherine was reported to have 'very little appetite' and was 'very stupid and troublesome'.[11] In September, Edward visited on 18th and 25th, but Catherine was still 'very restless'; and on 24 September she 'had a slight fit in the yard' that left her with a high temperature.[12] However, on 27 September Catherine had an incident with

[1] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 624, 11 May 1900.
[2] "The Life of a Lunatic," *West Australian Sunday Times*, Perth WA, 7 October 1900, 9.
[3] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 625-628, 12-21 May 1900.
[4] Ibid, Folio 629-631, 24-31 May 1900.
[5] Ibid, Folio 683-639, 15-20 June 1900.
[6] Ibid, Folio 640, 22 June 1900.
[7] Ibid, Folio 645-646, 2-3 July 1900.
[8] Ibid; "The Life of a Lunatic," *West Australian Sunday Times*, 9.
[9] Ibid; Folio 648, 7 July 1900.
[10] Ibid, Folio 650-651, 17 July 1900.
[11] Ibid, Folio 528, 2 August 1900.
[12] Ibid, Folio 674-676, 18-25 September 1900.

another patient, Emily Isles [Iles], who 'scratched her face a little'.[13] After the incident, Catherine was reported as 'restless', and on 28 September it was noted that she had died at 2.15 pm.[14]

On 5 October 1900, Dr Thomas Henry Lovegrove, Principal Medical Officer for Western Australia and District Coroner for Perth and Fremantle, and Dr Hope 'held an investigation in to the late Mrs Clifford's death'.[15] However, the story was brought to the attention of the newspapers by the member for North-East Coolgardie, Mr Vosper, who detailed Catherine's death in a motion to the Legislative Assembly; Vosper claimed that Catherine 'had died from the effects of an assault which had been committed upon her by another female inmate of the institution'.[16] He stated that 'the unfortunate Mrs Clifford, who was of a quiet and harmless disposition, had been placed in the same cell as a violent, strait-waistcoated inmate, who freed herself from her bonds and brutally assaulted her companion, who died shortly afterwards'.[17] He reported that no inquest 'had been held in connection with the death, and the matter had simply been passed over as one of common occurrence'.[18] Vosper 'strongly condemned the asylum buildings at Fremantle, and the main treatment of the unfortunate demented creatures who are confined therein'; thus, Premier Sir John Forrest 'promised that the matter would receive the immediate attention of the Government, and that a full investigation of the case would be made'.[19]

Merely two days later the *West Australian Sunday Times* reported in greater detail on "The Life of a Lunatic"; they received a declaration from Edward Clifford that 'told us a harrowing tale of the ill-treatment his wife had received'.[20] Edward claimed that 'on 25th September, on visiting her, I found her unconscious, with her eye blackened and closed, her face very much cut and bruised, and I was informed by the chief officer that she had been assaulted by a violent maniac, who was confined in the same room with her'. However, the asylum records indicated that Catherine had a fit on the 24th and was scratched on the 27th; perhaps the fit was the cause of the injuries, or the incident was recorded at a later date. However, as the *West* stated, 'the rule is that an inquest shall always be held where death follows violence of any kind, it appears that the coroner was deliberately deceived by the suppression of the facts'.[21] However, Dr Lovegrove's investigation of the incident led him to state that the Assembly was 'made to assume a graver aspect than the

[13] Ibid, Folio 677, 26-27 September 1900; Emily's surname is spelt both Isles and Iles.
[14] Ibid, Folio 678, 27-28 September 1900.
[15] Ibid, Folio 680, 5 October 1900; Kimberly, *History of West Australia*, 87.
[16] "Parliament: Parliamentary Chips," *The Daily News*, Perth WA, 5 October 1900, 2.
[17] "Parliament," *The Daily News*, 2.
[18] Ibid.
[19] Ibid.
[20] "The Life of a Lunatic," *West Australian Sunday Times*, 9.
[21] Ibid.

particulars warranted' and that Catherine's death 'was due purely to natural causes. Though a quarrel did occur between the deceased and the woman who occupied the same room with her, it in no way contributed to Mrs Clifford's death'.[22] However, on 11 October *The West Australian* reported the name of the woman deemed to have caused Catherine's death: Emily Iles.[23]

Emily Iles (neé Eddison) was thirty-eight years old when she admitted to the asylum on 19 August 1899 with epileptic insanity and delusions.[24] Within a week of admission, Emily's friends visited her twice, and she was afterwards noted as 'quieter, appetite improving'; her sister-in-law and friends consistently visited her while she was incarcerated, but there is no record that her husband, William, ever visited.[25] Much like Catherine, Emily was 'restless and troublesome all the time' and was given draughts to aid in sleeping.[26] After Catherine was admitted in May, they were often reported on together with similar complaints; 'Mrs Isles and Mrs Clifford slept well after their draughts'.[27] However, on 28 May, Emily was attacked by patient Mary Naughton who 'blackened Mrs Isles' eye'.[28] In July, Emily had several other incidents; on 7th she 'fell in her room and bruised her head', on 9th she 'cut her nose, caused by falling out of bed', and on 17th she 'had a fit in the yard…lay quite still all the evening'.[29] These incidences took place at the same time that Catherine was ill in hospital and, considering they were similar in behaviour and treatments they were under care in the same room; 'Mrs Isles and Mrs Clifford very troublesome, no improvement'.[30] However, after the scratching incident, Emily was not reported on for five days, when she was noted to be 'noisy from 1.30 am'.[31]

In Dr Lovegrove's report, he stated that 'it to me seems hardly possible that Iles's scratching assault upon patient Clifford had anything to do with her death' and that 'she was wearing a jacket made of linen, more to prevent her throwing the clothes off than for any other purpose'.[32] He noted that Nurse Kerr remarked 'that Clifford was very weak, and that she had been into her ward very frequently during the night and given her milk, and that the scratching took place while she was absent for a few minutes'; he added that 'these occurrences happen at times in the very best and

[22] "Lunatic Asylum Administration," *The West Australian*, Perth WA, 8 October 1900, 2; "News and Notes," *The West Australia*, Perth WA, 9 October 1900, 5.
[23] "Lunatic Asylum Administration," *The West Australian,* Perth WA, 11 October 1900, 3.
[24] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 520, 19 August 1899; "Death at the Fremantle Lunatic Asylum: The Inquest on Mrs Isles," *The Daily News,* Perth WA, 31 October 1900, 3.
[25] Ibid, Folio 524-592, 25-27 August; 7 November; 6 February 1899.
[26] Ibid, Folio 598, 27 February 1900.
[27] Ibid, Folio 631, 1 June 1900.
[28] Ibid, Folio 632, 28 May 1900.
[29] Ibid, Folio 645-652, 3-27 July 1900.
[30] Ibid, Folio 660, 11 August 1900.
[31] Ibid, Folio 679, 2 October 1900.
[32] "Lunatic Asylum Administration," *The West Australian,* 3.

heaviest staffed asylums, and can only be lamented when they occur'.[33] In reference to Emily's admission, he stated that her husband claimed she was not dangerous to others, while her admitting physician, Dr Joel observed that she was violent; Lovegrove added, 'of course, a patient may be violent in many ways without being dangerous to others. She might smash crockery, break windows, etc.'.[34] Dr Hope stated that Emily had 'no homicidal tendencies' and Nurse Whealon reported she had 'never known late patient Clifford and patient Iles to quarrel'.[35] Lovegrove stated:

> As the result of my inquiry, I am of opinion that no blame is attachable to any member of the staff of the Fremantle Asylum in connection with the death of late patient Clifford: that on the contrary, every care that could be taken was taken of her and all that was possible to do in that institution was done for her recovery.[36]

He finished with the statement: 'I recommend very strongly that the building of the new asylum be proceeded with at once. I also recommend that arrangements be made to have two nurses at a time on night duty at Fremantle, and that 'tell-tale clocks' be instituted there'.[37] However, the *West Australian Sunday Times* doubted Lovegrove's investigations as 'unjudicial, prejudiced, and [of] unscientific spirit' and that 'none admit that maniacs are subject to sudden accesses of abnormal strength, although this is a well known phenomenon amongst the insane'.[38]

In the asylum, on 16 October, Emily was reported to have 'had slight convulsions' but slept on a draught; on 29th she 'took at fit at noon' but the 'fits continued all day' and at night she had a fit that lasted until four in the morning where a 'second fit came on at 5.30 am'.[39] On 30 October, Emily's sister in law visited and 'stayed with her to the end. The fit Mrs I. took in the morning (5.30 am) continued till after midday. Mrs Isles died at 3.20 pm'.[40] Emily died just over a month after Catherine. *The Daily News,* reporting on Emily's death, claimed that Dr Hope stated that she 'had never been in any way violent. She had, in fact, been incapable of violence'.[41] An inquest was held into Emily's death, and the Chief Coroner Dr Black found that it was 'death from natural causes'.[42]

Simultaneously, the government established a Select Committee to inquire into the condition and conduct of Fremantle and Whitby Falls Lunatic Asylums, and the report was presented

[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] "Catherine Clifford's Case," *West Australian Sunday Times,* Perth WA, 14 October 1900, 8.
[39] *Female Occurrence and Daily Strength Book*, 1895-1901, Folio 684-689, 16-30 October 1900.
[40] Ibid, Folio 690, 30 October 1900.
[41] "Death at the Fremantle Lunatic Asylum," *The Daily News,* 3.
[42] Ibid.

to the Legislative Assembly on 21 November 1900.[43] The members noted that they lacked medical and scientific knowledge so employed Drs Tratman and Davy to provide a written report of the asylums.[44] The report from the physicians and committee concluded that:

> (a) The Fremantle Asylum is utterly unfit for the purposes for which it is used; that (b) Its continued occupancy as an asylum is calculated to retard, if not altogether prevent, the cure of patients; and (c) That the management and system of this institution is full of serious defects, which, however, the officials in charge are unable to remedy, owing to the faults of the structure, which interfere with all good organisation, prevent classification, and render the lives of patients and attendants alike unwholesome and unhappy. In brief, the Fremantle Asylum is practically a prison, which is exactly the reverse of what an asylum should be.[45]

However, they added that 'under the circumstances most, if not all of the officials have done their duty well and faithfully' and that 'the late Dr Barnett, Dr Lovegrove, and Dr Hope have alike repeatedly officially appealed to the Executive to inaugurate a better state of affairs, but, so far, without practical effect'.[46] Therefore, 'they deserve the thanks of the colony for having done their best under most disheartening and discouraging circumstances'.[47] The committee also acknowledged that the Lunacy Act of the colony 'is an out-of-date statute' and recommended:

> (a) That the present asylum building at Fremantle be demolished, as unfit for the purpose for which it is now used. (b) That a new asylum be erected forthwith, on some suitable site, easily accessible for either Perth or Fremantle, in which the arrangements generally shall be in accordance with the teachings of science and the dictates of humanity. (c) That in making future arrangements with regard to the asylum staff, care should be taken that a large proportion of those engaged as attendants should be experienced in the management of the insane…(d) That a resident medical officer to attend solely to the insane be at once appointed at Fremantle, it being unjust alike to the patients and to the present acting occupant of the office to attempt to continue the existing system.[48]

The committee urged the government of the 'necessity of immediate remedial measures'.[49] Thus, Acting-Superintendent Hope's annual report for 1900 defended some of the claims but ultimately agreed that 'the unsuitableness of the present buildings for an asylum has been recognised and reported upon by those immediately responsible for the administration'.[50]

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[43] "Management of Lunatic Asylums: Report of Select Committee," *The West Australian*, Perth WA, 22 November 1900, 2; The committee was Chaired by Mr Vosper and contained Messrs. D. Forrest, Higham, Locke, and Rason.
[44] "Management of Lunatic Asylums," *The West Australian*, 2.
[45] Ibid.
[46] Ibid.
[47] Ibid.
[48] Ibid; Dr Montgomery was instrumental in drafting new lunacy legislation, as detailed in Chapter Three.
[49] Ibid.
[50] "Fremantle Lunatic Asylum," *The West Australian*, 3.

Both Catherine and Emily's experiences are representative of the ills within the Fremantle asylum; the want of classification and separation, overcrowding, underfunding and understaffing. Their cases led to the push for improved mental health care facilities in Western Australia. Thus, the Claremont Hospital for the Insane, opening in 1908, was deemed the antidote to Fremantle. Even the name containing the word hospital had positive connotations over the word asylum. Claremont was a brilliantly lit, thoroughly functional clinical space, surrounded by a rural pastoral area of terraced gardens.[51] From 1908 to 1910, Dr Montgomery and his medical staff, including Drs Anderson and Bentley, were beginning to specialise in differing areas of mental illness.[52] However, within a few years of operation Claremont, like Fremantle, was overcrowded.[53]

To ease the intake into Claremont, Montgomery established mental observation wards in Perth and Kalgoorlie.[54] However, this resulted in only intractable and long-term patients being sent to Claremont, which transformed it from a hospital back into an asylum.[55] Claremont also later treated returned soldiers from World War One, who required hospitalisation; however, these men were housed in the same wards as civilian patients.[56] In September 1919, a Select Committee was appointed to inquire into conditions at Claremont and recommended 'that the food of the patients should be more varied', 'that greater freedom should be allowed to certain cases of patient' and that 'legislation be introduced in the direction of supporting a board of commissioners, who would have full control of all mental defectives in Western Australian'.[57] They stated that 'the falling off in recoveries was largely due to the intensely overcrowded state of the institution which prevented proper classification'.[58] In 1921 a Royal Commission into Lunacy was held, and it also noted overcrowding and poor maintenance.[59] The Report recommended that 'the number of patients in residence in the hospital should not be permitted in any circumstances to exceed 1,200', as they argued 'it is generally considered that when this number is exceeded economy is no longer

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[51] Peter McClelland, "Contours of Madness: Montgomery's Claremont: Quickly Falls the Shadow," *Studies in Western Australian History* 17 (1997): 62. https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=980303143;res=IELAPA>ISSN: 0314-7525.

[52] McClelland, "Contours of Madness," 73; Montgomery researched the links between syphilis and insanity, Anderson examined the aetiology surrounding General Paralysis, and Bentley focused on the epileptic patients.

[53] Philippa Martyr, "A Hopeless Hill: Oral Histories from Claremont, Swanbourne and Graylands Hospitals, 1935-1995," *The Oral History Association of Australia Journal* 33 (2011): 3. https://search-informit-com.au.ipacez.nd.edu.au/documentSummary;dn=9 84785091896611;res=IE LHSS>.

[54] Martyr, "A Hopeless Hill," 3.

[55] Ibid.

[56] Davina J. French, "Building Lemnos Hospital: The Practice of Emotions in the Aftermath of World War One," *Studies in Western Australian History* 32 (2018): 51. https://search-informit-com-au.ipacez.nd.edu.au/documentSummary;dn=828042000284209;res=IELAPA> ISSN: 0314-7525.

[57] "Claremont Asylum: Select Committee's Report," *The West Australian*, Perth WA, 12 November 1919, 8.

[58] "Claremont Asylum," *The West Australian*, 8.

[59] Roth, "'Died Today'," 61.

obtainable that even this number is beyond the capacity of one superintendent if he is to know each and every one of his patients intimately'.[60] Therefore, a lack of separation and overcrowding continued well into the twentieth century. By the late 1960s, the then-named Claremont Mental Hospital was home to over 1,700 patients and employed over 600 staff.[61] Although the supposed cure to Fremantle's ills, Claremont suffered in similar ways. Bureaucratic ineptitude and the haphazard nature of its construction resulted in inadequate facilities.[62] Thus, institutional life would have been less orderly and benevolent than projected.[63]

Significance and Findings

Moral treatment saw a decline towards the end of the nineteenth century. In Europe and America, 'mental hospitals became custodial institutions for the mentally ill, who required further scientific study until appropriate treatments could be determined'.[64] However, 'improvement rates for moral treatment had not been scientifically determined and were probably grossly exaggerated'.[65] Although, there were lower rates in improvement with moral treatment, those who believed in the method attributed the statistic to a difficult patient population and a new generation of psychiatrists who lacked the conviction of previous physicians.[66] Differences in rationales and practices enabled ambiguity in the assessment of moral treatment's success in remediating or even curing insanity.[67] However, as Mary de Young argues, the second major reason for the eventual disappearance of moral treatment had more to do with sociological than ideological or statistical factors.[68] Moral treatment was best suited to smaller asylums with a high physician-to-patient ratio and a relatively homogenous patient population; however, the new public asylums in the early twentieth century were larger, with a lower physician-to-patient ratio and diverse patients.[69]

Therefore, it should be no surprise that the overcrowded asylums of Western Australia struggled to implement moral treatment. However, physicians implemented what was manageable and affordable, often with patient comfort and amusement in mind. Moral treatment methods also

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[60] *1921 Report and Appendices of The Royal Commission in Lunacy* (Perth, Western Australia: Government Printer, 1922), 5, http://www.parliament.wa.gov.au/intranet/libpages.nsf/WebFiles/Royal+Commission+in+lunacy+1922/$FILE/Royal+commission+-+report+and+appendices+of+the+royal+commission+in+lunacy+1922.
[61] Martyr, "A Hopeless Hill," 3.
[62] McClelland, "Contours of Madness," 62.
[63] Ibid.
[64] Donald K. Routh and John M. Reisman, "Clinical Psychology," in *Handbook of Psychology: Volume 1: History of Psychology*, ed. Irving V. Weiner (New Jersey: John Wiley & Sons, Inc., 2003) 340.
[65] Routh and Reisman, "Clinical Psychology," 340.
[66] Ibid.
[67] De Young, *Encyclopedia of Asylum Therapeutics,* 250.
[68] Ibid.
[69] Ibid.

reinforced the nineteenth-century ideas of womanhood. The female patients in Fremantle experienced domestic chores as rehabilitation, which highlighted the primary role for women: marriage and motherhood. If a woman maintained her asylum chores, she was deemed well enough to care for her family; therefore, willingness and sufficiency to launder and clean were stressed as signs of a proper, sane, woman. These ideas of womanhood were further emphasised by moral treatment theories on the provision of amusements and punishments, through seclusion and mechanical restraint. Thus, behaviours deemed "good" by nineteenth-century standards were rewarded, while "bad" behaviours were punished; for women, this included anything violent, unladylike, noisy, or prurient. For some women, moral treatment was successful, enabling them to return to their families. However, as discussed, some women's deeper psychological concerns went untreated and resulted in repeat readmission or prolonged incarceration.

Thesis Outcomes

This thesis has examined shifting understandings of women's insanity as they evolved in nineteenth-century Britain and Western Australia. Part I revealed the context in which the medical superintendents of Fremantle asylum were studying and working during the nineteenth and early twentieth centuries. This context is an essential component of the thesis, as it establishes the framework through which the asylum building, operations and patient care can be understood.

Next, I determined how Western Australia responded to such understandings in the provision of care to "insane" women. My examinations of patient and other data in Part II reveal experiences of the asylum's female patients, including the impact of staff and changing medical understandings over time. By interrogating evidence of patient treatment between 1858 and 1908, I have revealed that the asylum's female patients most-likely ranged in age from twenty to thirty-nine upon admission, they were generally Australian, Protestant, married, and most likely had delusions. Further examinations revealed that women had varied occupations on admission but that they were generally domestic workers or housewives. Trends in the data also found that female patients were most likely to be admitted by and discharged to a male family member, especially their husband. However, female family members were more likely to receive discharged patients than admit them.

Socio-biographical studies of patients in Parts II and III demonstrate that moral treatment was applied to female patients of the asylum regardless of diagnosis, with varying effect, and in a fashion that entrenched existing socially-accepted gender roles. The implementation of domestic chores as rehabilitation reinforced nineteenth-century gender roles by attributing sanity to willingness and proficiency in domestic tasks. The moral treatment theory was also implemented in

entertainments and punishments as behaviours were considered acceptable or unacceptable for female patients based on punishment or reward. It is clear that moral treatment was applied regardless of diagnosis, and that the treatment had varied success rates. Some women were, potentially, left untreated or re-traumatised. While other women, especially the chronic patients and intellectually disabled, remained in the asylum completing tasks merely for utility.

Contribution of New Knowledge

This study has presented and analysed new data which I have collated from information in the patient registers and case books within the SROWA, and other sources. I have contributed significantly to our public history by presenting, for the first time, a comprehensive index of each female patient within the Fremantle Lunatic Asylum from 1858 to 1908.[70] This valuable information allows us to discern trends and evidence of the female patient experience within the asylum. Importantly, when combined with my extensive socio-biographical research, the thesis delivers new understandings within the Fremantle asylum and the care experiences of the asylum's female patients. More broadly, and with international significance, the thesis improves our understandings of the application and outcomes of moral treatment in mental health. It contributes to modern feminist discourse regarding mental health, female sexuality, and definitions of womanhood. An understanding of nineteenth-century women's experiences, even in a small sample like Western Australia, adds to the historical and feminist discussions on modern womanhood.

My research also offers new knowledge to our understandings of nineteenth-century Fremantle. I provide in-depth, new information regarding one of the town's most important institutions—the asylum—while also assessing the lived experiences and expectations of Fremantle's working-class women.

Finally, this thesis gives voice to those who have, historically, been silent. The journeys made by women discussed within this study reveal the harsh reality of insanity in colonial Western Australia: incarceration, diagnosis, domestic rehabilitation, cure or long-term institutionalisation. This thesis acknowledges the women's trauma, commiserates their setbacks, mourns their deaths, and celebrates their recoveries.

Recommendations for Further Research

There are several avenues for further study related to the Fremantle Lunatic Asylum. Firstly, examinations of the male patient experience at Fremantle will be invaluable as their stories are also

[70] See Appendix for full list of 452 women admitted to the Fremantle asylum.

under-researched. A comparison to the female experience could provide significant insights into treatment methods and trends in diagnosis, admissions, and discharges. In particular, it would indicate whether the application and outcomes of moral treatment were affected by gender.

Secondly, a comparative study of Fremantle with the other colonial asylums in Australia will prove to be valuable. Research of this kind could highlight the similarities and differences across patient care in nineteenth-century Australia, identifying trends of medical experience. Lastly, analysis of the women's experiences in the Claremont Hospital for the Insane will provide endings to the stories of those women who were transferred from Fremantle in 1908. Combined with research currently underway by other scholars, including Philippa Martyr's, will provide interesting and important insights into mental illness and society in twentieth-century Western Australia.

APPENDIX

List of the Female Patients admitted to the Fremantle Lunatic Asylum (1858 – 1908)[1]

Key:
A= Admission
D = Died
Dis = Discharged
RA: Readmitted
BDM = Birth, Death, and Marriages Index

Surname	Given Names	Admission/Discharge/Death/Transfer
Abbott	Louisa Alberta	A: 14/5/1907 D: 11/6/1907
Abbott	Sarah	A: 9/10/1899 T: 29/5/1908
Adams	Ann Unity	A: 7/10/1904 D: 11/11/1904
Anderson	Alice Mary	A: 30/12/1901 Dis: 22/3/1902
Anderson	Helena	A: 29/10/1906 Dis: 23/5/1907
Andrews	Elizabeth	A: 30/5/1905 T: 1908
Andrews	Iris	A: 10/1/1902 Dis: 24/12/1902
Anthony	Mary Catherine	A: 6/5/1903 Dis: 28/2/1904 RA: 25/1/1905 Dis: 4/11/1906 RA: 15/12/1906 T: 1908
Arnold	Hilda Martha	A: 20/4/1907 Dis: 12/6/1907
Arnott	Sarah	A: 19/7/1904 Dis: 12/9/1904

[1] Data accessed from: *Register of Female Patients*, 1858-1873; AUWA S507, Cons 112004; *Female Register Fremantle Lunatic Asylum Case Book*, 1873-1878; AUWA S2219, Cons 57591; *Case Book Female Patients*, 1878-1897; AUWA S2219, Cons 272403; *Case Book Female Patients Chronic Medical Conditions*, 1901-1908; AUWA S2219, Cons 310301; *Case Book Female Patients*, 1901-1908; AUWA S2219 Cons 310001; *Case Book Female Patients*, 1906-1908; AUWA S2219 Cons 272404.

Atkinson	Margaret	A: 14/11/1889 Dis: 24/2/1893
Badman	Jane	A: 3/12/1907 Dis: 17/2/1908
Barker	Edith	A: 15/10/1906 D: 28/1/1907
Barry	Margaret	A: 6/12/1904 Dis: 5/2/1905
Barzay	Elizabeth	A: 24/9/1871 D: 17/4/1872
Basford	Elizabeth (alias Madam Adele)	A: 25/3/1907 Dis: 6/9/1907
Basset	Jessie	A: 4/4/1879 T: 12/6/1908
Bee	Minnie	A: 3/1/1908 T: 16/5/1908
Bell	Sarah Jane	A: 11/6/1874 D: 8/2/1891
Bentley	Maria Anna Louisa	A: 3/11/1900 Dis: 28/9/1903
Berry	Fanny Louisa	A: 26/9/1905 D: 29/12/1905
Best	Elizabeth	A: 28/3/1900 T: 29/5/1908
Bishop	Amelia	A: 25/3/1865 D: 12/12/1906
Blackmore	Catherine/Caroline/Mary	A: 26/1/1863 Dis: 2/10/1865 RA: 24/10/1895 D: 18/1/1899
Blackmore	Elizabeth	A: 8/11/1895 Dis: 6/3/1896 RA: 5/8/1896 Dis: 23/1/1897
Blay	Elsie Edith	A: 6/12/1903 D: 23/12/1903
Bone	Jane	A: 19/8/1899 T: 27/5/1908
Bottomley	Eliza Ann	A: 27/12/1894 T: 5/6/1908
Bounds	Julia	A: 16/4/1907 T: 29/5/1908

Boundy	Annie	A: 27/7/1907 D: 9/3/1908
Bourke	Alicia	A: 2/7/1884 D: 2/9/1890
Bovell	Matilda	A: 23/3/1897 T: 1908
Bowen	Selina Teresa	A: 23/7/1904 T: 11/5/1908
Bowron/Bowring/Bowren	Susanna	A: 5/8/1879 Dis: 8/3/1880 RA: 5/3/1882 Dis: 26/4/1882 RA: 22/12/1885 Dis: 11/11/1887 RA: 12/8/1889 T: 29/5/1908
Bradshaw	Hannah Louisa	A: 25/6/1907 Dis: 30/5/1908
Bree	Anne	A: 18/7/1901 T: 1908
Brine	Jane	A: 26/9/1906 T: 27/5/1908
Brooking	Catherine	A: 23/12/1874 Dis: 16/3/1875
Brooks	Emma	A: 4/9/1907 T: 11/5/1908
Brooks	Ethel	A: 29/3/1907 Dis: 30/11/1907
Brown	Annie	A: 7/10/1889 Dis: 4/12/1889 RA: 6/7/1901 T: 11/5/1908
Brown	Flora Mary	A: 27/9/1903 Dis: 23/9/1904 RA: 27/9/1905 T: 5/6/1908
Bryan	Louisa	A: 20/9/1886 D: 19/9/1888
Bufton	Mary	A: 23/10/1881 T: 11/5/1908
Bull	Maria Jane	A: 26/5/1902 T: 16/5/1908 BDM – D: 1908
Bunn	Jane	A: 21/5/1901 D: 12/9/1906

Burns	Ann	A: 3/2/1870 T: 27/5/1908
Burns	Sarah	A: 12/7/1858 D: 6/7/1904
Burton	Elizabeth	A: 12/10/1906 D: 15/3/1908
Bush	Jane	A: 23/10/1903 Dis: 22/3/1904
Butler	Judith	A: 27/5/1874 T: 27/5/1908
Butler	Olive Edith Caroline	A: 22/6/1904 D: 16/4/1906
Byrnes	Issie	A: 2/4/1902 Dis: 21/10/1904
Cain Wright	Louisa Maud	A: 1/8/1906 T: 8/6/1908
Callaghan	Bridget	A: 12/1/1902 T: 12/6/1908
Callaghan	Mary	A: 30/11/1882 Dis: 11/1/1883 RA: 7/2/1883 D: 14/12/1896
Cameron	Jane	A: 31/7/1907 Dis: 16/10/1907
Campbell	Charlotte	A: 11/12/1906 T: 16/5/1908
Campbell	Christina	A: 15/3/1904 Dis: 12/10/1904 RA: 28/1/1907 T: 29/5/1908
Canter	Annie May	A: 14/3/1907 T: 5/6/1908
Carey	Mary Eliza	A: 28/8/1903 D: 22/5/1908
Carroll	Harriet	A: 27/5/1908 T: 8/6/1908
Carrotts	Mary	A: 1/11/1879 D: 20/4/1881
Casey	Anne	A: 10-12/7/1858 D: 23/6/1897
Casey	Catherine	A: 9/7/1862 T: 2/6/1908

Chan	Ann	A: 26/5/1872 Dis: 8/10/1872
Chessum	Mary	A: 15/2/1893 Dis: 16/3/1893 RA: 25/7/1907 Dis: 13/11/1907
Chipper	Jessie	A: 2/4/1888 Dis: 1/5/1888 RA: 25/8/1888 Dis: 12/4/1889
Chitty	Grace	A: 30/7/1881 T: 29/5/1908
Clark	Mary	A: 11/5/1900 D: 20/9/1906
Clarke	Margaret	A: 27/2/1905 Dis: 24/5/1905
Clayton	Catherine	A: 30/5/1885 Dis: 20/11/1885
Clayton	Mary Ann	A: 11/11/1905 T: 27/5/1908
Cleasby	Mary	A: 8/6/1905 Dis: 12/8/1905
Clifton	Francis	A: 8/1/1894 T: 2/6/1908
Clisby	Frances Jane	A: 17/6/1907 Dis: 21/1/1908
Cockram	Edith Augusta	A: 27/1/1905 T: 29/5/1908
Cockram	Mary	A: 18/12/1887 Dis: 9/6/1888 RA: 16/6/1888 Dis: 20/12/1888 RA: 3/12/1889 Dis: 2/4/1890
Collings/Collins	Sarah Elizabeth	A: 19/1/1888 T: 1908
Collins	Mary	A: 13/8/1897 T: 27/5/1908
Conduit	Charlotte	A: 26/12/1904 T: 2/6/1908
Connerton	Mary Anne	A: 14/6/1867 Dis: 10/5/1869 RA: 1/9/1871 Dis: 1/5/1873 RA: 6/11/1874 D: 20/12/1879

Conway	Agnes	A: 16/2/1907 Dis: 2/5/1908
Conway	Emma Imelda	A: 7/6/1902 Dis: 2/12/1902 RA: 25/6/1907 T: 27/5/1908
Coombs	Ellen	A: 10/2/1904 D: 20/9/1905
Cooper	Ada Alethea	A: 22/1/1906 Dis: 20/3/1907
Coppin	Susan	A: 27/11/1874 Dis: 22/12/1874
Cousins	Alice	A: 3/7/1878 Dis: 1/10/1878
Coyle	Eliza	A: 5/6/1906 D: 12/6/1906
Craig	Mary Daisyletta	A: 25/1/1906 T: 2/6/1908
Cramond	Ada Susannah	A: 6/2/1908 T: 29/5/1908
Crampton	Matilda Maria	A: 25/11/1894 T: 2/6/1908
Cree	Elizabeth	A: 6/9/1896 Dis: 30/9/1896
Crudace	Clara	A: 17/10/1905 Dis: 1/2/1906
Cummings	Annie	A: 18/1/1886 Dis: 20/3/1886 RA: 24/3/1886 Dis: 21/8/1886
Cunningham	Margaret	A: 7/1/1907 T: 12/6/1908
Curley	Margaret	A: 12/7/1858 Dis: 30/10/1858
Daly	Maria	A: 2/10/1906 T: 1908
Darvell	Maggie	A: 10/1/1908 D: 19/3/1908
Davidson	Frances Edith	A: 6/3/1903 Dis: 13/7/1903 RA: 22/10/1904 Dis: 1/5/1907 RA: 6/8/1907 T: 1908

Davis	Bridget	A: 28/5/1897 D: 18/4/1904
Davis	Catherine	A: 26/12/1902 Dis: 12/2/1903
Davis	Lydia Agnes	A: 1/3/1905 Dis: 25/5/1905 RA: 25/5/1905 Dis: 3/7/1906
Day	Elizabeth	A: 8/1/1904 D: 10/12/1904
Deer	Emily	A: 14/9/1889 D: 21/10/1889
Delbridge	Ethel/Edith Maud	A: 18/9/1902 Dis: 22/8/1903 RA: 21/1/1904 D: 12/1/1907
Denehy	Mary	A: 29/6/1906 T: 24/5/1908
Dewar	Johanna	A: 3/6/1898 T: 9/6/1908
Dick	Francis	A: 30/6/1905 Dis: 18/4/1906
Dixson	Julia Annie	A: 25/10/1907 T: 8/6/1908
Domenick	Lena	A: 15/4/1904 D: 9/1/1905
Donovan	Elizabeth Mary	A: 13/7/1894 Dis: 22/9/1894
Dowling (Clements)	Emily	A: 7/8/1878 Dis: 5/11/1878 RA: 9/5/1900 T: 5/6/1908
Dray	Elizabeth Ann	A: 18/10/1906 Dis: 2/3/1907
Drown	Elizabeth Ann	A: 15/5/1894 Dis: 12/7/1894 RA: 20/1/1908 T: 27/5/1908
Drummond	Alice	A: 6/9/1901 T: 8/6/1908
Duff	Lucy Matilda	A: 10/4/1905 T: 11/6/1908
Dunn	Ann	A: 1/9/1881 Dis: 26/11/1881

		RA: 1/12/1881 Dis: 9/2/1898
Dunn	Annie	A: 24/7/1903 Dis: 9/10/1903
Dunn	Elizabeth “Bessy”	A: 8/7/1862 Dis: 27/2/1864
Durant	Margaret	A: 23/8/1878 Dis: 5/9/1893
Durnin/Durnan (Hocking)	Kate/Catherine	A: 4/4/1890 Dis: 14/6/1890 RA: July 1898 Dis: June 1899 RA: 1/8/1902 D: 6/7/1904
Earle	Jane	A: 1/5/1872 Dis: 9/6/1872 RA: 24/4/1873 - RA: 19/9/1874 Dis: 21/10/1874 RA: 14/1/1876 Dis: 24/7/1876 RA: 19/9/1877 D: 28/4/1878
Eddy	Mary	A: 28/10/1905 Dis: 28/11/1906
Edwards	Elizabeth/Rosamund/ Eliza R./Rosanna	A: 2/11/1869 D: 13/9/1905
Egerton Warburton	Mary Frances Edith	A: 26/8/1907 Dis: 31/1/1908
Enrille	Bridget	A: 21/4/1902 Dis: 2/6/1902
Erskine	Annie	A: 16/10/1903 T: 2/6/1908
Facey	Annie	A: 2/11/1903 T: 5/6/1908
Fahey	Mary	A: 24/5/1879 Dis: 8/7/1879 RA: 28/8/1879 Dis: 27/12/1879 RA: 14/2/1880 T: 1908
Falconer	Georgina	A: 1/1/1908 D: 4/1/1908
Faul	Agnes Maria	A: 15/8/1905 Dis: 30/7/1906

Fay	Mary Ann	A: 10/7/1907 D: 17/7/1907
Ferguson	Elizabeth	A: 9/8/1904 T: 11/5/1908
Fibbins	Caroline Isobel	A: 27/6/1903 T: 27/5/1908
Fields	Susan Maria	A: 16/8/1887 Dis: 19/9/1887
Fillis/Fillas	Margaret	A: 10/10/1893 T: 27/5/1908
Fitzgerald	Nora (Honora)	A: 15/6/1861 Dis: 5/2/1863 RA: 9/6/1888 Dis: 13/8/1888
Fleay	Emily	A: 1/8/1905 T: 5/6/1908
Fleming	Catherine	A: 3/3/1897 Dis: 28/2/1898
Fletcher	Caroline	A: 17/11/1906 Dis: 8/12/1907
Forbes	Margaret	A: 1/3/1864 D: 25/1/1904
Forster	Minnie Louise	A: 26/4/1906 Dis: 16/7/1906
Gaisford	Sarah	A: 1/6/9/1894 Dis: 8/11/1894 RA: 17/11/1894 Dis: 1/5/1895
Galvin (Harris)	Mary Ann	A: 20/9/1907 T: 2/6/1908
Gerschow	Ida	A: 3/11/1906 Dis: 24/8/1907
Gilby	Florence	A: 21/12/1901 Dis: 27/6/1902 RA: 5/10/1903 Dis: 21/8/1904
Gilham	Ada Jane	A: 3/12/1906 T: 5/6/1908
Gilmore	Mary Anne	A: 12/7/1858 D: 29/1/1892
Goedecke	Mary Anna	A: 10/9/1905 Dis: 10/7/1906 RA: 22/10/1906 D: 18/4/1907

Good	Alice	A: 21/6/1895 Dis: 18/7/1895
Goodall	Mary	A: 13/9/1865 Dis: 25/8/1866 RA: 15/6/1868 Dis: 9/8/1869 RA: 15/8/1878 Dis: 31/10/1879
Goode	Ruth	A: 27/3/1895 Dis: 24/12/1895
Gooley	Annie Miriam	A: 23/3/1906 Dis: May 1906
Govan	Jane May	A: 6/4/1907 T: 27/5/1908
Grimes	Margaret	A: 6/1/1905 T: 2/6/1908
Hackett	Annie	A: 30/6/1903 Dis: 7/9/1903
Hackett	Catherine	A: 20/11/1883 T: 12/6/1908
Hackett	Rose	A: 5/7/1907 Dis: 19/1/1908
Haggerty	Margaret	A: 1868 Dis: 13/7/1870 RA: 27/2/1871 D: 14/12/1872
Hall	Edith	A: 3/2/1908 Dis/T: 25/3/1908
Halliday	Alice	A: 12/1/1869 D: 26/10/1899
Hamdorf	Ellen	A: 6/12/1906 Dis: 18/3/1907 RA: 16/1/1908 Dis: 3/5/1908
Hamilton	Elizabeth	A: 18/1/1905 T: 11/5/1908
Hamilton	Rachel	A: 17/5/1876 Dis: 11/6/1876 RA: 11/6/1876 Dis: 22/7/1876 RA: 27/7/1876 Dis: 4/10/1876 RA: 6/3/1880 Dis: 19/6/1880
Hammond	Jane	A: 15/7/1904 T: 11/5/1908

Hammond	Maria	A: 3/10/1885 T: 2/6/1908
Hand	Lilly	A: 5/2/1903 T: 5/6/1908
Hanrahan	Ellen	A: 21/10/1905 Dis: 18/5/1906
Harding	Sarah	A: 20/12/1869 Dis: 21/7/1870 RA: 1/1/1871 Dis: 8/1/1878
Hardy	Cecelia	A: 10/7/1858 Dis: 22/9/1864
Hargreave	Margaret	A: 16/6/1904 T: 8/6/1908
Hargreaves	Margaret C.	A: 17/5/1894 Dis: 8/11/1894
Harken	Maud Marian	A: 5/6/1908 T: 1908
Harmsworth	Elizabeth	A: 21/8/1900 T: 11/5/1908
Harold	Emma Elizabeth	A: 19/1/1906 Dis: 18/6/1906 RA: 4/9/1906 Dis: 12/1/1908
Harris	Mary	A: 9/10/1879 D: 6/9/1887
Harris Andrew (Mann)	Fanny	A: 2/9/1888 Dis: 15/9/1888 RA: 22/7/1894 D: 18/12/1895
Hartley	Florence	A: 29/4/1907 T: 16/5/1908
Hasses	Mary (Coloured)	A: 23/11/1883 Dis: 30/1/1884
Hawkins	Anne/Ann	A: 14/4/1868 Dis: 4/6/1868 RA: 15/11/1869 Dis: 15/1/1870 RA: 19/1/1870 Dis: 4/7/1870 RA: 18/11/1870 Dis: 30/5/1871 RA: 7/6/1871 Dis: 28/6/1872 RA: 5/7/1872 - RA: 2/1/1874 Dis: 23/10/1876

		RA: 23/10/1878 Dis: 24/1/1879 RA: 1/12/1880 Dis: 24/7/1882 RA: 19/2/1885 D: 29/3/1902
Hayes	Alice Kate	A: 31/3/1907 T: 2/6/1908
Hayes	Ann/Annie	A: 21/10/1879 T: 12/6/1908
Hayes	Mary Jane	A: 15/2/1881 Dis: 28/2/1881 RA: 14/6/1881 Dis: 14/7/1881 RA: 22/5/1889 Dis: 7/6/1889 RA: 10/8/1889 Dis: 25/9/1889 RA: 18/11/1898 T: 12/6/1908
Head	Bridget	A: 17/5/1905 T: 1908
Hearne Cranstone	Annie	A: 2/12/1899 Dis: 16/1/1900 RA: 10/9/1902 Dis: 6/12/1902
Heckler	Arabella Louisa	A: 17/12/1901 Dis: 11/6/1902
Hefferman	Ellen	A: 8/4/1908 T: 11/5/1908
Hehires	Mary	A: 19/3/1907 Dis: 26/8/1907
Helverston	Sarah	A: 1/1/1897 T: 5/6/1908
Hembry Cox	Pollie	A: 10/7/1907 T: 27/5/1908
Henderson	Margaret	A: 6/4/1906 Dis: 30/6/1906 RA: 27/12/1906 Dis: 17/7/1907
Herbert	Ada	A: 5/3/1892 Dis: 18/3/1892
Hescons	Catherine	A: 19/10/1872 Dis: 4/4/1873
Hester	Alice Theodoria	A: 8/7/1879 T: 12/6/1908

Hickey	Mary	A: 12/12/1904 D: 6/10/1906
Hicks	Louisa Matilda	A: 7/10/1904 D: 9/5/1905
Hilder	Alice	A: 29/5/1908 T: 8/6/1908
Hind	Lilian	A: 18/1/1907 T: 8/6/1908
Hirst/Hurst (Withers)	Mary Isabel	A: 14/8/1893 Dis: 21/11/1893 RA: 17/12/1901 Dis: 1/1/1903
Hiscox	Katherine/Catherine	A: 8/3/1897 Dis: 7/6/1897
Hiscox	Mary	A: 11/8/1893 D: 1/4/1895
Hoare	Emma	A: 26/9/1907 T: 8/6/1908
Hoddy	Angelina	A: 31/11/1901 Dis: 5/2/1902
Hodge	Rose Anna/Ann	A: 5/2/1904 Dis: 10/3/1905 RA: 28/11/1907 Dis: 26/2/1908
Hoefer (Holfer)	Emily	A: 14/9/1902 Dis: 28/11/1902 RA: 28/5/1908 T: 8/6/1908
Hollingsworth	Elizabeth	A: 11/6/1903 T: 12/6/1908
Holman	Fanny	A: 15/2/1896 D: 3/8/1896
Hoolihan	Mary	A: 20/9/1906 T: 29/5/1908
Hough	Isabella/Isabel	A: 1/8/1896 T: 12/6/1908
Howe	Hannah	A: 17/10/1906 D: 18/10/1906
Huges	Ada	A: 10/4/1895 Dis: 13/5/1895
Huggard	Mary	A: 20/6/1903 T: 2/6/1908
Hundy	Catherine	A: 29/11/1898 T: 1908

Hunter	Emma	A: 24/4/1907 Dis: 30/6/1907
Hunter	Mary	A: 2/9/1864 D: 21/6/1867
Hyde	Elizabeth	A: 24/9/1896 T: 8/6/1908
Inman	Caroline	A: 24/1/1905 Dis: 21/11/1905
Irving	Mary Elizabeth	A: 26/3/1907 T: 12/6/1908
Jarvis	Sarah Ann	A: 7/1/1905 Dis: 17/10/1905
Jeffrey	Amelia	A: 6/1/1902 Dis: 24/5/1902
Jeffries	Maud	A: 1/11/1900 Dis: 3/4/1903
Jenkins (alias Jones)	Rose	A: 14/3/1902 Dis: 14/7/1902
Johnson	Rose	A: 25/3/1904 T: 2/6/1908
Johnstone	Sarah Winifred	A: 16/11/1905 Dis: 26/2/1906 RA: 1/3/1906 T: 11/5/1908
Jones	Edith Maude	A: 5/10/1904 Dis: 12/1/1905
Jones	Ellen Elizabeth	A: 21/1/1906 T: 1908
Jones	Emily	A: 17/5/1895 Dis: 1/12/1896
Kane/Kaine/Cain	Margaret	A: 17/11/1863 D: 18/5/1876
Keats Rostron	Alice	A: 30/1/1897 Dis: 19/2/1897
Kelly	Jenny	A: 13/10/1904 T: 8/6/1908
Kelly	Mary	A: 21/11/1894 T: 27/5/1908
Kelly	Sam	A: 24/8/1885 Dis: 11/9/1885
Kelsall	Catherine	A: 8/9/1905 Dis: 31/3/1906

		RA: 13/4/1906 T: 11/5/1908
Kenane	Katie	A: 3/10/1901 T: 5/6/1908
Kennedy	Elizabeth	A: 21/10/1866 D: 29/7/1872
Kennedy	Mary	A: 23/8/1906 Dis: 16/12/1906
Kerr	Julia	A: 18/6/1906 D: 29/4/1907
Keys	Mary Beatrice	A: 7/9/1903 Dis: 11/4/1904 RA: 2/6/1904 Dis: 6/5/1905
Kirtley	Mary	A: 10/1/1906 Dis: 16/6/1906
Kitson	Mary	A: 27/9/1905 D: 30/11/1905
Kobayashi	Toma	A: 12/4/1907 T: 14/6/1908 D: 1/10/1908
Koskey (Regan)	Adelaide “Ada” Alberta (alias Kanowna Kate)	A: 21/3/1907 T: 11/5/1908
Kribbenan	Louisa	A: 13/9/1905 T: 29/5/1908
La Herriser	Anna	A: 29/12/1906 Dis: 16/6/1907
Langdon	Elizabeth	A: 11/1/1908 T: 1908
Langsford	Sarah Catherine	A: 11/7/1878 Dis: 11/9/1879
Law Sinclair (Hare)	Margaret “Maggie”	A: 17/7/1902 Dis: 28/9/1902 RA: 3/8/1904 T: 12/6/1908
Leahy	Nellie	A: 26/12/1902 T: 1908
Lechowski	Sophie	A: 18/3/1908 T: 5/6/1908
Lee Gong	Alice May	A: 2/2/1904 D: 12/2/1904
Lefroy	Annette	A: 7/2/1879 Dis: 18/2/1879

Leslie	Charlotte Ellen	A: 14/11/1903 Dis: 5/5/1904
Leverman	Mary Ann	A: 5/11/1903 Dis: 19/6/1904
Lillis	Sarah	A: 2/5/1908 T: 5/6/1908
Lloyd	Hannah Elizabeth	A: 18/9/1881 Dis: 13/10/1881
Lloyd	Joanna	A: 24/4/1873 D: 17/10/1899
Lockyer	Eliza	A: 28/7/1886 Dis: 28/6/1897 RA: 8/3/1907 T: 2/6/1908
Londer	Emma	A: 24/11/1903 D: 16/12/1903
Longmore	Alice	A: 26/3/1893 D: 6/1/1894
Lord	Rose Blanche	A: 29/8/1903 Dis: 21/1/1904
Lyford	Charlotte Isabella	A: 11/1/1904 Dis: 4/5/1904
Lynch	Margaret	A: 1/12/1862 D: 9/8/1870
Mackie	Bridget	A: 12/7/1858 D: 16/12/1882
Maley	Mary	A: 1/8/1891 D: 23/12/1901
Manning	Matilda	A: 24/3/1873 T: 9/6/1908
Markie	Ellen	A: 8/4/1865 D: 29/12/1885
Marsh	Bessy Mary	A: 25/9/1892 Dis: 4/2/1893 RA: 9/2/1893 Dis: 7/6/1893
Martin	Ellen	A: 11/8/1879 Dis: 31/10/1879 RA: 18/11/1886 -
Martin	Mary	A: 19/4/1904 Dis: 3/9/1904
Martin	Maud	A: 18/10/1905 Dis: 1/2/1906

Mathieson	Ellen	A: 9/5/1907 T: 29/5/1908
Matthews	Bertha	A: 16/8/1894 Dis: 28/8/1894 RA: 10/9/1894 Dis: 18/2/1895
Mawby	Alice Sophia	A: 24/8/1906 Dis: 20/11/1906
Mayes	Caroline	A: 1/7/1891 T: 12/6/1908
McAllister	Johanna	A: 30/9/1898 T: 1908
McCabe (Keefe)	Mary	A: 16/11/1896 Dis: 9/9/1898
McCormack	Alice	A: 18/6/1870 Dis: 23/7/1870
McCormick	Catherine	A: 7/10/1858 D: 5/7/1886
McCracken	Marina Elsie	A: 3/7/1907 Dis: 20/11/1907
McDonald	Agnes	A: 4/9/1902 D: 5/5/1904
McDonald	Bridget	A: 6/3/1879 Dis: 22/4/1879
McDonald	Nellie	A: 20/3/1902 T: 2/6/1908
McGee	Agnes	A: 26/11/1885 Dis: 27/3/1886 RA: 23/5/1886 Dis: 18/1/1888 RA: 30/9/1893 T: 11/5/1908
McGregor	Mary	A: 10/12/1906 T: 12/6/1908
McKay	Margaret	A: 3/7/1882 Dis: 23/6/1885
McLaren	Mabel	A: 6/12/1906 Dis: 25/4/1907
McLaughlin	Florence Gertrude	A: 22/10/1903 Dis: 2/5/1904
McMahon	Mary	A: 18/10/1898 T: 2/6/1908
McMahon	Rosanna	A: 23/5/1867 Dis: 3/8/1867

		RA: 18/10/1867 D: 4/3/1907
McRae	Mary	A: 23/6/1896 D: 22/11/1896
Mead	Esther	A: 16/7/1907 T: 12/6/1908
Meade	Bridget	A: 11/9/1886 Dis: 21/9/1886
Melfi	Maria	A: 3/7/1903 Dis: 28/2/1904
Mews	Elizabeth	A: 27/1/1878 Dis: 3/6/1878
Middleton	Rebecca Matilda	A: 8/1/1908 T: 2/6/1908
Milne Johnstone	Margaret June	A: 3/4/1903 D: 21/11/1907
Montgomery	Mary/Margaret	A: 10/11/1886 T: 12/6/1908
Moore	Julia Maria	A: 3/11/1879 Dis: 27/11/1879
Moore	Margaret “Maggie” (alias Mrs Ah Sing)	A: 10/2/1906 D: 12/11/1906
Morell	Ellen Blanche Rose	A: 6/6/1902 Dis: 25/11/1902
Moullin	Agnes	A: 13/12/1907 T: 11/5/1908
Mullins	Margaret A.	A: 2/11/1861 D: 23/1/1879
Murray	Mary	A: 11/3/1892 D: 8/1/1898
Murrie	Agnes	A: 8/5/1907 D: 15/5/1907
Nash	Emily	A: 22/9/1906 T: 1908
Naughton	Mary	A: 16/8/1899 T: 1908
Nicholls	Mary	A: 11/4/1907 T: 1908
Noble	Sarah Jane	A: 4/11/1907 T: 27/5/1908
North	Margaret Emily Frances Muriel	A: 1/1/1906 Dis: 9/8/1906

Nunn	Emily	A: 7/12/1904 Dis: 14/1/1905
O'Brien	Anne	A: 18/3/1867 D: 17/12/1869
O'Brien	Frances	A: 23/8/1907 T: 5/6/1908
O'Byrne	Clementina	A: 2/12/1867 Dis: 20/1/1869 RA: 4/1/1870 D: 1/7/1878
O'Cairn	Bridget	A: 31/12/1902 Dis: 21/9/1903
O'Connor	Caroline	A: 17/11/1906 T: 29/5/1908
O'Grady	Hannah	A: 13/5/1870 Dis: 15/5/1871
O'Reilly	Mary	A: 30/10/1901 T: May 1908
Owen	Minerva "Minnie" Jane Tabitha	A: 17/9/1904 Dis: 12/4/1905 RA: 6/6/1906 Dis: 11/2/1907
Page	Maria	A: 30/5/1903 Dis: 9/9/1903
Payne	Amelia Valentine	A: 19/7/1905 T: 2/6/1908
Paynting	Mary Ann	A: 2/1/1908 T: 12/6/1908
Peskin	Pessie	A: 14/12/1907 T: 5/6/1908
Peter	Mary	A: 25/11/1879 Dis: 4/2/1880 RA: 9/11/1884 Dis: 20/11/1884
Phelan	Mary Hannah	A: 2/3/1908 T: 5/6/1908
Phipps	Ester Jane	A: 4/1/1898 Dis: 9/9/1903
Phoebe	Evelina Lilian May	A: 14/10/1904 D: 23/6/1906
Pidgen	Charlotte	A: 26/4/1888 D: 9/5/1888
Pope (Doran)	Elizabeth	A: 20/11/1861 Dis: 7/7/1862

		RA: - Dis: 31/10/1879
Porter	Amelia (alias Bunowes)	A: 30/9/1899 D: 5/1/1907
Pratt	Mary	A: 12/10/1890 Dis: 18/2/1891
Prince	Hilda Blanche	A: 15/7/1904 Dis: 19/8/1904 RA: 17/9/1905 Dis: 2/1/1906
Prinsep	Charlotte	A: 21/1/1881 Dis: 5/2/1881
Ptolomey	Ann	A: 24/3/1879 D: 10/6/1879
Rampling	Elizabeth	A: 28/3/1876 D: 16/8/1899
Randall	Emily	A: 16/7/1886 T: 5/6/1908
Ranford	Bertha Louisa	A: 3/3/1907 Dis: 14/6/1907
Rayner	Agnes	A: 19/9/1900 T: 8/6/1908
Rayner	Lily/Lillie Frances	A: 13/11/1903 Dis: 23/2/1905 RA: 14/8/1906 T: 16/5/1908
Read	Ellen Selina	A: 17/11/1904 Dis: 22/3/1905
Read	Mary Frances	A: 8/8/1895 Dis: 4/9/1895
Reany	Catherine	A: 15/11/1871 D: 6/12/1906
Reith	Isabella Ada	A: 3/7/1901 Dis: 17/10/1902 RA: 1/5/1903 Dis: 1/4/1905
Reyer	Mary	A: 24/8/1902 D: 6/2/1903
Richards	Mary	A: 8/4/1908 T: 1908
Richardson	Harriet	A: 19/11/1907 T: 8/6/1908
Roberson	Elizabeth Maria	A: 30/6/1907 Dis: 14/9/1907

Robertson	Frances	A: 12/10/1899 D: 29/12/1906
Rodoreda	Isabella	A: 1/10/1888 Dis: 17/12/1888
Rogers	Martha	A: 24/4/1875 Dis: 13/5/1875
Rogers	Mary (Maria) Anne	A: 20/2/1864 D: 15/9/1906
Rogers	Mary Anne	A: 29/3/1906 T: 29/5/1908
Ross	Ann	A: 12/11/1904 D: 17/8/1907
Rouse	Martha	A: 7/7/1894 Dis: 5/11/1894
Rowe	Emily	A: 3/4/1902 Dis: 26/8/1902 RA: 25/10/1905 Dis: 30/6/1906 RA: 4/10/1907 T: 29/5/1908
Rowen/Rohan (Carney)	Margaret Josephine	A: 10/1/1906 Dis: May 1906 RA: 25/3/1907 T: 8/6/1908
Rumble	Lily Amy	A: 16/6/1906 T: 29/5/1908
Ryan	Catherine	A: 7/12/1903 T: 27/5/1908 D: 5/11/1908
Ryan	Kate	A: 2/6/1902 D: 14/6/1902
Ryan Sermon	Mary	A: 26/5/1896 Dis: 6/8/1896
Sakniac	Mary Elizabeth	A: 25/2/1904 D: 19/2/1906
Salter	Clara	A: 10/9/1902 Dis: 11/6/1903
Salter	Sarah	A: 10/7/1858 D: 25/3/1880
Sanders	Louisa Charlotte	A: 4/12/1907 D: 9/5/1908
Sang	Omurnie	A: 3/9/1903 T: 1908

Saunders	Ada	A: 22/12/1899 T: 11/5/1908
Scanlon	Bridget	A: 4/5/1908 T: 5/6/1908
Scarlett	Emily Maria	A: 7/4/1906 Dis: 21/6/1906 RA: 10/4/1907 Dis: 17/7/1907
Schneider	Emma	A: 27/8/1903 Dis: 14/12/1906
Schwarz	Clara	A: 18/4/1907 T: 5/6/1908
Scollard	Catherine	A: 18/2/1894 Dis: 19/4/1894 RA: 11/4/1895 D: 20/8/1906
Scott	Jeanie	A: 2/9/1905 D: 4/10/1905
Scott	Louisa	A: 20/10/1887 T: 12/6/1908
Secombe	Evelyn	A: 27/2/1907 T: 29/5/1908
Selway	Laura H.	A: 27/6/1896 Dis: 21/10/1896
Sforcina	Louisa Mary	A: 5/8/1907 Dis: 1/3/1908
Sharkey	Bridget	A: 18/7/1900 T: 29/5/1908
Shaw	Mary Ellen	A: 7/7/1903 T: 1908
Shaw	Sarah	A: 26/8/1903 D: 2/10/1903
Shawyer	Rachel Mary	A: 11/4/1905 D: 17/6/1906
Sheedy	Margaret	A: 18/3/1897 T: 1908
Sherry	Bridget	A: 22/3/1905 T: 8/6/1908
Simms	Elizabeth	A: 16/12/1901 T: 1908
Skrimski	Hannah	A: 1/11/1905 D: 25/5/1907
Smith	Anne/Annie/Ann	A: 30/12/1871 Dis: 25/2/1873

		RA: 11/6/1874 D: 8/1/1881
Smith	Emily	A: 31/12/1904 T: 8/6/1908 D: 6/8/1916
Smith	Jane	A: 8/4/1884 D: 7/7/1893
Smith	Jane	A: 8/4/1905 T: 5/6/1908
Smyth	Mary Jane	A: 28/9/1881 Dis: 11/10/1881
Smyth	Rachel	A: 20/3/1907 T: 11/5/1908
Souper	Elizabeth	A: 10-12/7/1858 Dis: 30/1/1871
Spark	Sarah Ann	A: 7/8/1904 D: 14/12/1905
Spencer	Louisa	A: 20/12/1896 Dis: 26/3/1897
Squires	Alice	A: 30/4/1906 T: 27/5/1908
Stacey	Charlotte	A: 9/5/1899 Dis: 13/8/1906
Stanbrook	Ann	A: 11/7/1902 T: 1908
Stapp	Katherine	A: 2/11/1903 Dis: 7/6/1904
Stephens	Emma	A: 15/4/1903 D: 11/12/1903
Stirling	Christina Laura	A: 13/9/1900 D: 14/11/1904
Stockdell	Elizabeth	A: 1/5/1907 Dis: 18/9/1907
Stokes	Catherine	A: 12/7/1858 D: 8/9/1874
Straube	Emma	A: 12/12/1901 Dis: 24/6/1902
Sylvester	Joanne	A: 20/4/1878 D: 22/5/1881
Taylor	Eliza	A: 11/8/1882 Dis: 3/1/1883
Taylor	Mary	A: 25/10/1862 Dis: 2/12/1869

		RA: 26/2/1870 Dis: 30/9/1871 RA:6/5/1872 D: 11/5/1892
Taylor	Mildred Mary	A: 20/2/1888 Dis: 10/4/1888
Tegadine/ Tegerdine	Rachel	A: 3/6/1902 T: 1908
Thompson	Ellen Matilda	A: 2/3/1907 T: 12/6/1908
Thompson	Helena Jean	A: 26/7/1907 Dis: 11/1/1908
Thompson	Hester Ann	A: 26/12/1895 Dis: 11/1/1896
Thompson	Mary	A: 4/11/1871 T: 11/5/1908
Thompson	Rebecca Rosanna	A: 20/10/1901 Dis: 20/8/1904 RA: 17/8/1905 Dis: 2/7/1906
Thompson	Sarah	A: 10/3/1900 T: 1908
Thornton	Isabella	A: 3/6/1902 T: 1908
Tippett	Anne	A: 16/4/1864 Dis: 16/5/1865 RA: 15/3/1866 D: 30/8/1883
Tonkin	Sarah	A: 26/8/1907 T: 1908
Toohey	Annie	A: 23/6/1900 Dis: 7/2/1902
Toohey	Margaret	A: 22/9/1897 T: 27/5/1908
Tracey	Mary	A: 26/12/1906 D: 9/1/1907
Tredrea	Emily Elizabeth	A: 31/10/1885 Dis: 16/11/1885
Trew	Selina	A: 5/6/1906 Dis: 28/11/1906
Trigg	Agnes Ethel	A: 22/4/1886 T: 29/5/1908
Turner	Selina	A: 13/5/1874 Dis: 6/7/1874 RA: 2/11/1886

		Dis: 26/11/1886 RA: 9/10/1894 Dis: 15/12/1894 RA: 6/2/1902 D: 7/8/1903
Vernon	Laura	A: 21/7/1906 Dis: 30/4/1907
Waddingham	Caroline	A: 14/8/1905 Dis: 5/8/1906
Wallgren	Letitia Amelia	A: 26/7/1907 T: 8/6/1908
Walsh	Hannah	A: 24/11/1902 T: 29/5/1908
Walsh	Margaret	A: 12/11/1907 T: 12/6/1908
Walsh	Mary	A: 30/1/1880 Dis: 13/10/1881 RA: 13/7/1882 Dis: 17/3/1886 RA: 7/5/1897 Dis: 1/9/1899 RA: 5/8/1901 D: 3/1/1907
Wansbrough	Emily Millicent	A: 10/12/1904 T: 1908
Ward	Christina	A: 20/5/1903 D: 15/6/1903
Warren	Mary	A: 8/12/1906 T: 11/6/1908
Watson	Mary Elizabeth	A: 14/11/1903 T: 11/5/1908
Watson Henderson	Agnes	A: 14/8/1902 T: 12/6/1908
Weir	Eliza	A: 18/2/1907 Dis: 15/6/1907
Weir/Wear	Annie/Ann (Hannah)	A: 25/6/1876 Dis: 26/7/1876 RA: 9/9/1876 Dis: 4/10/1876 RA: 1/10/1879 Dis: 31/1/1880 RA: 1/10/1880 Dis: 31/10/1880 RA: 5/2/1881 T: 1908
Whaley (Stewart)	Kate	A: 30/3/1898 T: 2/6/1908

Wilkins/Wilks	Caroline	A: 2/1/1882 Dis: 19/8/1882 RA: 25/9/1884 Dis: 7/2/1885 RA: 20/3/1889 Dis: 17/7/1889 RA: 19/9/1890 Dis: 21/9/1893 RA: 24/12/1895 D: 4/2/1903
Winterhalter	Caroline	A: 14/2/1901 T: 9/6/1908
Wood	Margaret	A: 7/12/1889 D: 29/5/1890
Woodward	Ada	A: 25/10/1902 Dis: 25/2/1903
Woolhouse	Pricilla	A: 21/8/1882 Dis: 23/12/1882
Wright	Catherine	A: 3/4/1896 D: 18/10/1906
Wright	Lola	A: 8/7/1892 Dis: 30/7/1892 RA: 31/7/1895 Dis: 12/9/1899
Wynne	Alice	A: 20/5/1907 T: 8/6/1908
Yandell	Leonora	A: 27/12/1902 Dis: 10/3/1903
Young	Barbara Annie	A: 24/12/1905 T: 5/6/1908
-	Maria (Native)	A: 27/2/1878 Dis: 15/3/1878 RA: 18/3/1878 Dis: 17/9/1878 RA: 9/6/1884 Dis: 7/7/1884
-	Omoyal	A: 13/3/1900 Dis: 16/5/1903
-	Giety (alias Cranky)	A: 13/3/1903 D: 30/5/1907
-	Lame Polly (Aboriginal)	A: 23/3/1906 D: 25/4/1906
-	Cannering (alias Darkie)	A: 13/7/1906 T: 1908

Female Patients who were admitted during 1898-1900 and are NOT included in data collection[2]		
Surname	Given names	Admission/Discharge/Death/Transfer
Albert	Ethel Martha	A: 9/5/1900 Dis: 16/5/1900
Aldean	Annie	A: 9/10/1900 Dis: 16/11/1900
Burns	Essey/Essie	A: 8/6/1899 Dis: 22/3/1900
Burrows	Annie	A: 30/9/1899 -
Cardwell	Mary	- Dis: 3/8/1900
Clifford	Catherine	A: 11/5/1900 Dis: 22/6/1900 RA: 2/7/1900 D: 28/9/1900
Crawford	Annie	A: 5/9/1900 -
Cunningham	Louisa	A: 23/4/1899 D: 25/4/1899
Daulby	Annie	- Dis: 14/3/1898
Ellis	Mary	A: 30/1/1899 Dis: 5/3/1899
Fallon	Mary	A: 6/1/1901 -
Ferguson	Ruth	A: 17/12/1898 Dis: 4/6/1900
Freman	Dora	A: 5/11/1898 Dis: 11/5/1899
Gettrel	Mary Ann	- Dis: 16/12/1899
Gollins	Bridget	A: 4/5/1900 Dis: 16/5/1900
Heggins (Higgins)	Martha	A: 2/4/1898 Dis: 22/6/1898
Holt	Susan	A: 21/6/1898 D: 13/4/1899
Horgan	Mother Joseph	A: 14/4/1898 D:18/12/1900

[2] Data accessed from: *Female Occurrence and Daily Strength Book*, 1895-1901, AU WA S2216 Cons 75455.

Housten	Emily	A: 18/5/1898 D: 13/2/1899
Hughes	Maria	A: 20/6/1899 Dis: 12/12/1899
Hutton	Emily	A: 27/6/1900 -
Isles	Emily	A: 19/8/1899 D: 30/10/1900
Lean/McClean	Charlotte	A: 19/3/1898 Dis: 15/4/1899
Lewis	Jessie	- Dis: 7/2/1898
Lloyd	Amy Mary	A: 4/7/1899 D: 3/12/1899
Marriott	Margaret	A: 29/7/1898 Dis: 5/2/1899
McCaskell	Laura	A: 22/9/1899 Dis: 30/9/1899
McMahon	Catherine	A: 17/6/1899 D: 21/10/1899
O'Leary	Bridget	A: 2/6/1899 Dis: 22/2/1900
Oldfield	Eliza	A: 14/5/1898 Dis: 22/5/1898 RA: 19/7/1900 -
Pillard	Bella	A: 21/12/1899 Dis: 24/4/1900
Purcell	Annie	A: 14/6/1900 Dis: 15/10/1900
Rigby	Catherine	- Dis: 23/10/1899
Rodgers	Emily	A:11/1/1898 Dis: 5/2/1898
Ross	Mary	- Dis: 13/1/1899
Scott	Emma	A: 23/1/1899 Dis: 20/2/1899
Stewart	Bridget	A: 23/3/1899 Dis: 7/7/1899
Thomas	Rachel	A: 27/6/1900 Dis: 18/8/1900

		RA: 15/9/1900 Dis: 29/10/1900
Tondutt	Charlotte	A: 18/9/1900 -
Travis	Alice	A: 20/7/1899 D: 23/7/1899
Vinnier/Vinneir	Catherine	A: 26/5/1900 -
Ward	Sarah	A: 5/1/1899 Dis: 6/7/1899
Wells	Margaret	A: 3/10/1900 Dis: 2/11/1900
Westley	Bertha	A: 23/2/1898 Dis: 3-4/6/1898
Weston Cowley	Edith	A: 13/7/1898 Dis: 17/7/1898
Whitehurst	(Ellen) Sarah	A: 19/8/1899 D: 16/10/1899

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