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Maternal insanity in Victoria, Australia: 1920-1973

Alison Watts

Southern Cross University

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Maternal Insanity in Victoria, Australia:

1920–1973

Alison Watts, BA (Hons)

A thesis submitted in fulfilment of the degree of

Doctor of Philosophy

Southern Cross University

2 September, 2015
Thesis Declaration

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Alison Watts, 2 September, 2015.
Abstract

This thesis examines puerperal insanity and child-birth related illnesses in early twentieth-century Australia. It investigates the psychiatric and social discourses that linked motherhood and birthing with mental illness. The research draws on clinical case notes of thirty-one patients, including a member of the researcher’s family, Ada (pseudonym). These women were committed to Royal Melbourne Reception House, Victoria, between the years 1920 and 1936.

The work examines the ways that nineteenth-century medical interest in women’s diseases remained highly influential on twentieth-century ideas of gender, mothers and mental illness. In particular, a diagnosis of puerperal insanity could be prompted by any one of several symptoms; violent and harmful behaviour, hallucinations or mania. It usually occurred within the days or weeks following childbirth, and for mothers the condition was known to cause death, suicide, and at its worst, infanticide, at a time usually associated with joy within the family.

Scholars generally agree that the diagnosis of ‘puerperal insanity’ belonged to the nineteenth century, when child-birth was connected to a host of women’s diseases perceived as affecting their brain. However, the thirty-one women’s patient clinical notes used in this study illustrate that puerperal insanity remained a valid cause to commit mothers in Australia, even though it was no longer in use in Britain and the United States by the turn of the century, according to historical studies cited in this thesis. This thesis is significant in its contribution of new knowledge to the history of puerperal insanity and
maternal insanity in Australia, as no other work has been undertaken on these topics in the early twentieth century context. It therefore seeks to address this gap.

This thesis applies feminist poststructuralist approaches to the ways both psychiatric and lay language constructed mothers as ‘unfit.’ It is set in the social context of the federated nation, where women continued to be caught in nineteenth-century gendered power relations in both the patriarchal nature of families, psychiatry and medicine. It provides distinctive aspects of puerperal insanity unique to the context of twentieth-century Australian women, as well as to medical and psychiatric contexts and conditions. This thesis argues that given the ‘othering’ of mothers in psychiatric and social discourses within the patriarchal society, a diagnosis of puerperal insanity and birth-related illness was often arbitrary, and that it instead should be understood as directly linked to cultural beliefs about the home, family and the mother role.
Acknowledgements

I would like to thank my two supervisors: Dr Angela Coco, my chief supervisor at Southern Cross University and Professor Catharine Coleborne, my co-supervisor from the University of Waikato, New Zealand and recently the University of Newcastle for their expert guidance and encouragement. Sincere thanks to the archivist Catharine Greene who has assisted greatly in the collection of the women’s files and her willingness for ongoing assistance. I am also especially grateful to Karen whose warmth and generosity helped to make this a very rich thesis.

I would also like to thank my fellow PhD candidates who have shared this journey with me at various stages: Robert Lingard, Theresa Mason and Monica Torland. The networking opportunities with postgraduate students through my service with the Southern Cross Postgraduate Association management committee has been very rewarding. I would like to thank Craig Wilson who provided me with feedback on early drafts and especially Branca Mircev whose strong friendship, support and insights have sustained me throughout my candidature.

I thank my family: my son Lucas who grew from a young teenager into a bright young man over the course of my study. My father Barry, for believing in me and the value of the project and providing a wealth of stories, books, research leads and editing support.

Thank you
Dedication

I dedicate this thesis to my father Barry and my grandmother, with love.
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<th>Description</th>
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<tbody>
<tr>
<td>AIF</td>
<td>Australian Imperial Forces</td>
</tr>
<tr>
<td>AS</td>
<td>Accession Number</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<tr>
<td>DSM</td>
<td>Diagnostic Statistical Manual</td>
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<td>ECN</td>
<td>Ethical Clearance Number</td>
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<tr>
<td>FOI</td>
<td>Freedom of Information</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GPI</td>
<td>General Paralysis of the Insane</td>
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<tr>
<td>HREC</td>
<td>Higher Research Ethics Committee</td>
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<tr>
<td>ICT</td>
<td>Insulin-Coma Treatment</td>
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<td>NEAF</td>
<td>National Ethics Application Form</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>PND</td>
<td>Postnatal Depression</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SCU</td>
<td>Southern Cross University</td>
</tr>
<tr>
<td>TAB</td>
<td>Typhoid types A and B vaccine</td>
</tr>
<tr>
<td>VPRS</td>
<td>Victorian Public Record Series</td>
</tr>
<tr>
<td>WRANS</td>
<td>Women’s Royal Australian Naval Services</td>
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Publications

The following works were produced as part of this research project:

Introduction: Maternal insanity in Victoria, Australia: 1920–1973

The patient is cheerful and talkative. She says that lately she has had numerous auditory and visual hallucinations. She is quite disoriented as regards time and place. Her answers to questions are quite irrelevant and she smiles and says she is cheerful for most of the time.
- Ada, Royal Park Receiving House Patient Clinical Notes, AS/94/508/129

Continuous irrelevant talking & whistling. She accuses certain persons of poisoning and murdering many children. Had an attack after birth of son 7 years ago. Child was born 2 weeks ago. She claims her father is King of Spain and is a Russian. Rambles from one subject to another in an incoherent fashion.
- Joanne, Mont Park Clinical Patient Notes, AS/1994/00104/0021

Introduction

This thesis examines the histories of women committed to Victorian mental institutions with puerperal insanity and childbirth related ailments in the early twentieth century. It investigates how puerperal insanity came to be equated with ‘unfit’ mothers at a time when childbirth was perceived as the key event in causing insanity in mothers. Puerperal insanity usually occurred within days or weeks following childbirth and was known to be accompanied by violent and harmful behaviour, hallucinations and mania. Scholars agree that the diagnosis of puerperal insanity emerged in the nineteenth century at a time when childbirth was viewed as being connected to a host of women’s diseases.

The study is based on thirty-one women’s mental patient files. These women were all diagnosed with puerperal insanity and childbirth related ailments. All were committed to Royal Melbourne Reception House, Victoria, between the years 1920 and 1936. One patient is a member of the researcher’s family, Ada (pseudonym), who was diagnosed with ‘puerperal insanity’ and committed in 1936. This study examines the ways puerperal insanity remained a valid diagnosis for the committal of mothers, though scholars believed it was no longer in use in Britain and the United States by the twentieth century.
Puerperal insanity was a broad, general term which ‘encompassed diverse forms of mental illness associated with childbirth’ with symptoms ranging from violence, delusions, mania and melancholia.\(^1\) It usually occurred within days of giving birth, with good prognosis of recovery, but was known to be occasionally fatal.\(^2\) It has long been recognised that acute mental disturbance can occur following childbirth, and has been called ‘puerperal mania’, ‘puerperal insanity; or ‘puerperal psychosis.’\(^3\) Hilary Marland argues that the psychiatric profession’s increased focus on puerperal insanity from the mid nineteenth century onwards, with a proliferation of publications on its identification and treatment, the condition gained wide acceptance in psychiatric literature.\(^4\) It was one of the most clearly recognised disease entities of the nineteenth century as doctors confidently recognised childbirth as the key moment of instability and the common cause of insanity in women.\(^5\) Scholars Elaine Showalter and Ian Brockington agree that puerperal insanity was responsible for seven to ten per cent of female asylum admissions in the nineteenth century.\(^6\)

Many articles were devoted to the condition in medical journals written by both obstetricians and alienists (specialists in charge of asylums).\(^7\) The nineteenth-century

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\(^3\) Ibid. p. 200.
medical debates regarding mental diseases assumed ‘insanity’ was an ‘illness’ that required medical and psychiatric attention. Stephen Garton warned these debates should be treated with suspicion when ‘there is no generally agreed upon definition of insanity or precise knowledge of its causes and cures.’ The same can be said of puerperal insanity: it was without a widely accepted definition, it had wide ranging symptoms, and there were varied theories of its cause, including childbirth, and it involved numerous treatments. Despite this, medical doctors defined insanity as a disease, and the asylum as the only place for the specialist care of patients.

The formative background to this early twentieth-century study can be found in the wide acceptance of puerperal insanity in the nineteenth century. Historians have examined the long-held assumptions that women’s reproductive systems were thought to be the cause of a range of mental disturbances. The uterus (or womb) was thought to lead to insanity, particularly at vulnerable times of menstruation, childbirth, lactation and menopause. This set of psychiatric theories fixed female madness to the reproductive cycle exemplified by puerperal insanity. Nineteenth-century medical arguments were used to

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legitimise traditional roles for women as wives and mothers only, and to disqualify women’s access to education and career development.\textsuperscript{14} The surge of cases of puerperal insanity in the nineteenth century challenged Victorian ideals of maternal love, domesticity and feminine propriety.\textsuperscript{15} Insane mothers who committed the act of child murder or infanticide, were treated with compassion in court proceedings by pleading insanity and received a lesser sentence.\textsuperscript{16}

\textbf{Justification for the research}

The justification for this research is that there has been no work undertaken on puerperal insanity in twentieth-century Australia. This lack of scholarly attention is due to two main factors: first, the restricted access to twentieth-century mental patient files, and second, scholars agree that puerperal insanity was dropped from psychiatric classifications at the turn of the twentieth century. This thesis undertakes to examine this history and to address both these factors.

Limited access to twentieth-century mental patients’ files over time has prevented historical examinations of themes and data central to this study. Current embargos severely restrict the writing of the histories of institutions and their patients.\textsuperscript{17} The few studies that have been undertaken reflect the more flexible approach to accessing files in the 1980s and 1990s. For example, Stephen Garton’s study of New South Wales mental patients used patient files he accessed through the NSW State Archives office.\textsuperscript{18} Jill

\begin{itemize}
\item \textsuperscript{15} Showalter, \textit{The Female Malady} (1985), p. 58.
\item \textsuperscript{17} Stephen Garton, 'Shut Off from the Source', \textit{The Australian}, 22 November, p. 45.
\item \textsuperscript{18} Stephen Garton, \textit{Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940} (Sydney, New South Wales University Press, 1988).
\end{itemize}
Matthews had the support of the then South Australian Director of Mental Health Services, the Superintendent of Glenside Hospital, and the Glenside Hospital Research Committee to access their female patient records. Psychiatrist John Cawte wrote a non-academic memoir using patient files from Enfield Receiving House in Adelaide, South Australia, where he was the superintendent between 1951 and 1963. Cawte found the patient files had been saved and stored, once the Receiving House had been demolished. However, since the production and publication of these studies, the shift towards tighter controls closed access to patient clinical notes and resulted in very few studies of twentieth-century Australian patients and institutions.

For the present study, I gained permission to access Ada’s patient case files as a family member through the Freedom of Information Unit in Victoria. The further thirty files, normally closed for seventy-five years, were accessed through permission from the then Victorian State Minister for Health and the state Chief Psychiatrist. The justification for this research seeks to address the lack of work undertaken on twentieth-century female patients in Victoria, and in this way, this thesis complements Garton’s work on New South Wales patients and Matthews’ work on South Australian patients. In drawing from files normally closed, this research will act as precedent to the remaining modern archive when it is released.

The second justification for this research concerns my wish to counter historians’ arguments that puerperal insanity had all but disappeared by the twentieth century. The

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21 Shut Off from the Source, p. 45.
use of the term puerperal insanity and childbirth related illness in Ada’s files, and in those of her thirty peers, illustrates that puerperal insanity had currency as a valid reason to commit mothers in early twentieth-century Australia. Hilary Marland argues ‘it began to be written out of psychiatric textbooks and out of asylum records’ in Britain by the twentieth century due to Emil Kraepelin’s re-classification of mental disorders at the turn of the century.22 Kraepelin, an eminent German psychiatrist, separated psychosis into two distinct categories: dementia praecox and manic-depressive in 1899, effectively leaving puerperal insanity out of psychiatric classification.23 Ian Brockington and his colleagues concur that puerperal insanity was ‘one of the clearly recognised psychiatric entities during the nineteenth century’ and by the twentieth century it became the ‘casualty of the Kraepelin diagnostic system.’24 Irvine Loudon suggests Kraepelin effectively consigned puerperal insanity to oblivion, with no official existence.25 David Healy and his colleagues point out that Kraepelin saw no unique features of the post-partum period which led to puerperal insanity vanishing from his re-classifications and being subsumed under the manic-depression category.26 However, the treatments of Ada, and the other mothers in this study, illustrate that the diagnosis of puerperal insanity, and reference to childbirth-related ailments were both still in use in Australia to commit ‘unfit’ mothers up to 1936. This evidence provides a clear justification for investigating how and why puerperal insanity was still in use in Australia, especially when the scholars cited above argue it had disappeared from use by the twentieth century due to Kraepelin’s re-

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classification of mental disorders.

**Research aim**

The principle aim of this research is to investigate the issues that connected perceived ‘unfit’ mothering with mental illness, which resulted in the diagnosis of ‘puerperal insanity’ in Victoria. The central question of the research is therefore: how were Australian women constructed as ‘unfit’ mothers, leading to the diagnoses of puerperal insanity and confinement to mental institutions in the early twentieth century?

The diagnosis of puerperal insanity is the juncture point where perceived ‘unfit’ motherhood, and committal as insane, intersects. As childbirth was the key event described in diagnoses, this work investigates how puerperal insanity came to be equated with ‘unfit’ mothers. It therefore provides ways to investigate ideologies of maternity, domesticity and femininity specific to mothers in Victoria in the interwar years. This work addresses gendered power and treatments within the psychiatric milieu of Victorian institutions. Gendered discourses which circulated among psychiatric professionals are examined for the ways these influenced the type of treatments prescribed to women. Therefore, the objective of this study is to examine both the psychiatric and social construction of puerperal insanity equated with ‘unfit’ mothers.
**Research approaches**

This work uses Foucauldian theories to analyse the ways psychiatric discourses and practices construct patient identities. Foucault insisted on historical specificity that ‘reflects the discourses that were prevalent in society at the time in which the files were created.’

The present study draws upon the nineteenth-century legacies in the wide acceptance of puerperal insanity, the rise of asylums, and the professionalisation of psychiatry relevant to Australian conditions as a British colony. Additionally, feminist poststructuralist approaches allow me to offer a critique of the dominant psychiatric account that women’s reproductive abilities were responsible for a whole host of sicknesses, diseases and insanity. I argue here that the legacy of gendered nineteenth-century power relations continued to have significant bearing on pathologising mothers in twentieth-century Australia.

Puerperal insanity, centred on the event of childbirth, and a specific disorder affecting women, provides the opportunity to apply feminist maternal theories. On the one hand, ‘mother blame’ is found in the historical discourses of eugenics and heredity degeneration, and at the same time, fears concerning the lack of population growth insisted that European mothers populate the new federated nation with white babies.

Shifting ideas of ‘good’ and ‘bad’ mothering emerged and was reflected in both the broader society and in the language of psychiatry, as notions of ‘unfit’ mothers changed over time, with differing historical, social and cultural contexts.

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The thesis then moves away from historical methodologies into feminist social science approaches, marked by low-risk interviews, family stories and the researcher’s reflective journal. The researcher’s position is stated, as both outsider and insider as a member of Ada’s family, in a brief self-reflexive section. This set of approaches is particularly relevant to the chapter devoted to Ada’s biography, which blends historical, social science and feminist discourses. The biographical approach has its limitations, because Ada was lost to our family due to her thirty years of confinement in several Victorian institutions. During this confinement, Ada resided and worked in Dr Donnan’s family home, the superintendent of the Beechworth Mental Hospital, during the late 1950s and early 1960s. In addition to Ada’s clinical patient files, her biography is powerfully supplemented by interviews with a member of Dr Donnan’s family. This supplementary material provides substantial richness and insight into Ada’s life not available through her clinical notes.

**Contributions of this thesis**

The major contribution of this thesis lies in its analysis of the ways that puerperal insanity continued to have currency and power as a valid diagnosis into the twentieth century, as it had done in the century before. It concerns psychiatrists’ preference for the term ‘puerperal insanity’ in the twentieth century, perhaps arguably for its strong connection between a recent birth and pregnancy and mother’s mental instability. There are several arguments which together account for this. Australian doctors ignored Kraepelin’s new classification system, which subsumed puerperal insanity into the category of manic-depression. This new system may not have adequately described the clinical picture Australian psychiatrists saw in mothers. At the same time, several scholars argue the
rapid pulse and delirium of high fevers following childbirth were often misread as puerperal insanity, as many as ‘30 per cent to 40 per cent of cases of puerperal insanity were attributed to toxic psychoses in the first half of the twentieth century.\textsuperscript{29}

The transfer of infection from patient to patient by birth attendants was not understood until the mid-1920s.\textsuperscript{30} Infection was finally brought under control with the use of sulphonamide drugs in 1935, and by 1944, the use of penicillin.\textsuperscript{31} Mothers could have been suffering from serious infection transferred by unhygienic practices in medically assisted births. The symptoms of infection connected childbirth to mental instability, in the form of hallucinations and fever, similar to the symptoms doctors had seen in cases of puerperal insanity. This had grave implications for the group of mothers in this present study, who gave birth in a time before penicillin was introduced.

In addition, doctors in general practice were bound by the compulsory legal requirement in the provision of two certificates. This necessitated the recording of some form of insanity to certify and admit patients into mental institutions. Doctors may have recorded ‘puerperal insanity’ and other birth-related ailments as a necessity to meet bureaucratic requirements in the committal certificates. In some cases, ‘puerperal’ related insanity appears to be arbitrary, particularly for some mothers whose most recent childbirth was years before committal. Other reasons for mental breakdown can be found deep within


\textsuperscript{30} Janet McCalman, Sex and Suffering: Women’s Health and a Women’s Hospital: The Royal Women’s Hospital, Melbourne, 1856-1996 (Melbourne, Melbourne University Press 1998), p. 33.

the file notes included marriage troubles, failure in love, childbirth when unwed, multiple pregnancies, miscarriage, marriage annulment, husband’s unemployment and desertion, grief and loss following the Great War, and financial ruin during the Great Depression. These problems were connected to social issues, such as poverty, the pressures of working-class motherhood, and illegitimate births, for example, all of which indicate puerperal insanity was not simply or necessarily connected to a recent childbirth, but in fact related to the many aspects connected to being a wife and mother in this era. Therefore, puerperal insanity was a diagnosis applied broadly to any distressed mother who presented to a psychiatrist.

Ann Oakley, who studied sixty-six women having their first babies in London in the mid-1970s, argues that a negative birthing experience, one that involved unwanted intervention, predisposed mothers to postnatal depression. The files in the present study lack much detail on the kind of labour and birth the women experienced, despite childbirth being the key event for precipitating a diagnosis of puerperal insanity. However, with hospital births on the increase in the period under investigation, women may have had negative experiences of medically assisted birth, especially when suffering the complications from anaesthesia, instruments and surgery. In this way, insane mothers were caught between the separate professions and distinct knowledges of medicine, psychiatry and obstetrics.

Women committed to institutions with puerperal insanity in the interwar period were subject to separate expert knowledges, the social pressures of maternity, and risks of

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infection from medicalised hospital births prior to the advent of penicillin. This study examines the experimental psychiatric treatments applied to this group of women, within the walls of the institution. These treatments included typhoid inoculation, insulin-coma treatment, therapeutic abortion and sterilisation. As was the case with nineteenth-century practices, psychiatrists struggled to produce efficacious treatments. Puerperal insanity sits at the nexus point; it links the ways psychiatric discourses construct ‘unfit’ mothers and how these ideas translated into, and were informed by, the cultural ideals of the ‘good mother’ within the social contexts of domesticity, femininity and maternity. This thesis traces these nineteenth-century legacies and provides distinctive aspects of puerperal insanity unique to the Australian twentieth-century context and its conditions.

**Overview of the thesis**

The overall structure of the thesis is comprised of seven chapters, including this introductory chapter and five themed chapters. It is an interdisciplinary thesis where each chapter draws upon different qualitative methods that require various methodological approaches. The relationship between the chapters and the range of disciplinary theories and concepts remain essentially empirical with each section contributing to the overall picture in the mental health issues concerning mothers in the early twentieth century. The combination of history, social history, family history and biography provides an original thesis that is innovative and unique in its approaches.

Chapter One discusses the practice of historiography and literature review. It also briefly examines the positionality of the researcher through a self-reflexive inquiry. This is particularly relevant, because as the researcher, I am also a member of Ada’s family,
which led me to begin this study. The chapter outlines the historical methodological approaches that explain the particular use of the primary documents used in this study, the patient clinical notes. In addition, because birthing and motherhood are specific to women, the chapter also makes the case for the feminist approach taken to this study. In particular, feminist poststructuralist approaches examine the ways discourses constructed ‘unfit’ mothers as insane. The writing of Ada’s biography combines several methodological approaches, from both historical and social sciences, which draw information from Ada’s patient files, interviews with Sally, the daughter of Beechworth Superintendent Dr Donnan, and our family stories.

Chapter Two introduces the methods and explains the position of the researcher as both outsider and insider more closely. It describes the process of gaining access to Ada’s files through the Freedom of Information Unit as a family member, which initiated the researcher into this field of study. It also discusses the early changes to the research design and the ethical dilemmas in family research raised by the university’s ethics committee. The chapter explains in full the process of the collection of the further thirty mental patient files, a process which has taken the same diagnosis, institution and era as Ada herself to determine the selection of cases. Lastly, it shows how the multiple qualitative methods used to narrate Ada’s biography draw from a bricolage of sources.

The history of women’s madness is examined in Chapter three. Specific attention is given to puerperal insanity in the nineteenth century, as evidence of gendered power relations in nineteenth-century Britain. The psychiatric theories that fixed female madness to the reproductive cycle are examined in-depth, with a particular focus on childbirth as the key event in diagnosing ‘puerperal insanity’. This is set in the context of the professional
competiveness that wrestled for dominance over women’s diseases, childbirth and puerperal insanity, between midwifery, obstetrics and psychiatry. In an Australian context, the analysis of women patients in Australian colonial asylums provides context and background to the mothers in this study who were committed in the early twentieth century.

A brief biography of Ada’s life is presented in the fourth chapter, which draws from her patient files, interviews and family stories. Biography is an historical method which provides some insights into Ada’s social situation and her subsequent thirty years in mental institutions in Victoria. Ada is reconnected to our family’s history, having stemmed from the sense of discontinuity and of broken lineages. There are gaps in Ada’s life story when she was lost to our family through her years of institutionalisation. This has meant that some details of Ada’s early life and the connections to her family of origin have become obscured. By drawing from her patient files, this chapter recounts the first six years of her trial leave at home and the intensive treatments Ada underwent. The mid-1950s marks a new phase for Ada, when she was transferred to a large mental institution at Beechworth, situated in rural Victoria. Here, Ada lived and worked in Dr. Donnan’s home, the superintendent in charge of the institution. Ada’s files say little about this time, but are powerfully supplemented by interviews with Sally (pseudonym), Dr. Donnan’s daughter. It goes on to describe the early 1960s, and the circumstances in which Ada was rediscovered by her then adult children. Historians of Australian women have long recognised that family secrets, lies and silences offer radical potential in family histories, whether complex
colonial family structures, aboriginality or in Ada’s case insanity. In chapter four Ada is reconnected to our family’s history and I reflect on the family stories and the issues of ethical family research.

Chapter Five provides an in-depth reading of the mental patient files of all thirty-one mothers committed to Royal Melbourne Reception House, Victoria, between the years 1920 and 1936. Reception houses served as the initial place for observing patients and provided short-term treatment. If patients were considered incurable or chronic at the Royal Melbourne Reception House, they were transferred to Mont Park Hospital for the Insane. The analysis of the gendered construction of patient identities as ‘unfit’ mothers’, draws on the psychiatric language used to connect childbirth with insanity. The chapter examines the emergent themes from these mothers’ files, including their employment prior to committal, unwed mothers, patients’ silences, the roles of husbands and relatives in women’s committals, the threat of and fear of violence, and patients’ religious expression. The patient’s expression of emotions are analysed, some expressing despair for their children and loss of their own maternal identities. The constraints of motherhood, the increase in scientific mothering and the rise of professional advice during the 1920s and 1930s are examined for ways both families and psychiatry policed mothers’ behaviour.

Chapter Six examines the gendered treatments, both medical and social, applied to the female patients within the mental institutions. Ideally, treatments attempted to procure

recovery and return the mother to her family in order to assume her domestic responsibilities. In the 1920s and 1930s, insanity was thought to be a physical disease of the body and doctors believed patients were in need of somatic treatments. Some of the physical treatments discussed include typhoid vaccine, the Wasserman test used to detect syphilis, and insulin-coma which were applied to all types of asylum patients, whereas sterilisation and therapeutic abortion applied to one female patient only. The second kind of treatments examined in this chapter is the twentieth-century approach to social therapeutics. These include work therapy, trial leave, leisure activities, occupational therapy and religious practice. The ways mothers achieved recovery, discharge and release, whether through physical or social treatments or a combination of both, is further examined.

Finally, Chapter Seven draws upon the entire thesis, tying up the various theoretical strands in order to summarise findings and the implications of this research. It sets out the contributions to knowledge and methodology made by this thesis. It also puts forward some possible opportunities for further research. Finally, the thesis ends on a note of reflection and looking back at its processes of research and interpretation. The researcher’s journey is articulated through the reflective journal provided as an epilogue to this thesis titled Epilogue: The Researcher’s Journey.

**Conclusion**

This thesis examines the ways psychiatrists found puerperal insanity as a legitimate reason for the cause of women’s insanity, when it had been dropped from use in Britain and the United States. It uses poststructuralist, feminist and historical approaches in its
examination of the language used to construct women’s identities as ‘unfit’ mothers. In Australia, doctors continued to link childbirth with insanity, as they had done in the century before. Psychiatric discourse persistently viewed insanity as a physical disease that required physical treatments well into the twentieth century. For many women, both married and unmarried, pregnancy and giving birth was the last straw, placing them in precarious and disadvantaged positions.

The social context between the two world wars was an era marked by the rise of experts in maternal and baby health care. Experts imposed the ideology of scientific mothering, a controlling influence by distinguishing ‘good’ from ‘bad’ mothers. Poststructuralist feminists have sought to unpack such mother ideologies of essentialism where mothering was taken for granted as a uniform and universal experience. As a result, feminists argue, issues concerning pregnancy, childbirth and lactation were pathologised, and turned into medical and psychological problems. When their maternal skills were perceived to fall short, it resulted in mothers being shut away from their families, children and community networks into mental institutions. Classified as ‘insane’, women’s committal to mental institutions indicated their mothering was inadequate, scrutinised and policed.

This study illustrates that despite advances in women’s rights to vote in Australia (1902) and the introduction of the maternity allowance (1912) within the federated states of the new nation, women continued to be caught by the gendered power relations in both the patriarchal nature of families, psychiatry and medicine. The implications and significance of this thesis contributes to new knowledge on puerperal insanity in the Australian twentieth-century context. This thesis argues that
given the ‘othering’ of mothers in psychiatric and social discourses within the patriarchal society, the diagnosis of puerperal insanity and birth-related illness was often arbitrary, and given to many women whose distress or instability was seen to be connected to their mothering.
Chapter One: Literature review and historiography

Introduction

This chapter identifies and critically situates the approach to this research. It explores the methodologies and provides a literature review used to answer the main thesis research question: how Australian women were constructed as ‘unfit’ mothers, which led to their diagnoses of puerperal insanity and confined to mental institutions in the early twentieth century. Feminist poststructuralism is adopted as the theoretical framework to analyse the power relations embedded in knowledge produced by psychiatrists and their institutions, as evident in the major primary sources for this study. Foucauldian approaches to language in the construction of identities allows for the examination of the gendered discourses that constructed mothers as insane patients in the past.

Medical discourses traditionally constructed women’s bodies as primarily reproductive, so that states of maternity and motherhood were viewed as women’s biological and social destiny.¹ Mothers were the subject of burgeoning nineteenth-century discourses in psychiatry, obstetrics and gynaecology, and their clinical interventions. By the early twentieth-century women were judged by their capacity for maternity and reproduction within the social and cultural imperative to populate white Australia.² Doctors were the main commentators on, and shaped ideas about, race, population, degeneration and whiteness, and represented themselves as experts in white citizenship and national destiny.³ In this way, medical authority and knowledge extended beyond the scientific

into the political and the social worlds. This extension legitimised medicine as having authority over women’s bodies and their reproduction, an authority which was central to the construction of femininity and maternity. Doctors became the dominant sources of social and medical authority over both ‘fit’ mothers and ‘unfit’ mothers who were certified as insane and committed to mental institutions.

The primary sources are the mental patient files for thirty-one women who were committed to the Royal Melbourne Reception House, Victoria, between the years 1920 and 1936. As these female patients were mothers, it is necessary to apply feminist approaches to the construction of gender, which underpins feminist debates concerning maternity, motherhood and mothering. All thirty-one women were mothers, or mothers-to-be, committed to the mental institution with puerperal insanity and childbirth related ailments. One mental patient, Ada, is a member of the researcher’s family. She was committed to the institution in 1936 with puerperal insanity. A single chapter in this thesis is devoted to the biography of Ada’s life, and it draws upon feminist history and social science approaches. The multiple or bricolage of methods used to construct her biography include Ada’s mental patient files, as well as interviews and family stories. This use of multiple methods assists in triangulation of information to check for internal consistency, rigour and for confirmation and completeness. Feminist influences acknowledge the inclusion of the researcher’s positionality, and because I am a member of Ada’s family, I include a self-reflexive section about how I came to this research topic and my background as a researcher.

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5 Featherstone, Breeding and Feeding (2003), p. 4.
The sources in this thesis are used in two ways: first, to locate the gendered assumptions pertaining to motherhood which are embedded in psychiatric language and practices, and second, to investigate how medical knowledge reflected and was informed by wider social meanings of motherhood during the interwar years in Victoria. The time period in which these women were committed sets the context for these mothers’ lives, commencing with 1920, following the end of World War I, and through the Great Depression, with the committal period ending in 1936. Moreover, the analysis extends beyond this period into the 1940s, 50s and 60s, as many women remained in institutions far beyond the interwar period. Not only does this thesis provide insights into the ways ‘unfit’ mothers were constructed and committed to the mental institution, it extends across their lives of institutionalisation and the circumstances of their recovery and subsequent release over time and beyond the interwar period, which has implications for Australian histories of mental health and gender.

In this chapter, the first section discusses the issues related to addressing the research question in greater depth. Then, the insider position of the researcher is examined. This locates the researcher as a member of Ada’s family, who is one of the thirty-one women’s files in the data collection, and is relevant to interpretive methodologies and feminist poststructuralist approaches. Next, the chapter examines methodological approaches to mothers’ institutional committal. This includes an overview of literature and methodological approaches adopted by the anti-psychiatry poststructuralists, feminist critiques of psychiatry, Australian histories of psychiatry, and international studies of women institutionalised in the twentieth century. Maternal theories are articulated and applied to the context of Australian mothers in the early twentieth century. The final part of this methodological section breaks from traditional historical methodologies into
feminist social science approaches to help with the later presentation of Ada’s biography in chapter four.

**Research question**

The principle aim of this research is to investigate the issues connecting mothering with mental illness, which resulted in the diagnosis of puerperal insanity in Victoria. There is extensive research on nineteenth-century patients, from both Australian institutions and other countries, and burgeoning international studies on twentieth-century psychiatry. However, there have been no Australian scholars who have investigated puerperal insanity in Australia, let alone in the twentieth century.

Problems in accessing restricted mental patient files, particularly in NSW, have meant very few studies have been undertaken on Australian twentieth-century psychiatric institutions and their patients. For this thesis, I accessed Ada’s files as a family member, through the Victorian Freedom of Information Unit. I gained access to the further thirty women’s files, normally closed in Victoria for seventy-five years, by seeking permission and subsequent approval from both the Health Minister of Victoria and the Chief Psychiatrist of the state. Therefore, the relevance and timeliness of this investigation into Ada’s life, and her thirty peers, is enhanced by permission to access restricted files and address a gap in our knowledge of the past.

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**Locating the researcher**

The recognition that the researcher is part of the research process marks a distinction in interpretive social sciences paradigm in that the subjective is embraced as part of ‘disciplinary uniqueness.’ Reflexive approaches to research can be seen as one of feminism’s major contributions to research methodology. As Reinharz states, ‘the researcher’s personal experience is a distinguishing feature of feminist research.’

Feminist scholars have sought to develop epistemologies emphasising ‘situated knowledges’ that encourages researchers to make it explicit their own particular location and position they bring to the research. Self-reflexivity becomes essential in understanding how knowledge claims are selective, partial and positioned. Both positions, that of the researcher and that of a member of Ada’s family, have direct influence upon the research questions, how the research is conducted and how the research is written.

My interest in Ada’s life is the personal starting point of this present work which Reinharz calls the ‘epistemology of insiderness’. An insider’s perspective can engage her voice of the ‘passionate participant.’ It makes explicit the links between my personal experiences, the consequences within the family of Ada’s incarceration and the research project in which I am engaged. The very selection of this topic itself reflects the

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researcher’s insider status and identifies that this research is socially situated. Self-reflexivity offers a way to examine bias, and the relationships between the positionalities of myself as the researcher and the researched. In Graeme Davison’s valuable chapter on the boom in family histories since the 1970s, the insider position of the family researcher or genealogists is a given, or taken for granted, position. Akemi Kikumura, in straddling the simultaneous positions of outsider and insider when interviewing her mother, found her insider status provided rich and authentic insights based on intuitive sensitivity and empathy as an immediate member of the family that may otherwise have been obscured to others.

The reflexive process adopted in this thesis makes explicit how Ada and her files are used to shape the research design and how these determined the parameters in the collection of the further thirty mothers’ files. Several scholars, like Kikumura, have located themselves inside, and offer a family connection to, their area of research, and in many cases, this connection led them to their research. Jane Ussher’s experience as a child of her mother’s madness provided the drive for Ussher to train as an expert psychologist and live her life differently to that of her mother’s life. Other researchers have commented, if only briefly, on the family connection to their work. Diana Gittins dedicated her book, a work on Severalls Psychiatric Hospital, Essex, in memory of her mother who died in Severalls. Catharine Coleborne said her mother’s childhood memories of Bloomfield, the Orange Mental Hospital and orphanage in NSW, sparked her interest in institutions

and people confined. For Victoria Haskins and Lynette Russell, both their great-grandmothers became the focus of their research in biographical histories. Haskins wrote of inter-racial relations between her great-grandmother Ming and her involvement in Aboriginal affairs through Ming’s hiring of Aboriginal domestic servants in the 1920s and 1930s. Lynette Russell uncovered that her great-grandmother Emily had been Aboriginal and committed to both Kew and subsequently to Sunbury Mental Institutions for a total of sixteen years in the 1920s and 1930s. Like myself, Russell had accessed Emily’s mental patient files as a family member, and like Ada, Emily had worked as a domestic in the Superintendent’s home.

The next section of this chapter locates the researcher as both outsider and insider in her field of study and is relevant to understanding the interpretive methodology and feminist poststructuralist approach used in this thesis. It marks the break from traditional history approaches of positivism that emphasise the objective truth by a narrator who is an omnipresent, invisible and detached outsider. Instead, it works from a subjectivist epistemology where reflexivity is appropriate, as Ann McGrath argues, it is like other historical tools that must inform and be directly relevant to the subject at hand, it is worthy of inclusion.

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Reflexive self

I commenced my Bachelor of Arts undergraduate degree in 1998, at age thirty-five, as a single mother when my son was two-and-half years old. There was little feminist content in the media major units I undertook until I commenced electives in literature and writing. Studying *Jane Eyre* by Charlotte Bronte and the prequel *Wide Sargasso Sea* by Jean Rhys sparked my interest in how the character Bertha’s madness was constructed in these two books. I found myself sympathetic to Berthas’ plight, realising I had my own madwoman hidden in the attic, that of my female relative Ada. This initiated discussions with my parents about Ada and the circumstances of her institutionalisation and I continued to research women’s madness informally throughout my honours year.

In March 2008, Germaine Greer spoke to a full auditorium at Southern Cross University on her research and the writing of her then recent book *Shakespeare’s Wife.*\(^{21}\) I was struck how Greer managed to craft a full narrative on the personal life of Ann Shakespeare, nee Hathaway, in which very little is documented. Like my relative Ada, Ann left no diary, and without any direct voice from Ann, Greer constructed Ann’s life by investigating Elizabethan women’s lives, the rituals of marriage, courtship, mothering and their daily work routines sourced from parish registers. Like other female figures lost from history due to the scarcity of sources, Greer’s feminist strategy raised Ann from obscurity. While a very different project to my own, Greer’s approach inspired me to further investigate Ada’s life, once hidden and lost to the family. This led me to seek access to Ada’s files, following discussions and consent given by my family.

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On the strength of the extensive information contained in Ada’s mental patient files, I enrolled as a PhD candidate in 2009. Forming my feminist sensibilities over many years, I am very interested in the social and material conditions of mothering both historically and today, particularly in the Australian context. I have a deep empathy with Ada’s plight as a mother, cast as an ‘unfit’ mother where her removal from her children’s lives had deep ramifications in our family.

**Reflexive journal**

Throughout this research journey, I have maintained a self-reflective research journal which is referenced occasionally in this thesis. It makes visible my insider status as both researcher and a member of Ada’s family. I met Ada when I was a child and have journaled my recollections and the family stories told about her over the years, providing another layer to the richness and complexity. Michelle Ortlipp says her aim in keeping and citing her research journal in her work was to make her decisions, and the thinking, values and experiences behind those decisions transparent to both herself and the reader. In this way, the journal reflects my ‘rite of passage’ as a naïve beginner and explores the development of the researcher’s understanding of the field over the course of time. This research journal sits as an epilogue following the conclusion, titled: *Epilogue: The Researcher’s Journey* and will be referred to throughout this thesis.

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Methodological approaches to mothers’ institutional committals

As interdisciplinary research, the following section examines the various qualitative methodologies of historical and social science approaches to mothers’ institutional committals. It includes an analysis of the trends in the writing of the history of psychiatry, beginning with the methodological approaches adopted by the antipsychiatry poststructuralists of the early 1960s. This is followed by feminist critique of psychiatry concerning gender, motherhood and mental illness, and the rise of the nineteenth-century diagnosis of puerperal insanity. Then an overview of Australian histories of psychiatry by scholars who have used institutional reports and mental patient files as their primary sources in both nineteenth and twentieth-century studies. Following this, I provide an overview of international studies of women institutionalised in the twentieth century which use social science approaches. Maternal theories are articulated, particularly the patriarchal myths and institution of motherhood that policed and regulated maternal behaviours. These are then applied to the context of Australian mothers in the early twentieth century, where doctors and emerging experts became authorities in the construction of womanhood and maternity. The final part of this methodological section takes up the challenge of feminist social science approaches in the presentation of Ada’s biography.

Poststructuralist histories of psychiatry

Poststructuralism is a theory about the way that language constitutes meaning. Poststructural approaches position discourse as a major constitutive force in social relations. They enable a researcher to identify historically-specific discursive relations and social practices. The power of scientific gaze constructs the individual as an

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observable, describable object, and as the product of psychiatric discourses. The following section provides a brief overview of poststructuralist histories of psychiatry, the ways psychiatric discourses produced and constituted insane populations, providing a context for examining the situation of insane mothers.

In the early 1960s, the works of Michel Foucault, Andrew Scull, Irving Goffman, Ronald Laing and Thomas Szasz strongly criticised psychiatric theory and practice and revitalised new interest in the writing of the history of madness, mental patients, asylums and their practices. Their works loosely formed an ‘antipsychiatry’ movement by questioning the value of modern mental hospitals and their historical predecessors in the asylum system. In 1961, Foucault wrote *Madness and Civilisation* on the ‘great confinement’ of the insane in the eighteenth and nineteenth centuries. His social control theory that the asylum and moral treatments ushered in an era of surveillance and social control enriched subsequent scholarship in the history of psychiatry. Foucault used the conceptual division between reason and unreason to expose the constructed nature of madness as ‘seemingly natural categories’.

The way that anti-psychiatric scholarship questioned the roots of psychiatry itself, its purpose, its basic concepts of mental illness and the very distinction between madness

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and sanity itself, is of particular interest. These debates pinpoint the fact that there was little consensus on the definition of insanity or precise knowledge of its causes or cures. The concept of ‘illness’ within psychiatric discourses was not empirically proven, yet this did not undermine psychiatry’s hegemony as the ‘true’ discourse of mental disturbances. Alternative and original ways of thinking about mental illness included Freud’s psychoanalysis and Jung’s analytical psychology. These therapies required individual treatment that were virtually impossible to implement in Australian asylums given the crowded conditions and focus on physical treatments. The strength of criticism by the anti-psychiatry poststructuralists that questioned the normative practices of mainstream psychiatry, institutions, and physical treatments remain highly relevant to this work on mothers’ institutionalisation.

Anti-psychiatry ideas were further examined by Andrew Scull, who argued that psychiatry’s power was as an agent of social control for undesirable behaviours. Scull examined the psychiatrist’s drive for professional dominance by widening the criteria for madness and insanity, labelling difficult behaviours as mental diseases found in the body. Psychiatrists responded by treating patients with physical cures which dominated nineteenth-century asylum treatment. Bodies continued to be the focus in treating the insane well into the twentieth century. The specific treatments applied to patients in this

30 Ibid.
current study are examined in-depth in Chapter six: *Gendered Treatments in Twentieth-Century Australia*.

Roy Porter argued that the treatment of the mad was *ad-hoc* in the eighteenth century, ending with the English reforms of the early nineteenth century. Reforms led to the Act of 1808 which established state-led public asylums and marked the paradigm shift into the English golden age of public asylums in the nineteenth century.\textsuperscript{33} Both Scull’s and Porter’s work built upon Foucault’s thesis, and established the ways insanity was medicalised by psychiatrists, how they manoeuvred themselves to be specialists in charge of asylums, and convinced both the public and the government that the asylum was the rightful place to confine society’s troublesome people.\textsuperscript{34}

English legal reformations were reflected in the Australian colonial legislation in 1843 with the New South Wales *Dangerous Lunatics Act*, which applied to Victoria at that time.\textsuperscript{35} This law legitimised the provision of two medical certificates of insanity, necessary to commit and detain people in asylums.\textsuperscript{36} Further discussion of the roles of medical authorities in certification and committal of lunatics in the colonies is taken up later in this chapter. The psychiatrist’s rise as a profession and the asylum as a social control mechanism in Britain and Europe are highly relevant for understanding the asylum system adopted by the Australian colonies as a British outpost.


\textsuperscript{34} Garton, ‘The Melancholy Years: Psychiatry in New South Wales, 1900-1940’ (1982), p. 139.


This thesis employs Foucault’s poststructural focus on language and text to examine the ways psychiatric discourses produced and constituted insane populations. By adopting Foucault’s social theories of control, surveillance and punishment as tool boxes, feminists have examined power for the ways it operates differently on sexed bodies, in particular the female body.37 The study of women by historians and social scientists became central to the second-wave feminist writers of the late 1960s and 1970s. By placing women centrally in the newly emerging scholarship, methodological approaches were transformed into more inclusive analysis of social experience.

**Feminist poststructuralist perspectives**

Feminist scholars turned to history to trace the origins of women’s second class status.38 Poststructuralist feminists critique classical assumptions that biological difference is natural, fixed and universal. Rather than locking individuals into fixed subject positions and categories as natural facts, feminist poststructural principles argue that the meaning of gender and sexual difference is constructed by culturally-made divisions and practices and socially produced as artificial constructs that maintain the power of dominant groups.39 Medical science, in particular, has contributed to the construction and regulation of gender and oppressive gendered power relations.40 Biological theories of difference, central to nineteenth-century and early twentieth-century scientific accounts in biology, psychiatry and medicine essentialised or restricted woman’s being to her reproductive role. Measured against the white male norm, these gendered accounts assumed women

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deviated from the norm in ways that fit them only for domesticity and motherhood.\footnote{Chris Weedon, \textit{Feminism, Theory and the Politics of Difference} (Oxford, Blackwell Publishers, 1999), p. 6.}

Feminists have challenged this ‘science’ by exposing masculine claims to alleged objectivity and the ways science has functioned to support the patriarchal status quo.\footnote{Evelyn Fox Keller, \textit{Reflections on Gender and Science} (New Haven, Yale, 1985).}

Feminist historians of psychiatry aimed at investigating more inclusive frameworks by addressing gendered power relations within psychiatric discourses, practices and institutions.\footnote{Nancy Tomes, ‘Feminist Histories of Psychiatry’, in \textit{Discovering the History of Psychiatry}, ed. by Mark Micale and Roy Porter (New York, Oxford University Press, 1994).}

The 1960s second-wave feminist scholars forced a fundamental re-examination of psychiatric claims embedded with male centeredness and fixed notions of disease. Simone de Beauvoir, Germaine Greer, Kate Millett and Shulamith Firestone challenged the ways in which psychiatric authority was entrenched with masculine assumptions of western culture, justified female subordination, and ignored how women’s experiences differed from those of men.\footnote{Ibid. pp. 350-351.}

In particular, feminist thinkers exposed the biological determinism embedded in science, medicine, psychiatry and Freudian psychoanalysis discourses which oppressed women. Poststructuralist theories of language, discourse and power offer ways to understand the discursive production that assigned specific meanings to women’s bodies. Feminists critiqued medical bias that defined female reproduction in the language of disease.

Ehrenreich and English argue that the masculine bias in medicine found that women were inherently pathological and their normal state was to be sick.\footnote{Ehrenreich and English, \textit{For Her Own Good} (1978), p. 111.} Women’s madness has a
long history in assigning female reproductive functions as responsible for their insanity. The historical meanings of puerperal insanity, as a specific disease of women, reveal psychiatry’s patriarchal bias towards women’s reproduction. Foucault argued that women’s bodies were subjected to medical science and given meaning as nothing more than wombs from the beginning of the eighteenth century. The burgeoning psychiatric and gynaecological literature in the nineteenth century on hysteria and puerperal insanity constructed the female body as innately diseased. The long history of womb or uterine centred theories located maternal insanity within the female body illustrates the deep masculine bias embedded within medicine and psychiatry.

Within medical orthodoxy the uterus (or womb) was thought to be responsible for all female ailments triggered by puberty, child-bearing and menopause, and if mismanaged would lead to insanity or death. These biological arguments were used to rationalise female inferiority and preserve existing social relationships, particularly in advising women to avoid careers and higher education, as it was thought to lead to producing feeble children and the degeneration of ‘racial health’. Nineteenth-century doctors focused on the uterus, as the supposed cause of women’s nervous complaints, and tried to cure female insanity by applying ‘leeching’, ‘injections’, and ‘cauterization’ directly to the uterus.

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47 See Poovey, 'Scenes of an Indelicate Character' (1986).
The fixed idea that women’s place in social relations is circumscribed by her childbearing function has long been a staple of masculine thought.\(^{51}\) The prevailing assumptions concerning women’s vulnerability to insanity at times of menarche, pregnancy, childbirth and menopause defined their character, position and value to such a degree that authorised the medical professions management of women.\(^{52}\) Women expressed their limited agency by adopting the sick-role of hysteria, a classic female disease of the nineteenth century, as a form of resistance to their burdensome domestic duties as wives and mothers.\(^{53}\)

The attitudes to female reproduction and the medical treatment of women ‘are particularly sensitive indicators of cultural attitudes’.\(^{54}\) The medical discourses about women’s bodies were not based on scientific evidence, but on male assumptions that fixed women in the home tied to their maternal role. Womb theories reveal much about medicine’s rudimentary knowledge in women’s diseases, their limited understanding of feminine sexual identity and the strict social roles as mothers in the nineteenth century.

Elaine Showalter’s landmark study, *The Female Malady: Women, Madness and English Culture, 1830–1980*, drew upon sources from art and literature, as well as patient and asylum histories. Showalter’s argument rested upon the idea that madness was a distinctively female ailment and that women outweighed men in British asylum populations.\(^{55}\) Her work has been criticised for its narrowness of sources and

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\(^{52}\) Poovey, ‘Scenes of an Indelicate Character’ (1986), p. 146.


oversimplifying the gender ratios, when men and women were both prone to madness. However, with these criticisms in mind, Showalter was one of the first scholars to investigate puerperal insanity in the nineteenth century. Cases of puerperal insanity shocked doctors, as mothers displayed violence, obscenity, masturbation, neglect, suicide and in the worst cases infanticide. Showalter examined the biological determinism embedded in psychiatric discourses concerning the perils of puberty, pregnancy, childbirth, lactation, menstruation and menopause. The social problems women faced, whether unmarried, poor and destitute were examined briefly, and are themes relevant to understanding puerperal insanity in the present study.

The historical works by Smith-Rosenberg, Poovey, Douglas Wood, and Elaine Showalter examined female patients exclusively, seeing gender as an important category which defined mental patients. These feminist poststructuralist approaches illustrate the workings of gendered discursive power in psychiatric knowledge. Assumptions about women’s nature underpinned womb theories, and translated into facts constructing hysteria and puerperal insanity as disease categories belonging to women. Womb theories were biological explanations of sex difference, and tied women’s social functions to reproduction, regulated by marriage and responsibility for families and children’s wellbeing. Such discursive production on the nature of women’s bodies was central to constituting the social norms of femininity. By the mid-nineteenth century the cultural

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meaning of femininity was arguably synonymous with motherhood.\textsuperscript{60} The hegemonic assumptions concerning femininity, motherhood and reproduction were so tightly prescriptive that mothers had little opportunity for either resistance or individual expression. With little room to move, those who resisted rebelled or fell sick were labelled as failed women with hysteria, and ‘unfit’ mothers with puerperal insanity. Feminist poststructuralist critiques of psychiatry investigate the multiple ways language, gender and discourses shape patient identities. Historians drawing from nineteenth-century female case books, recognised the gendered constructions and masculine language that objectify the female patient.\textsuperscript{61} Psychiatric language conflated notions of femininity, sexuality and reproduction with women’s symptoms of illnesses.\textsuperscript{62} With the power and language of the Western biomedical model, medicine and its experts managed gender itself.\textsuperscript{63} The lack of understanding about women’s bodies, and their lives, meant that male doctors were attributing illness to specific gendered categories such as hysteria and puerperal insanity.\textsuperscript{64} Such categories were efforts to fit women’s bodies, and in the case of puerperal insanity, maternal bodies, into the texts and records of the asylum.

Many scholars have found that puerperal insanity was one of the most clearly recognised disease entities of the nineteenth century.\textsuperscript{65} Doctors confidently recognised childbirth as

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\item \textsuperscript{61} Cathy Coleborne, 'She Does Her Hair up Fantastically', in Forging Identities: Bodies, Gender and Feminist History, ed. by Janice Gothard, Helen Brash, and Jane Long (Nedlands, University of Western Australia, 1997), p. 63.
\item \textsuperscript{63} Alison Bashford, 'Gender, Medicine and Empire', in Gender and Empire: The Oxford History of the British Empire, Vol. 6, ed. by Phillipa Levine (Oxford, Oxford University Press, 2004), p. 113.
\item \textsuperscript{64} Wendy Chan, Dorothy E Chunn, and Robert Menzies, 'Introduction', in Women, Madness and the Law: A Feminist Reader, ed. by Wendy Chan, Dorothy E. Chunn, and Robert Menzies, p. 8.
\end{itemize}
the key moment of instability and the common cause of insanity in women.\textsuperscript{66} Puerperal insanity was considered a severe mental illness, connected to a recent birth, with hallucinations and delusions as particular features or symptoms.\textsuperscript{67} Hilary Marland argues that the professions of both psychiatry and obstetrics emerged on the strength of their identification of puerperal insanity.\textsuperscript{68} By the middle of the nineteenth-century physicians cited heredity as the primary cause of puerperal insanity.\textsuperscript{69}

In settler colonies of the British Empire, fears around failure to increase white populations were of major concern in the imperial project of colonisation and to secure claims to new territories. Puerperal insanity was thought to be inherited through the female line, and in the settler colony of New Zealand, mothers were blamed for hereditary decline of the white race.\textsuperscript{70} Puerperal mania sufferers, who were ignoring or harming their children, were classed with deviant maternal behaviour, failing ‘proper’ motherhood. At the same time, families and doctors failed to acknowledge that frequent childbirth, overwhelming household duties and poverty exacted their toll on mothers.\textsuperscript{71} Hilary Marland argued that ‘alienists and medical practitioners saw infanticide as an anticipated accompaniment, almost a symptom of puerperal insanity’.\textsuperscript{72} It was used as a defence plea for mothers accused of infanticide and afforded sympathy and leniency in

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\item \textsuperscript{67} Brockington, \textit{Motherhood and Mental Health} (1996), p. 200.
\item \textsuperscript{68} Marland, \textit{Dangerous Motherhood} (2004), p. 28.
\item \textsuperscript{69} Theriot, 'Diagnosing Unnatural Motherhood' (1989), p. 77.
\item \textsuperscript{71} Labrum, 'The Boundaries of Femininity' (2005), p. 75.
\item \textsuperscript{72} Marland, \textit{Dangerous Motherhood} (2004), p. 172.
\end{itemize}
court, with either short gaol sentences or acquittal.\textsuperscript{73} A more in-depth analysis of puerperal insanity in the nineteenth century is provided in Chapter Two: \textit{Puerperal Insanity as Gendered Power in Nineteenth-Century Britain and Colonial Australia}.

Nineteenth-century womb theories achieved the status of medical and scientific ‘facts’. Puerperal insanity was used to substantiate female inferiority, that childbirth caused insanity, and that mothers were responsible for the degeneration of populations. The discriminatory language and misogynistic assumptions transformed into social conventions that reinforced strict gendered roles for women in ‘proper’ motherhood. As Anne Digby succinctly states, women lives were restricted within their biological straightjacket.\textsuperscript{74} Psychiatric discourse reveals a complex set of power relations that both reinforced, and were informed by, societal attitudes about mothers and childbirth. Discourses and expectations concerning motherhood and maternity were represented in contradictory ways. Mothers were responsible for the future of white settler populations, and equally blamed for a host of disease, insanity and degeneration in their offspring.

Prior to the prominent writings of Esquirol (1818), Connolly (1846) and Marce (1857) it had long been recognised that acute mental disturbance can occur following childbirth. It had been called ‘puerperal mania’, ‘puerperal insanity; or ‘puerperal psychosis’.\textsuperscript{75} The condition gained wide acceptance in the nineteenth century through the proliferation of writing on puerperal insanity from within the fields of psychiatry and gynaecology. Its prevalence was well established and yet the statistics of asylum committals remained low.

\begin{thebibliography}{9}
\bibitem{Digby} Digby, ‘Women’s Biological Straightjacket’ (2012), pp. 193-216.
\end{thebibliography}
at approximately ten per cent of female asylum admissions.\textsuperscript{76} This committal rate was due to the fact that the majority of cases being managed at home, particularly in the first half of the century.\textsuperscript{77} Whether in or out of the asylum, patient’s prognoses were good and mothers made full recoveries within months.\textsuperscript{78}

However, several scholars have stated that by the twentieth century, puerperal insanity was no longer a psychiatric term used to commit mothers to mental institutions. Puerperal insanity began to be written out of psychiatric textbooks and out of asylum records during the late nineteenth century in Britain.\textsuperscript{79} It was Kraepelin’s new diagnostic system for mental illness, in 1899, which excluded puerperal insanity as a separate and distinct category.\textsuperscript{80} Lanczik and colleagues argued that Kraepelin could not justify a separate entity for postpartum psychosis, as it was not different from psychoses that occurred outside the childbirth period.\textsuperscript{81} Instead, Kraepelin simplified the diagnosis of insanity into two groups: manic-depressive illness and dementia praecox, with the latter term renamed as schizophrenia by Bleuler.\textsuperscript{82} In a study on American patients, Theriot found that puerperal insanity had disappeared by World War I.\textsuperscript{83} The author said that physicians no longer saw puerperal insanity as a legitimate illness. Theriot does not state whether physicians were influenced by Kraepelin’s new system, or not. Despite the fact that the diagnosis of puerperal insanity was purported to be no longer in use elsewhere, the

\begin{footnotesize}
\begin{enumerate}
\item Marland,  \textit{Dangerous Motherhood} (2004), p. 64.
\item Marland, ‘Destined to a Perfect Recovery’ (1999), p. 152.
\item Brockington,  \textit{Motherhood and Mental Health} (1996), p. 205.
\end{enumerate}
\end{footnotesize}
present study will illustrate that twentieth-century Australian doctors continued to
diagnose puerperal insanity as a valid illness.

**Australian histories of psychiatry**

The Australian colonial penal settlements housed the mad with the convicts, until the first
purpose built asylum was established at Tarban Creek, Sydney, in 1838.\(^{84}\) Australian
colonial asylums and psychiatric treatments were largely based on British practices, and
the colonies were dominated by public asylums.\(^{85}\) These government funded institutions
housed all classes of patients, a unique feature of Australian colonial asylums, when very
few private institutions existed.\(^{86}\) The work of Australian historians, including Milton
Lewis, Mark Finnane, Stephen Garton and Catharine Coleborne have identified
psychiatric patients caught by the stresses of both colonial and twentieth-century life, the
conditions of the asylum environment and together map Australian psychiatric
developments, doctors and their patients. In the following section, the developments of
the colonial asylum, with a particular focus on Victoria where Ada lived, sets the
historical context and background for this twentieth-century study.

Milton Lewis mapped the developments of psychiatric services including mental health
policy, asylum administration and legislation changes from each colony, through to the
twentieth-century developments in each state. The New South Wales *Dangerous Lunatics*
Act of 1843 embedded the requirement of certification from two medical practitioners to

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\(^{84}\) Kenneth C. Kirkby, 'History of Psychiatry in Australia, Pre-1960', *History of Psychiatry* 10, June (1999),
p. 193.


\(^{86}\) Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial
commit a person to the asylum. This law required the provision of two medical certificates of insanity, necessary to commit and detain people in asylums. Coleborne argues that this legislation, and the Lunacy Statutes that followed in Victoria, legitimised the asylum and endorsed the roles of medical authority as integral in the legal requirements of certification and committal of lunatics. Medical certification and compulsory confinement imprisoned lunatics rather than hospitalising them, and came to be known as ‘involuntary admission’ into the asylum. With the medical practitioner embedded into the procedure of confinement, the legal and medical apparatuses together produced the ‘lunatic’ identity in the nineteenth century, and reflect how the body was central in nineteenth-century lunacy legislation. Doctors had emerged as authorities in the construction of the female body and defined the physical and mental capacities of the woman. With the legal power to certify insanity, medicine determined and produced the female lunatic body, whether ‘unfeminine’ or overtly feminine, as deviant, loose, disordered, diseased and dangerous.

Mark Finnane found that ‘gender was the most enduring distinction in the asylum’ in colonial asylums in Queensland. The segregation of male and female wards and the fencing of gendered-only spaces characterised the role gender played inside the asylum.

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89 Cathy Coleborne, 'Legislating Lunacy and the Female Lunatic Body', in Sex, Power and Justice: Historical Perspectives of Law in Australia, ed. by Diane Kirkby (Melbourne, Oxford University Press, 1995), p. 87.
90 Mark Finnane, 'From Dangerous Lunatics to Human Rights? The Law and Mental Illness in Australian History', in Madness in Australia: Histories, Heritage and the Asylum, ed. by Catharine Coleborne and Dolly McKinnon (St Lucia, University of Queensland Press, 2003), p. 27.
95 Ibid. p. 75.
Catharine Coleborne concurs, in the study of gendered discursive practices of female madness employed in patient casebooks from Victorian colonial asylums. Gender is identified as the primary distinctive category which created and produced sexual differences in the classification of patients. Female insanity reflected the dominant Victorian ideas about insanity being inherent within women’s reproductive bodies, whereas male insanity, Coleborne argued, was subject to external factors in the vicissitudes of colonial life.

Hair, appropriate clothing and overall appearance have been traditionally important markers of femininity. In the asylum, femininity was used as a measure of sanity. For example, as illustrated by one inmates case notes, the changes in Lucy’s appearance measured her progress from insanity: ‘she does her hair up fantastically’ then, as she improved: ‘the hair is now dressed in an ordinary way, and the general aspect is much more sane.’ Psychiatrists imposed conventions of normative femininity in appearance to mark the patients’ progress, if any, from insane to sane. The ‘look’ of puerperal insane sufferers was captured in photographs and kept within the patients case notes and formed an important part of institutional record keeping. This was exemplified by Connolly’s analysis of the four portraits taken of a woman suffering from puerperal mania. The poses progress from the patient’s untidy hair that represent her madness in the first portrait, to

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97 Ibid. p. 2.
98 Ibid. p. 7.
100 Coleborne, 'She Does Her Hair up Fantastically' (1997), p. 57.
the appropriate feminine attire of a bonnet covering her hair, and paisley shawl in the final pose, signifying her recovery prior to discharge.\textsuperscript{103} Motherhood was the ultimate expression of femininity and this patient’s return to sanity as the ‘good mother’ was performed through her neat hair and feminine attire.

Bronwyn Labrum analysed how mothers were perceived to deviate from the strict codes in domesticity and motherhood which made them vulnerable to committal in nineteenth century, New Zealand mental asylums.\textsuperscript{104} Labrum investigated four themes of maternal transgression: self-expression, housework, marital relations, and maternal behaviour, which defined their abnormality and constituted their removal to mental institutions as unfit for motherhood.\textsuperscript{105}

The perceptions of patient’s families and relatives served as triggers for committal. Assumptions about feminine respectability were directly related to the patient’s performance in her role as wife, mother, and housewife.\textsuperscript{106} The role of husbands and families in women’s committals is examined in-depth in Catharine Colebornes’ study on \textit{Madness in the Family Insanity and Institutions in the Australasian Colonial World, 1860–1914}. Here, Coleborne analyses the lay language of insanity used by families, and how that language became part of asylum clinical discourse.\textsuperscript{107} Drawing upon patient records and, in particular, the correspondence between patients, families and the institutions reveal in many cases the family was deeply engaged with the asylum.\textsuperscript{108}

\textsuperscript{104} Labrum, ‘The Boundaries of Femininity’ (2005), pp. 72-73.
\textsuperscript{105} Ibid. p. 69.
\textsuperscript{106} Ibid. p. 77.
\textsuperscript{108} Ibid. p. 106.
role of the family, so crucial to both committal and release, and the lay understanding of both insanity and motherhood, is further examined in *Chapter Four: Ada’s story: 1912–1973* and *Chapter Five: Insane Mothers in Modernity 1920–40s.*

Frameworks for interpreting the adoption of British models in public asylums reflect colonial imperatives and gendered codes of acceptable behavior in Australian colonial society. The gendered discursive practices found within nineteenth century patient case books describe the female lunatic body through the lens of normative femininity in appearance and performance. Transgressive maternal behaviours, so tightly bound to strict codes of femininity, were identified by husbands and families, and prompted committal. The legacy of compulsory committal legislation continued in the psychiatric practices of the twentieth-century. All thirty-one mothers in this study, were compulsorily, or involuntarily committed to the institution, accompanied by the required two medical certificates. The continued usage of puerperal insanity as a classification to certify and commit mothers, found doctors sustaining puerperal insanity as a valid psychiatric term for ‘unfit’ mothers in the twentieth century.

**Australian twentieth-century histories of psychiatry**

In this section, the developments of Australian twentieth-century psychiatry are mapped to contextualise the ‘unfit’ mothers in this study. It builds upon the customary nineteenth-century frameworks, and, at the same time contributes to new narratives about mothers caught within twentieth-century psychiatric systems, practiced in Victoria, Australia, from the 1920s onwards.
As the thirty-one mothers in this study were committed to one Victorian mental hospital, to establish the local context it is necessary to address the histories written about twentieth-century Victorian institutions, doctors and their patients. Milton Lewis focused on legislation, hospital conditions and therapies that shaped patient lives in all Australian states in the twentieth century. Prominent Victorian doctors were celebrated for their major psychiatric discoveries and reforms in the treatment of insane patients. Dr Reginald Ellery successfully treated neurosyphilis (GPI) with malariotherapy in 1925. John Cade’s discovery of lithium salts in the successful treatment of manic-depressive illnesses (later bi-polar) in 1949 has been the subject of much attention from within psychiatry and historians alike. Melbourne, the capital of Victoria, was also the centre for two new professional groups. The Melbourne Institute of Psychoanalysis was established in 1940 and by 1946, the Australasian Association of Psychiatrists held its first official meeting in Melbourne, chaired by its founder Dr. Henry (Hal) Maudsley.

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The highlights described above did not negate three highly critical reports in the 1940s and 1950s that found Victorian mental institutions suffered overcrowding, poorly maintained buildings and severely short-staffed. The 1949 Kennedy inquiry recommended a closer cooperation between universities and medical agencies could be achieved by establishing the new Mental Hygiene Authority. The third report undertaken by Stoller and Arscott in 1955 investigated the mental services of all states in Australia, and found that Victoria was the best equipped in the commonwealth, yet still fell short of desirable standards and overcrowding still occurred.

Histories of twentieth-century Victorian patients are hard to find. Tanya Luckins’ work on women suffering grief, loss and mental breakdown stemmed from patients losing family members in World War I of 1914-1918. Her research draws from women’s mental patient files, from several institutions across Victoria and contains poignant stories of the gendered nature of wartime loss. Luckins’ work sets the context for the 1920s time period in this present study that follows on from World War I. As studies from the state of Victoria are rare, it is necessary to investigate two landmark studies from Stephen Garton on New South Wales patients and Jill Mathews on South Australian women that both draw patient files from the twentieth century.

Stephen Garton’s work *Medicine and Madness*, 1988, applied Foucauldian arguments in the ‘productivity of discourses and practices that constructed an insane population, which changed over time.’ By drawing on patient casebooks Garton charts the shift from typical lunatics in 1880 as single, rural, itinerant male labourers, and then, by 1940 typical patients were women, often depressed domestic servants or suburban housewives. In the chapter Garton devoted to *Women and Madness*, the author argued that the family was the common context in which women were found to be ‘mad’ and medical science continued to situate biological events of puberty, childbirth and menopause as key features in women’s instability. These findings have direct correlations to the present study on twentieth-century Victorian mothers. Like Garton’s study on NSW female patients, mothers in this Victorian study were cast as unfit by their families and psychiatry continued to find female insanities linked to childbirth and their reproductive functions.

The work of Jill Matthews, *Good and Mad Women: The Historical Construction of Femininity in Twentieth-Century Australia* drew upon thirty-one female mental patient records, committed between the years 1932-1970, at Glenside Hospital, Adelaide (formerly Parkside Mental hospital) in South Australia. Matthews examined women’s mental illness to demonstrate the ways women were caught within complex contradictory modes of femininity and sexuality as wives and mothers. In arguing that madness was both a response and resistance to gender order in Australian twentieth-century society,

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119 Ibid. p. 147.
Matthews provides a landmark and influential model for analysing gender in patient file material in many recent studies, especially the female patient files in the present study.

Both Matthews’s study on SA female patients and Garton’s work based on NSW patients, while very different studies, are drawn from twentieth-century mental patient archives. The reason so few studies have been undertaken on Australian twentieth-century patients remains a contentious problem for historians. Garton argued that ‘we cannot write the social history of many aspects of the twentieth-century Australian life when historians are prevented from using essential records due to increased privacy laws. The policies in NSW for mental patient files are closed for 100 years, and in Victoria seventy-five years, effectively historians are shut off from the source of archival material necessary to uncover the richness of our past’. Garton’s and Matthews’ works were both landmark scholarships in the 1980s, and as Coleborne comments these studies would no longer be possible in today’s climate of embargo and privacy law restrictions in accessing government archives. For example Matthews gained approval from the authorities of the SA government, the superintendent and research committee of the Glenside Hospital, while Garton was gained approval through the NSW archivist, in order to access patient’s files for their respective research. Within the present era of tighter controls in accessing archives, permission was granted to access the twentieth-century Victorian mothers’ files that were drawn upon for this study. A full explanation of the process in seeking permission and method of access to these restricted files is provided in the following

121 Shut Off from the Source (2000).
Milton Lewis mapped twentieth-century developments of psychiatric services including mental health policy, asylum administration and legislation of all Australian states. One feature was the change to Victorian lunacy legislation in 1914, which enabled patients to be voluntarily admitted to hospitals for the insane. Voluntary admission could provide treatments without the stigma of certification. It is worth noting here that the thirty-one mothers in this present study were certified and compulsorily committed. The alternative provision in voluntary admission was not introduced in NSW until 1934, which may indicate a progressive approach in Victoria at the time.\textsuperscript{123} Another feature was the Victorian Hygiene Bill introduced in 1933. Lewis argued that, the transformations of official terms from ‘Hospital of the Insane’ to ‘Mental Hospital’ and ‘Inspector General of the Insane’ to the ‘Director of Mental Hygiene’, were attempts to reflect modern attitudes toward mental illness, reduce stigma and encourage early treatment.\textsuperscript{124}

Lewis discussed the new physical, and at times, controversial treatments that were developed and applied to patients from the interwar period, 1918-1939, onwards. These new treatments marked an important shift for psychiatric doctors and their patients, as doctors moved from keepers or custodians to modern clinicians.\textsuperscript{125} Treatments included malaria treatment in the 1920s, insulin coma therapy in the 1930s, electroconvulsive therapy (ECT) in the 1940s. By the 1940s both lithium and penicillin were applied therapeutically and by the 1950s psychotropic drugs were used.\textsuperscript{126} These developments

\textsuperscript{124} Ibid. p. 40.
\textsuperscript{125} Ibid. p. 55.
\textsuperscript{126} Ibid. pp. p 43-56.
advanced the medical model of mental disorder, and for many patients the relief of symptoms and hope of recovery and release were made possible. The doctors’ practices and the treatments applied to the mothers in this study are further examined in Chapter Six: Gendered treatments in twentieth-century Australia. Treatments identified include typhoid inoculation for puerperal insanity, the Wassermann test for syphilis, insulin coma, sterilisation, and therapeutic abortion.

However, despite new treatments, the mental hospitals had long been in a state of disrepair, overcrowded, in need of clothing and amenities for patients, and in need of substantial increase of staff. This was due to the government’s refusal to inject much needed funds. By 1952, the British psychiatrist Eric Cunningham Dax was appointed as the Chair of the new Victorian Mental Health Authority to reorganise Victorian psychiatric services. This era was marked by an increase in federal funding following the post-war economic boom, and combined with Dax’s skills in government administration, increased professional and academic training, and his focus on public relations, the cumulative result increased professional status and clinical practice in the public mental health system. Driven to find alternatives to the high costs required in maintaining the large old mental institutions, and made possible by improved pharmacology, Cunningham Dax instigated the shift away from the hospital setting to community services. These reforms are exemplified by his book published in 1961 Asylum to Community: The Development of the Mental Hygiene Service in Victoria. Dax’s use of art therapy with

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mental patients culminated in the collection of 15,000 artworks on permanent exhibited at the Dax Centre located on the grounds of the University of Melbourne.\textsuperscript{130} It is hard not to see Cunningham Dax as a maverick, whose scope of achievements gained him a national and international profile, while transforming the then dilapidated mental health system in Victoria.\textsuperscript{131}

**International twentieth-century histories of psychiatry**

International studies of twentieth-century doctors, patients and institutions are extensive, while work on the Australian context are more limited. Volker Hess and Benoit Majerus argue that for twentieth-century studies there is no reliable narrative that captures the substantial changes in twentieth-century psychiatry, namely institutional reforms, modern psychopharmacology, and deinstitutionalisation.\textsuperscript{132} This section will discuss international work that draws from feminist, social science approaches, adopted by Phyllis Chesler, Kerry Davies, Diana Gittins and Elizabeth Lunbeck. These works offer models that help interpret the developments that characterise twentieth-century psychiatric reforms and developments.

Phyllis Chesler’s classic work *Women and Madness*, published in 1972, exposed the cultural and psychiatric practices that defined women’s experience as pathological. Her work asserted that the male-dominated mental health system in the United States worked to control and diminish women and to ensure their powerlessness in gender roles. Chesler


argued that evidence that psychiatrists were punishing women by classifying them as insane was reflected in the over-representation of women in mental institutions in the twentieth-century. Her feminist critique of psychiatry argued women were labelled as sick when they were seen to reject the stereotypical female role and violate societal norms of rationality and femininity.\textsuperscript{133} In this way, normality for women was madness. Chesler’s radical feminist argument posited patriarchy as the problem and received criticism by overlooking social stratifications other than gender, such as class, race, ethnicity, first world, third world, and sexuality, for example. However, Chesler adopted social science approaches by interviewing patients, which contextualised their experiences and gave them voice.

The present project deals less with patient subjectivities, as no interviews with patients was attempted given the time period, and only few expressed how they felt about their predicament in their files. Nevertheless, patient narratives offer unique insights into the experiences of psychiatric institutions from the mid-twentieth century. Kerry Davies’ work on twentieth-century patient narratives from Oxfordshire and Dianna Gittins’ interviews with patients and staff from Severalls Psychiatric Hospital, Essex, both applied the methodologies of oral history which offer ‘history from below’ perspectives. Davies’ work examines the ways former patients negotiated language, metaphor and presentation of self. Together, their recollections formed a collective narrative experience of institutional care since the National Health Service was introduced in 1948.\textsuperscript{134}

\textsuperscript{133} Phyllis Chesler, \textit{Women & Madness} 1st edn(Garden City, N.Y., Doubleday, 1972), p. 118.
Gittins conducted in-depth interviews with patients, nurses and a doctor from Severalls Hospital, that allowed people ‘who lived, worked and were confined there to speak in their own words of their own memories and impressions.’\textsuperscript{135} Women patients entered the hospital with a variety of experiences including rape, child abuse, giving birth to illegitimate babies, and mothers burdened by large families and poverty, and suffering postnatal depression.\textsuperscript{136}

Severalls hospital opened a mother-baby unit in 1967, where babies could be cared for by their mothers while recovering from psychiatric illness.\textsuperscript{137} This modern, twentieth-century approach to keep mothers and babies united in supported care is opposite to the psychiatric practices for mothers in Victoria in this present study. There were no mother-baby units in Victorian institutions, so certification and committal enforced the separation of babies from their mothers. The patient clinical notes rarely mentioned the whereabouts or safety and welfare of insane mothers’ children.

Sociological perspectives were taken up by Elizabeth Lunbeck in her analysis of twentieth-century psychiatric practice at Boston Psychopathic Hospital. Using race, gender and ethnicity as lenses, Lunbeck maps the ‘momentous shift’ from nineteenth-century asylum practice to the modernism of mental health in psychiatric thinking.\textsuperscript{138} Instead of assessing the sane and insane, Lunbeck argues the new psychiatry shifted to the normal and abnormal in everyday life.\textsuperscript{139} Through the investigation of sex difference,

\textsuperscript{136} Ibid. pp. 128-132.
\textsuperscript{137} Ibid. pp. 130-132.
\textsuperscript{139} Ibid. p. 306.
homosexuality, the sexual politics of marriage, womanhood and manhood, Lunbeck found psychiatrists asserted their cultural authority as arbiters of social and gendered norms establishing normativeness itself.\footnote{Ibid. p. 77.} Lunbeck argued that ‘the essentials of the Victorian gender system were modernized but not fundamentally displaced’ in the twentieth-century American institution.\footnote{See quote from ibid. p. 308.} This work highlights how psychiatric language changed, but not the social norms, and offers ways to think about how puerperal insanity continued in use in Australia in the twentieth century. Feminist sociological scholarship provides the social context of mental illness, gendered norms, and the institutional practices as psychiatry attempted to modernise in the twentieth century. It also provides ways to understand how mothers continued to be subject to male hegemony, and psychiatric bias in this present study.

**Feminist maternal theories**

The mother has always been central to defining womanhood and femininity. Prevalent throughout history, women’s ability to give birth has been wedded to their social functions as wives and mothers.\footnote{Nancy Chodrow, *The Reproduction of Mothering* (University of California Press, 1978).} In this section, key maternal theorists who have examined the ideologies, concepts and experience of motherhood is presented. Feminist maternal theory is relevant to this thesis as all the women were mothers and mothers-to-be committed with childbirth-related mental illness. I begin with second-wave feminist scholars who condemned motherhood as it was seen to trap women to their biological functions. Then, from the 1970s onwards, feminists began to adopt poststructuralist approaches by including mothers’ subjective experiences of mothering.
Elaine Tuttle Hansen notes that feminist thinking about maternity from the early 1960s onwards is told ‘as a drama in three acts: repudiation, recuperation, and, in the latest and most difficult stage to conceptualize, an emerging critique of recuperation that coexists with ongoing efforts to deploy recuperative strategies’.\(^\text{143}\) The first act of ‘repudiation’, in Hansen’s schema, is represented by the works of early second-wave feminists Simone de Beauvoir, Betty Friedan, Kate Millett, and Shulamith Firestone. Their work understood women’s naturalised position as mothers as the source of women’s oppression.\(^\text{144}\) Simone de Beauvoir, in 1949, rejected the idea of maternal instinct by arguing that the role of wife and mother was a destiny of subordination which suited men only, which caste women as weak, inferior and the ‘other’ to man’s superior roles.\(^\text{145}\) Betty Friedan’s work in 1963 maintained that motherhood was unfulfilling, and women should combine marriage, family and fulltime paid work outside the home.\(^\text{146}\) Kate Millett argued that sexual relations were political ones, and that patriarchy was a set of systemic structures of male power based on biological difference between men and women.\(^\text{147}\) Shulamith Firestone radically called for the end of biological motherhood in order to liberate women from the drudgery of motherhood and the tyranny of reproduction.\(^\text{148}\) Instead, Firestone advocated a utopian vision of artificial reproduction where genital differences between the sexes would no longer matter culturally.

\(^\text{144}\) Ibid.  
These texts, Ann Snitow labelled as ‘demon texts’ for demonising and rejecting motherhood. Maternity is presented as a uniformly negative experience, an argument that rested upon essentialist accounts of motherhood, where biology is inherently oppressive for all women. Ludmilla Jordanova explains these radical feminist texts failed to challenge the woman-nature association, and in this way reinforced assumptions of womanhood. Their reluctance to deal with female reproductive processes, as key aspects of womanhood, was motivated by avoiding patriarchal models of femininity.

Their work did not question assumptions that biology made motherhood women’s destiny, and took for granted her ability to give birth which cemented her social role to mother and nurture. Instead, the second-wave feminists were concerned with a wider agenda of liberation by exploring greater personal autonomy through women’s role outside the home and family. The key to feminist thinking, at this time, saw motherhood in direct contradiction to the goals of the women’s liberation and was characterised as the antithesis of liberation. Snitow counters that the criticisms of radical feminist texts misconstrued the writers’ work which intended to smash patriarchy and not mothering.

Feminist thinkers in the 1970s, the second act in Hansen’s schema, recuperate mothering by reclaiming and revaluing maternity as a positive experience. Jeremiah proposes this shift moved away from essentialism to a more positive ‘poststructuralist awareness of

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maternal subjectivities as diverse, multifaceted, and shifting.\footnote{Jeremiah, 'Motherhood to Mothering and Beyond Maternity in Recent Feminist Thought' (2006), p. 22.} This group of feminist scholars are as wide ranging as Adrienne Rich, Nancy Chodorow, Dorothy Dinnerstein, Ann Oakley, Sara Ruddick, Mary O’Brien, Juliet Mitchell and the French theorists Luce Irigaray, Helene Cixous and Julia Kristeva. These feminists sought to identify the fundamental causes of maternal myths and reconfigured mothering as life affirming. Nancy Chodorow argued that women gain gratification from mothering. Mothers produce mothers through mother-daughter relationships, gain maternal capacities and the desire to mother.\footnote{Judith Lorber, Rose Laub Coser, Alice S. Rossi, and Nancy Chodorow, 'On “the Reproduction of Mothering”: A Methodological Debate'. \textit{Signs}, 6, 3 (1981), pp. 500-504.} Both Adrienne Rich and Mary O’Brien advocated that it is when women remain in control that experiences of motherhood can be positive. Rich’s work served as a breakthrough in identifying two distinct meanings of motherhood: first, the institution of motherhood as the patriarchal ideology that ensured women’s oppression under male control.\footnote{Adrienne Rich, \textit{Of Woman Born: Motherhood as Experience and Institution} (New York, W.W. Norton & Company Inc, 1977), p. 13.} Secondly, that women’s experiences of mothering could be a source of power: personal satisfaction that connects women to their bodies. Rich saw the social norms and myths of motherhood embedded in patriarchal ideologies as the actual problem and not mothering itself. Ann Oakley articulated three myths of motherhood ‘that all women need to be mothers, that all mothers need their children and that all children need their mothers... are unevidenced assumptions.’\footnote{Ann Oakley, \textit{Housewife: High Cost, Low Value} (London, Pelican Books, 1974), p. 186.} Such myths present motherhood as natural, instinctual and intuitive.\footnote{Sarah Blaffer Hardy, \textit{Mother Nature: Maternal Instincts and How They Shape the Human Species} (New York, The Ballantine Publishing Group, 2000).} Oakley argues that maternal instincts do not exist, for example many women do not automatically know how to breastfeed, instead it can be learned.\footnote{Oakley, \textit{Housewife} (1974), p. 202.}
Sara Ruddick expands the idea that maternal caring is not an instinctive part of the female psyche, but an ability that can be learned by all people.\textsuperscript{161} Ruddick’s vision of peace politics argues that maternal practices: protection, nurturing and training can be applied to ‘taking care’ of communities and nations as a global peacemaking endeavour. Ruddick separates women’s biological role from the learned social role of taking care, which has been historically assigned to women. These feminist scholars identified the underlying causes of maternal myths, and generally agree motherhood ideologies are sustained, maintained and perpetuated by patriarchy. However, women of colour accused Western feminist theorists from the 1960s and 1970s for their Eurocentric, middle-class and heterosexual bias, when the lives and experiences of women of colour were left out. This, Butler has argued, contested the category of ‘woman’ as a universalising term and the wrestle over the term ‘woman’ is the ‘ungrounded ground of feminist theory.’\textsuperscript{162}

Maternity, once seen to be the common ground of experience and gendered identity, Butler argues, is not the rallying point for politicisation in feminism for many. Overall, feminist maternal theorists successfully highlighted the pervasiveness of patriarchy, gendered social relations and questioned the family as a natural institution within which women performed the mothering and nurturing roles.\textsuperscript{163}

**Women in the Australian colonial setting**

This discussion moves to the Australian colonial context in order to understand how historical factors have shaped and influenced the cultural meanings of motherhood in the early twentieth century. The nation-state building and drive for control over supposed

new territories established white Australian penal colonies within the British project of colonial-modernity. White settlement occurred to the destruction of Aboriginal culture, language, and dispossessed. The unbalanced gender ratio of transported convicts found that males far outweighed the females. Within this gender minority, the bulk of convict women transported to the colonies were aged between sixteen and thirty-five, with 62 per cent of the total women transported being single.\textsuperscript{164} As a minority in the population, convict women transported on lesser crimes so as to reduce the gender imbalance. They were stigmatised as depraved and disorderly, marginalised by both gender and class as criminals.\textsuperscript{165} Their work as mothers in reproduction, unpaid housework and production for family consumption remained excluded from the calculations of the economic growth, wealth and output of the colonies.\textsuperscript{166} Colonial prosperity depended on procreation, and within the first decade the birth rate increased as women produced thirty-six children in 1788 compared to 862 by the end of the 1790s.\textsuperscript{167}

Ada was born and raised in Melbourne, and was, like the other women in the archives, committed to Melbourne mental institutions. Melbourne was the Port Phillip settlement of the New South Wales colony and originally settled by escaped convicts from Van Diemen’s Land. When transported convict labour ended in 1840, the influx of single free settler women, especially from Ireland, as domestic workers, wives and mothers, was in high demand. By the 1850s, Victoria rapidly flourished with the discovery of gold in this newly separated colony. Family structures were truncated due to transportation and


\textsuperscript{165} Joy Damousi, \textit{Depraved and Disorderly: Female Convicts, Sexuality and Gender in Colonial Australia} (New York, Cambridge University Press, 1997).

\textsuperscript{166} Deborah Oxley, 'Packing Her (Economic) Bags: Convict Women Workers', \textit{Australian Historical Studies}, 26, 102 (1994).

\textsuperscript{167} Kociumbas cited in Damousi, \textit{Depraved and Disorderly} (1997), p. 120.
migration patterns. Disconnected from close kinship ties and extended family networks, the small-sized families operated as separate and isolated economic units. This narrow range of kin meant that the Australian colonial family was arguably ‘born-modern’.168 However, many men did not marry due to the bride shortage, which led men to form strong mateship ties, particularly when working in isolated geographic locations.169 Hostile attitudes against family life and women in particular were injected into Australian culture.170 This low regard for women emerged from male dominated convictism, representing competing ideologies between mateship and domesticity.171 For those who did marry, within this strong patriarchal society, strict gender roles attributed femininity with motherhood.

Feminist histories of mothering in the Australian context

In the Australian context, feminist historians’ writing came from women liberationists in the 1970s who saw their work as a political strategy and feminist intervention against orthodox positivism.172 The growth in writing on women’s historical experiences in the 1970s emphasised the ‘counter hegemonic discourses about women that ignored, distorted, or trivialised women’s history, experience, and potential’.173 At the same time a major paradigm shift saw subjectivist epistemology emerge which claimed that

knowledge is value-based. Feminist research does not accept the notion of ‘un-biased’ or ‘value-free’ methodology.\textsuperscript{174} Feminist principles insist on the experience and existence of women, as Lather articulates clearly that ‘the overt ideological goal of feminist research in the human sciences is to correct both the \textit{invisibility} and \textit{distortion} of female experience in ways relevant to ending women’s unequal social position’.\textsuperscript{175}

Poststructural feminists have examined the family and women’s roles as mothers within existing power relations. Women’s social role as mothers has always been historically and socially specific in its organisation, social meanings and values.\textsuperscript{176} The meaning of motherhood in Victoria in the early twentieth-century was defined by the specific discourses of surveillance by doctors and experts. The policing of maternal behaviours took for granted that biological and social concepts of motherhood were one and the same. Lisa Featherstone found that by the First World War, Australian mothers and their pregnancies were increasingly under a regimen of surveillance by doctors through increased medicalised birthing and the emergence of antenatal care. Doctors’ authority over the bodies of women and their babies developed as a response to wartime anxieties over the perceived decline in population, and maternal, infant and foetal mortality rates.\textsuperscript{177}

Feminists argued that Australian mothers, in the early twentieth century, required special, scientific training in order to fulfil their civic duties to raise the future generations of

citizens.\textsuperscript{178} Mothers in Melbourne from 1900 onwards were increasingly subject to state authorities and experts in modern scientific standards of domestic cleanliness and family management in order to become exemplars in scientific housewifery and modern mothercraft.\textsuperscript{179} The proliferation of advice books and manuals on mothercraft and child rearing produced a governing, civilising trend upon mothers, attempting to transform child-rearing practices.\textsuperscript{180} The state-led, infant welfare movement imposed a certain order upon families. In the interwar years, professionals from the infant welfare movement determined that mothers were in need of increased education and training in the care of their children, as parenting was thought to be less guided by instinct or learned naturally.\textsuperscript{181} These ‘respectable’ mothering practices in the interwar period set up stereotypes of the ideal mother, constrained to reproduce within marriage and responsible for both the physical and social wellbeing of her children and family. The wage structure consolidated women’s economic dependence on their husbands and firmly tied mothers to the home and their families.\textsuperscript{182} The entrenchment of the domestic ideal of marriage meant that women had to guard against illicit pregnancies and illegitimate babies. Unwed mothers were shunned and shamed by their families and society, and deemed bad mothers due to their sexual activity outside or prior to marriage. Their options were severely limited, many endured forced adoptions, an Australian hospital practice that targeted unmarried birthing mothers. Some may have procured an abortion, while others tried to

\textsuperscript{179} Kerreen Reiger, \textit{The Disenchantment of the Home: Modernising the Australian Family 1880-1940} (Melbourne, Oxford University Press, 1985), p. 82.
encourage the father to wed them. Forced adoptions punished unwed mothers and stigmatised the fatherless child.\textsuperscript{183}

In concluding this section on maternal theories, feminists have attempted to move their analysis beyond medical and psychiatric discourses and unpack the myths of motherhood. Maternal unhappiness, dissatisfaction, depression and distress, symbolised by puerperal insanity, was attributed to failure within the individual mother. A good mother is a happy mother; an unhappy mother is a failed mother. This myth attributes responsibility for the conditions of motherhood to the individual, not the system or society. Dianne Speier argues the psychological components, beyond the medical aspects of childbirth, have yet to be fully comprehended in understanding the complexity of childbirth.\textsuperscript{184} Lisa Held and Alexandra Rutherford found that the idea of the perfect mother perpetuated by experts and the media, silences any negative emotion mothers may experience.\textsuperscript{185} Ann Oakley’s \textit{Women Confined}, 1980, found many first-time mothers experience depression and postnatal blues in the first five post-partum months.\textsuperscript{186} Oakley argued against the traditional medical view that blames postnatal depression clearly on the mother. Instead, the kinds of birth experience woman experienced, particularly the degree of technological intervention and prior experience with babies, are among the factors which predispose women to experience postnatal depression.\textsuperscript{187}

Negative birth experiences are worth considering as contributing factors for the mothers committed as insane in this present study. However, due to the separate knowledges, sets of expertise and practices between obstetrics, gynaecology, paediatrics and psychiatry, very few references to the type of childbirth and labour mothers experienced are found in the mental patient files. Very few psychiatric doctors questioned mothers about this, or if they did, they may have been met with silence. Jane Ussher critically examined how women’s expression of misery and dissatisfaction is a reasonable response to the somatic, psychological, and social experience in their lives. In this way, Ussher argues it is necessary to move beyond the scope of mental illness, and the pathologising of women, and instead recognise the gendered nature of all social phenomena.\textsuperscript{188}

From the 1990s onwards, maternal theorists took on new ways of understanding mothers and wider notions of mothering.\textsuperscript{189} Personal narratives, written from reflective positions, provide mothers’ subjectivities on their lived experiences. O’Reilly argues maternal narratives move beyond normative maternity to explore differences among and within individual women that are multifaceted.\textsuperscript{190} The proliferation of feminist work on mothering goes toward breaking the silence and myths that surround mothering, childbirth, breast feeding, working mothers, contraception and childcare, to list a few examples. The multidisciplinary nature of current maternal scholarship exemplifies a diversity of social contexts, where motherhood is no longer seen as a universal experience, no longer a fixed and stable maternal identity, once perceived to be common to all mothers.\textsuperscript{191}

\textsuperscript{189} Andrea O’Reilly and Silvia Bizzini Caporale, \textit{From the Personal to the Political: Toward a New Theory of Maternal Narrative} (Selinsgrove, Susquehanna University Press, 2009), p. 9.
\textsuperscript{190} Ibid. p. 12.
\textsuperscript{191} Andrea O’Reilly, \textit{Encyclopedia of Motherhood, Volume 1} (California, Sage, 2010), pp. vii-x.
Overall, from the turn of the twentieth century onwards, femininity continued to be subjected to heterosexual hegemony imposed by the state in marriage, domesticity and motherhood. These deeply entrenched roles for women, later came under scrutiny by the poststructural feminists who unpacked the essentialist ideological assumptions that biology made motherhood women’s destiny. This literature brings new theoretical insights to bear on the situations of women whose files are examined in this study.

Methodological approaches to Ada’s biography

Ada is pivotal in this thesis, and her story remains central to the argument concerning mother’s committals. Her patient clinical notes were the first to be accessed, and it is the information found in Ada’s files that determined the further collection of other mothers’ clinical notes. Ada was committed to the Royal Park Receiving House in Melbourne, which led to accessing thirty mothers’ files committed to that same institution. Her second baby was fourteen days old, when Ada was committed with puerperal insanity in 1936. Her details guided the selection of patients committed with maternal-related insanities in the same era of the interwar period.

In this thesis, the chapter devoted to Ada’s life combines traditional historical methodologies with feminist social science approaches. Archives combined with local family contexts, and in this case, family stories and interviews, offer an interdisciplinary approach. It contributes to new narratives about mothers caught within Australian twentieth-century psychiatric systems. The presentation of Ada’s biography in Chapter
four applies mixed method approaches and draws from Ada’s mental patient files, interviews with ones who knew her, family stories and my reflective research journal. The interdisciplinary approaches taken up to produce Ada’s biography, reveal a unique life trajectory, in comparison to her institutionalised peers in this study. With her committal with puerperal insanity in 1936, her mental patient files show Ada underwent intensive treatments of insulin-comas, therapeutic abortion and sterilisation, not recorded in the other thirty files. Notes about Ada’s later work as a domestic servant within the superintendent’s home at Mayday Hills Psychiatric Hospital, Beechworth, is powerfully complemented by interviews with Sally, the superintendent’s daughter. Sally, an older woman at the time of our interviews, recalls her childhood memories of Ada assisting Sally’s mother in domestic duties. Sally also recalls Cunningham Dax’s regular visits to Beechworth mental institution, as part of his duties as the chair of the new Mental Health Authority, when Sally’s father, Dr Donnan was superintendent at Beechworth in the 1950s and early 1960s. The inclusion of Sally’s story challenges traditional history writing about institutions and patients, often devoid of personal narratives when drawn from reports and patient files only. Her contribution not only illuminates aspects of twentieth-century institutional life, but crucially explains parts of Ada’s life not previously known to our family.

The writing of Ada biography attempts to open the usually hidden and private nature of women’s lives. It draws upon other Australian maternal biographies that uncovered family silences and secrets. These include Drusilla Modjeska’s *Poppy*, Anne Summers’ *The Lost Mother*, Lynette Russell’s *A Little Bird Told Me*, and Victoria Haskins’ work...
One Bright Spot.192 The writing on female ancestors can affirm the writers’ present lives in contrast to the silenced and, at times, degraded lives of their mothers and their grandmothers. Ada’s biography offers radical possibilities in family history, like that of Haskins work One Bright Spot, in the discovery of previously unknown events in female ancestors’ lives.193

Conclusion

This chapter has examined the methodological approaches to mothers’ institutional committal. The well-established poststructuralist approaches used to interpret the nineteenth century include the professionalisation of psychiatry, the asylum as the place of control, and scientific gendered bias, have been examined, drawn upon and expanded for twentieth-century contexts. Twentieth-century anxieties concerning declining white populations, embedded women within the patriarchal family, instituted mothering as the only acceptable form of femininity for women. Feminist poststructuralist approaches illustrate that failure to perform ‘good’ femininity, motherhood and childbirth continued to be key features of women’s committal in the twentieth century. New treatments, from the 1920s onwards, improved the status of psychiatric doctors by medicalising conditions and cures of the mind, while patients experienced dilapidated and overcrowded conditions. Families, experts and the state policed mothers, and when maternal skills fell short of expected new standards, mothers were shut away from their families, children and community networks into mental institutions. Despite twentieth-century psychiatric

reforms and new experimental treatments, the continued usage of puerperal insanity show gendered norms had not changed from the nineteenth-century. Feminist research examines the contradictory meanings of motherhood, and attempts to makes visible the ways mothers are blamed for their circumstances, rather than understanding the difficult conditions under which they mothered within the structural inequalities in society.

In the next chapter, the range of qualitative methods is examined indepth. Each chapter in this thesis draws upon different qualitative methods and each chapter contributes a piece of the picture concerning mother’s mental health issues in the early twentieth century. The nonlinear developments in the data collection that required changes to the original research design are chartered. The chapter describes the first collection of Ada’s patient clinical notes from the Freedom of Information Unit, the ethical dilemmas of family interviews, through to collecting a further thirty patient clinical notes and the interviews concerning Ada’s time with the Donnan family at Mayday Hills Mental Hospital, Beechworth, during the 1950s and 1960s.
Chapter Two: The methods and sample

Introduction

In this chapter the different qualitative methods for each chapter are examined, and together build a cohesive picture of mother’s mental health issues in Victoria. Historical methodologies are deployed in the archival sources of mothers’ patient clinical notes, and the multiple social science research methods used in the construction of Ada’s biography. Early changes to the research design meant that the collection of data has not always been a linear, pre-planned process, but a process marked by change and reinvention, like many research projects. As a result, this account of the methodology provides a somewhat chronological narrative that articulates which data were collected first and describes the progress and setbacks throughout the collection process. This description of the sequence of methodological decisions helps to indicate the milestones of progress that have shaped my thinking.

The historical methodology in using Ada’s patient clinical notes and the process of obtaining them from the Freedom of Information Unit is first described in this chapter. An examination of my reflexive research journal follows, and makes visible my insider status as both researcher and a member of Ada’s family. The original research design intended to serve as a biography of Ada’s life, by undertaking interviews with family members, and supplemented with information drawn from her patient clinical files. The chapter then discusses the Southern Cross University’s Higher Research Ethics Committee objections to the research design and the author’s ethical dilemmas that emerged as she considered conducting family interviews. These concerns led to changes in the original research design. The decision not to conduct family interviews altered the focus of the research design early in the research process. An alternative source of data to
family interviews was sought. This led to the archival collection of a further thirty mothers’ patient clinical notes. Working within the modern archive raised further issues, particularly in the ways twentieth-century doctors changed their record keeping from the nineteenth century. These changes affected the ways archivists manage and categorised patient records. The process of accessing these files and the practicalities of how the data collection was conducted helps to illustrate the changed nature of note taking, record-keeping and administration of mental patient clinical notes in the early twentieth century.

Qualitative research is always interpretative and lends itself to a ‘bricolage’ or patchwork of methods of data collection, presentation and analysis.¹ The final section of this chapter describes how the construction of Ada’s biography provides an interpretive bricoleur approach by using multiple methods which draw from a range of qualitative sources. This biographical approach to Ada’s life breaks from traditional history methods, as it not only draws from her patient clinical notes, but combines with multiple methods from the social sciences. These include low-risk interviews, family stories, and the researcher’s reflective journal. The late addition of low-risk interviews with Sally has strengthened Ada’s biography by furnishing crosschecking information necessary in triangulation.² Yet Sally’s stories go beyond the corroboration of dates, locations and facts by providing rich descriptions of her childhood memories of Ada, who lived with Sally’s family on the grounds of Mayday Hills Mental Hospital, Beechworth, in country Victoria. Ada’s patient clinical notes were collected first, and in the following section I examine the process of accessing her files through the Freedom of Information Unit, Victoria.

Documentary method: freedom of information

The sourcing of primary documents can prove difficult when patient clinical notes are closed to the public. This is due to the seventy-five-year closed file policy of the Public Records Office, Victoria. Ada’s patient clinical notes were accessed through the Freedom of Information Unit, Victoria, with the support from another family member, necessary in signing approval to access Ada’s files as next-of-kin. First, I purchased Ada’s 1934 marriage certificate. It provided Ada’s date of birth and correct maiden name spelling, necessary to request the correct person’s clinical notes in the Freedom of Information request.

I received Ada’s patient clinical notes in full. They spanned nearly forty years from her first committal in 1936 through to her death in 1972, amounting to 112 pages. She was first committed into Royal Park Receiving House, Melbourne, in 1936, at the age of twenty-four. Ada was committed as insane following the birth of her second child. ‘Puerperal’ was entered as the ‘cause of attack,’ when her baby was fourteen days old. Ada’s files are the largest amongst the set of thirty-one mother’s files. This is likely due to the Freedom of Information Unit’s ability to access material from a variety of archival sites. They include Ada’s patient index cards, committal certificates, transfer approvals and notices to the receiving institutions, letters between family members and the superintendents, and her patient clinical notes. Produced by her attending psychiatrists and medical officers in their own handwriting, the patient clinical notes record Ada’s

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5 Ada Mont Park Patient Clinical Notes, AS/1994/508/129
basic demographic details, admission and discharge dates, and the treatments prescribed, across three mental institutional settings. A small black and white portrait photograph was pasted into the second page, showing Ada as a smiling young woman looking away from the camera. From Ada’s clinical notes the following history is gleaned.

The Royal Park Receiving House, the institution of Ada’s first committal, and the adjacent Royal Park Hospital for the Insane were established in Parkville, Melbourne in 1907 (see Figures 1 and 2). The Receiving House was a place for short stay observation of patients and if deemed ‘recoverable’ patients were transferred to Royal Park Hospital for the Insane. Patients considered incurable or chronic were sent onto Mont Park Hospital for the Insane, which opened in Macleod in 1911, on the outskirts of suburban Melbourne. These three metropolitan institutions worked as an integrated system depending on the patients’ prognoses. The only other Receiving House in Victoria was located at Ballarat, in country Victoria, and was attached to the Ballarat Mental Hospital.

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6 The Mental Hygiene Act 1933 changed the title of ‘Hospitals for the Insane’ to ‘Mental Hospitals’.
7 Bourke, Anne, 'The Lure of the Land – Mont Park Hospital for the Insane' (University of Melbourne: 2010), p.61
8 Ibid
9 Report of the Director of Mental Hygiene for the Year Ended 31 December, 1936 (Melbourne, E. J. Green, Government Printer, 1937), p. 16
Figure 1: The former Royal Park Psychiatric Hospital. Photographed by the researcher, 2011

Figure 2: Memorial plaque at the former site of the Royal Park Psychiatric Hospital. Currently used as privately owned townhouses. Photographed by the researcher, 2011
After only three months at the Royal Park Receiving House, in 1936, Ada’s prognosis was considered ‘chronic’ and she was transferred to Mont Park Mental Hospital. In 1938, Ada was discharged as recovered. However, she returned again in May 1940 to the same Receiving House, but this time with the ‘cause of attack’ entered as pregnancy. Ada was soon transferred to Royal Park Mental Hospital in July 1940, and then by March 1942 she was transferred onto Mont Park where she spent the next fourteen years. By 1956 Ada was transferred to Beechworth Mental Hospital, known as Mayday Hills, in country Victoria, accompanying the Donnan family where Dr Donnan took the new post as psychiatric superintendent.

There is a scarcity of other primary sources about Ada herself. I have one letter written by Ada kept by a family member and two letters Ada wrote while in the mental institution, that were unsent and kept within her patient clinical notes, as per the legislation of the period. Ada left no diary, so these mental patient records are the only source of information on Ada’s life and her fractured motherhood.10

Historian Mary Elene Wood is doubtful of patient histories that rely solely on case records when it is ‘attendants [who] play a much larger daily role in patients’ lives than doctors do’.11 Yet it is the psychiatrists who compile patient records, sometimes at yearly intervals only. The reading of Ada’s handwritten files proved difficult at times. The original files are imperial quarto (15 inches in height x 11 inches wide); a loose-leaf folio

format introduced in 1912.\textsuperscript{12} This altered from the previous format of casebooks which held many patient notes bound together. The new format provided a separate and individual file for each patient ‘which meant that the case notes could be transferred with the patient whenever they were removed to another hospital or forwarded to the Lunacy Department when the patient was discharged or died.’\textsuperscript{13} The imperial quarto would fit neatly into an A3 paper size, however, the Freedom of Information Unit supplied photocopies reduced to A4 size, which meant the handwritten notes in Ada’s clinical notes were difficult to decipher in places. Some entries were extensive and ran into the margins, other entries were illegible, as is the nature and limitations of patient records. For easier retrieval, and with the help of a magnifying glass, Ada’s files were transcribed into word documents as data sheets. This transcription process allowed Ada’s files to be reorganised into a sequential timeline of committals, transfers, trial leave and treatments across three mental institutions in chronological order. This proved to be a labour-intensive activity, and allowed the researcher to deeply immerse in Ada’s institutional life.

It is only through Ada’s committal to the mental institution, and her marriage four years before, that her life became formally documented through official records. Her life prior to committal has been difficult to research and account for. Her institutional stays, combined with our family’s secrecy concerning Ada’s whereabouts, effectively cut off our part of the family from Ada’s family of origin, her relatives and her side of the family. Our family has no knowledge about where Ada grew up or where she went to

\textsuperscript{12} Sunbury Hospital for the Insane, Female Patients 1912-1956, Description of This Series, VPRS: 8245 (Public Records of Victoria).

\textsuperscript{13} Ibid
school, for example. There is a paradox that through committal, Ada is known to our family for a period of time, albeit through institutional records.

**The researcher’s journey: reflective journal**

The reflective journal which forms part of my research maps the evolution of the research design, the changes to qualitative research methods and my responses to Ada’s files as her family member. Feminist influences acknowledge the researcher herself as part of the research process. In clearly identifying the approaches and position as a researcher, not only will the reader be aware of my standpoint positioning, but it will help ensure the research is clearly informed by theory and guided by an ethical best practice.

The reflective journal has similar aims to that of Michelle Ortlipp’s research journal: ‘to make her decisions, and the thinking, values and experiences behind those decisions transparent to both herself and the reader. In this way, the journal reflects my ‘rite of passage’ and progress from a naïve beginner. The reflective journal is presented as an epilogue chapter, following the concluding chapter in this thesis titled *Epilogue: The Researcher’s Journey*.

This section on the Researcher’s Journal and this whole methods chapter attempt to make explicit the progress, stumbling blocks and accomplishments in my research process. Archival records are considered an unobtrusive method since they do not require

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human contact, as interviews do. However, I would argue that as unobtrusive as the archives are, this does not exclude them as sensitive research. Pranee Liamputtong defines socially ‘sensitive research’ involves groups which ‘are often hard to reach; they are the silent, the hidden, the deviant, the tabooed, and the marginalised. In Stone’s words the disadvantaged are the ‘invisible vulnerable’ populations in society. Both Stone and Liamputtong are essentially describing the obtrusive methods of interviews, focus groups and observations. Their definitions of sensitive research apply to this present study, as it requires the disclosure of behaviours or attitudes, which would normally be kept hidden. This present work is ‘sensitive research’ because mothers in mental institutions were both a vulnerable social group and a hidden population. In this way, the application to interview Ada’s family members in the original research design, proved too sensitive in nature for the Southern Cross University’s HREC to approve. The next section explores the ways data collection affects researchers, and we affect the research.

Raymond Lee reminds us how conducting sensitive research can place emotional demands on the researcher and can have great impact on the personal lives of sensitive researchers. Virginia Dickson-Swift and colleagues recognise the emotional work involved in qualitative research on sensitive topics, and that unobtrusive data collection

methods can have a number of impacts on researchers. In undertaking this research, I have had emotional experiences that have affected me personally, for which I was unprepared. Not only has Ada’s story affected me, but many of the other mothers’ clinical notes used in this research contain very sad stories. Liamputtong argues the need for support strategies for the researcher in the form of a professional confidant, formal supervision, regular meetings and emotional support to safeguard researchers. A plan for my own emotional management was recommended by the Southern Cross University’s Chair of HREC in our meeting. The writing of the Epilogue: The Researcher’s Journey journal, recommended by my supervisors, is one part of this strategy that has helped me with the emotional work necessary in this research journey. Other support strategies have included regular study group meetings with other PhD students, professional psychological counselling, but most valuable support has come from friends, who have walked the research path empathetically with me.

Ortlipp points out ‘keeping and using reflective research journals can make the messiness of the research process visible and avoid misrepresenting discourses of research as neat and linear process.’ The unusual nature, multiple methods and structure of this thesis has meant I have wrestled, at times, with the messiness Ortlipp refers to. On occasions the writing from both insider and outsider positions has proved difficult. I have oscillated between distancing myself as an omnipresent writer and writing sensitively about Ada’s life as a member of my family. I have grappled with the ethical dilemmas in how much I should share with my family the contents of Ada’s files, and how much to protect the

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family from itself. I have wrestled with how far I can go, how I can really say what I feel, know and think, especially when too much self-disclosure brings risks of exposure to myself, my family and the university. The personal dimensions of this thesis reach beyond traditional historical methodologies in reading archives. Awareness of the details held within Ada’s patient clinical notes: the treatments, the power of her husband’s testimony, the transfers from one institution to another, her work in the superintendent’s home, all once hidden from our family, had and continue to have deep ramifications, particularly for her two children who grew up without their mother.

The reflective journal is a place to process my emotions concerning the various discoveries I found about Ada, and the issues that concern communicating those discoveries with my family. Practical and emancipatory reflection is useful in making sense of my family’s lived experiences and predicaments through context and subjectivity.25 The value of reflection brings new insights, which then transform my understanding and knowledge into something more meaningful.26 Lastly, transformation has occurred in a two-way process: the social experience of this research has changed me personally, and hopefully this research can transform, as Coffey says, ‘public accountable knowledge’.27

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26 See ibid. p. 192.
Ethical dilemmas in family research

Originally the research design involved undertaking interviews with my family members. Such interviews may have helped to understand family members’ experiences of Ada’s absence and help to put in context the circumstances of Ada’s committal. Researchers of the family have raised concerns for the potential risks of exposing a family to itself and/or to the public as inherent ethical problems in qualitative studies of the family. Human research that involve more than low-risk must be presented in the National Ethics Application Form (NEAF) to the University’s Higher Degree Ethics Committee (HREC). Low-risk research is described in the National Statement on Ethical Conduct in Human Research as research in which the only foreseeable risk is one of discomfort. In the NEAF application to undertake interviews with my family members, I identified the kinds of harm, discomfort or inconvenience, and in gauging the degree of risk, I outlined the efforts to minimise these risks. As per the usual requirements, I submitted the interview design and questions, informed consent forms and information sheet for participants.

The Ethics Committee required certain ethical issues relating to the interviews to be addressed before full approval could be issued. In particular, I had not addressed ways to manage the possible risks to myself as the family participant researcher to the Ethics Committee’s satisfaction. The application also needed to identify protocols more tightly suited to family members’ potential distress, other than using Lifeline services. The researcher’s statements: ‘non-participation will in no way have any consequences’ and ‘All effort to ensure the privacy and confidentiality of participant identities’ were considered too vague by HREC. The NEAF application was reworked to address these

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concerns and re-submitted. This re-worked NEAF application did not satisfy the Ethics Committee. My principal supervisor and I were asked to attend a meeting with the Chair of HREC. It was requested that we withdraw this NEAF application, or at least put family interviews on hold for the time being. The Chair recommended further work on insider research was needed, and to provide evidence to demonstrate my awareness of risk to myself and outline strategies for my emotional management.29

In the eyes of the Ethics committee, the likely benefits of this research did not justify any risks of harm, distress or discomfort to family member participants or to the researcher. A great deal of effort and forethought went into protecting family from emotional distress, especially in the interview design and consent documents required as part of the Ethics Committee application. Ada’s records are closed to the public and considering the taboo nature of mental illness even today, there were potential benefits for family members. These benefits include the experience of healing and reconciliation gained from both the interview process and the dissemination of this research. Over time, this research may become a valuable contribution to family history. In addition, others from the both the university and the wider community have been prompted to share with me, informally, similar experiences of their own family members’ committal to mental institutions, enabling possible therapeutic benefits in the wider population. However, the benefits described above do not render the risks as invalid. At that time, I decided not to persevere with family interviews, which was a source of disappointment, especially when some family members were very interested in participating in the interview process. As for me, I had invested a fair amount of emotional labour in cultivating family members’ support

29 See Epilogue: The Researcher’s Journey
for interviews, which resulted in a fair degree of humiliation as the family researcher, when I had informed them.

Larossa and colleagues examined the importance of anonymity, and cite the worst case of exposure. For example, the characteristics of a particular family were so rare and unique, they were recognised in publication as the family under study. This resulted in a furore, threats of law suits and great damage done to members who were unaware of certain details within their own family life. However, the cases Larossa et al have cited, are not studies of the researcher’s own families, but other people’s families. So what does this mean for researchers researching their own families? Early in this project there was an upset between two family members. Some family members did not want other family members involved in the project. In hindsight, family interviews had difficulties from the beginning.

The HREC stipulated there must not be privacy issues, and that participants must have definite assurance that all information is confidential and de-identified. I began to see ethical dilemmas at every step. For example, as a woman who has not taken another’s surname through marriage, I carry the surname of my family of origin. As the author of this research, how can I provide a tight case for anonymity and protect my family’s identity, when I carry the same surname as theirs. Can I say this is the story of my family the ‘Brown’ family when the thesis is authored by Watts? In an effort to remove identifying markers, I began to change the way I described my kinship relationship with Ada. Rather than describing her in kinship terminology such as my mother, aunt, sister or

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31 See Epilogue: The Researcher’s Journey
grandmother, for example, I began instead to use words like female relative, or female ancestor, or family member. This obscured our direct relationship through use of language, but it removed a fair degree of authenticity and historical accuracy by blurring kinship ties so crucial in genealogical work. The same issues concerned me with correctly citing a family member’s unpublished autobiography, meant it was difficult to de-identify their authorship, and their kin relationship to Ada and myself. The HREC’s sanction on family interviews meant a new research design needed to be devised in order to conduct valid and adequate doctoral research.

The collection of a further thirty patient clinical notes

Without family interviews, changes to the research design and methods were necessary. This led to making the request to access a further thirty mothers’ patient clinical notes from the interwar period 1920–1934, with the same diagnosis as Ada and from the same institution, the Royal Park Receiving House, Melbourne. The revised research design was approved by HREC (ECN-10-175). However, due to the seventy-five-year embargo on patient clinical notes in Victoria, I requested, and gained permission from the then Victorian Health Minister and the Victorian Chief Psychiatrist to access this archive held at the Victorian Human Services Department in Melbourne.

In order to make valid comparisons, four key descriptors of Ada’s life were identified and used to select a sample of thirty files. The main features were patients of the same institution in their first committal in Victoria: The Royal Park Receiving House, the same

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32 See Epilogue: The Researcher’s Journey
33 See Appendix C: Request letter to Hon. Daniel Andrews MP
reason for committal of ‘puerperal’ and or birth-related insanity, and in the same era as Ada’s committal, that of the interwar years. This makes it explicit that it is Ada’s clinical notes that shaped the research sample and determined the parameters in the collection of the further thirty mothers’ clinical notes.

It is worth noting that the method in obtaining Ada’s files came first in this research. Rather than coining a research problem or question first, then designing the best methods to suit answering it, this research began with Ada’s files, and her committal with ‘puerperal’ birth-related insanity. In this way, the research problem emerged from Ada’s files, which determined which files were needed in the later collection. In other words, if Ada’s committal had been due to something other than ‘puerperal’, like melancholia or dementia for example, this research and the collection of the further files, would have taken a very different course.

With few twentieth-century Australian studies, it is necessary to draw from historians’ work on the colonial archives. Most of the work on medical and asylum archives have come from colonial contexts, where poststructuralists have examined the ways imperial power of colonial authorities are exposed within the archive themselves. 34 Historians remind us too that archives are also governed by the rules of the time, location and purpose for which they were created. 35 Ann Stoler restates Foucault’s approach in that archives are systems of statements, and the rules of practice in record keeping shape and

Regulate what can and cannot be said.36 The archives in this present study were not created in the colonial setting, but instead in the new federated nation of states of the early twentieth century. The value of the nation as the framework and context of these archives finds event and movements in Britain remained highly relevant to Australia, with its history and place in the British Empire.37 The adopted British systems of power in law, medicine and psychiatry, well established in the colonial era, continued the imperial dimension in the new nation.38

In her study of New Zealand colonial case files, Emma Spooner argues that the advantage in reading fewer cases has allowed the researcher to develop an in-depth poststructuralist understanding of the cases’ uses, meanings and context of their construction.39 In the same vein, but in the context of the twentieth century, and in a different national context, the present study draws upon thirty-one mothers’ cases, considered a small set of files or cases. Like Spooner’s work, this allows for an in-depth examination of the gendered psychiatric language that was used, and the physical limitations of the bureaucratic forms doctors were required to use. The present work also builds upon Tanya Luckins’ work on the ways loss and grief were experienced and expressed in patient clinical notes of women committed to Victorian mental institutions during the Great War. Luckins’ work illustrates how clinical notes can be read for wartime loss of Australian women who lost husbands, sons and brothers during the high death tolls in fighting in Europe on the

37 Ann Curthoys, 'Cultural History and the Nation', in Cultural History in Australia, ed. by Hsu-Ming Teo and Richard White (Sydney, University of New South Wales Press, 2003), p. 27.
Western front.\textsuperscript{40} The use of the thirty-one patient clinical notes, in this present study, permits a reading of the meaning, language and context of the ways these mothers’ case files help us to understand the construction of ‘unfit’ maternal identities in the new nation of the twentieth century. Statistical data helps to place this small sample in context and is placed in Table 1.

Table 1 shows the total number of lunatics (\textit{sic}), and the male and female percentage, registered in Victorian Hospitals for the Insane for the years 1920–1936. Over the sixteen-year period female lunatics remained marginally higher (at 50–52 per cent) than the male population.

\begin{footnote}
\textsuperscript{40} Luckins, “Crazed with Grief?” The Asylum and the Great War in Australia’ (2003).
\end{footnote}
Table 1: Total number, and percentages, of registered female and male lunatics in Victorian Hospitals for the Insane for the years 1920–1936

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of registered lunatics on the Books of Public Hospitals on 31st December</th>
<th>Total Males registered for the Year</th>
<th>Male % of Total Lunatics for the Year</th>
<th>Total Females registered for the Year</th>
<th>Female % of Total Lunatics for the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>5,830</td>
<td>2,888</td>
<td>50%</td>
<td>2,942</td>
<td>50%</td>
</tr>
<tr>
<td>1921</td>
<td>5,842</td>
<td>2,869</td>
<td>49%</td>
<td>2,973</td>
<td>51%</td>
</tr>
<tr>
<td>1922</td>
<td>5,997</td>
<td>2,909</td>
<td>49%</td>
<td>3,088</td>
<td>51%</td>
</tr>
<tr>
<td>1923</td>
<td>6,026</td>
<td>2,932</td>
<td>49%</td>
<td>3,094</td>
<td>51%</td>
</tr>
<tr>
<td>1924</td>
<td>6,096</td>
<td>2,923</td>
<td>48%</td>
<td>3,173</td>
<td>52%</td>
</tr>
<tr>
<td>1925</td>
<td>6,192</td>
<td>2,977</td>
<td>48%</td>
<td>3,215</td>
<td>52%</td>
</tr>
<tr>
<td>1926</td>
<td>6,326</td>
<td>3,055</td>
<td>48%</td>
<td>3,274</td>
<td>52%</td>
</tr>
<tr>
<td>1927</td>
<td>6,360</td>
<td>3,053</td>
<td>48%</td>
<td>3,307</td>
<td>52%</td>
</tr>
<tr>
<td>1928</td>
<td>6,501</td>
<td>3,150</td>
<td>48%</td>
<td>3,351</td>
<td>52%</td>
</tr>
<tr>
<td>1929</td>
<td>6,531</td>
<td>3,168</td>
<td>49%</td>
<td>3,363</td>
<td>51%</td>
</tr>
<tr>
<td>1930</td>
<td>6,669</td>
<td>3,234</td>
<td>48%</td>
<td>3,435</td>
<td>52%</td>
</tr>
<tr>
<td>1931</td>
<td>6,704</td>
<td>3,235</td>
<td>48%</td>
<td>3,469</td>
<td>52%</td>
</tr>
<tr>
<td>1932</td>
<td>6,742</td>
<td>3,274</td>
<td>49%</td>
<td>3,468</td>
<td>51%</td>
</tr>
<tr>
<td>1933</td>
<td>6,812</td>
<td>3,297</td>
<td>48%</td>
<td>3,515</td>
<td>52%</td>
</tr>
<tr>
<td>1934</td>
<td>6,927</td>
<td>3,343</td>
<td>48%</td>
<td>3,584</td>
<td>52%</td>
</tr>
<tr>
<td>1935</td>
<td>6,979</td>
<td>3,353</td>
<td>48%</td>
<td>3,626</td>
<td>52%</td>
</tr>
<tr>
<td>1936</td>
<td>7,144</td>
<td>3,420</td>
<td>48%</td>
<td>3,724</td>
<td>52%</td>
</tr>
</tbody>
</table>
Table 2: Total new admissions for each year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number Admitted in the Year</th>
<th>Total Females Admitted in the Year</th>
<th>Female % of Total Admitted in the Year</th>
<th>Total Males Admitted in the Year</th>
<th>Male % of Total Admitted in the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>864</td>
<td>399</td>
<td>46%</td>
<td>465</td>
<td>54%</td>
</tr>
<tr>
<td>1921</td>
<td>802</td>
<td>419</td>
<td>52%</td>
<td>383</td>
<td>48%</td>
</tr>
<tr>
<td>1922</td>
<td>838</td>
<td>404</td>
<td>48%</td>
<td>434</td>
<td>52%</td>
</tr>
<tr>
<td>1923</td>
<td>827</td>
<td>357</td>
<td>43%</td>
<td>470</td>
<td>57%</td>
</tr>
<tr>
<td>1924</td>
<td>809</td>
<td>407</td>
<td>50%</td>
<td>402</td>
<td>50%</td>
</tr>
<tr>
<td>1925</td>
<td>746</td>
<td>347</td>
<td>47%</td>
<td>399</td>
<td>53%</td>
</tr>
<tr>
<td>1926</td>
<td>841</td>
<td>407</td>
<td>48%</td>
<td>434</td>
<td>52%</td>
</tr>
<tr>
<td>1927</td>
<td>825</td>
<td>395</td>
<td>48%</td>
<td>430</td>
<td>52%</td>
</tr>
<tr>
<td>1928</td>
<td>877</td>
<td>394</td>
<td>45%</td>
<td>483</td>
<td>55%</td>
</tr>
<tr>
<td>1929</td>
<td>868</td>
<td>409</td>
<td>47%</td>
<td>459</td>
<td>53%</td>
</tr>
<tr>
<td>1930</td>
<td>881</td>
<td>456</td>
<td>52%</td>
<td>425</td>
<td>48%</td>
</tr>
<tr>
<td>1931</td>
<td>835</td>
<td>411</td>
<td>49%</td>
<td>424</td>
<td>51%</td>
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<tr>
<td>1932</td>
<td>782</td>
<td>350</td>
<td>45%</td>
<td>432</td>
<td>55%</td>
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<tr>
<td>1933</td>
<td>848</td>
<td>443</td>
<td>52%</td>
<td>405</td>
<td>48%</td>
</tr>
<tr>
<td>1934</td>
<td>862</td>
<td>465</td>
<td>54%</td>
<td>397</td>
<td>46%</td>
</tr>
<tr>
<td>1935</td>
<td>893</td>
<td>476</td>
<td>53%</td>
<td>422</td>
<td>47%</td>
</tr>
<tr>
<td>1936</td>
<td>876</td>
<td>456</td>
<td>52%</td>
<td>420</td>
<td>48%</td>
</tr>
</tbody>
</table>

Table 2 shows new female admissions ranged between 347 and 476 per year, and reached its highest at 54 per cent in 1934 with sixty-eight more admissions than men across the state. New male admissions ranged between 383 and 483 per year and was at its highest in 1923 at 57 per cent, with 113 more men than women committed that year.

Table 2 indicates new male admissions each year were generally higher than females, until 1933, when females outnumbered new male admissions. Yet Table One illustrates females were the larger population overall. This meant that without an increase of new female admissions until 1933, women were staying longer over time, with fewer being discharged. Luckins identified that in 1916 women exceeded men for the first time since
1891. Her study attributed this to grief experienced by the loss of relatives and friends who served in the Great War.

Once I gained access to the Department of Human Services archive, I began using the term ‘puerperal’, from Ada’s clinical notes, to search for further female patient clinical notes with puerperal and other birth-related illnesses. I drew from the terms used in the Report of the Director of Mental Hygiene in the yearly mandatory reports published in the Parliamentary Papers. The four probable causes of insanity relating to childbirth for patients admitted in the same year as Ada, 1936, were listed as ‘pregnancy’, ‘parturition’, ‘puerperal states’, and ‘lactation’, and are shown in Figure 3.

41 See endnote 1 in ibid. p. 257.
42 The Mental Hygiene Act 1934, changed the name of the Inspector General of the Insane to the Director of Mental Hygiene and the Lunacy Department became the Department of Mental Hygiene.
### Figure 3: Report of the Director of Mental Hygiene 1936, No. 10, in Papers Presented to Both Houses of Parliament 1937, Vol 2. p.10

#### Table VIII — Showing the Probable Causes of Insanity in the Patients Admitted during the Year 1936.

<table>
<thead>
<tr>
<th>Causes of Insanity</th>
<th>Admissions</th>
<th>No. of Cases</th>
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<th></th>
<th></th>
<th>Mat.</th>
<th>Female</th>
<th>Total</th>
<th>Mat.</th>
<th>Female</th>
<th>Total</th>
<th>Mat.</th>
<th>Female</th>
<th>Total</th>
<th>Mat.</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>As Primiparing Cases</td>
<td>Mat.</td>
<td>Female</td>
<td>Total</td>
<td>Mat.</td>
<td>Female</td>
<td>Total</td>
<td>Mat.</td>
<td>Female</td>
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<tr>
<td>Moral</td>
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<td>Mat.</td>
<td>Female</td>
<td>Total</td>
<td>Mat.</td>
<td>Female</td>
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<td>Domestic trouble (including loss of relatives and friends)</td>
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<td>Adverse circumstances (including business anxieties and pecuniary difficulties)</td>
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<td>Mental anxiety and worry (not included under above two heads), and overwork</td>
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<td>Love affairs (including seduction)</td>
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<td>Fright and nervous shock</td>
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<td>Intemperance in drink</td>
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<td>Intemperance (sexual)</td>
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<td>Venereal diseases</td>
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<td>Self-murder (sexual)</td>
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<td>Over exertion</td>
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<td>Accident or injury</td>
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<tr>
<td>Parturition and the puerperal state</td>
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<td>Lactation</td>
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<td>Uterine and ovarian disorder</td>
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<td>Change of life</td>
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<td>Privation and starvation</td>
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<tr>
<td>Other bodily diseases or disorders</td>
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<td>Previous attacks</td>
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<tr>
<td>Hereditary influence ascertained (direct and collateral)</td>
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<tr>
<td>Congenital defect ascertained</td>
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<tr>
<td>Other ascertained causes</td>
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<tr>
<td>Unknown</td>
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<td>Total admissions</td>
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</tbody>
</table>

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*Note: The table provides a detailed breakdown of the causes of insanity among patients admitted during the year 1936, categorized as primiparous or subsequent cases, and further divided by gender.*
In Table 3, ‘pregnancy’, ‘parturition’, ‘puerperal states’, and ‘lactation’ were a small percentage of the overall female admissions for each year. This low rate of birth-related committals is similar to nineteenth-century admissions into English Asylums at approximately 10 per cent of women.\textsuperscript{43}

Table 3: Total, and percentage, of females admitted with Puerperal and related causes

<table>
<thead>
<tr>
<th>Year</th>
<th>Total of new females admitted in the year</th>
<th>Total admitted with Prenancy, Parturition, Puerperal States &amp; Lactation as probable cause of insanity in the year</th>
<th>% of total with Prenancy, Parturition, Puerperal States &amp; Lactation admitted in the year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>399</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>1921</td>
<td>419</td>
<td>24</td>
<td>6%</td>
</tr>
<tr>
<td>1922</td>
<td>404</td>
<td>21</td>
<td>5%</td>
</tr>
<tr>
<td>1923</td>
<td>357</td>
<td>25</td>
<td>7%</td>
</tr>
<tr>
<td>1924</td>
<td>407</td>
<td>22</td>
<td>5%</td>
</tr>
<tr>
<td>1925</td>
<td>347</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>1926</td>
<td>407</td>
<td>29</td>
<td>7%</td>
</tr>
<tr>
<td>1927</td>
<td>395</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>1928</td>
<td>394</td>
<td>19</td>
<td>5%</td>
</tr>
<tr>
<td>1929</td>
<td>409</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>1930</td>
<td>456</td>
<td>21</td>
<td>5%</td>
</tr>
<tr>
<td>1931</td>
<td>411</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>1932</td>
<td>350</td>
<td>23</td>
<td>7%</td>
</tr>
<tr>
<td>1933</td>
<td>443</td>
<td>17</td>
<td>4%</td>
</tr>
<tr>
<td>1934</td>
<td>465</td>
<td>15</td>
<td>3%</td>
</tr>
<tr>
<td>1935</td>
<td>476</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>1936</td>
<td>456</td>
<td>14</td>
<td>3%</td>
</tr>
</tbody>
</table>

Once working within the Department of Human Services archive, I used the four terms ‘parturition’, ‘puerperal state’, ‘lactation’ and ‘pregnancy’ to identify patients within the

Admission Registers for the Royal Park Receiving House.\textsuperscript{44} The Admission Registers are large books, the pages have multiple columns with one row devoted to each patient. One column was headed ‘Diagnosis’, the next column heading was ‘Supposed Cause of Insanity’ (See Figure 4). The terms entered in the ‘Diagnoses’ column were much more varied than the terms provided in the Annual Reports, for example they included: ‘puerperal insanity’ ‘recent melancholia’, ‘acute and recurrent melancholia’, ‘mania puerperal’, ‘delusional puerperium’ and ‘pregnancy’. Under the column heading ‘Supposed Cause of Insanity’, the terms ranged from ‘childbirth’, ‘miscarriage’, ‘strain of child-bearing’, ‘illegitimate child’ to ‘confinement’ or simply ‘puerperal’, ‘puerperium’ and ‘parturition’.

I drew from both columns to select patients with childbirth related insanity. From these entries in the Admission Registers each patient’s index card was located. These cards list the institution the patients last resided in, and it is this last institution in which the full patient clinical notes are grouped and archived. Suzanne provides an example of

\textsuperscript{44} Royal Park Receiving House Admission Registers, AS/96/278, Vol 6-11.
puerperal insanity recorded as the diagnosis on a patient’s index card (see Figure 5).\footnote{Suzanne Mont Park Index Card, AS/1994/0093/0013.} Due to her unfavourable prognosis, and like other patients deemed incurable or chronic, Suzanne was transferred to Mont Park Hospital for the Insane. Patient clinical notes were transferred with the patient from institution to institution, and by ascertaining that Mont Park was the last institution Suzanne resided in, the full patient clinical notes were located in the archive dedicated to Mont Park. The first two pages of the clinical notes are pre-printed and the third and subsequent pages are lined for doctors’ handwritten entries (see Figure 6).
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recieving House</td>
<td>30.7.29</td>
</tr>
<tr>
<td>Mental Hospital</td>
<td></td>
</tr>
<tr>
<td>Hospital for the Insane</td>
<td>20.8.29</td>
</tr>
<tr>
<td>On Trial Leave</td>
<td>26.12.30</td>
</tr>
<tr>
<td>Boarded Out</td>
<td></td>
</tr>
<tr>
<td>Discharged - Reassessed</td>
<td></td>
</tr>
<tr>
<td>Relieved - 1.12.33</td>
<td></td>
</tr>
<tr>
<td>Not Improved</td>
<td></td>
</tr>
<tr>
<td>Died</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6: Page 1 of Suzanne’s patient clinical notes
The first page is a simple, two-column table with handwritten entries of the patients’ dates of reception, trial leave, boarded out and discharged. For example, the entries on page one of Suzanne’s clinical notes indicate she was committed to the Receiving House on July 3, 1932, transferred to Hospital for the Insane (Mont Park) in August 1929, went on trial leave by December 1930, and discharged in 1933.46

46 Suzanne Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0027
Figure 7: Page 2 of Suzanne’s patient clinical notes
The second page (see Figure 7) provides the patients’ demographic information, diagnosis, age, whether married, number of children, general physical condition, general mental condition and report of relatives, for example. Suzanne was an unmarried, twenty-three-year-old domestic servant, committed when her baby was six-weeks old. ‘P. D.’ was entered as Suzanne’s diagnosis, an abbreviation for ‘primary dementia’ listed in the Annual Reports as a common form of mental disorder.47 Puerperal insanity was recorded within Suzanne’s clinical notes, entered on August 29, 1929 on page three.48

There was a lack of uniformity of terms and a far wider variety of terms used than the Annual Reports indicated. For example, in the Admission Registers, the diagnosis for Beatrice was entered as ‘Recent Melancholia.’ At first glance, this did not appear relevant to this thesis. However, moving along this row in Beatrice’s entry revealed ‘childbirth’ under the ‘Supposed Cause of Insanity’ column. Beatrice was transferred from the Royal Park Receiving House to Sunbury Mental Hospital in 1920 where ‘puerperal’ is indicated on her index card.49 Within her file ‘childbirth’ is entered as the ‘cause of attack’, with the diagnosis of ‘Recent Melancholia.’ 50

The first point of reception for all the thirty-one women in this study, was at the Royal Park Receiving House, where women were assessed and transferred to various hospitals for the insane. Twenty patients’ clinical notes were collected from the Department of Human Services archive of women transferred to Royal Park, Mont Park and Beechworth for this time period. A further ten were requested from Public Records, Victoria, which

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50 Beatrice Sunbury Patient Clinical Notes, PRO-V, VPRS: 8236/P1/4
hold the records for women transferred to Kew, Sunbury and Yarra Bend. Thirty patient clinical notes were collected in total, from both the Department of Human Services archive and Public Records, Victoria. Two files were collected from each year from 1920 through to 1934, being a fourteen-year period. The collected sample ended at 1934, which honoured the seventy five year closed file embargo.

The timeline below indicates the date range of Ada’s life, her patient clinical notes and the further thirty mothers’ clinical notes under examination in this research.

![Timeline of Ada’s life, her clinical notes and the date range of the thirty mother’s clinical notes.](image)

Some patient files are extensive and fill pages of handwritten entries. Others are more scant, with few entries and lack detail. The disdain for record keeping can be found in Reg Ellery’s autobiography, *The Cow Jumped over the Moon: Private Papers of a Psychiatrist*, a well-known Melbourne psychiatrist. When Ellery was the junior medical officer at Kew Hospital for the Insane in Melbourne, he described finishing his morning rounds through the wards, then returned to his office ‘to make a few bald entries in the case books’ and ‘regarding the case books, the less said the soonest ended’. Ellery, *The Cow Jumped over the Moon* (1956), p. 92.
especially when there was possibly very little progress to report. Minimal entries, misfiled and lost records leave the historian with disappointment and the sense of partiality when the trail in tracing a patient runs cold. Other patient clinical notes could not be found. For example, one patient’s index card stated ‘puerperal insanity’, but her full mental patient file could not be located. Such is the problematic use of the archives, often fractured accounts and fragmentary narratives of insanity.

These inconsistencies for the historian can be frustrating. For example, in Freda’s case, (see Figure 9) ‘puerperal insanity’ appeared in the admission book, but the ‘Diagnosis’ and ‘Cause of Insanity’ within the patient file has been left blank. Yet deeper within the file notes, the reason for the patient’s committal can be found where it is stated that the patient became unstable through a recent childbirth. This requires much from the researcher to piece together some semblance of facts.

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52 Coleborne, Reading Madness (2007).
53 Ibid.
54 Freda Royal Park Patient Clinical Notes, DHS, AS/1997/93/085
Figure 9: Freda’s patient clinical files
The clinical notes illustrate that psychiatrists also undertook physical examinations of their patients upon their first reception. The condition of the patient’s heart, and lungs were recorded in most cases. Scientific developments in pathology saw the use of urine and blood tests performed for patients in this present study. The identification of the syphilis spirochete and the subsequent Wassermann test of patients’ blood to diagnosis the presence of syphilis in 1910 expanded the role of pathologists in the Victorian Lunacy Department. Among the women in this present study, eight patients were tested for syphilis with the Wasserman test; the results found seven women negative and one woman, Suzanne, found positive for syphilis.

The newly developed triple typhoid vaccine (T.A.B.) proved extremely effective in reducing the incidence of typhoid fever amongst the Australian Imperial Forces at Gallipoli in World War I. Four women patients were given the typhoid vaccine, and the Victorian Lunacy Department pathologist, Dr Lind, recommended that the typhoid vaccination be mandatory for all insane patients. Certainly these advances in medical technologies gave psychiatrists and physicians of the early twentieth century advantages over their nineteenth-century peers.

Of the thirty-one mothers selected, five were unmarried and twenty-six were married women. Their ages ranged from twenty to forty-four and their lengths of stay were from five weeks to fifty-one years. Eleven mothers were committed after their first

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baby. All mothers can be presumed white, as it was not otherwise stated. The majority (twenty-eight) of women were born in Australia (twenty-three in Victoria, two in NSW, two in Tasmania and one in South Australia) with three born overseas in both Scotland and England. The majority (twenty-three) came from Melbourne suburbs including Hawthorn, South Melbourne, Richmond, Kensington, Fairfield, Preston, Kew and Elwood, with one woman from New South Wales. Seven women came from country Victorian towns including Colac, Eurora, Benalla, Yarra Glen, South Gippsland, Geelong and Wonthaggi. The women were Christians with fourteen identified their religious affiliation as Church of England, seven as Roman Catholic, five Methodist, with the remaining identifying themselves as Presbyterian, Congregational, and Church of Christ.

Table 4: Patients religious affiliation

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Number of mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church of England</td>
<td>14</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>7</td>
</tr>
<tr>
<td>Methodist</td>
<td>5</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
</tr>
<tr>
<td>Congregational</td>
<td>1</td>
</tr>
<tr>
<td>Church of Christ</td>
<td>1</td>
</tr>
</tbody>
</table>

This section has applied historical methodologies that illustrate how Ada’s information and the ‘puerperal’ terms from annual reports were used to select the sample of thirty women’s files from the archive. It describes the nature and archival organisation of patient files and the wide variety of terms and causes used to describe women’s illnesses.
and insanity linked to post-birth mental disorders. In brief, the women were a diverse group in both age and range of birth places, and at the same time they had in common Christian affiliation, of presumably white-Anglo descent and all compulsorily committed by certification of various kinds of maternal insanities. In the next section, the interdisciplinary nature of this thesis is introduced and the use of multiple qualitative methods in the writing of Ada’s biographical narrative is described.

**Ada’s biography: multiple qualitative methods**

Qualitative research characteristically employs multiple methods to triangulate information.\(^58\) Norman Denzin provides the range of sources used in the biographical method which could combine the following: case histories, case studies, life stories, personal experience stories, oral histories and personal histories, for a fully triangulated biographical investigation.\(^59\) For Ada’s biography, multiple methods combined history methods, in her patient files and letters, along with the social science methods in low-risk interviews, and family stories. Family members, particularly Ada’s two adult children, shared their childhood recollections in growing up without their mother and their subsequent reconnection with Ada years later. Multiple methods were used to enhance rigor, breadth, complexity, richness and depth to Ada’s biography.\(^60\) As no interviews undertaken could be undertaken with Ada, her biography does not represent her voice or subjective experiences. Yet we get glimpses of the various phases of her life directly through the three letters written by Ada, which were found in her clinical notes, and the

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\(^{60}\) See Denzin and Lincoln, *The Sage Handbook of Qualitative Research* (2005), p. 5.
multiple, low-risk interviews with Sally, the daughter of the Beechworth superintendent, Dr Donnan. Both offer the research a complex picture not available through the archive method in reading Ada’s files.\textsuperscript{61}

The interviews with Sally about her childhood recollections of Ada at Beechworth Mental Hospital were a late additional method in the research process. This required a change of protocol and ethics approval to undertake low-risk interviews (ECN-13-018). Interviews strengthened Ada’s biography as they provide a means of cross-checking information necessary in triangulation.\textsuperscript{62} Crucially Sally’s interviews provided rich descriptions of Ada, her personal appearance, her domestic work, and insights into family life within the institutional grounds. The discovery of Sally was unanticipated and not set in advance. Here, a brief explanation outlines the process in finding Sally and her willingness to participate in the project.

By the early 1960s, Ada had left the mental institution and moved into a hostel, Carmel House, in Melbourne. This was a time of rediscovery and reconnection with her adult children, after nearly thirty years of living in institutions and absence from her family. One family member told me he used to meet Ada in the city for lunch every week on her day off from domestic work at the boarding house. It was from these lunchtime chats that Ada talked about her time at Beechworth with Dr Donnan, his wife and children. Ada’s Beechworth years and her relationship with the Donnan family piqued my curiosity. Once I had received Ada’ patient clinical notes, I quickly skipped the early pages and

\textsuperscript{61} Pranee Liamputtong and Douglas Ezzy, \textit{Qualitative Research Methods} 2nd edn(South Melbourne, Oxford University Press, 2005), p. 41.

Maternal Insanity in Victoria, Australia

Chapter 2: The methods and sample

 proceeded to the Beechworth entries, which began in 1956 (see Figure 10). These entries confirmed Ada’s work in Dr Donnan’s residence, and it was the first time schizophrenia appeared in Ada’s records. Otherwise, the files were disappointingly brief about her work in the Superintendent’s home.

![Figure 10: Ada’s patient clinical files, Beechworth entries](image)

It reads:

20/01/1956: Patient has been working at Dr Donnan’s residence for a few weeks, very happy there

20/02/1956: No change

27/03/1956: No change

20/04/1956: Patient continues to work at Dr Donnan’s residence

18/05/1956: No change

10/06/1956: No change

06/07/1956: As above
12/07/1956: No change
10/06/1957: As above
8/07/1958: No change in her mental condition
10/06/1959: No change
11/07/1961: As above
08/08/1962: Does satisfactorily in routine jobs. Upset by the smallest change. Refuses to be examined by anybody but the Superintendent, because she is not a patient, but a worker! [Signed] Bozan


This led me to register with Ancestory.com in search for members of the Donnan family who could recall Ada at Beechworth. There was one Donnan family tree posted online with members located in Australia. This began an email exchange with a Donnan family member who confirmed their grandfather, Dr Donnan, was the superintendent psychiatrist at Beechworth. Shortly after, I was referred to contact another family member, who confirmed that Sally and her sister Clare were Dr Laurance Donnan’s two daughters. Sally had clear memories of Ada, who lived with her family in the residence on the grounds of the institution. Sally invited me to visit her, and I travelled to her home in November 2013. By the time this first face-to-face meeting took place, we had already established rapport, trust and curiosity about each other through multiple telephone interviews. Staying at Sally’s home illustrated her generosity, her keen interest in Ada’s life and support for this research project. Participants tend to be more comfortable being

64 For more information on the use of online communities like Ancestory.com for family historians, geneaologists and academic historans see Evans, 'Secrets and Lies: The Radical Potential of Family History' (2011), p. 58.
65 See Epilogue: The Researcher’s Journey.
66 See Appendix D: Interview consent form.
67 Liamputtong and Ezzy, Qualitative Research Methods (2005), p. 70.
interviewed in their own home, and this was true for Sally. Her home was quiet, private and comfortable.\textsuperscript{68}

The indepth interview is a qualitative research method that is often unstructured in nature, which supports the building of intimacy in mutual self-disclosure.\textsuperscript{69} Feminist qualitative researchers have developed the indepth interview as a method that allows women participants to speak freely about their thoughts, ideas and memories in their own words.\textsuperscript{70} The interviews with Sally were more like conversations, with both of us digressing from the research topic occasionally and sharing experiences on topics including education, travel, employment, marriage and children.\textsuperscript{71} This gave us both insights into our realities outside the interview, and through active listening and occasional probing questions, I learned a great deal about her and her childhood recollections of Ada.\textsuperscript{72} Feminists Sandra Harding, Ann Oakley and Shulamith Reinharz have advocated the open-ended interview as the primary means for feminists to actively engage with interviewees, and the importance of the researcher’s self-disclosure in creating mutual trust.\textsuperscript{73} In this way, I was happy to answer Sally’s questions of about myself. She was curious to know more about Ada’s life before she entered the institution, and after Sally’s family left Beechworth and I was pleased to offer what I knew.

Together, through our mutual exchanges, we became co-constructors of Ada’s story in piecing together facts, dates and recollections. Reciprocity was established between us, with each gaining a great deal from the experience.\(^74\)

The interviews with Sally provided powerful insights into Ada’s life at Beechworth not available from Ada’s clinical patient notes, such as personal relations, domestic work and family life.\(^75\) She provided rich descriptions with clear detail of Ada’s involvement in both the minor and major events of Sally’s family’s life. For example, Sally recalled the daily routines as a young child, in which Ada was integral as their live-in domestic servant. Sally told of memorable family events: her step-brother’s wedding, an approaching bushfire and the regular visits from her father’s boss, Dr Eric Cunningham Dax, the then Director of the Mental Hygiene Authority. Unexpectedly, we also learn about what it was like for Sally and her older sister as children growing up within the grounds of a mental hospital.

Sally’s stories of Ada have added an authentic personal dimension to Ada’s biography. This multi-method approach provides a richer life story by drawing from a bricolage of sources: Ada’s letters, clinical notes, Sally’s interviews and my family recollections.

\(^{74}\) Juliet Corbin and Janice M. Morse, ‘The Unstructured Interactive Interview: Issues of Reciprocity and Risks When Dealing with Sensitive Topics’, *Qualitative Inquiry*, 9, 3 (2003), p. 349.

Conclusion

This chapter has outlined the research strategies and processes adopted for this study. I have outlined the non-linear development of the methods and the flexibility necessary in adapting to a changed research design, as some methods were discarded and others added. The procedure, as a family member, in accessing Ada’s patient clinical notes, from the Freedom of Information Unit has been outlined. The ethics application journey mapped how interviewing family members about their insane relative proved too sensitive a topic for the Southern Cross University’s HREC to allow. This then shifted to describing the process of collecting thirty women’s mental patient notes in the Human Services archive and highlighted the new ways patient records were documented and archived in the twentieth century. It illustrated the new institutional bureaucracy that replaced patient casebooks with patient index cards and imperial quarto sized individual patient clinical notes and the process needed to locate individual files. The motivation to find a member of Dr Donnan’s family, has been articulated, which stemmed from family stories about Ada’s time at Beechworth. The process of finding Sally, her willing participation, and her childhood memories of Ada have added a personal and intimate dimension. Together, the multiple qualitative methods used in this present study is far richer in its historical perspectives, than it was as imagined in its first iteration.

In order to provide a social context for Ada’s biography, the next chapter investigates the rise of puerperal insanity in the nineteenth century more closely. It maps the history of uterine theories that connected female insanity to the reproductive cycle, assumed by psychiatry to be scientific fact. The key to understanding puerperal insanity is its centrality in professional struggles between traditional midwifery and the emerging professionals of obstetrics, medicine and psychiatry. Chapter three explores the role of
the family in committal processes, and the monopoly of the asylum as the place for treatment by the end of the nineteenth century. All these features provide the background context for puerperal mothers subject to twentieth-century Australian asylum and social practices concerning birth, mothers and maternity.
Chapter Three: Puerperal insanity and gendered power in nineteenth-century Britain and colonial Australia

Introduction

This chapter examines the complexity of the diagnosis of puerperal insanity in the nineteenth century. It analyses puerperal insanity as a medical label which stemmed from the gendered power which was embedded in nineteenth-century psychiatric and medical discourses, and which reflected social attitudes towards femininity and maternity. Lunatics of both sexes were seen as repulsive, dangerous, murderous, disorderly and sexually unbound. Shaped by social, political, economic and institutional structures of the Victorian age, maternally insane mothers were arguably the worst of feminine identities.

The first part of this chapter analyses the writings of asylum doctors, who were keen for scientific recognition and increased authority. Doctors’ texts uncritically based the ideas in their publications on long-held assumptions about gender.¹ Uterine theories from canonical texts were used by psychiatry to connect female insanity to women’s reproductive cycles. Despite the lack of sound evidence, such theories advanced to the status of scientific fact. These theories included female inferiority, the idea that childbirth risked mental disease, and that heredity insanity was transferred via the female line, and all reveal the gendered power to which women were subjected. These psychiatric theories also reflected the moral prudishness in broader society that reinforced strict roles for women as wives and mothers.² Psychiatrists were charged with the power to define madness based on forms of behaviour considered deviant and ‘unfit’. In the case of puerperal sufferers obstetricians and alienists (nineteenth-century asylum doctors) disagreed over the places for treatment, whether in the home or the asylum. The

² Ibid. p.193
symptoms of delirium and fever, caused by infection from medical interference at birth, were frequently misdiagnosed as puerperal insanity is further investigated. By the end of the century, obstetric care of mothers in the home lost ground to the management of insane mothers in the asylum system. The chapter discusses the treatments applied to all patients ranging from moral management to restraint and purging. As the focus in this study is mothers in mental institutions, the complex role of the family, in both institutional committals and the site of maternal stress, is also examined here. The family and the domestic setting were both the location for healing and recovery and sites of conflict, dysfunction and mental disease.3

The purpose of examining the gendered power embedded in the diagnosis of puerperal insanity, the role of the family in committal processes, and the monopoly of the asylum as the place for treatment by the end of the nineteenth century, provide the background context for examining the situations of puerperal mothers subject to twentieth-century Australian asylum practices. Historians, including Marland, Brockington and Theriot suggest that puerperal insanity had disappeared or was classified out of existence by the twentieth century. However, this present study indicates that puerperal insanity continued to commit mothers as insane in the Australian twentieth-century context. At the end of the chapter, some examples of mothers who were committed to Melbourne mental institutions with puerperal insanity during the 1920s are provided. In this way, the themes are set for the chapters which follow.

**Nineteenth-century medical science and gendered power**

This section provides an examination of the ways gendered power was produced through the medical discourses and scientific ideologies, which had contradictory results for mothers. This brief overview of male hegemony in the development and continuation of uterine theories sets the context for nineteenth-century asylum doctors and their keen interest in the pathologisation of woman due to her reproductive system. Also examined is the inherent sexism of these uterine theories reflected in the strict moral prudishness that bound women to her ‘biological straightjacket’.⁴

In Britain prior to the Victorian era, charitable organisations and private proprietors housed the mad in workhouses and prisons alongside criminals and other inmates.⁵ By the nineteenth century the compulsory public asylum system established through the legislation passed in 1808 and the subsequent Lunatics Act of 1845.⁶ This marked an important shift into an age of state intervention for the confinement and welfare of the insane and the burgeoning number of paupers. Asylum doctors created a professional niche for themselves as employment opportunities expanded in asylum care and styled themselves as ‘alienists’ or ‘psychological doctors’.⁷ Nineteenth-century alienists’ increased interest in female reproductive problems, combined with advances in gynaecological knowledge, gave alienists the much needed scientific authority, as they carved out their emerging speciality.⁸ Asylum doctors drew on previous uterine theories in an increasingly positivist age. Uterine theories were seen to be the cause of female

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⁴ Digby, ‘Women's Biological Straightjacket’ (2012).
⁷ Ibid p.18
madness and stemmed from Hippocratic, Galenic and Platonic traditions which associated the womb with insanity. Plato, in particular, interpreted ‘the wandering womb’ as the single cause of all nervous disorders in women.⁹ Over the centuries uterine theories developed into the categorisations of puerperal insanity and hysteria, and by the nineteenth century both were seen to be caused by menstruation, childbirth, and menopause. This firmly established the link between the womb and women’s madness as scientific fact.¹⁰

Carol Smith-Rosenberg argued that hysteria encompassed a wide variety of ailments from menstrual pain and irregularity, sterility, uterine disorders and vaginal infections.¹¹ Galen’s, Plato’s and Hippocrates’s theories remained an important point of reference for classifying women’s insanity. Nineteenth-century Western science and medicine uncritically adopted these canonical texts in order to legitimise themselves as experts on the disease and its treatments.¹² These gendered ideologies about women’s reproductive systems were understood to be responsible for all female mental and emotional instability. The development of hysteria over the centuries is covered more fully elsewhere.¹³ Yet puerperal insanity and hysteria as disease entities were complex cultural productions in which neither doctors nor their patients could shake themselves free of the assumptions and prejudices of their era.¹⁴

Middle-class men in the nineteenth century continued to develop sciences of biology, neurology and immunology. They drew from uterine theories to establish a philosophy of superior masculinity. Male hegemony in scientific research, with its focus on autonomous, objective, observable truths concerning the nature of reality, has a long history of attributing masculinity to rationality and scientific thought. Francis Bacon (1561–1626) emphasised the importance of the scientific method in the domination of nature for the enlightened rational progress of society. Bacon used gendered language to describe the earth and its natural resources as a nurturing mother and womb of life, and that nature’s secrets needed to be understood in order to plunder for human and economic advancement. He used female imagery to illustrate the domination over nature: ‘I am come in very truth leading to you Nature with all her children to bind her to your service and make her your slave.’ Much of Bacon’s work reflected the female persecution and misogyny underpinning the inquisition and witch trials, events which occurred at the time of Bacon’s writing. His gendered metaphors were a powerful language tool which ‘personified nature as an indifferent, destructive and uncontrolled woman.’ Bacon’s work subjugated nature cast in the female gender, and in turn subordinated the human female in alignment with the natural world.

Merchant argued that Bacon’s gendered rhetoric was integral to the definition of scientific method as power over nature through domination by science, technology, and

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capitalist production. Despite Bacon’s empirical advances in the observation of nature, the outmoded assumptions about male-female hierarchy established female reproductive biology as scientific evidence for female inferiority. ‘Reproduction, hormones, menstruation, and pregnancy were used to infer and justify the female economic dependence brought about in the seventeenth century transition from subsistence to capitalist modes of production.’ By the nineteenth century, what we might term ‘sexist bias’ was ingrained in the scientific milieu, which continued to generate medical prejudice that believed women’s reproductive functions was the cause of mental illnesses. Such assumptions were adopted uncritically, without sound scientific proof, by male specialists forging new fields of study and practices in gynaecology, obstetrics and asylum psychiatry in the nineteenth century. The gendered psychiatric categories of both hysteria and puerperal insanity reinforced the link between mental instability and the physical processes in becoming a mother; specifically targeting women.

The apparent rapid rise in interest and the perceived prevalence of puerperal insanity provide insights into how the meanings of motherhood and femininity were understood in the nineteenth century. The Victorian era in Britain was characterised as an era of moral prudishness. The narrow and limiting standards of female propriety found that ‘puerperal mania rocked prevailing Victorian mores and notions of maternal affection and feminine behaviour.’ Women’s social role became increasingly confined to the domestic sphere.

20 ibid. p. 163.
where maternity, family and the household were women’s rightful place. Strict attitudes concerning female sexuality and propriety stipulated motherhood could only occur within marriage. Chastity prior to marriage was paramount and sexual exclusivity to her husband essential. These developments guaranteed legitimate offspring and secured direct lineage essential in the transfer of private property.\textsuperscript{25} Marriage was integral to the social construction of femininity for women, bound by heterosexuality, monogamy and economic dependence.\textsuperscript{26} For unmarried mothers, the stress in hiding unwanted pregnancies, the condemnation of becoming a mother outside of wedlock and the economic hardship pregnancy wrought, meant she was dangerous to the social order.\textsuperscript{27} Women resorted to the few choices available to them including infanticide, abortion, baby farming and contraception, amid the harsh legal and material consequences that persecuted unwed mothers.

In legal cases, historians have shown that the insanity plea was used as a defence for puerperal insane mothers who committed infanticide. Alienists took the opportunity to demonstrate their expertise in law courts by presenting child murder as a symptom of puerperal insanity.\textsuperscript{28} Despite the lack of economic support, unmarried mothers were constructed as the dominant group responsible for child murders, pathologised with puerperal insanity and committed to the asylum.\textsuperscript{29} Single women were left to their fate and for married women it was difficult to achieve divorce. Husbands would be granted

\textsuperscript{26} Matthews, \textit{Good and Mad Women} (1984), pp. 112-113.
\textsuperscript{27} Carol Smart, 'Disrupting Bodies and Unruly Sex.', in \textit{Regulating Womanhood: Historical Essays on Marriage, Motherhood, and Sexuality}, ed. by Carol Smart (London, Routlege, 1992), p. 4.
\textsuperscript{29} Smart, 'Disrupting Bodies and Unruly Sex.' (1992), p. 17.
divorce by proving his wife’s adultery alone, whereas the double standard required the wife to prove additional grounds of cruelty or desertion, as well as adultery. These points expose the Victorian double standard of morality where marriage was the key signifier in the construction of Woman. On the one hand, married women were seen as the angel of the house, subject to her husband’s power, and on the other hand, the unwed mother was the most dangerous of all.\textsuperscript{30} For both married and unmarried mothers subject to the strict attitudes to sexuality and reproduction, the asylums were places of refuge, offering women protection from negative experiences, such as abusive husbands and unwanted pregnancies.\textsuperscript{31} Within the asylum, mothers were subject to the power of gendered psychiatric categories that linked women with insanity. For example, puerperal insanity connected reproduction and childbirth as causes of insanity, and hysteria was connected to sexuality, or in what was regarded as sexual dysfunction, such as nymphomania and frigidity. These gendered terms indicate how women’s sexuality was pathologised as illness and rose simultaneously with puerperal insanity in the nineteenth century.

This section has established the sexist bias inherent in nineteenth-century scientific thought regarding women, femininity and motherhood, based on long-held assumptions about the nature of the sexes. Puritan attitudes in the Victorian era idealised mothering as the rightful place for women, while ambiguously degrading maternity as the source of vulnerability to mental instability. The gendered power of the diagnosis of puerperal insanity was founded upon psychiatric theories which assumed female inferiority, that childbirth risked mental disease, and heredity insanity in most cases was believed to be

\textsuperscript{30} Ibid. p.24
transferred via the female line. All of which underpinned asylum committal for insane mothers. The gendered, unequal power relations in the wider society were embedded in legal sanctions against wives pursuing divorce and the social ramifications of birthing outside wedlock. All point to the fear of a perceived unruly female reproductive body in need of control, which exposed how maternity and mothers’ insanity was understood.

In the next section, I describe the rapid rise of puerperal insanity as a diagnostic label and the ways expert discourses revealed professional struggles between obstetricians, midwives and asylum doctors. The battles between the emerging professions over the location of care for puerperally insane sufferers is examined. Home management by midwives and obstetricians was thought to ensure recovery, but by the end of the nineteenth century, the asylum dominated as the place for treatment.

**Puverplal insanity in nineteenth-century Britain**

Puerperal insanity was one of the most clearly recognised disease entities of the nineteenth century; doctors confidently recognised childbirth as the common cause of insanity. Asylum doctors (alienists) and medical practitioners became increasingly fascinated with women’s mental instability. Insanity in women was perceived to occur during the various processes of women’s reproductive life: menstruation, pregnancy, childbirth and menopause. Mental instability in men was thought to be caused by external forces like alcoholism, for example, which could be avoided by exercising their will to adopt a moderate lifestyle. However, women’s mental instability was thought to

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be caused by their biological functions and the periodicity of her life as internal forces.  

Puerperal insanity was a ‘catch-all’ phrase used to cover a range of mental conditions perceived to be connected to both pregnancy and childbirth. Brockington argues that the terms ‘puerperal mania’, ‘puerperal insanity’ or ‘puerperal psychosis’ refer to severe mental disturbance, which appeared suddenly and unexpectedly shortly after childbirth.

Alienists wrote on puerperal insanity by building upon the existing uterine theories. In his book, *Psychology of Mind* (1895), Henry Maudsley recognised insanity of pregnancy associated with first pregnancies and illegitimacy as the effects of uterine changes in an unstable brain. Prominent alienist John Haslam, who worked in Bethlem Royal Hospital, London from 1795 to 1816 wrote ‘in females who become insane the disease is often connected with the peculiarities of their sex’. George Burrows argued in 1828 ‘The functions of the brain are so intimately connected with the uterine system, that the interruption of any one process which the later has to perform in the human economy may implicate the former.’ The link between women’s reproduction with insanity was firmly entrenched in medical discourses.

It was midwives and obstetricians who had direct practical involvement attending and assisting births, and both treated sufferers of puerperal insanity at home or in lying-in

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hospitals, which were devoted to treating patients outside of the asylum. Obstetricians predominantly wrote on this condition, in the early part of the nineteenth century, asserting their authority on puerperal insanity. For example, in 1820, Robert Gooch, the British obstetrician, was the first to write on the specific condition of puerperal insanity, *Observations on Puerperal Insanity.* From extensive case notes as a midwife/obstetrician at both lying-in hospital and his private practice, Gooch observed the onset of the disease identifying a wide range of symptoms including quick pulse, restless nights and short temper, followed by ‘indescribable hurry’ and wild and incoherent language as women elevated into manic states following childbirth. Alternatively, he proposed the melancholic form was gradual in onset, the mother’s health declining, with confusion, depression of spirits, bewilderment and anxiety. Gooch established the two types of symptoms in puerperal insanity as mania and melancholia, and was widely influential as the authority on puerperal insanity. In 1858, John Charles Bucknill and Daniel Hack Tuke published *A Manual of Psychological Medicine.* Here, Bucknill and Tuke further defined the symptoms into categories of insanity of pregnancy, puerperal insanity and insanity of lactation. The rates of recovery were between one week and one year and Bucknill and Tuke stated that ‘perfect recovery of the mental faculties follows in a large proportion of instances.’

Both Loudon and Marland argue that due to the confusion around the terms used, it is difficult to ascertain an accurate picture of the prevalence in asylum committals.

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42 Ibid. p. 31.
Puerperal insanity and puerperal mania were used interchangeably, despite, in some cases, years between giving birth and the onset of mental illness.\textsuperscript{45} Puerperal melancholia was known, and was usually treated at home in the domestic setting, otherwise it was difficult to treat in the asylum in a chronic state.\textsuperscript{46} The developments of knowledge and literature between the specialities of obstetrics, medicine and psychiatry was extensive, however cohesion between them was lacking. Nevertheless, these specialty discourses generally agreed that the mania form of puerperal insanity was the most common in asylum committals for its obvious symptoms of raving madness, with florid and often flamboyant behaviour soon after childbirth.\textsuperscript{47} Sufferers of puerperal mania were destined to recover, however deaths did occur. Despite differences in treatment, doctors from both the asylum and obstetrics concurred that puerperal insanity was brief, and in most cases recovery was likely, therefore the disease was considered to be curable.\textsuperscript{48} Mothers’ negative experiences in giving birth were also considered responsible for the occurrence of puerperal insanity, whether they involved the deaths of newborns, stillbirths or miscarriages, or difficult and protracted deliveries and the mishandling of obstetric tools.\textsuperscript{49}

\textbf{Midwifery, obstetrics and puerperal insanity}

This section establishes the strong link between obstetric interventions in childbirth practices with puerperal insanity. It outlines the developments in obstetric practices in the nineteenth century, the high risk of infection, which confused the numbers of puerperal

\textsuperscript{46} Ibid.
\textsuperscript{48} Marland, \textit{Dangerous Motherhood} (2004), p. 34.
fever with puerperal insanity sufferers.

Practising female midwives monopolised childbirth in the home until the newly emerging profession of obstetrics began to dominate as exclusive experts in childbirth. Midwives were labelled as ignorant, yet most were trained by some form of formal or informal apprenticeship. University medical training was offered exclusively to male students who boasted of greater education and skills than their female counterparts. As a result, female midwives were exploited and lost their position as traditional birth attendants. Midwives continued to attend births, but very few took up the use of obstetric tools such as forceps. Surgeons and obstetricians were called to attend emergencies and difficult deliveries due to their exclusive use of birth tools and anaesthetics. The use of forceps and anaesthesia distinguished scientific obstetricians from midwives, and formed an exclusive enclave of male obstetric monopoly in the medicalisation of birth.

In 1847, Dr James Young Simpson, professor of midwifery at Edinburgh University, used chloroform in obstetric cases and widely promoted its benefits especially in the pain management of childbirth. Chloroform relieved the pain of labour, rendered the mother’s body as ‘unresisting’ and allowed the surgeon to artificially extract the infant. The Chamberlen brothers developed obstetric forceps, kept as a family secret and passed down through three generations of Chamberlen male midwives. They vehemently guarded their forceps design and its application in handling difficult labours. It was

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51 David Harley, 'Provincial Midwives in England', ibid.
53 Ibid. p. 137.
54 Ibid. p. 141.
through Edward Chapman’s publication in 1773 on the developments in midwifery that the Chamberlen forceps became public knowledge.\textsuperscript{55} Until this time, the Chamberlen’s secrecy over their use of forceps in labour maintained their own professional superiority to the exclusion of midwives. Midwives refused to use forceps, though some tried, instead preferring to use their hands to guide the baby’s head through the birth canal.\textsuperscript{56}

Midwives handled straightforward, uncomplicated births until difficulties occurred that required the emergency attendance of an obstetrician. In many cases, the difficult deliveries were responsible for the occurrence of puerperal insanity.\textsuperscript{57} Obstetric texts stated puerperal insanity was a regular complication of obstetric intervention which students were instructed to prepare for.\textsuperscript{58} Their rough and too ready use of forceps and other instruments, left women, in some cases, with infection, a damaged vagina, bladder and pelvis.\textsuperscript{59} Obstetricians unknowingly increased the incidence of puerperal fever and puerperal insanity through the use of unclean instruments, causing infection and physical damage to the birthing mother.

Within the extensive historical research on puerperal insanity, authors have argued that the mania of puerperal insane mothers was confused with the delirium of fever from infection.\textsuperscript{60} Puerperal fever was highly contagious and caused by transmitting bacteria to the mother. The high risk of infection was not then well understood, neither were

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\textsuperscript{56} Ibid. p. 150.
\textsuperscript{58} Loudon, 'Puerperal Insanity in the 19th Century' (1988), p. 76.
\end{flushright}
hygienic practices in surgery. As early as 1842 Thomas Watson recommended hand washing and the changing of surgeons’ clothes to avoid spreading contagion from one patient to another, but was largely ignored.\textsuperscript{61} Ignaz Semmelweis’s similar findings were not well received either. He was professionally rejected and died in the Vienna Insane Asylum, unfortunately, from an infected wound. Likewise, the American doctor Oliver Wendell Holmes wrote in 1843 ‘the disease known as Puerperal Fever is so far contagious as to be frequently carried from patient to patient by physicians and nurses.’\textsuperscript{62} But Holmes’s findings were met with astonished denial from his profession, unwilling to admit their hands were unclean and responsible for the spread of infection and maternal deaths. Joseph Lister’s work, building on Pasteur’s identification of streptococcus in the blood of a female patient, developed antiseptic practice in surgery.\textsuperscript{63} Like Watson, Semmelweis and Holmes before him; Lister’s work was met with doubt and disbelief from his medical colleagues. The resistance to hygienic childbirth practices in the nineteenth century resulted in high death rates from puerperal fever, distorting the mortality figures for puerperal insanity.\textsuperscript{64}

Deaths were attributed to puerperal insanity but instead were caused by infection. Further, the behaviour associated with delirium experienced during fever from infection were misdiagnosed as puerperal insanity.\textsuperscript{65} This conflated the number of deaths when both infection and mania presented similar symptoms, with both closely tied to a recent delivery. The delirium from infection presents clinically as:

\textsuperscript{62} Oliver Wendell Holmes, \textit{The Contagiousness of Puerperal Fever} (New York, P.F. Collier & Son, 1909), p. 5  
Disorientation, restless disorganized behaviour, hallucinations (especially visual), transient delusions, misidentification of persons, amnesia for the illness and birth, and occasionally retrograde amnesia. But manic features like extreme loquacity and wild excitement, expansive ideas, laughter and singing are sometimes seen.\(^{66}\)

In comparison, Henry Maudsley, the Medical Superintendent of Manchester Royal Lunatic Hospital, described the symptoms of puerperal mania:

> It is of an acute and extremely incoherent character, a delirious rather than a systematized mania, marked by noisy restlessness, sleeplessness, tearing of clothes, hallucinations, and in some cases by great salacity, which is probably the direct mental effect of the irritation of the generative organs.\(^{67}\)

The lack of understanding of infection meant mothers were misdiagnosed with puerperal insanity and puerperal mania and committed to the asylum. Child-bed fever or puerperal fever was understood to be related to childbirth but assigned to gastric fever, rheumatic fever or pneumonia and thought to be caused by childbirth, yet usually diagnosed after the event.\(^{68}\) The knowledge of contagion and how the spread of infection occurred was yet to be understood, therefore Shorter reminds historians that they, ‘Should assume that virtually all infection occurring within one month after delivery is obstetric in nature. Thus, deaths assigned to pneumonia and such should really have been included in puerperal infection.’\(^{69}\)

The obstetric nature Shorter refers to, are the interventions used during birth by either surgeons, obstetricians or general practitioners. Showalter argues that surgeons and physicians posed the greatest risk to mothers, as they attended cases other than childbirths. Their duties in dissecting cadavers and treating other diseased patients proved

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\(^{69}\) Ibid.
dangerous in the transmission of deadly bacteria through surgeon’s unclean hands in internal examinations during labour.\textsuperscript{70} Shorter argues midwives were equally responsible for the transfer of infections resulting in delirium and deaths as unhygienic childbirth was practiced across all types of birth attendants.\textsuperscript{71} Contrary to this, Ignaz Semmelweis observed in Vienna that midwives had a lower rate of puerperal fever in their section of the hospital. In comparison to the higher rate of puerperal fever in the section run by physicians, Semmelweis noted that the medical students and physicians performed autopsies while the midwives did not.\textsuperscript{72} After the death of a colleague from septicaemia from an infected wound incurred during an autopsy, Semmelweis insisted all doctors wash their hands with chlorinated lime solution. This significantly reduced mortality rates of puerperal fever from 18 per cent to 3 per cent in 1847.\textsuperscript{73}

The increase in obstetric practices was directly related to the plague of puerperal fever as women suffered the complications of infection through surgical intervention during their birthing.\textsuperscript{74} Throughout the nineteenth century, obstetricians increasingly moved into the field of normal deliveries and the use of forceps became widespread.\textsuperscript{75}

Both alienists and obstetricians agreed that the act of childbirth was the common cause of puerperal insanity. Despite the differences between the newly emerging professions, the overall medical discourse understood pregnancy, birth and lactation to be in need of doctors’ intervention. The pathologising of reproductive processes as ill health resulted in

\textsuperscript{71} Shorter, \textit{A History of Women's Bodies} (1983), p. 137.
\textsuperscript{73} De Costa, \textquote{The Contagiousness of Childbed Fever} (2002), p. 667.
\textsuperscript{75} Harley, \textquote{Provincial Midwives in England} (1993), p. 39.
women being subjected to various kinds of interventionist and, at this time, obstetric, experimental surgery. Many insane women underwent medical and surgical procedures. Nancy Theriot suggests that the ‘removal of the ovaries was the most popular operation, but more and less extreme operative procedures were also tried, such as hysterectomy and birth repair.’ These procedures were an attempt to cure women’s insanity in the nineteenth century but results were mixed. Isaac Baker Brown performed clitoridectomy and claimed a high success rate in curing epilepsy and hysteria, both conditions which Brown attributed to masturbation. Clitoris removal eliminated female sexual pleasure, which ultimately reduced female sexuality to reproductive purposes only. Browne argued that masturbation was the cause of female insanity, others argued it was the result of insanity. Either way, Browne was expelled from the Obstetric Society London as patients complained he had threatened, tricked and coerced them into this treatment. Despite the advances in the use of anaesthetics and hygienic practices, surgery remained hugely risky.

In cases of puerperal insanity, obstetric practitioners opposed asylum treatment, instead advocating for the domestic management where seclusion, quiet and nursing care could take place. Unless the disease became unmanageable at home, asylum committal was only recommended by obstetricians in acute cases where the mother was thought to need rest away from the worries and stresses of the domestic setting. Home management for puerperal insane mothers would account for the incongruity between the wide occurrence of symptoms and the actual low intake into the asylum.

80 Ibid.
81 Ibid. p. 137.
**Home management**

In the early part of the nineteenth-century midwives (male and female) and obstetricians, including Gooch, attended birthing mothers in their homes. Male midwives and obstetricians asserted their authority on puerperal insanity, and strongly urged sufferers the best treatment was in the domestic setting rather than the asylum.\(^{82}\) The role the family played in puerperal sufferers was both complex and ambiguous. On the one hand, the rightful place for women was the home; women were expected to derive satisfaction from their role in the family as both wives and mothers. On the other hand, the family pressures, discordant relationships with husbands and relatives, along with the precarious nature of material realities in mothers’ domestic settings was seen to be the cause of mental instability in mothers. Conflicting messages to families on the appropriate treatment for puerperal insane mothers instructed that mild cases could be dealt with at home, yet early removal to the asylum was recommended to hold off deep entrenchment of insanity.\(^{83}\)

Some families managed unwell mothers at home, while others were applauded for ensuring asylum committal.\(^{84}\) Both Brockington and Marland argue that clinicians in the nineteenth century urged for puerperal insanity sufferers to remain out of the asylums and that they were best treated in the home.\(^{85}\) There, the patient could maintain her role as wife, homemaker and mother to other children, develop her relationship with the newborn.

\(^{84}\) Ibid. p. 159.
baby and continue breast feeding.\textsuperscript{86} For many mothers, remaining in the home was less than ideal. Home visits from midwives and obstetrician in private practice witnessed the ill-treatment of mothers in their domestic settings. Family members, especially husbands, were blamed for inadequate care, whether through abuse of their wives, neglect and poverty.\textsuperscript{87} In such cases, disruptive family influences were either banished from the home or the suffering mother was quarantined within the home in order to separate her from any disturbing family influences.\textsuperscript{88} Puerperal insanity gave obstetricians access to mothers’ domestic spaces and found the household unfavorable for their recovery.\textsuperscript{89}

Throughout the nineteenth-century women suffering puerperal insanity were at the centre of the professional struggles for the location of their care. Obstetrics lost ground in the care of puerperal insanity, as women suffered from the complications of increased obstetric surgical intervention.\textsuperscript{90} Instead, psychiatry gained power, and by the mid and latter part of the nineteenth century, alienists argued stridently that the best strategy to manage puerperal insanity sufferers was within the asylum, under their care and authority.\textsuperscript{91} This diminished the role of midwives and obstetricians in the care of puerperal insanity at home. The increased interest in the supposed female vulnerability affecting their mental states through their reproductive life dominated psychiatric discourse and as Hilary Marland states ‘interest in the condition tracked the formation of the profession of psychiatry.’\textsuperscript{92}

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\item \textsuperscript{86} Brockington, 'Puerperal Disorders' (1998), p. 317.
\item \textsuperscript{87} Marland, Dangerous Motherhood (2004), p. 161.
\item \textsuperscript{88} Ibid.
\item \textsuperscript{89} Peter Bartlett and David Wright, 'Community Care and Its Antecedents', in Outside the Walls of the Asylum: The History of Care in the Community 1750-2000, ed. by Peter Bartlett and David Wright (London, Athlone Press, 1999), p. 14.
\item \textsuperscript{90} Loudon, 'Puerperal Insanity in the 19th Century' (1988), p. 76.
\item \textsuperscript{91} Marland, Dangerous Motherhood (2004), p. 64.
\item \textsuperscript{92} Marland, 'Destined to a Perfect Recovery' (1999), p. 140.
\end{itemize}
With the professionalisation of psychiatry medical practitioners fashioned themselves alienists, as an exclusive enclave of experts on insanity. They petitioned the government to ensure that they were authorised as the only legitimate group to control asylums. The asylum securely monopolised the treatment of the insane and effectively excluded competitors, including lay-superintendents and obstetricians. With puerperal insanity firmly under the authority of the alienists and sufferers located within the asylum, the discourse of hereditary insanity and the issues of whether insanity ran in the family became pertinent to the identification of puerperal insane mothers.

**Degeneration, heredity, and the family**

In the early nineteenth century asylum psychiatrists began to theorise that insanity and other chronic diseases were due to hereditary causation passed down through families. Hereditary predisposition in the onset of mental illness was not a psychological disorder, but instead ‘an irreversible brain condition and as a product of degeneration caused by a poor environment and nutrition, or by alcohol abuse, and subsequently transmitted through heredity.’ Environmental factors and heredity theories combined together as arguments for the moral decline and degeneration in populations. Charles Darwin characterised women’s maternal instincts and their ability to raise children as belonging to the lower races and of a past and lower state of civilization. Maudsley concurred as he saw mothering and the care of infants particularly disgusting, and aligned women’s mothering abilities as primitive and a base activity. Psychiatrists seized Darwinism as a

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97 Ibid.
legitimate scientific method in the study of insanity, which called attention to hereditary taint compounded by immoral lifestyle habits causing madness and insanity. The mother’s lifestyle was thought to risk producing degenerate and weak children, whether through excessive reading and studying, dressing in unsuitable clothing, working in factories or by languishing in upper-class luxury. Mothers were targeted as the agents responsible for hereditary transmission through the female line. Maudsley argued that a child’s constitution is affected by its mother’s state of mind before it is born. Further, insanity in a woman’s family was considered the predisposition to mental instability. Fathers did not receive the same scrutiny in the perceived degeneration in offspring especially when ‘it is agreed by all alienist physicians, that girls are far more likely to inherit insanity from their mothers than from the other parent.’

By the middle of the century, physicians cited heredity as the primary cause of puerperal insanity. Tuke argued that one third of patients with puerperal insanity can be traced to the female side of the family, and in his mind this ‘proved’ heredity as the cause. Male fears targeted mothers for being responsible in the transmission of supposed degeneration and insanity into the next generations. Like Bacon before him, Darwin’s theory of evolution was accepted as scientific knowledge, which effectively reinforced the pervading Victorian values of the supposed naturalness of sexual stereotypes, maternal

101 Ibid.
instincts and feminine modesty. In this way, Darwin’s evolutionary theory did not break from traditional thinking, but instead reinforced beliefs of female inferiority based on their reproductive system, effectively preserving the status quo of male domination and superiority. As theories and speculation around the hereditary causes of insanity gained momentum, family history was sought from both patients and their relatives upon committal. The recording of patient stories were mediated by their asylum doctors, with a strong emphasis on details collected from family, friends and neighbours, as those closest to the patient. Information was sought on whether the patients experienced previous mental breakdowns, and any relatives committed to the asylum. Both points had significance for asylum doctors, and was particularly damning for puerperal insane patients. Hereditary links within the family were thought to predispose patients to puerperal insanity and diminish their recovery. Despite the lack of rigorous research or understanding of genetically inherited processes, perceived hereditary insanity in families ultimately sealed mothers’ fate to the asylum. Relative’s testimonies also provided insights into families, the nature of female mental breakdown, and puerperal insanity specifically as an illness directly connected to the home, family and the mother role.

The complexities of the role of the family in puerperal insane sufferers remained central to their care, treatment and supervision both in a domestic setting and in the decisions involved in their removal to the asylum. Environmental factors combined with what was considered ‘bad blood’ in family hereditary traits had great bearing on whether mothers were expected to recuperate or decline further. The ambiguous nature of puerperal

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106 Ibid.
108 Ibid. p. 165.
insanity located the family as both the place for recovery, a return to household duties, and the place of domestic tensions and pressures which could cause puerperal insanity. Women can be seen as reacting to their difficult lives as mothers through their illness of puerperal insanity.  

This section has illustrated the complexity involved in unravelling the various forces at play in the diagnosis of puerperal insanity in nineteenth-century Britain. It mapped the history of puerperal insanity as a diagnosis and the professional struggles involving midwives, obstetricians and asylum doctors. The role of the family, central to domestic management, may have hidden the number of sufferers within the private sphere, while the misdiagnosis of post-birth fever from infection as puerperal insanity may have conflated the numbers of sufferers until antiseptics were adopted in surgical practice. The consideration of environmental factors in the home as contributing to mothers’ breakdown goes towards understanding the difficulties and hardships of motherhood in the nineteenth century. Midwives and obstetricians caring for sufferers in the home lost ground to asylum psychiatry as the dominant location for treatment by the mid to late nineteenth century. The next section focusses on asylum treatments prescribed for mothers suffering puerperal insanity.

**Treatments for puerperal insanity in nineteenth-century British asylums**

The eighteenth-century madhouses, run as private asylums, treated the insane as brutes and animals using physical restraints of chains and handcuffs, in filthy and harsh

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109 Ibid.
conditions. A Select Committee investigated madhouse conditions and practices in 1814–15 and found medical treatments to be useless in the treatment or cure of the insane. The evidence of Thomas Monro, the physician at Bethlem public asylum, said patients were ‘ordered to be bled… after they have been bled they take vomits once a week for a certain number of weeks; after that we purge the patients, thereafter, of course, patients were kept chained to their beds at least four days out of every seven.’ Monro further admitted to the Select Committee that medicine had no effect in curing insanity, but continued to employ these therapies when he did not know any better practice.

Anne Digby argues that ‘the frequent and indiscriminate use of purges, vomits, blisters and bleedings was partly designed to lower the vitality of the patient and hence to make him (sic) less violent and troublesome.’

In contrast, the success of the mild form of moral treatment for the insane at the York Retreat, in England, achieved national attention through Samuel Tuke’s book Description of the Retreat, published in 1813. A Quaker hospice established by Tuke’s grandfather William Tuke in 1796 developed moral treatment as the non-medical humane treatment of the insane based on Quaker values of benevolence, charity, discipline, self-restraint and temperance. Patients were encouraged to learn and exercise self-restraint and were rewarded with more comfortable quarters. No patient was chained, physically abused or coerced, which reduced fear and helped to develop self-esteem and mutual respect with

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111 Scull, Social Order/Mental Disorder (1989).
112 Ibid. p. 133.
113 Ibid.
their attendants.¹¹⁶ Important to moral treatment was the country location and the layout of the Retreat with acres of farmland and gardens, good diet, plentiful food and an intimate familial atmosphere.¹¹⁷ Once patients were well enough they were occupied in cultivating the surrounding farmland and encouraged to participate in various arts and crafts. These practices marked the birth of modern occupational therapy.¹¹⁸ The success of moral treatment at the York Retreat was reflected in the large proportion of cases restored to sanity.¹¹⁹ Moral treatment and particularly the Description of the Retreat were crucial to asylum reforms in the early nineteenth century.¹²⁰

Dr Monro’s disclosure that traditional medical treatments (such as bleeding, leeches and blistering) were ineffectual was compounded by the Retreat’s success with Tuke as a non-medical lay superintendent. In response, medical practitioners asserted their expertise in the management of the insane by forging ideas that insanity was produced by a diseased brain; a physical cause that required medical somatic treatments, despite the lack of scientific proof.¹²¹ Asylum reforms instituted medical superintendents for both public and private asylums, which consolidated medical control of asylums and practices. Once asylums were controlled by medical experts, moral treatments were subsumed into medical approaches to the insane and effectively ended lay proprietors and superintendents.

¹¹⁸ Ibid. pp. 42-49.
By 1845, the compulsory establishment of public asylums fuelled a new therapeutic optimism for the cure of the insane.\textsuperscript{122} With the moral, humanitarian approaches, along with the end of restraints, the asylum became central to the treatment and management of the insane.\textsuperscript{123} Moral treatment was eventually subsumed into everyday asylum practices of custodialism and the Retreat, like other institutions, became dominated by ‘an increasingly authoritarian medical regimen.’\textsuperscript{124}

Patients suffering puerperal insanity within the asylum were noted to be in poor health and exhausted. Most physicians recommended rest, food, purging and sedation.\textsuperscript{125} Public asylums adopted moral treatment by encouraging women to take up sewing, ward and laundry work when well.\textsuperscript{126} Ann, for instance, was committed to the Royal Edinburgh Asylum, Morningside in 1851:

Ann was single, working as a domestic servant when she was committed to the asylum three weeks after her delivery. She was depressed, sleepless, exhausted and contemplated suicide. Upon admission she was put to bed and given stimulants and purged. She alternated between restlessness and deep dejection, yet kept herself busy working in the laundry and washhouse. After improvement over the following eight months Ann was discharged as cured.\textsuperscript{127}

Ann’s case illustrated the focus on bed rest and the importance in being usefully occupied as central to recovery. The idea of cure was contentious when women suffered further breakdowns and returned to the asylum. Food, rest and treating physical illnesses led to mothers’ recoveries, but did not eliminate recurring episodes. Medical superintendents were known to be competent administrators tending to physical illnesses, yet their inability to produce cures did not seem to affect their perceived expertise and status in the

\textsuperscript{122} Parry-Jones, 'Asylum for the Mentally Ill' (1988).
\textsuperscript{123} Ibid. p. 408.
\textsuperscript{126} Marland, \textit{Dangerous Motherhood} (2004), p. 44.
\textsuperscript{127} Ibid. p. 96.
field of managing the insane.\textsuperscript{128} Parry-Jones agreed and stated that ‘treatments tended to be more concerned with managing and containing disturbed chronic patients than with actively curing their disorders.’\textsuperscript{129} In asylums, provision for recovery occurred, but cure remained elusive. The inability of asylum doctors to produce cures did not damage the illusion that the asylum was the rightful place to confine society’s troublesome people.\textsuperscript{130} This speaks to the culture of silence surrounding the inability to cure insanity. Gittins argued that employed staff were too frightened to say anything about their work, as ‘their status in the outside world depended on the silence and silencing any activities, events or behaviours that would draw attention to their precarious position.’\textsuperscript{131} Silence, both within and without the asylum, was necessary to avoid undermining the asylum’s authority. Repeated admissions to the asylum left the claim of cure questionable. The best case scenario for sufferers of puerperal insanity was to support recovery and return mothers to their families, and for them to resume their household duties.

Recovery from puerperal insanity depended on the look of normality as indicated by women’s appearance in neat hair and appropriate feminine attire.\textsuperscript{132} Photographic portraits were used as proof of recovery, where women were posed with their hair neat or tucked under a bonnet, hands resting in their laps, or holding embroidery work. For mothers to be discharged as cured, their appearance was crucial to illustrate that they had been restored to proper femininity, prepared to take up their role as wives and mothers.\textsuperscript{133}

\textsuperscript{129} Parry-Jones, 'Asylum for the Mentally Ill' (1988), p. 408.
\textsuperscript{130} Scull, \textit{Museums of Madness} (1979), p. 178.
\textsuperscript{133} Ibid. p. 199.
Brockington criticised the mother’s removal to the asylum and stated that: ‘the asylum era subsequently had a disastrous effect on these patients’ management, leading to their incarceration for months, isolated from their infants and families.’\textsuperscript{134} The separation of the mother from her infant was standard practice in asylum committals. However, little thought was given to care of the newborn and the social impacts for the family. The infant was omitted from both the literature and the women’s asylum records, as Marland states ‘it was simply assumed that someone will take care of the newborn in the mother’s absence.’\textsuperscript{135} Until the mid-twentieth century, the removal of the mother to the mental institution ensured her separation from her infant and was considered the best practice.\textsuperscript{136} The consequences of this forced separation for both mothers and their children is further examined in Chapters Four and Five.

\textbf{Obstetrics in colonial Victoria}

Obstetric developments, surgical interventions and the lack of hygienic practices contributed to puerperal fever, deaths and puerperal insanity in colonial Victoria.

Australian medical journals reflected the dominant medical approach of childbirth as illness, with puerperal fever remaining a constant danger.\textsuperscript{137} This section examines the developments of obstetric practices and midwifery, with the specific focus on patients labelled with puerperal insanity who were suffering from delirium of fever from infection in colonial Victoria.

\textsuperscript{135} Marland, \textit{Dangerous Motherhood} (2004). p.60
\textsuperscript{136} Howard, ‘The Separation of Mothers and Babies in the Treatment of Postpartum Psychotic Disorders in Britain 1900-1960’ (2000). p.1
Very few experienced midwives migrated until the gold rushes in the 1850s, which left the attendance of women in childbirth to neighbours and working-class women. Family assistants offered practical help to families in need. Historians suggest that by ‘the 1880s midwives made up over one third of the health care workforce.’ The University of Melbourne commenced the first medical course in the 1860s which included obstetric medicine and diseases of women and children in the fifth year of the syllabus. As doctors attended more deliveries they encountered poor pregnant women, previously handled by neighbourhood women. The use of antiseptics in labour and surgery, like elsewhere, was hotly contested among medical practitioners. The outbreak of puerperal fever from infection in 1875, followed by an epidemic of scarlet fever, in the following year, closed the Melbourne Hospital for three months. As in Britain, medical practitioners remained unconvinced that they were the carriers of infection, despite Listerism and germ theory being presented to the Medical Society of Victoria in 1867 by Dr William Gillbee. Midwives were blamed for the lack of hygienic practices, yet women suffered at the hands of both midwives and doctors for their lack of knowledge in obstetrics and hygiene. Dr Richard Tracy gave the inaugural lecture on obstetrics in 1865 to students at the University of Melbourne Medical School and said: ‘that some of the very worst complications of labour he is called to treat, are directly brought on by the mischievous meddlesomeness of ignorant midwives.’ Thus the professional struggles over childbirth and its rightful attendants continued in Melbourne between male

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141 McCa
142 Ibid. p. 55.
143 Ibid. p. 17.
obstetricians and traditional female midwives, as it had done in Britain. Male doctors
gained greater control over obstetric clinical practice through university medical training,
which legitimised the emerging profession. While women could enrol in university
education at Melbourne University in 1880, they were barred from enrolling in medicine.
This essentially maintained medicine as an exclusive male domain. By 1885 women were
admitted into medicine at Sydney University and Melbourne University followed suit in
1887. Nurses training, registration and midwifery in the hospital setting was
formalised in 1904 with the founding of the Royal Victorian Trained Nurses’
Association.

As doctors increased their obstetric knowledge through education, new surgical
interventions increased maternal mortality through the spread of puerperal fever.
Caesarean section was first performed in Melbourne in 1886 by Dr John Cook at the
Alfred Hospital but the death rate from infection was large as hygienic practice was slow
to be adopted. Forceps were used, yet Dr Meyer of the Royal Women’s Hospital
warned against the damage they could cause through misuse in 1899. Chloroform was
widely used as a sedative during labour but it slowed, delayed and even suppressed
labour. Dr Tracy, working in the Royal Women’s Hospital, Melbourne found chloroform
beneficial mainly in difficult and protracted labour that required forceps and in cases of
eclampsia. Ethel Turner, a well-known Australian writer, notes the use of chloroform
in her diaries when in labour with her first child, Jean, in February 1898:

My little girl was born at 20 minutes past 7. I was seventeen hours ill; the last eight
being exquisite agony. Pain will always be a matter of comparison now; I believe I

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146 Ibid. p. 103.
147 Ibid. p. 119.
148 Ibid. p. 25.
should be able to smile over a trifling matter like having a limb sawn slowly off. They used a 2oz. bottle of chloroform on me but it scarcely had any effect, I was never quite unconscious a moment, and knew all the time what they were doing.\textsuperscript{149}

The success of obstetric hospitals was judged on the record of maternal deaths in childbirth. In 1858, the Melbourne Lying-in reported twenty-three maternal deaths in the first nine years of operation. Nine of these deaths involved operative intervention using forceps and craniotomy, eleven from severe infection, two from puerperal mania and one of obstetric shock. Puerperal mania was accompanied by high fever followed by death, and remained an unexplained phenomenon at the time.\textsuperscript{150} By 1872 ‘39 per cent of these women [admitted to Melbourne Lying-in hospital] had a complication, 24 per cent resulted in death of the mother, the baby or both.’\textsuperscript{151} This rise in maternal deaths reflected the lack of knowledge in hygienic standards in the spread of infection. Fever struck the hospital in 1882 with the maternal death rate as high as 4.5 percent. The hospital was in crisis, wards were closed and birthing mothers were boarded at midwives’ homes.\textsuperscript{152} By 1884, the crisis worsened as the maternal death rate rose to one in fifteen.\textsuperscript{153}

At the Lying-in Hospital in Melbourne (which became the Women’s Hospital, then later the Royal Women’s Hospital), neither medical practitioners nor midwives had the necessary skills or knowledge, especially in emergency admissions. This was reflected in legal actions brought against both doctors and midwives for deaths in childbirth.\textsuperscript{154} The problem can be found in the ways puerperal fever was understood. Doctors believed in miasmic theories in which fever was thought to be emanations in the air.\textsuperscript{155} As the science

\textsuperscript{149} Philippa Poole, \textit{The Diaries of Ethel Turner} (Sydney, Collins, 1979), p. 172.
\textsuperscript{151} Ibid. p. 34.
\textsuperscript{152} Ibid. p. 57.
\textsuperscript{153} Ibid. p. 64.
\textsuperscript{154} Ibid. p. 17.
\textsuperscript{155} Featherstone, \textit{Breeding and Feeding} (2003), p. 123.
of bacteriology developed, pathogens began to be identified, but there was no systematic understanding of puerperal fever or how to prevent or cure it. The hazards of puerperal fever in childbirth meant that it was safer for women to avoid the hospital and give birth at home.\textsuperscript{156}

Psychiatrists could not distinguish puerperal insanity from the confusional states and mania caused by delirium from infection and fever.\textsuperscript{157} As many as 30 to 40 per cent of cases of puerperal insanity were attributed to toxic, acute infection, in the first half of the twentieth century.\textsuperscript{158} It was not until antiseptic practices were adopted and the introduction of sulphamides in 1936, and later penicillin, that doctors could decrease the incidence of puerperal fever.\textsuperscript{159} Mothers who did survive childbirth, may have experienced negative birth experiences such as long labours, difficult births, the mishandling of obstetric tools, birth repair surgery and infection. Many risked committal to the asylum due to the physical and emotional toll following surgical intervention during childbirth.

Obstetricians, unaware of social conditions, were not connecting infection and fever with their unhygienic practices, and the effects on mothers’ health. Equally, asylum doctors were not connecting mothers’ ill health with their patients’ experiences of obstetric intervention and infection during birth. This raises several questions about whether the obstetrician’s power to intervene in birth actually alleviated suffering or, in effect, created

\textsuperscript{159} Loudon, ‘Deaths in Childbed from the Eighteenth Century to 1935’ (1986), p. 41.
more pain for mothers. Many doctors who were sought to procure abortions failed to accurately report deaths and illnesses related to this procedure to avoid detection in the illicit abortion trade.\textsuperscript{160} Abortion was one option to control family size while the more drastic measures of baby-farming and infanticide occurred.\textsuperscript{161} The conundrum of the declining low birth-rate, high infant mortality, smaller family size and maternal mortality resulted in the 1903 Royal Commission into the Decline of the Birth-rate. The Commission’s attitude that women were suspected of acting selfishly in avoiding their reproductive roles was informed by wider imperatives to populate the new nation which reflected in the masculinist pro-natalist agenda of this commission.\textsuperscript{162} Whether women were limiting or expanding their families they risked illness, infection and death. The component and separate parts of the specialist medical knowledges of obstetrics, gynaecology and psychiatry were in no way cohesive. The development of birth knowledge by experts in obstetrics (childbirth) and psychiatry (post-birth ill-health) failed to integrate the separate discourses into a meaningful whole for the treatment of new mothers.

**Victorian asylums in the colonial period**

In the nineteenth century, the Victorian colony, known as Port Phillip district until 1851, housed lunatics in gaols along with convicts. The Yarra Bend Asylum originally performed as a ward of the New South Wales asylum of Tarban Creek in 1848, and was not established as a separate asylum until 1867. Two rural asylums were built in 1867 at Ararat and Beechworth, followed by the Metropolitan Asylum at Kew in 1871 in

\textsuperscript{161} Ibid, p. 43
\textsuperscript{162} Ibid, p. 86.
Melbourne. All three were state-run public asylums which housed people from all classes. Unlike Britain, there were no private institutions for wealthier clients in the Victorian colony.\textsuperscript{163} Doctors and medical attendants were brought from England to both govern public asylums and maintain standards practiced in English asylums. In this way, English ideas of gender relations and concepts of female insanity were transplanted into the colonial Victorian asylum system. British dominant medical approaches to childbirth as an illness were reflected in Australian medical journals reporting that puerperal fever remained a constant danger to the life of the mother.\textsuperscript{164}

By the later decades of the nineteenth century, the emerging middle class along with industrialisation, influenced the division of labour where men sought waged work while women were responsible for raising the children. By the early 1890s excessive speculation and drought led to economic collapse, which in turn resulted in financial ruin and destitution for many. The high risk of failed speculations, whether through unemployment, drought or gold seeking, led many to destitution and despair. For some, failure in business and for others, failure in love, led people to the asylum. For men, sunstroke and alcoholism were physical causes of madness, yet for women the supposed mental vulnerability was seen to be caused by pregnancy, childbirth.\textsuperscript{165} Female insanity reflected the difficult conditions of family life and the low status of colonial mothers. Migrant women entered the Yarra Bend Lunatic Asylum ‘some with infants, pregnant, battered, homeless and sick.’\textsuperscript{166} As Coleborne argues, the difficulties of women’s lives, in

\textsuperscript{163} Coleborne, \textit{Madness in the Family} (2010), pp. 5-6.
\textsuperscript{164} Featherstone, ‘Confined: Constructions of Childbirth in Popular and Elite Medical Culture in Late Nineteenth-Century Australia’ (2011), p. 16.
the wake of their migration, brings into sharp relief the gendering of insanity within imperial discourses.¹⁶⁷

More men than women were committed to colonial asylums, despite the proliferation of asylum discourses on female tendency towards insanity.¹⁶⁸ In the 1889 annual report, childbirth remained among the major causes of insanity in women in Kew, one of Melbourne’s mental asylums.¹⁶⁹ Non-normative maternal behaviour transgressed codes of conduct were grounds for committal to the asylums. For example, unacceptable female behaviour in patients at Auckland Asylum were found in four areas of self-expression, housework, marital relations and maternal behaviour. Drunkenness and vagrancy were more obvious pathways to the asylum for women generally, but for mothers their neglect, or violence, towards their children, refusal to cook, house-keep, the rejection of a subservient role towards their husbands, and the ill-treatment by husbands were reasons for committal as insane.¹⁷⁰ In effect, mothers who transgressed codes of maternal conduct following a recent birth were classified as maternally insane.

Childbirth and maternal behaviour remained the key to classifying mothers with puerperal insanity. This is exemplified by William Beattie-Smith, a well-known Melbourne alienist, in his presidential address to the British Medical Association, in 1903. He acknowledged the medical practitioner was frequently called to treat puerperal insanity, and argued that the breakdown of women within six weeks of childbirth was an

¹⁶⁷ Ibid.
easily recognisable condition requiring clinical classification.\footnote{William Beattie Smith, 'Insanity in Its Relations to the Practioner, the Patient, and the State', \textit{Intercolonal Medical Journal of Australia}, viii, 2 (February, 1903), p. 66.} He then recommended treatment at home if possible, unless the sufferer experienced hallucinations and attempted suicide then treatment with certificates and committal was demanded. The treatment Beattie-Smith recommended for puerperal insanity, is thoroughly prescribed in detail:

The home treatment should be the same as the institutional treatment; the genito-urinary system must be attended to; saline aperients are useful invariably; the breasts require attention; full, frequent, and if necessary, forcible feeding from the start; stimulants, of which stout is the best, in large doses, as well as milk, eggs, and jellies are indicated. Amongst sedatives, I would strongly dissuade you from the use of opiates; chloral is the best; paraldehyde is useful, but nasty smelling; sulphonal is not efficacious. Rest in bed till excitement abates is a safe rule, then short walks, and, perhaps, massage. As to recovery, one must bear in mind that no case is really recovered till menstruation is regular, and to this end, aloes and iron, with hip baths are useful.\footnote{Ibid. p. 67.}

Beattie-Smith’s recommendations of rest, good diet and sedatives did not offer any new approaches to the well-established nineteenth-century British treatments for insane mothers. The recommencement of regular menstruation was Beattie-Smith’s key to recovery from puerperal insanity, however very few doctors, whose notes were accessed in the patient files in this present study, made any notes concerning this point. The moral management of patients in NSW including employment, leisure activities, religious practice and a balanced diet was also reflected in Victorian practices.\footnote{Garton, \textit{Medicine and Madness} (1988), pp. 165-167.} The context of these regimens was shaped by the physical environment which separated the female and male wards, along with gender specific workspaces and outdoor areas.\footnote{Catharine Coleborne, 'Space, Power and Gender in the Asylum in Victoria, 1850s-1870s', in \textit{Madness in Australia: Histories, Heritage and the Asylum}, ed. by Catharine Coleborne and Dolly MacKinnon (Brisbane, University of Queensland Press, 2003), p. 53.} The divisions between male and female work activities resembled the gendered division of labour in
broader society. The patient’s productivity and good behaviour in social therapeutics, whether in work, trial leave or entertainment events were seen as indicators of mental improvement, and a measure for possible future release.

Mothers give birth to the nation

The decline in white birth rates from 1880 onwards placed increased emphasis on the responsibilities of motherhood.\textsuperscript{175} Doctors were prominent in the pronatalist discourses on maternal and infant mortality and the use of birth control, set within the concern for the future of the white race.\textsuperscript{176} As an isolated British outpost, anxiety concerning invasion by non-whites, led to the Immigration Restriction Act. This legislation restricted the entry of non-whites into Australia, as one of the first acts of Parliament in the newly federated nation in 1901. Fears of the ‘unfit’ reproducing and concepts of degeneration of the white race were fuelled by discourses of hereditary insanity and criminality.\textsuperscript{177} These eugenic ideas combined with low birth rates and fears of the racial other saw white motherhood valorised and central to the new national experience. The offspring of Aboriginal mothers were systematically removed into state care, adopted by white families or taken into private employment.\textsuperscript{178}

The 1903 Royal Commission into low birth rates concluded that the extensive use of artificial birth control and abortion were responsible for the decline in births among the

middle and upper classes, while lower classes continued to be prolific. One of the outcomes of the Commission was to ban the importation and advertising of contraceptives, in an effort to encourage increased birth rates. Pronatalist discourses pervaded medical, social and political realms and insisted that it was women’s patriotic duty to reproduce and ensure the future of white society. The healthy white baby was elevated to the status of a national resource. At the same time, the 1902 Commonwealth Franchise Act granted women the vote in federal elections. This was a landmark for women’s rights, but it had the specific exclusion that ‘No Aboriginal native of Australia, Asia, Africa or the island of the Pacific, except New Zealand, shall be entitled to be placed on the electoral roll.’

This denial of Aboriginal rights continued with the introduction of the five pound Maternity Allowance in 1912, which excluded Aboriginal, Asian, Papuan and Pacific Islander women living in Australia. The allowance was payable to all live, white births including those of unmarried white mothers. This inclusion of white illegitimate babies born to unwed mothers drew strong criticism, but it did indicate the high value placed on white babies, rather than Aboriginal or migrant babies. These strategies were designed to keep the racial purity of whiteness of the British race in Australia.

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Furthermore, the Maternity Allowance was tied to medical supervision by doctors prior to, and during confinements. This marked the government sanctioned shift from domestic midwifery to medical doctors as birth attendants, in an effort to reduce infant and maternal mortality.\textsuperscript{185} This formalised medicalised childbirth, and at the same time pronatal discourses racialised the good mother as the white mother. In this way, white mothers were valorised for the contribution of future citizens in the new nation, yet at the same time they suffered a high risks of infection, mania, asylum committal and possible death.

\textit{Mothers and puerperal insanity in twentieth-century, Victoria}

Hilary Marland argues that puerperal insanity was a disorder that belonged to the nineteenth century and, by the twentieth century; it was in decline as a diagnosis for committal in Britain.\textsuperscript{186} Loudon agrees that puerperal insanity was classified out of existence by the early twentieth century and argues this was due to Kraepelin’s new diagnostic system for mental illness which excluded puerperal insanity as a distinct and separate category.\textsuperscript{187} Instead, Kraepelin divided insanity into two major groups: manic-depressive illness (now known as bipolar disorder) and dementia praecox (now known as schizophrenia).\textsuperscript{188} The cases of puerperal insanity were subsumed into manic-depressive illness; others belonged to dementia praecox and others to toxic confusion, or neurotic states.\textsuperscript{189}

\textsuperscript{188} Edward Shorter, \textit{A History of Psychiatry: From the Era of the Asylum to the Age of Prozac} (New York, John Wiley and Sons, 1997).
In Theriot’s American studies, she states that the ‘puerperal’ part of insanity was left off as psychiatry recognised that puerperal mania was no different to other mania, and so too puerperal melancholy was similar to other melancholy. Increased scientific studies in gynaecology, Theriot argued, recognised insanity was not caused by women’s diseased reproductive organs and by World War I puerperal insanity was cured and disappeared. Doctors could no longer legitimise puerperal insanity as an illness when the misogynistic construction and the gendered embeddedness of medical categories such as puerperal insanity could no longer be sustained. Further evidence of the waning usage of puerperal insanity as a mental illness category is found in Marland, quoting Dickson, who argued that puerperal insanity was ordinary insanity only slightly modified by childbirth. The title of Dickson’s article, published in the Journal of Mental Science, 1870, indicated his scepticism in its usage: A Contribution to the Study of the So-called Puerperal Insanity.

However, this present study illustrates the continuation of ‘puerperal insanity’ as a diagnosis in an Australian twentieth-century context. Based on thirty one clinical patient notes, mothers were committed to Melbourne mental institutions with ‘puerperal insanity’ during the 1920s and as recent as 1936. In some cases, only the word ‘puerperal’ appeared in the patient’s records to describe women’s mental instability, in other cases the full term ‘puerperal insanity’ was used, yet both diagnoses were accompanied by the recent act of giving birth. Despite historian’s arguments that ‘puerperal insanity’ had been re-classified, cured or simply disappeared from psychiatric usage in other countries,

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191 Ibid. p. 70.
192 Ibid. p. 84.
Victorian doctors continued its usage to commit mothers displaying disturbed maternal behaviour, whether suffering the delirium of fever, well into the twentieth century. Evidence of the diagnosis of puerperal and maternal insanities are found in twentieth century studies based on patient files in other Australian states.

Garton and Matthews both documented mothers committed as insane in New South Wales and South Australia, respectively. Stephen Garton’s work on the insane indicated that childbirth continued to be a source of insanity for mothers committed to Callan Park, Gladesville and Parramatta, in New South Wales in the early twentieth century. Jill Matthews’ work applied gender order to the oppression of women with a specific focus on the gender ideology of femininity. Drawing from mental patient files of women committed to Glenside Hospital Adelaide (formerly Parkside Mental Hospital) in South Australia, 1932–1970, Matthews argued that those women who deviated too far from the path of feminine motherhood were committed as insane and denied the right to be mothers at all. The present study addresses the gap in twentieth-century Australian scholarship on mothers’ insanity, focusing on ‘puerperal insanity’ in the State of Victoria.

My family member, Ada, for example, spent nearly forty years in various Victorian institutions following her committal with ‘puerperal insanity’ in 1936. The length of stay varied amongst puerperal women. For example, Freda was discharged after a five month stay. Freda was a married woman, age twenty-five, when committed in July 1924 with ‘puerperal’ listed as the cause of insanity. Freda’s baby was four weeks old at reception.
and her doctor noted ‘delusion of religious nature – says the virgin told her she would lose her baby’. One month later Freda was improving and by November the same year Freda was discharged as recovered after a five months stay.\textsuperscript{197}

In both Olive and Suzanne’s cases the full term ‘puerperal insanity’ was used and both were unmarried mothers. Olive was age nineteen and unmarried when committed to the Royal Park Receiving House in Melbourne in January 1921. No diagnosis was provided at the time of committal, yet the cause of attack was listed as ‘puerperal’. The doctor noted Olive’s baby was five days old and the ‘patient is resistive, maintains silence with questions.’\textsuperscript{198} Further notes stated that Olive’s ‘father is serving sentence for carnal assault on daughter’ and it is likely Olive’s baby was her father’s child. After six weeks Olive was transferred to the Yarra Bend hospital for the insane and re-examined. Here it was stated Olive ‘is insane suffering from puerperal insanity.’\textsuperscript{199} Olive died in July the same year, six months after her original committal. Both lungs were reported to be heavily congested, however no cause of death was provided.

Suzanne was age twenty-three and single when committed in July 1929, diagnosed with primary dementia when her baby was six weeks old. Her occupation was listed as a domestic servant. ‘She became delusional and hallucinatory – receiving messages from spirits – and thought she was to be cut up.’\textsuperscript{200} Transferred to Mont Park one month later, Suzanne was examined by the superintendent who entered ‘puerperal insanity’.\textsuperscript{201} After eighteen months Suzanne left the institution on trial leave, and by 1933 she was

\textsuperscript{197} Freda Royal Park Patient Clinical Notes, DHS, AS/1997/93/085.
\textsuperscript{198} Olive Yarra Bend Patient Clinical Notes, PRO-V, VPRS: 7417/P1/14
\textsuperscript{199} Ibid. p. 3.
\textsuperscript{200} Suzanne Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0027.
\textsuperscript{201} Ibid.
discharged. The engagement in sexual intercourse and giving birth outside of wedlock in the 1920s-30s was unacceptable and socially taboo. Both Olive and Suzanne would have been shunned by their families, friends and society and found themselves hidden away from public scrutiny and shame into the seclusion of the hospital for the insane. A more full analysis of the thirty-one mothers committed with ‘puerperal’, ‘puerperal insanity’ and birth related ailments in Victoria, is provided in Chapter Five: Insane Mothers in Modernity 1920–40s.

**Conclusion**

Australian colonies in the nineteenth century adopted British asylum practices for psychiatric treatment. Many colonial Australian asylum superintendents were trained in Britain and Scotland. While Australia was distant, it was not absent from developments in asylum management in other countries, as Kirkby argues, Australian medical associations were branches of their British parent bodies. These points indicate that the exchange of knowledge did occur across continents and, as Coleborne’s study indicates, trends in the management of the insane were traded across four colonial sites: Queensland, New South Wales, Victoria and New Zealand. Yet by the early twentieth century Kraepelin’s new diagnostic system was not implemented in Australia. This could suggest the delay in knowledge exchange where the dissemination of new developments in Europe and Britain did not occur. Alternatively, the new diagnostic system proved unsatisfactory to Australian superintendents, still needing to link childbirth as the crucial event for mental instability in mothers. By ignoring Kraepelin’s new psychiatric

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205 Coleborne (2010).
classifications, doctors in Victoria continued to legitimise puerperal insanity as an illness and the reason to commit perceived unfit mothers to mental institutions.

Psychiatric training was conducted in a culture of masculinity, with the gendered practices of the profession reflecting nineteenth-century uterine theories. Links between race, nationhood, mothers and reproduction saw doctors as authorities in the construction of femininity and maternity. Mothers were cast as ‘abnormal’ when they were seen to transgress expected maternal conduct. Doctors were in the superior position to construct perceived abnormal mothers as insane patients. Charged with the power to commit insane mothers to the asylum, psychiatrists effectively created the demand for their own services in asylums and ensured their monopoly of power in an unequal gendered hierarchy. This hierarchy of gendered power between the mother as patient and the committing doctor was about sexual difference, and gendered classifications such as puerperal insanity were specifically about the female reproductive body, and its perceived failures. Asylum doctors rose as influential authorities in the treatment of the maternally insane in the nineteenth century.

Unfortunately, for Ada and the women in this study, the gendered embeddedness of ‘puerperal insanity’ as a distinct medical category continued to be used to commit mothers to hospitals for the insane. The power inequality inherent in the doctor-patient relations, familial control, and treatment of the insane did not end with the turn of century, post WWI, or the Great Depression years. If ‘puerperal insanity’ was very much a product of the Victorian era, twentieth-century Australian mothers found themselves captured by the oppressive conditions of the nineteenth century. Despite the advances Australian women achieved in both Federal voting rights in 1902 and the five pound
Maternity Allowance payment in 1912, Australia in the early twentieth century was still very much in the Victorian age. Cases of ‘puerperal insanity’ continued to violate twentieth-century ideals of motherhood, as it had done in the nineteenth century. The medical definition of ‘puerperal insanity’ and the public discourses of what constitutes the ‘good mother’ ignored family power relations, social conditions and the material realities of mothering in this era. In an effort to ensure social order, twentieth-century mothers continued to be moved from one institution (the family) to another, that of the mental institution.  

In the next chapter Ada’s biography serves to illustrate how medical discourses and the social context of the early twentieth century conspired to disempower ‘unfit’ mothers. I explore Ada’s life more fully, her work as a single woman in Melbourne, then her marriage and relocation to a rural area. It focusses on her committal, following the birth of her second child, which led to nearly thirty years of institutionalisation that silenced Ada and rendered her invisible to my family. Ada’s files are extensive with evidence of periods of trial leave, changes to her diagnosis, experimental treatments, her domestic work, and the eventual reunion with her adult children in the early 1960s when Ada was living in the community.

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Chapter Four: Ada’s Story: 1912–1973

Introduction

The previous chapter examined the gendered discourses surrounding ‘puerperal insanity’ in nineteenth-century Britain and colonial Australia. This thesis has so far foregrounded the continued usage of the term in twentieth-century Australia. This chapter takes a more direct and in-depth approach to Ada’s biography and draws from a bricolage of qualitative methods that include a rich archive of sources. Ada’s story is told here in a way that honours a biographical approach, not often found in traditional asylum and patient histories. Oral histories bring Ada’s story alive, offering unique insights into her children’s circumstances and Ada’s institutional domestic work. It exposes her powerlessness, in a time when women were subjugated to the masculine authority of psychiatry, medicine, the law and marriage. Her story also reveals aspects about Ada previously hidden from our family due to the silences, stigma and shame that shrouded her maternal insanity. This chapter moves through Ada’s life and tackles themes that include childbirth, the issues of mothering and families, mental institutions and their treatments. Ada’s biography functions as part of the overall thesis argument that Australian mothers continued to be committed with puerperal and maternally related insanities in Victoria, in the early twentieth century.

The ‘biographical turn’ in historical writing has been reinvigorated and is exemplified by the wide scope of biography and life-writing articles in the 2012 issue of *Australian Historical Studies*. Ada’s biography contributes to the ‘new family history’ by importantly re-focusing from male ancestry to an emphasis on female ancestry. This work

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rejects traditional patriarchal history in the tracing of the male line only. Rather than celebrating the families’ past achievements, of land and lineage of pioneer family dynasties, this work grows out of the broken lineage, mental breakdown and loss which affected our family. Feminist historians denounce the false claims of masculine knowledge by writing about what were once taboo and silenced episodes of family life. Oral histories provide revelations, exposing secrets and silences that had once kept Ada hidden from our family. New family histories challenge classical approaches to the solidity of the history of the family, which in turn problematise the history of the nation and its agendas.

Several Australian maternal biographers have acknowledged that, once their female relative had died, the urge to know and understand that relative compelled the authors to narrate their stories. Lynette Russell felt that her Nanna’s death enabled her to find out who her Nanna really was and stated, ‘death frees us from the restraints of politeness and respect.’ Drusilla Modjeska’s work Poppy reflected on her mother’s passing, that in not knowing her mother she could not know herself. In Anne Summers’ The Lost Mother, the author was motivated to reconcile the past after her mother’s unexpected death in 2005, through the theme of loss.

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3 Ibid. p. 103.
6 Modjeska, Poppy (1990), p. 5.
7 Summers, The Lost Mother (2009).
By knowing their female relatives, in turn authors know and understand themselves. Written self-consciously and particularly self-reflexively, the dialogic relation between maternal biography and autobiography is a feminist narrative strategy that resists and subverts the dominant literary tradition. Maternal biographers establish their own female identity, through the writing of their female ancestors and their female blood line. Written from the hard-won vantage point of the women’s liberation movement with increased rights in equality and education for Western women, the authors are affirming their present lives in contrast to the silenced and degraded lives of their mothers and their grandmothers. Drusilla Modjeska’s, Lynette Russell’s and Marsha Hunt’s maternal biographies all reported that their female relatives were committed to mental institutions.

Drusilla Modjeska’s work *Poppy* mixed fiction with biography to uncover the circumstances of her mother, Poppy’s depression and hospitalisation in an English sanatorium in 1959. Poppy’s increased silence and subsequent breakdown Modjeska found was her mother’s response to her life as an isolated, married woman with children within a middle-class English family in the 1950s. Silence and family secrets are exposed in Lynette Russell’s *A Little Bird Told Me*. The author uncovers her great-grandmother Emily's Aboriginal identity. The necessity for Emily to ‘pass’ as white was a means to avoid the removal of children, by state agencies, in order to keep the family intact. Yet this ‘necessary lie’ meant the family lost identification with the Indigenous social, cultural and ancestral community. Furthermore, the author uncovered her great-

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9 Ibid. p. 52.
grandmother’s ‘other’ secret. Russell discovered Emily experienced a series of committals to several Melbourne mental institutions from the early 1920s, through to her final release in 1941. The author convincingly argued that Emily’s insanity and consequent committals stemmed from the repression of her Aboriginality, and from protecting her family from further poverty through ending her unwanted pregnancies.  

Marsha Hunt discovered her paternal grandmother, Ernestine, living in a poor boarding house, mute and aged, following fifty-two years in mental institutions in America’s Deep South. This biography examined two key factors including racism and the family silence surrounding Ernestine’s committal to the mental institution. Hunt’s grandmother’s medical records revealed a range of omitted information including no acknowledgement of Ernestine’s three young sons, no testimony from her husband, no family background, and no recognition of completing her high school education. As a light-coloured African-American, Ernestine’s biography raised concerns over slave ancestry, racism and skin colour both within Hunt’s father’s family and within society at large.

The interest in genealogy and family histories research has burgeoned in recent years with over 75 per cent of family researchers being women. This gender ratio is changing as men’s interest in family history has emerged, especially when it is combined with military history. The unexpected high number of female family researchers reflects the

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idea that women are the keepers of family stories, nurturers and keepers of family traditions. In many ways, this has merit in my case. Ada’s story is full of secrets and in many ways she still remains mysterious and unknown. She was at risk of being perceived as not belonging to our family, but a woman who simply married into it. Women’s invisibility, stemming from surname changes at marriage and their less public profiles, presents difficulties in tracing female ancestors. This invisibility was compounded when Ada disappeared from view behind the walls of institutions. Family members keeping Ada’s whereabouts secret made her invisibility more profound. Ada’s institutionalisation separated her both from her children and her grandchildren for many years. The ties were lost to Ada’s family of origin. This strong sense of discontinuity is recouped somewhat by the contribution of a family genealogist tracing other descendants. The writing of Ada’s biography has had its difficulties as very little is known about her parents, siblings, type of upbringing and the type of education she experienced.

This work is not ‘life-writing,’ as Ada left no autobiography, or diary, and of the letters she may have written, very few have survived the years. There are no interviews with Ada, no direct, personal voice as her death was forty years ago. Instead, I draw from oral histories, family recollections and the stories I grew up listening to, along with Ada’s patient files. I have used pseudonyms for Ada, other family members and interview participants. Several photographs of Ada have emerged as a consequence of this research that were not previously known about. Some information is drawn from a family genealogist with whom we share common great-grandparents. I purchased Ada’s birth,

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17 Kyle, We Should Have Listened to Grandma (1988), p. 27.
18 Ibid.
marriage and death certificates and draw from Ada’s mental patient records, which commenced three years after her marriage, up until the time she was rediscovered by our family in the early 1960s. The low-risk interviews about Ada’s activities at Beechworth proved a boon, particularly when the information from her files revealed so very little about this time in the late 1950s and early 1960s.

In brief, this chapter covers Ada’s life trajectory including her marriage, the birth of her two children, and the circumstances of her committal as insane. It maps Ada’s subsequent trial leave, discharge, and her third pregnancy that resulted in a therapeutic abortion, sterilisation, and her final re-committal. It also examines her treatment with insulin-coma at Mont Park in the early 1940s which aided her recovery, however temporarily. By the 1950s Ada worked for the Donnan family as their live-in housekeeper in the superintendent’s residence situated in the grounds of Mayday Hills Mental Hospital, Beechworth, in country Victoria. Then, by the early 1960s, Ada lived at Carmel House, a residential boarding house for female patients, run by the Mental Health Authority, until her death in 1973.¹⁹

Ada’s life story is no longer lost, relegated to the mysteriously silenced domain of women’s stories, or confined to the bureaucratic forms of the mental hospital, but rather is part of the feminist political agenda to reclaim the reality of Ada’s life. This biography works towards rectifying both Ada’s obscurity and reinstating her place within our family. As the researcher, the writing of this chapter is coloured by my position as Ada’s blood relative. This close proximity has influence upon the type of questions I have

asked, how I have conducted the research, the interpretations I produce and how I write this biography. Traditionally, self-reflexive writing has not been part of history writing, but has emanated from feminist social science approaches. Yet historians, too, as the literature mentioned above shows, have begun to engage with this type of writing.

Ada: Her early years, 1912–1936

Ada’s parents married in 1899 and had six children. The first five were boys and their last child was Ada, born in May, 1912. On Ada’s birth certificate, her father’s occupation is listed as machinery manager, he was age forty-four and her mother was aged forty at the time of Ada’s birth.20 Little is known of Ada’s early years, her family life or where she went to school. It is difficult to provide an account of the gap between her birth, her marriage in 1934, and her subsequent committal in 1936 at the age of twenty-four.

Feminist historians have been interested in the social changes for women in the interwar period, particularly the issues concerning single women and the growth in their employment opportunities.21 Ada’s marriage certificate stated her occupation as ‘comptometer operator’ prior to her wedding.22 The following section briefly examines how the development of clerical work expanded for unmarried women in the 1920s, as it provides the history of the cultural milieu in which Ada worked as a young woman.

20 Certified Copy of Ada’s Birth Certificate: 2 May 1912, (Victoria, Registry of Births, Deaths and Marriages).
22 Certified Copy of Ada’s Marriage Certificate: 28 April 1934, (Victoria, Registry of Births, Deaths and Marriages).
Melanie Nolan argues that the first half of the twentieth century was the era of the single ‘business girl’. The steady rise of female clerical employment in Victoria grew from 3.4 per cent in 1880 to 55 per cent in 1939. During WWI, Australia did not direct women’s employment into munitions production or essential services, as it had in Britain. Instead, women’s employment in clerical work increased before the war. This was due to the expanding economy, compulsory secondary education, scientific management in business practices, and the growth in office technologies. Both women and men were competent operators of the telephone switchboard, the typewriter and the adding machine which was known as the comptometer. The comptometer machine was a mechanical, key-driven calculator, requiring speed and accuracy from operators who were predominantly women. It was used in timekeeping, financial and statistical record keeping necessary for efficiency and accountability in the newly emerging scientific management approaches in business.

It was compulsory for students to stay in school until fourteen, and Ada may have learned typing and shorthand, if she stayed on to complete her Intermediate Certificate, at year nine in the state secondary-school system. Given Ada’s employment as a comptometer operator, it was likely she achieved a reasonable level of secondary education, with options for further study in the wide variety of courses available through private business.

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24 Ibid. p. 77.
schools and colleges in Melbourne.\textsuperscript{30} Office work opened up a whole new area of employment for young, single women like Ada, but it certainly was not well-paid. Women’s pay rates were fixed by law at 50 per cent of that of the male, enshrined in the Harvester Judgement in 1907.\textsuperscript{31} For employers, it was cheaper to employ women as office workers in a whole range of industries. But the fixed wage structure ignored the large proportion of female breadwinners supporting their families.\textsuperscript{32}

Wage-earning single women in the 1920s had access to newly found freedoms, independence and desire for pleasure-seeking activities. Their greater public visibility in cafes, restaurants, beaches and dance halls, unchaperoned, flouted Victorian social conventions.\textsuperscript{33} Young women found new ways to express femininity which was epitomised by the flapper. They embraced their freedom and independence and enjoyed Hollywood cinema, dancing, flying, driving motor cars and smoking.\textsuperscript{34} Fashion changed to short hair, plucked eyebrows, lipstick and high heels and the loose clothing allowed women to go uncorseted. ‘For the first time in over a century, corsets were not considered an automatic or indispensable part of fashionable woman’s dress.’\textsuperscript{35} Prior to World War I women had struggled with physical movement dressed in long skirts and tightly laced corsets. By the 1920s, shorter hemlines to just below the knee took on an erotic focus, after a millennia of hiding women’s legs.\textsuperscript{36} The lack of restrictive corsetry allowed

\textsuperscript{30} Ibid. pp. 71-73.
\textsuperscript{32} Ibid. p. 84.
women a freedom of movement and action in sport and pastimes including lawn tennis, roller-skating, croquet, and riding bicycles.\(^{37}\) The feminine visibility in 1920s Australia, in both entering public space, and the performance of appearance, Liz Connor argues, culminated in visually spectacular feminine identities as the epitome of modernity.\(^{38}\)

The term flapper was predominantly a white-middle class female phenomenon. For employed single women, like Ada, wages were so low that most lived in relative poverty, with such luxuries as cars and washing machines out of their reach.\(^{39}\) Ada would have adopted aspects of flapper identity and behaviour that were affordable to her.\(^{40}\) Many newly established hostels for ‘business girls’ were available to employed, single women in Melbourne throughout the interwar years.\(^{41}\) They offered protection, fun and friendship, illustrating the changing attitudes and needs of single women. The Methodist Girls Hostel, North Melbourne, offered every home comfort and necessity of the modern girl necessary for the wellbeing of her coming womanhood.\(^{42}\) As for Ada, whether she had continued to live at home with her parents while employed, or boarded in a girls’ hostel, she may have had some opportunity to experience the prosperity of the 1920s during a time of social and economic changes for women. A photograph from Great-aunty Jean ‘shows four young women working in an office situation. The girls are all sitting at desks smiling at the camera and the young lady on the left is Ada, working a

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\(^{40}\) Barbara Cameron and Janet McCalman cited in Smart, ‘Feminists, Flappers and Miss Australia: Contesting the Meanings of Citizenship, Femininity and Nation in the 1920s’ (2001), p. 3.
comptometer machine.' Great-aunty Jean said ‘we were best friends, we worked together.’ It later transpired that Ada and Jean, two office girls from the city, married two brothers from the country.

However, prosperity was to be short lived as the economic crisis of the Great Depression during the early 1930s was precipitated by the stock market crash in America in 1929. Prices for Australian exports lowered, borrowing from overseas sources ended and, by 1932, a conservative estimate indicated that one-third of wage earners were unemployed. Unemployed men felt the ‘dole relief’ payments were emasculating and they resented working women, both single and married. The ‘working woman’ produced anxiety especially with disaffected, unemployed men, who expected married women to devote themselves to raising their families and to do housework. Margaret Power states that:

...antagonism towards female employment implicitly assumes that women do not have the right to paid work, that female unemployment is not ‘real’ unemployment and that, when work is short, married women should devote themselves to household work and child-care.

This anxiety surrounding female employment stemmed from the belief that women were encroaching upon male-dominated spaces for work and professions. Yet female-dominated industries like ‘food, textiles, drink, clothing and services – were less severely

43 Family member, *Caprice in the Valley: Growing up in Yarra Glen in the 1940s and 50s* (Unpublished autobiography, 2010), p. 17.
44 Ibid.
affected by the depression than masculine industries such as heavy metals, building and construction.  

By 1933, 94 per cent of women in public administration, professional and clerical positions were single, the majority being under twenty five. Young women like Ada would have been negotiating the contradictions and tensions of twentieth century femininity, between the established traditions for women in marriage and family and the pressures of being a wage earner. By 1930, Ada was aged eighteen; her mother was fifty-eight; her father was sixty-four. As the only daughter and youngest of six siblings, Ada’s domestic help and wages may have been relied upon by her aging parents, if she continued to live in the family home. Marriage and child rearing was a desirable goal for many women in the 1930s. Indeed, as Jill Matthews notes, marriage was ‘importantly the cornerstone of femininity’ which brought status and identity to women. Social attitudes deemed that employed married women should devote themselves to raising their families and to housework only, and not undertake paid work as well, while attitudes towards single women saw them as filling in time by working until they were married. Whether or not Ada actually was just filling in time until she married or that she actually needed the income to support herself is not known, whatever the case, she soon found a husband in David.

In April 1934 at the age of twenty-one, Ada married David, in the Methodist church in Caulfield, a Melbourne eastern suburb. David was aged twenty-eight and had an

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49 Ibid. p. 243.
established carrier business in the small rural Victorian town of Yarra Glen. He collected supplies in Melbourne for district farmers, general stores and the local hotel and delivered them to Yarra Glen twice weekly. Prior to this work, David hauled timber from the Murrindindi district, until he bought his first truck and commenced his carrier business in the early 1930s. David met Ada at a dance and later they took up married life together in Yarra Glen in 1934. For Ada, marrying David meant leaving her independence, job, and city life behind. It separated her from her existing social networks and her paid employment to the new rural setting of her husband’s domain and his family networks. Marilyn French, along with other feminists, argued that for a woman to be removed from the location of her familial ties and relocated to the place of their husband’s family networks placed them under the control of their husband’s lineage in order to claim parentage. It is difficult to ascertain whether Ada was welcomed and supported by the community and her husband’s family, or whether she experienced a sense of alienation in this new rural setting and was subordinated to his family’s ways of doing things.

Ada was a young woman in Melbourne at a time of significant cultural, social and political change. She was a single woman and city office worker in the late 1920s and early 1930s, experiencing some of the newly found freedoms available to single, young women such as greater public visibility, independence and employment in clerical labour, which characterised the modern woman. Once she married in 1934, Ada’s identity shifted focus to wife and mother.

54 Ibid. p. 15.
Fractured motherhood: mental hospital committal, 1936

Ada and David’s first child was a daughter, Hannah, born in May 1935. Ada wrote to her sister-in-law and said Hannah would be staying with her mother-in-law, presumably in preparation for the birth of her second child Graeme. ‘It will be hard parting with Hannah. She is so sweet and growing more intelligent daily.’ In the same letter, written two weeks prior to Graeme’s birth in November, 1936, Ada wrote:

Today has been a beautiful day, and the warm weather is making the plants grow more quickly. The roses have been lovely, and I’ve picked quite a number. I saw the doctor last week, and he said everything is alright.

Ada’s letter suggests an awareness of listening to doctors’ advice. One cannot say whether the doctor’s comment that everything is alright hints at knowledge of her possible changeable moods, or that the pregnancy itself was progressing normally. Graeme’s birth certificate stated that Ada gave birth at a private hospital ‘Ulele’ in Box Hill, then an outer suburb of Melbourne. The birth was attended by Nurse Sister Smith and Dr Harold Booth as the accoucheur (male midwife or obstetrician). ‘Ulele’ opened in 1935 for surgery and obstetrics under the direction of Sister Smith. Dr Booth ran a private practice in Box Hill from 1929 to 1960 as a family doctor and obstetrician, after graduating from his medical training at Melbourne University in 1924. Many nurses and midwives ran private hospitals and would manage births themselves unless the birth became too difficult or protracted it was not common practice to call for an obstetrician. It is likely Sister Smith called for Dr. Booth to assist Ada through a difficult labour as an uncomplicated labour could have been handled by the sister alone. If Ada did undergo

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56 Ada’s letter to her sister-in-law, 8 November, 1936.
57 Ibid
60 McCalman, Sex and Suffering (1998).
obstetric intervention during the birth, as Dr Booth’s attendance suggests, she risked
infection from unhygienic surgical practices. Infection remained the biggest danger for
birthing women in the 1920s and 1930s, and most infections occurred in the smaller
private hospitals, such as ‘Ulele’, as there were no means to isolate infected patients from
others.61 There were several public and private hospitals closer to the family’s home town
and it was unclear why Ada travelled as far as Box Hill to give birth. The reason may lie
with Dr Booth’s reputation ‘for not sending any accounts, and for putting any cheques he
received into a drawer, only cashing them when he required something to buy.’62 This
suggests a sense of generosity in overlooking patient accounts as a social service afforded
by wealthy practitioners.63 Dr Booth was soon to play an important role in Ada’s future
committals.

Within two weeks of giving birth to Graeme at ‘Ulele’, Ada was diagnosed with
puerperal insanity and committed to Royal Park Receiving House. One of the two doctors
required to certify Ada for committal was Dr Booth. He observed:

Medical Certificates: Drs Booth & Listough – confined 14 days ago. Puerperium.
Infant male. Onset nervous symptoms 7 days ago. Alternate depression &
exaltation. Auditory hallucinations.64

The medical examiner at the Royal Park Receiving House stated that Ada was ‘lucid on
admission’ however, four days later it was noted:

The patient is cheerful and talkative. She says that lately she has had numerous
auditory and visual hallucinations. She is quite disorientated as regards time and
place. Her answers to questions are quite irrelevant and she smiles and talks
cheerfully for most of the time.65

63 Ibid.
65 Ibid.
The committal into a mental hospital for Ada, must have been the worst place to recover from giving birth. However, for some, it was the only option for families who could not continue to manage at home. It is difficult to estimate whether the separation of mother and child was the best thing to do. Once Ada was committed, there was no mention of the welfare of her baby recorded in her clinical notes.

Committed within fourteen days after birthing, Ada’s maternal body would still have been in post-birth recovery mode with her breasts full of milk, shrinking uterus and carrying extra body weight. The trauma of separation from her newborn son and her daughter, despite her body being ready to sustain her baby son’s life, indicated acute symptoms. Ada’s motherhood became fractured as she was unable to protect, nurture and ensure the survival of both her children. Ada’s mother-in-law cared for her baby son Graeme, who was raised to believe his mother was no longer alive. This was probably due to both the family and townspeople reluctance to discuss his mother’s whereabouts in his presence.\(^{66}\)

**Six years trial leave and intensive treatments**

Over the following six years, Ada was granted a series of trial leaves home from the institution. Originally admitted to Royal Park Receiving House in December 1936, by February 1937 Ada had been transferred to Mont Park Mental Hospital. Anne Bourke explains the process of the entry to a Receiving House, which served as an initial place for observation, and was the first port of call for most patients:

> If the patient was considered ‘recoverable’ after observation in the Receiving House, a transfer was arranged to the adjoining Royal Park Mental Hospital for a

maximum six month admission prior to a release back to the community. If the patient was deemed incurable or chronic, a transfer was arranged to institutions such as Mont Park.67

John Cawte’s work as the Deputy Superintendent in the Enfield Receiving House in South Australia led him to remark that ‘once patients failed to respond well enough at the Receiving House, and had to be transferred to the asylum, chance of recovery were diminished.’68 Unfortunately for Ada, her transfer from the Royal Park Receiving House to Mont Park within three months of her original committal indicated her poor prognosis and in terms of Cawte’s observations would have hindered her improvement. Once received at Mont Park, the doctors record their observations:

9.2.37: Disorientated as to time, place or person. Laughs for no apparent reason. Admits to auditory and visual hallucinations but her statements are unreliable. Nurse says she is impulsive – has to be dressed and led as well.69

The next day Dr Dane visited Ada at Mont Park, at the request of Eric Lowe, Ada’s brother. Dr Dane was a prominent psychiatrist in Melbourne, with a private consultancy practice and was a strong proponent of Freudian psychoanalysis.70 His assessment of Ada was brief: ‘patient is still inconsequential, impulsive. At times exhibits flight of ideas and quick wit – but she is not a typical mania.’ It was unclear in what way Ada’s mania was not typical. Dr Dane may have furnished a full report to Eric Lowe, but there is no more mention of his assessment held within Ada’s clinical notes. Eric’s correspondence with the Superintendents and yearly visits with Ada, suggests he had an active interest in her plight over the years. Eric ran a successful pottery manufacturing business in Marrickville, Sydney, producing Diana ware, now highly collectable examples of

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Australian tableware.\textsuperscript{71} His affluence could have afforded him the ability to pay for Dr Dane’s fee, possibly out of reach for most.

In June, 1937, Ada’s doctor noted:

\begin{quote}
10.6.37: Quieter. Clearer mentally – says she has two children (correct) and will discuss her case. Says there are men in the ceiling. She soon becomes irrational and makes irrelevant remarks. Also her behaviour is affected by her voices.\textsuperscript{72}
\end{quote}

In September 1937, nine months after her original committal, Ada was granted trial leave and was sent home. By March 1938, Ada was fully discharged as recovered. There were no doctor’s notes on her discharge, just simply the recorded date.

Ada then spent the next two years at home in Yarra Glen. During this time she arranged for her son Graeme, then twenty-one-months-old, to be baptized at the local St Pauls Church Of England. A friend who attended the service recalled Graeme, who, as a toddler ‘spent most of the ceremony gathering up the kneeling cushions into a large pile.’\textsuperscript{73} During this two-year period at home, Ada became pregnant again. She underwent both a ‘therapeutic abortion’ and sterilisation procedures, and was then recommitted to Royal Park Receiving House on the 19 May, 1940. Dr Booth again completed one of the two committal certificates:

\begin{quote}
Ada became insane after the birth of a child three and a half years ago. She was then transferred to Royal Park and later to Mont Park. A number of months ago she was pregnant. Therapeutic abortion was performed, and sterilisation was performed by removing a portion of both fallopian tubes. Her mental condition was because insane during her pregnancy hence the abortion, after proper consultation with husband.\textsuperscript{74}
\end{quote}


\textsuperscript{72} Ada Mont Park Patient Clinical Notes, AS/1994/508/129.

\textsuperscript{73} Family member, Caprice in the Valley (2010).

\textsuperscript{74} Ada Admission Warrants: AS/94/114/41
Dr Booth’s involvement with Ada by this time has a long history which included attendance at the birth of Graeme as the obstetrician in 1936, and as the medical examiner for the first and this second committal. It is likely he also approved of the abortion and sterilisation, if not performing them himself. If this was so, it may explain why there were no consent or referral documents within Ada’s mental patient files for these two procedures. Instead, it is likely they were stored within Dr Booth’s private patient records.

Stephen Garton suggests that ‘voluntary sterilisation was explored as an option by the Commonwealth Department of Health and some State Mental Hospital Departments and it is likely that some operations were performed.’ Abortion in Australia was unlawful at the time, unless it could be medically justified in the interests of the life and health of the mother. Doctors did not agree as to what elements constituted a threat to the mother’s health and various scenarios, in regards to the law, were discussed by the Medico-Legal Society of Victoria, in a 1938 article, *The Law of Therapeutic Abortion*. Dr Clive Farran-Ridge, both a psychiatrist and pathologist, argued that a woman who was pregnant, mentally unstable and had a bad mental heredity, was a justifiable case for therapeutic abortion. ‘The idea of giving birth to a child might easily produce mental stress in her case, and might even bring about a mental breakdown on her part, and perhaps cause her to become insane’.

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Dr Booth stated that Ada had become insane during her pregnancy and her history with puerperal insanity was used to justify the decision to terminate this pregnancy, as a third child may have been deemed too risky to her mental health. Undergoing an abortion and sterilisation ended Ada’s childbearing years prematurely at the age of twenty-eight, compounding further Ada’s already fractured motherhood. Stephen Garton notes that there was no legislation passed in Australia for the sterilisation of the insane. In America, the compulsory sterilisation laws lead to the sterilisation of more than 60,000 people within institutions without their consent.

Eugenic reformers discussed the sterilisation of the mothers. Eugenics was a pseudo-science which sought the control of human reproduction in order to improve the quality of the human race through better breeding. Early twentieth century eugenic ideas built upon concepts from the late 1880s that insanity had heredity tendencies which ran in families. Psychiatrists and alienists observed that in patient populations, ‘the function of heredity was to pass on a pre-disposition to “defectiveness.”’ Persons whose parents had physical or mental problems were thought likely to succumb to some mental disease. The centrality of theories about heredity made eugenics discourses a real concern as they sought to reduce the number of those considered ‘unfit’ for reproduction. Eugenic reformers such as Marion Piddington advocated sterilisation for so called defectives. Her moral judgement grew out of fears that the wrong people were producing offspring.

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80 Ibid. p.2.
It revealed upper-class prejudice along class and racial lines. Stephen Garton stated both sterilisation and segregation were two eugenic schemes for preventing the reproduction of the unfit.\textsuperscript{82} Ada suffered both.

It is likely Ada experienced grief and loss and mourned for the lost child after it was terminated. She was also at risk of suffering emotional difficulties due to the relationship problems with her husband, which became evident in her files. Both the abortion and sterilisation procedures irrevocably denied Ada any future mothering opportunities, and may have been at odds with her religious or philosophical values. Such permanent and irreversible medical interferences in the reproductive lives of women considered genetically inferior and mentally unfit, was unlawful in Australia.\textsuperscript{83} However, Ada’s experience illustrated that some private practitioners were willing to perform the procedures.

The use of contraceptives may have saved Ada from these procedures but knowledge of various contraceptive options were limited. The advertising of contraceptives had been banned in all states except South Australia.\textsuperscript{84} This suppression in advertising abortifacients, contraceptives and general birth control information was both narrow-minded and puritanical.\textsuperscript{85} Dr Victor Wallace, a Melbourne doctor, requested information from his private patients, as to their need and use of contraceptives, and published their responses in his book \textit{Women and Children First: An Outline of a Population Policy for

\textsuperscript{82} Garton, 'Sound Minds and Healthy Bodies' (1994). p. 60.
\textsuperscript{83} Ibid. p.164.
\textsuperscript{84} Matthews, \textit{Good and Mad Women} (1984).
\textsuperscript{85} Summers, Damned Whores and God's Police: The Colonization of Women in Australia (1975).
Dr Wallace found that contraception was sought to keep his patient’s family size smaller, space their pregnancies and minimise unwanted or untimely pregnancies. Women claimed it was the financial hardship that led them to seek birth control when they could not stretch the family budget to accommodate more children. Lisa Featherstone points out that Dr Wallace’s study did not represent poor mothers, but only middle-class mothers who could afford Dr Wallace’s medical services and purchase expensive contraception. It is unlikely that Mont Park offered Ada any contraceptive advice in preparation for her trial leave home with her husband. Any contraceptives, if she had knowledge and access to them, may have failed in their effectiveness.

Undergoing both the therapeutic abortion and sterilisation procedures did not assist Ada in avoiding the mental institution when she was committed as insane again. T.N.A. Jeffcoate argues that a clear history of puerperal insanity is not an indication for therapeutic abortion and that insanity is just as likely to follow abortion as it could follow delivery at term. Ada’s husband, David’s account of her behaviour on the committal certificates state:

Yesterday she burnt my best suit in the incinerator and also all the towels in the house. She is […] complaining that the operation wound is healed on the outside but not on the inside. She never washes up the ordinary household dishes and neglects her housework.

Ada’s behaviour had become erratic. The description that the operation wound is healed on the outside but not on the inside, is disturbing. It may indicate either internal physical

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88 Ibid.
pain or the psychological pain of grief in losing a baby. Abortion and sterilisation were eugenic strategies that punished Ada as an unfit mother. Given Ada’s history of insanity, it was highly unlikely she had any power in the decision to end her pregnancy and her reproductive future. Both her husband and Dr Booth exerted their patriarchal power that rendered Ada incapable of bearing any more children. Inequality, discrimination and patriarchy left Ada powerless. The procedures violated her human rights and her bodily integrity thus constituting an act of violence. 91

Many women recognise the necessity for bed rest to recover from abortion and sterilisation procedures. However, rest was possibly not afforded to Ada as her husband may have seen this as neglecting her household chores. In her research of forty-eight women in North Carolina who underwent tubal ligation, Moya Woodside found that ‘… the lives of many women are haunted by fear of pregnancy; and with this removed, it was not surprising to learn that sexual and marital relationships in the group had greatly improved and that individuals were much happier.’ 92 Unfortunately, this was not the case for Ada. The removal of any fear of future pregnancies did not improve her marriage in fact, the files indicate her relationship was seriously at odds. Ada was possibly either unable to mourn the loss of her pregnancy or may have been preoccupied with grief, deepening her fractured motherhood, leaving her with less energy to deal with the demands of family life.

David’s observation that Ada had neglected the housework illustrates his construction of Ada as a failed housewife, subject to her husband’s standards and not complying with her husband’s expectations of her roles as wife and mother. After over two years at home, Ada was recommitted and re-entered the institution in May 1940, no longer pregnant and no longer fertile. It was clear by then that her marriage was disintegrating, as illustrated by her files entries below. So Ada was sent back to the institution, creating further disjointed family experiences with the lack of continuity in family life.

In this same committal, in May 1940, the second doctor, noted:

Well-oriented as regard time and space. Talks quite rationally. Says that for the last 12 months she has been hearing voices when there is no-one about; it seems as if her thoughts are being spoken aloud. Does not get on well with husband. She is the youngest of a family of six (5 brothers).93

Two months after committal into Royal Park Receiving House, the same doctor notes:

17.6.1940: Little change. Is apathetic and indifferent about her fate. Reluctant to go home again. Says does not get on well with home and appears to have no love in regard to him.94

Trial leave from mental institutions was granted when a patient had insight into their condition, and were oriented correctly as to the time and place. Ada met this criteria, and ten days later she went on trial leave, despite her reluctance concerning the disintegrating relationship with her husband. Ada spent the following ten months at home and upon her return, the following observations were recorded:

3.5.1941: Patient is a young lady in good physical condition. She talks freely with some affectionation of home. She has various delusions about her husband, thinks he is jealous of her listening to wireless. In addition she says he keeps taunting her about her mental illness. They are on the verge of divorce but husband wants to claim the

94 Ibid.
children. She has complained to police on many occasions mainly about her husband but she has been unable to get any satisfaction – feels that police force is corrupt.

Discussed domestics because she lingered in dining room to have a chat after bringing in afternoon tea. Also they (domestics) try to worm their way into children’s affections, they do this to hurt her. She has felt her life in danger.

Admits auditory hallucinations, still hears voices over wireless, flight of ideas, delusions and hallucinations.\(^{95}\)

It is clear from the previous three observations that Ada’s marriage was in trouble and ‘familial conflicts and tensions were often the reasons for committal.’\(^ {96}\) Her perception of her husband’s taunts would have added to her stress and compounded Ada’s unhappiness within her marriage. Her complaints to police may have been based on legitimate fears of domestic violence. If her husband had battered her; Ada gained no satisfaction or protection from the police. It is likely that as a mental patient on trial leave, the police did not take Ada’s complaints seriously. Teased by her husband, disbelieved by the police, and in jeopardy of being returned to the mental institution, would seriously affect her performance as a mother. The comment: ‘On the verge of divorce but husband wants to claim the children’ illustrated David’s concern for the children’s futures. Unfortunately, Ada’s ‘voices’, hallucinations and delusions undermined her ability to remain with her family.

It was around this time in 1940, when Ada was re-committed as insane and Graeme was cared for by his paternal grandmother. His older sister Hannah, then aged around four, later recalled her father trying to find somewhere for her to live:

> When it came to the point when he had no one to look after me. Obviously Gran didn’t want the two children at that stage, to look after. And, so, I have got this picture in my mind about this day. He said I’ve got to find somewhere for you to go, he said. So he started ringing up all the boarding schools in Melbourne. And

\(^{95}\) Ibid.
this was the last one he rang, Lowther Hall. And he pleaded with this woman. And I said, Oh I hope she doesn’t take me, you know. Little did I know what the alternative was, it was the orphanage. So he told me, he said I have to put you in an orphanage if I can’t get you into this one.  

Hannah was accepted and placed at Lowther Hall, a female only, Church of England grammar school in Essendon. Hannah recalls her time boarding at Lowther Hall:

In fact the matron was more or less my boss, she didn’t like it either. Didn’t like having a younger child in the group. The girls were not allowed to hold my hand, because I was the youngest in the school. I don’t know what they did with me when the kids were in class. I wasn’t really in the classes, I was just too young. Even for their kindergarten, I don’t think they really had a kindergarten in those days. But I just remember the general assemblies. I was allowed go to the general assemblies. The ones older than me would take me with them. We all had to march into this big hall. I remember where we slept in the upstairs balcony area.  

Her father visited on Sundays during the school terms, ‘I hated every time I said goodbye to Dad, I just hated it.’ The summer vacations and some term vacations were spent with Grandmother Lowe, Ada’s mother.

Hannah recalled her time at Lowther Hall:

The dining room was a very spectacular room, it had windows from floor to ceiling, all the way down of one side. I had to sit there and eat this terrible smelling stuff. Liver. Fried liver. I had to sit there and chew and chew and chew and swallow the stuff. I had to eat everything on the plate.

I was just about silent, I wasn’t speaking very much at all. In fact, I think I said practically nothing the whole time I was there. Not that I wasn’t thinking, I knew that I could speak.

I do remember the day I found out I was going to be leaving the place. Dad bought me back for the last term before they closed the school down. They closed the school because the Americans took it over as a hospital. And they didn’t have any option, the government took it. And so the headmistress, I was crying cause I had to leave Dad, and having to come back, and she looked at me and said well this will be your last year here so stop crying, this is your last term here. So that, it stuck into my mind I’m going to be going, I don’t have to come back again. So I was looking out these beautiful stained glass windows as I went up the stairs, and

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98 Ibid.
I was really happy, I was really happy.99

By 1942, the United States army arrived in Melbourne, and took over many buildings in the allied operation to protect Australia and the South Pacific from Japanese invasion. Lowther Hall was one of the many schools, including Mac Robertson Girls High and Melbourne Grammar, requisitioned for American requirements.100 For Hannah, the closure of the Lowther Hall proved to be an opportunity to be reunited with her younger brother Graeme, and live together with their paternal grandmother, whom they called Gran.

And it took me a while, after I came back to Gran’s, it took me a while to really unwind. Graeme was saying words and I would ask him to say that again and then I would say it aloud to myself, you know. And I was just catching up with things that I could do, that I hadn’t been doing. So he helped me to get my language going again. Gradually I started chattering away and everything, and I wasn’t frightened anymore. I remember Gran saying to one of her visitors Hannah started talking again.101

Hannah recalls visiting her mother at Mont Park:

I went to see her with Dad when she was at Mont Park. I remember that. I was only young, three or four or something like that. I can’t really say. I just have this memory of this terrible this iron fence around the place, and people trying to stick their heads though the gaps and calling out and all that awful stuff. And then we went in. She wasn’t there when we first went in, we had to sit down in the visitor’s area. I remember that. And when she came in she was very placid, just placid and Dad gave her some cigarettes and she started giving them to all the other people.102

These poignant memories illustrate the extraordinary experiences Ada and her children went through. The years back and forth between the institution and her family home must have been extremely destabilising for all concerned. Abortion and sterilisation had not

99 Ibid.
102 Ibid.
improved her mental health, as was hoped. Ada was yet to undergo further experimental
treatment, with no lasting effect.

**Insulin-coma treatment (ICT)**

Returning to Ada’s clinical notes the discussion turns to the change in her diagnosis to
primary dementia and the prescribed insulin-coma treatment (ICT) that followed:

17.7.1941: ‘Health good. Primary dementia. Erratic behaviour. Hallucinating
experiences.’

German E. Berrios and colleagues argued that various psychiatric terms have a
complicated and discontinuous history of competing understandings. Such is the case
in the uses and misuses of dementia, dementia praecox and schizophrenia. The various
understandings of dementia changed and converged from the seventeenth century ‘states
of psychosocial incompetence’ to the 18th century ‘intellectual deficit’ models. In the
nineteenth century, the essential feature of dementia was intellectual impairment, where
hallucinations and delusions were thought to be secondary and unrelated symptoms. By
the turn of the twentieth century, dementia was defined through the cognitive paradigm,
as irreversible memory loss in the elderly. Kraepelin is attributed to have created the
term ‘dementia praecox’ to describe the early degeneration of cognitive faculties, a term
designed to separate this condition from old-age dementia.
As Ada’s diagnosis changed to primary dementia, her mental faculties, including memory, were perceived to be reduced. Three days after her diagnosis changed to primary dementia in 1941, Ada underwent daily insulin-coma treatments for three months. This involved giving patients ‘injections of insulin to reduce their blood-sugar level and to induce hypoglycaemia [low blood-sugar] which produced coma.’

Every day, between ten and eleven a.m., Ada was injected with insulin. The doses were low at first, then slowly increased. She was revived by glucose drinks in the first ten or so comas, then tube fed to regain consciousness. A letter from Ada’s husband gave approval to commence this ‘special treatment’ after he had talked the matter over with Dr Wood. However, Ada had already been receiving the insulin-coma treatment for two months by the time his consent was received. ‘Dr Reynolds’ was written across the top of this consent letter, in large hand-writing. This would indicate the handwriting of the clerk would forward the consent for Dr Reynolds’s records.

Dr Reynolds and Dr Farran-Ridge were getting impressive results with their insulin treatment at Mont Park. Together, they co-authored their positive findings and published in the Medical Journal of Australia, 1938. The treatment was developed by Manfred Sakel, a Viennese psychiatrist, and reported the success of insulin comas in the management of schizophrenic patients in 1934. Dr Reg Ellery administered the treatment to three patients in his private practice, in Melbourne, 1936, but his results were inconclusive. This prompted Ellery to travel to Europe and receive technical instruction.

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111 Ibid.
in the administration of ICT. In 1940, Ellery published a thorough account of the treatment in *The Medical Journal of Australia*. He described the administration of insulin, the recommended length of comas, and concluded that ICT produced a complete remission of symptoms in the majority of cases. Ellery then completed the book *Schizophrenia: The Cinderella of Psychiatry*, in 1941, in which he promoted the value and effectiveness of ICT in treating schizophrenic patients.

ICT was one of the first treatments that psychiatrists perceived as aligning their profession closer to the field of medicine, rather than merely custodians of the insane. Wards were dedicated to ICT treatment as psychiatrists relished its efficiency. It was a treatment designed for schizophrenic patients, yet at the time Ada underwent ICT in 1941, she was diagnosed with primary dementia. Eugen Bleuler coined the term schizophrenia, in 1912, and recommended it replace Kraepelin’s dementia praecox. In response to Bleuler, there was much debate concerning whether schizophrenia and dementia praecox were the same illness. In Melbourne, Reynolds and Farran-Ridge published on ICT as a treatment for schizophrenia. In effect, they treated a wide range of patients, including Ada, as a primary dementia patient, and others with dementia praecox, puerperal insanity and manic-depressive insanity.

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Ada’s records indicate she underwent insulin-coma treatments every day for three months, totalling fifty comas. After two weeks of ceasing the treatment her doctor noted:

Marked improvement, well above treatment. Considerable gain in weight and improvement in physical condition. Mentally much improved – states she is no longer hallucinatory although remembers that she was so and seemed to have gained full insight into her condition. A satisfactory remission.\textsuperscript{120}

Full insight is a key criteria in qualifying for trial leave, and following treatment her hallucinations had stopped. Ellery wrote:

It is obvious that the repeated production of coma establishes a desirable rapport between patient and the physician which can often be readily augmented and made to serve desirable ends. Insulin shock breaks the structure of the patient’s autism. It frees the mind from its psycho-pathic encapsulation. It opens the door to reason.\textsuperscript{121}

The success of ICT allowed Ada to go on trial leave home, despite being on the verge of divorce. Ada spent six months at home, then returned to the institution in January 1942.

Her doctor noted:

14.1.1942: She talks freely but in unnatural fantastic manner. She is correctly orientated and her memory is good but she obviously has no insight into her present condition. She states that Mr [husband] is the person who should be here as he is out of his mind.\textsuperscript{122}

Unfortunately, Ada’s remission following ICT treatment was not sustained. It is difficult to pinpoint exactly what had transpired at home, but it is clear from previous entries the marriage was falling apart. Ada returned from trial leave to the institution worse than ever, experiencing numerous fantastic delusions.

14.1.1942: She also stated – you are an English Doctor, I am Oxford graduate myself, Dr F.E.M ie. Female doctor. Also an Insane specialist not practising and an R.P.M. practising. For a long time she would not disclose significance of R.P.M. but eventually stated meant Royal Pedigree M […] and referred M.O. to enquire from Churchill and British Secret Service.

She claims she arranged the introductions between Duke & Duchess of Kent. She is willing to oblige for a fee of 1,000 pounds to do same for the royal personages.

\textsuperscript{120} Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
\textsuperscript{121} Ellery, Schizophrenia: The Cinderella of Psychiatry (1941), p. 93.
\textsuperscript{122} Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
She stated this country is now known as L’Aurolia Republic – it was Australia prior to the revolution in 1900. She says she is a member of Russian Royal family and her real name is Lily Vertel Rose Alvaradora Icebel and says herself ‘Alvara Russia.’

She has numerous other fantastic and bizarre delusions. Naturally she is somewhat exalted. She admits hearing voices talking about British Secret Service work so cannot divulge subjects discussed.

She is cheerful and cooperative, her mood is cheerful, but she is living in a world divorced from reality.123

Delusions have been a key characteristic of madness and insanity. Stephen Garton found patients suffering exaltation and delusions of grandeur, whether fixated with notions of wealth, fame and notoriety, typically characterised male patients, but did find female patients were a small and distinct group.124 Ada’s referral to Churchill and the British Secret Service, leaves no doubt that Ada’s delusions were shaped by the Second World War, influenced by the wireless news bulletins from the BBC and newspapers of the time.125

The Royal marriage between Prince George, Duke of Kent, and Princess Marina, in 1934, was well covered in Australian media. It was celebrated as the World’s Most Popular Wedding and attended by members of British, European and Russian royal families.126 Another newspaper headline London’s Gone all Marina, found that since the announcement of their engagement, Princess Marina had overshadowed all other news.127

123 Ibid.
An advanced search in The National Library of Australia’s Trove site revealed 355 newspaper articles written on Princess Marina between the years 1934 and 1939, in Victoria (see Figure 11). With such media saturation, Princess Marina, her marriage and her royal heritage must have captured Ada’s imagination. Marina was the Princess of Greece and Denmark, and a descendant of the Russian Royal family. Marina’s mother was Grand Duchess Elene Vladimirovna of Russia, and granddaughter of Tsar Alexander II of Russia. Ada’s delusion of grandeur had strong links to these real world events. Prince George and Princess Marina, the Duke and Duchess of Kent, married in 1934, the same year Ada wed. Just like Princess Marina, Ada moved from her own kingdom to her husband’s kingdom upon marriage.

On the strength of Ada’s delusions, a request was submitted for her to be transferred to Mont Park. The following assessment, prior to transfer, indicated Ada’s delusions persisted, this time with an emphasis on superior education:

3.3.1942: Emotionally impoverished, apathetic and admits hallucinatory voices. Saying ‘voices seem to be in the fashion these days’. States she is a doctor, a surgeon, a medical specialist, graduated Oxford ‘1911, was born in 1906’. Graduated at 9 in the old fashioned way. States he started school at Eton at 2 years. Belongs to Russian royal family, her name is La Russe […]. She smiles inanely during all this discourse. She is quite indifferent although at times her behaviour is capricious and compulsive.’

A final assessment simply reads:

24.3.1942: Little change, somewhat more cooperative and less impulsive, cleans and tidies. To go onto Mont Park.

Certainly undergoing the procedures of abortion, sterilisation and insulin treatments failed to assist Ada in recovery or release. Once Ada returned to the institution with delusions, no more trial leave was granted. This ensured long-lasting estrangement from her children. The many entries and exits between home and institution throughout her six years of trial leave disrupted the patterns of their family life and created a fractured experience of motherhood. It was evident that Ada was in an unhappy marriage, and as Janice Chesters argues the asylum acted as a woman’s refuge, a safe place when there was nowhere else to go.\(^\text{130}\) Despite her previous employment and independence, Ada would have lost her social networks while being institutionalised, which left her unable to make alternative living arrangements for her trial leave periods. Throughout her six years of trial leave it is hard to say how much she saw her children, but from 1942, Ada disappeared from their lives for the next twenty years.

**Mont Park Mental Hospital: 1942–1955**

Ada’s delusions of grandeur of being an Oxford graduate, a surgeon and a Russian princess prompted her transfer from the Receiving House to Mont Park in March 1942.

She was assessed in December the same year:

23.12.42: Bodily health good. Primary dementia. Considerable mental reduction. Emotionally dull. She grins and smiles in a silly inane fashion. Behaviour is erratic and impulsive. Tends to be a solitary type. Clean and tidy. Occasionally does some ward work.\(^\text{131}\)


\(^{131}\) Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
In January 1943, Ada answered a recruitment advertisement to join WRANS, the Women’s Royal Australian Naval Services (see Figure 12).

![Image of WRANS advertisement]

**Figure 12: The World of Women, 300 Women sought by WRANS (1942, December 18). The Argus, Melbourne, Vic: 1848-1957**

The WRANS advertised regularly for recruits in 1942–43. Ada’s application letter to the WRANS was not sent and held with her patient clinical notes, dated January 3, 1943:

> Naval Recruitment Officer,
Dear Sir,

Before noticing the recent advertisement in the Herald, Melbourne for W.R.A.N.S., I would like to offer my services, as a medical doctor and surgeon, also insane physician and in surgeontry, for a naval commission.

I expect to be eligible in from three to six months.

I am a graduate of Oxford University, England, and of Sandhurst Military Academy England (also Melbourne) and served in the 1914–18 war at […] and elsewhere.

I am born in Russia in September 1901, a Roman Catholic, being Russian wedded Grecian, and non-practising, also an explorer and widely travelled.

Trusting that you will find use for my medical services in the Australian Women’s Naval Service and awaiting an early reply.

I am yours faithfully,

Ada [surname]
M.A. OXON
Dr FEM. C.C. OXON
& Surgeon
B. SC Melb

May I mention the following names as personal friends:
Sir Winston Churchill, England
Sir Anthony Eden, England
The late Mr. Chamberlain
Lord Halifass, America
Lady Margot, Asquith, Australia

Dr N RUSSE. SINGLE
OXFORD

This letter illustrated that Ada’s delusions persisted, as she used three different identities to sign-off. It does demonstrate a good level of literacy and her handwriting was consistent and neat, and she followed formal letter-writing layout and structure. The

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132 Ibid.
address given for applications in the advert was exactly the same Ada addresses used in her application. This anecdote also indicated that Ada had access to Melbourne newspapers at Mont Park. Another letter, written in the same year, 1943, illustrated Ada’s delusions persisted, and again the letter was not sent and held within her patient clinical notes. This time Ada addresses her husband:

One of the patients here has been friendly and helps to pass the time. With your consent, we are planning to go to England together, as I must see to my English affairs, being of Russian titled birth. I inherited from my father about twenty-six years ago, various properties in England, America and Australia, also Europe, these properties, and affairs await my attention in London.

Also my Army Commission, with the British Secret Service, which commission continues from my last visit to London (not having been notified to the contrary), including secret service to England and America during this war, also been specially called into commission in about 1938–39. That army report I must make in London at a convenient time, and visit my regiment.

And lastly, my enormous will, I must change it to include yourself, my husband, and only two children, and those several titles to descend upon both, also a ducal title upon yourself from marriage (to me), now Alva.

I should be pleased to have your co-operation about my proposed voyage, and sympathy.

That commission mentioned, being partly executed under your roof, I should be honoured to share that salary, and tender my apologies for the inconvenience.

In London, I have my own staffed residence waiting at Westminster, which matter I shall enquire before leaving Melbourne, and under the name – Lady, The Colonel, […] Alva Russe, of Special […] Surrey.

B.S.S
London
The Old Con[…] Regiment

I must leave now
Lots of love to all,
Your loving wife
Ada 133

Ada’s belief in her Royal Russian ancestry had expanded in this letter to include wealth and property. There is less focus on extensive higher education compared to the doctor’s notes of March 1942 and her WRANS application. It does repeat her delusion in working

133 Ibid.
with the British Secret Service, first mentioned in the doctor’s note from January 1942.

Her various versions of her Royal Russian identity: Alvara Russia, Alva Russe, La Russe and Dr N Russe, and connection to friends in high positions, are placed in the context of working undercover in the British Secret Service. Ada’s grand delusions were drawn directly from the Royal family wedding and Australia’s active wartime defence of mother England. The elevated and aspirational social rank as a Russian Princess, Oxford graduate, and agent of the British Secret Service, served as a coping mechanism and defensive strategy against the lack of social power and the low (lowest?) social rank as an insane mental patient, restricted from participating in Australia’s war activities.

**Mayday Hills Mental Hospital, Beechworth, 1955–1963**

In 1955, a medical officer, Dr Laurence Donnan, his wife Dorothy and their two daughters were living in a family residence on the grounds at Mont Park. Sally, Dr Donnan’s youngest daughter, who was then aged seven, recalled:

> I don’t recall Ada at Mont Park, my sister remembers that she and I got sick while we were living at Mont Park, it was the measles she believes, and Ada came in to help mum look after us. My sister remembers she was very sweet, and in a bit of a fluster. So I am sure that was the introduction of Ada into our household. It would have just gone on from there, with Ada being a help to mum and helping with the household routines.\(^{134}\)

Sally recalled that ‘Mont Park was a gloomy place with bad vibes, the pines trees were eerie.’\(^ {135} \) The Donnan family migrated from England in 1955 ‘on the P&O Strathmore, travelling through the Suez Canal, visiting Bombay and Cairo. A wonderful trip, and

\(^{134}\) Sally, *Personal Correspondence* (16 December, 2013).

\(^{135}\) Sally, *Phone Interview* (26 February, 2013).
sunshine. Dad had contacts in Bombay and met in clubs for dinner. We migrated as ten pound poms.\footnote{Sally, \textit{Interview} (13 November, 2013).}

For one year, Dad was the medical officer at Mont Park. Surrounded by those dark fir trees, it was a shock to the system. Dad looked at Sunbury first, and he was disappointed in it, as it was an awful place. Then the Beechworth position came up and he took the position there.\footnote{Ibid.}

Dr. Donnan’s position at Beechworth was reported in the Victorian Government Gazette as Chief Superintendent Psychiatrist in 1956.\footnote{Mental Hygiene Branch The Victorian Department of Health, ‘Victorian Government Gazette’, 745, August 8 (1956), p. 4327.} Sally remembers Ada travelling with the family from Mont Park to Beechworth:

Ada became attached to my Dad, because I remember Mum saying how upset she was that we were leaving to go to Beechworth Mental Hospital. So the decision was made for Ada to come with us.

There were five of us, including my elder sister, driving up to Beechworth in Dad's Alvis vintage car with lots of luggage. It got dark and none of us were that comfortable being in the middle of the bush at night. The car conked out at a river crossing, water was running over the road, in the dark. Ada was sitting between us two kids in the back, gripping our hands. Anyway we got going again, though I don’t remember the rest of the trip.\footnote{Sally, \textit{Interview} (13 November, 2013).}

The first time I made contact with Sally, I had asked her whether she knew of my female relative, Ada, who was a patient at Beechworth, the same time her father worked as the Superintendent. Sally replied:

Ada was not a patient in Mont Park or Beechworth Institutions, she lived with us in the family home. She was well suited to my mother’s personality, both very suited to routine, and both happiest when they both had a routine.\footnote{Sally, \textit{Personal Correspondence} (26 February, 2013).}

It took us both a few minutes to grasp the implications of our first conversation. I was unaware Ada did not live in the institution, but instead resided in the Donnan family

\begin{thebibliography}{9}
\bibitem{136} Sally, \textit{Interview} (13 November, 2013).
\bibitem{137} Ibid.
\bibitem{139} Sally, \textit{Interview} (13 November, 2013).
\bibitem{140} Sally, \textit{Personal Correspondence} (26 February, 2013).
\end{thebibliography}
home located within the Beechworth institutional grounds. Sally did not realise Ada was a mental patient, at first. Ada had her own room in the family home (See Figure 13).

![Figure 13: The Superintendent's residence on the grounds of Mayday Hills mental institution, Beechworth, where Ada resided with the Donnan family. Ada's room is to the right hand side of the photograph, built into the end of the veranda. Photograph from Sally's private family album.](image-url)

Sally described Ada’s appearance:

> I seemed to remember her being dressed very neatly every day, usually in a black skirt and white shirt. She wore her hair in a well cut bob. She struck me as being quite young, but her hair was grey so it was hard to tell her age. I always remember her wearing thick beige stockings and stout black shoes. Pink complexion, blue eyes. She never wore makeup. One day mum told me she had a son, which made me wonder a lot.\(^{141}\)

Beechworth Asylum was a large county institution built in the 1860s to cater for the influx of people seeking a fortune on the Victorian goldfields. It was one of three asylums situated in towns adjacent to the goldfields: Ballarat, Ararat and Beechworth.\(^{142}\) Also

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\(^{141}\) Sally, *Personal Correspondence* (14 February, 2013).

situated at Beechworth was the Ovens District Hospital, Beechworth Gaol and the benevolent asylum, as well as the lunatic asylum and together the town was a significant social welfare centre in Victoria.  

Asylum patient employment was a well-established practice from the nineteenth century. It was considered a ‘therapy’ for patients to ensure they remained occupied, but crucially, patients’ work was necessary for the functioning of the asylum economy. The type of work was divided along gendered lines: women worked inside while men worked outside. Sally said of Ada’s domestic work:

Mum and Ada were perfectly aligned with routine. A match made in heaven. Everything was on time, the routine, brushing hair, cleaning shoes, preparing school uniforms and meals.

The use of female patient labour as domestics and housekeepers was common for superintendents and medical officers who were provided with housing on the grounds of the institutions. At Kew mental institution, in Melbourne, during the 1930s, Emily, Lynette Russell’s aboriginal great-grandmother, worked diligently as the domestic servant in the superintendent’s home. Dr Reg Ellery was not so lucky. At Kew, in the early 1920s, Gertie, the patient assigned to his household chores, ‘was going off’ – right off the deep end with a big splash. Ellery had returned from his morning rounds to his cottage for lunch. He found that Gertie had prepared the lunch table for a dozen people, in the kitchen every dish, pot and pan was dirty, while outside she hurled dirt in the air.

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144 Coleborne, 'Space, Power and Gender in the Asylum in Victoria, 1850s-1870s' (2003), pp. 54-55.
145 Ibid. p. 55.
146 Sally, *Phone Interview* (26 February, 2013).
making a new path across the lawn. As for Ada, she became part of the Donnan family household and attended several family outings and events:

Ada had a day off during the week, so that she could go down into the town with mum to do some shopping. Ada loved buying things. Ada would also take me and my sister to the hospital cinema next to the main administration building, whenever there was a suitable film on. Ada loved the musicals. One night there was a film about Houdini and we got really scared, and so Ada took us home.

It was generally understood within the Donnan family, that Ada didn’t like anything unexpected that would upset her routine:

We tried to accommodate that. But sometimes of course things did happen. There was a bushfire one summer that was approaching those hills at the back of the hospital. We could see flames and smoke. The firefighters were onto it but we were all pretty agitated. Ada started filling up buckets of water and throwing water into the back yard. Luckily the fire got put out before it got close.

Sally’s older half-brother Darren, married in 1960 at Beechworth:

Ada was a tremendous help to my mum setting up the house for Daren’s wedding reception. Mum had worked herself into a state. My sister and I were bridesmaids and we had a patient as our dressmaker and she would come and measure us for clothes. The dressmaker lived in the institution, and she was a hard worker and very good at her craft. She was an anxious person, but chatty and quite cheerful sometimes.

Eric Cunningham Dax, the new Chairman of the Victorian Mental Hygiene Authority and a highly influential expert, was a regular visitor and would join the Donnan family for dinner (See Figure 14). Sally enjoyed Dax’s visits:

Father knew Dr Dax in England before migrating. He may have interviewed him, I’m not sure. I have fond memories of Dr Dax at Beechworth. I can remember Mum would light up when Dax was coming. The best bottle of wine would come out, the best dinner cooked and candles. So there was a lot to do. Ada was quiet, conscientious and hardworking and without her, I think my mum would have been under a great strain and would have found it all very hard.
Dr Dax would get on the floor with me and my sister and draw with us. He bought both of us presents every visit, glass and ceramic ornaments of animals. He would put the presents behind his back and get us to choose which one. He was fun and enjoyed himself with us. Mum said she would come in and find Dr Dax on the floor and didn’t know what to do. My sister remembers getting horse rides around the room.

Dax always appreciated Mum’s cooking. He was chatty, whereas my Dad was quiet. Mum enjoyed it, he had a very natural manner, playing with kids. Tall, imposing and impeccably dressed. After dinner Dax and Dad would go off to the hospital.153

Sally showed me a large color photograph of the Beechworth institution. We were both standing and holding the photograph (See Figure 15) between us when Sally said:

This picture gives you shivers, aware of odd people roaming around. There was a darkness there, we would run into patients on the grounds. We could hear the patients screaming and howling at the ha-ha wall at night. We could see the institution from the front of our house, the windows were small like eyes watching.154

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153 Ibid.
154 Ibid.
From Sally’s description, there is no doubt that the mental institution was a scary place for young children, full of frightening sounds and sights.

Sally said:

I did know almost from the start that Ada was a mental patient for want of a better word, and similar to some of the people at the hospital at Beechworth. It was simply called The Hill by everyone. I never heard it called Mayday, such an ironic name.

Ada did not show any variation in emotion, at least when we girls were around. There wasn’t any conversation, or interaction, which I knew wasn’t right. Ada was a comforting presence, maybe because she was always composed and unvarying and predictable. Mum could get stressed and lose her temper, which Ada never did.¹⁵⁵

¹⁵⁵ Sally, *Personal Correspondence* (9 July, 2015).
Dr Bozan, Chief Medical Officer at Beechworth, completed an examination with Ada, and entered the diagnosis of ‘schizophrenia’ for the first time in 1956. Sally, also knew of Dr Bozan, she said:

A doctor at Beechworth, Dr. Bozan was from Hungary, a nice family with a residence on the grounds too. He often was confused with Australia sayings and had asked Dad what did crook in the guts mean, what does crook mean?"157

On Ada’s admission card Dr Bozan noted: Diagnosis: Schizophrenic, and under Mental and Physical Health he wrote:

She is quiet, pleasant and affable. She is very well behaved and therefore: She exhibited before hallucinations of grandeur, but these do not influence her behaviour. She is in good general health.158

It seems very unusual that a schizophrenic patient could look after the superintendent’s children and work in his home. It is questionable that he would leave his children with any mental patient. However, from Dr Bozan’s assessment, Ada’s grand delusions did not interfere with her work and the superintendent, Dr Donnan, trusted Ada with his family. Aside from the schizophrenia diagnosis, the files yield very little of Ada’s confinement at Beechworth. There is only a single entry for each year: ‘no change’ and ‘as above’ for a period totalling seven years. Dr Bozan’s entry for August, 1962, recorded:

Does satisfactorily in routine jobs. Upset by the smallest change. Refuses to be examined by anybody but the Superintendent, because she is not a patient, but a worker!159

Ada’s reference to herself as *not a patient, but a worker*, provides an interesting insight into the image she had of herself. An earlier entry, from Mont Park, in May 1954 noted: *Settled in Ward. Works daily in B ward which she calls going to the office.*160

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157 Sally, Interview (13 November, 2013).  
158 Ada Beechworth Admission Card, AS: 95/134/2.  
160 Ibid.
humour, her comment harks back to when Ada was an office worker, prior to her marriage. Her self-belief denied her patient status, in preference for identifying as a worker. This was reinforced by Ada living and working with the Donnan’s in their family home, and by not living in the institution as other patients did. Ada’s ‘worker’ self-concept may have had redemptive qualities in the healing of her fractured motherhood, facilitated vicariously through caring for the superintendent’s children at Beechworth.

In 1963, Dr Donnan left Beechworth with his family and took up the position as Psychiatric Superintendent at the Brierly Mental Hospital, Warnambool, situated on the south-western coast of Victoria. Sally recalled:

When we left Beechworth it was because of Dad’s ill-health. It became too much for him and too hard for him to manage such a large hospital. Mum told me much later he had already had a couple of heart attacks, but I don’t remember anything untoward. I think there were other problems as well, maybe the diabetes.161

Brierly was a small institution opened in 1957 and expanded to five wards in 1961.162 Cunningham Dax reported on Dr Donnan’s move to Warnambool in his Annual Report, 1963:

A psychiatric service to the western district of Victoria, was opened when Dr. L. Donnan, took up residence in Warrnambool. Besides being Psychiatrist Superintendent of the Warrnambool Mental Hospital he conducts out-patient clinics at Warrnambool, Hamilton and Colac.163

For Sally and her sister, young teenagers by this time, the move to Warnambool was the first time they were not living on the grounds, and had a home away from the mental institution.164 The Donnan’s family move to Warnambool prompted Ada’s transfer back

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161 Sally, Personal Correspondence (16 December, 2013).
164 Sally, Interview (13 November, 2013).
to Mont Park in Melbourne. Ada’s last entry, made by Dr Bozan, at Beechworth briefly stated:

1/01/1963: To be transferred to Mont Park. Does well in routine jobs. Quiet, cooperative. On no treatment. Schizophrenic.\(^{165}\)

**Family Rediscovery and Reconnection**

During Ada’s last period of institutional living at Mont Park, she reconnected with her adult children through unusual circumstances. Graeme, then in his early twenties, lived with his wife and their two young children at his father’s house, while they saved for their own home. When they relocated to their newly built house two years later in a suburb nearby, Graeme redirected his mail from his father’s address to his new one. There, the family celebrated Graeme’s birthday, and to his great surprise, opened a birthday card signed from his mother. Believing that Ada had not been alive for a long time, Graeme accused a family member of playing a bad joke in faking this card from his mother. They denied it. His aunt said: ‘your father should have told you by now.’ Graeme asked her ‘know what by now?’ Graeme’s father confirmed that it was a genuine birthday card from his mother. Graeme soon made contact with Ada at Mont Park.

He recalled his first meeting with Ada. Graeme was nervous and apprehensive, and unsure what she would look like and what to say to her. On arrival at Mont Park, he was advised Ada would not be long, and he was seated in a small walled garden. Graeme said:

> I waited for twenty long minutes, and my anxiety increased. When she opened the door, there she was. But six people followed her, to take a look at her son. I didn’t know whether to give her a kiss or give her a hug. The first thing she said to me: ‘Graeme you look just like your father’. It was the last words I wanted to hear at that moment.\(^{166}\)

\(^{165}\) Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
On to Carmel House

Ada was not prescribed anti-psychotic drugs during her time at Mont Park. Although the fact that medication was being administered to schizophrenic patients in other Australian mental institutions during the 1950s, was well documented by both John Cawte and John Cade.\(^{167}\)

At Mont Park, Ada is assessed, the doctor noted:

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20/8/1964: \text{Patient is schizophrenic and is quiet most of the time. Occasionally deluded. Excellent worker. No medication at present. Arrangements have been made to board her out to Carmel House. She is anxious to go.}\(^{168}\)
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In August of 1964, Ada left Mont Park to live at Carmel House in Preston, and was placed under the supervision of Sister Albert. Eric Cunningham Dax described the acquisition of the building and its purpose:

Later in the year a building was acquired by the Mental Health Authority in Hotham Street, a few hundred yards from the Preston Clinic. This is an old mansion surrounded by beautiful lawns and gardens, and with a residence for the psychiatrist in charge. The building was being used as a private hospital known as Carmel. It is anticipated that this will be used as a hostel for some twenty female patients, which, in combination with the Preston Clinic will provide a psychiatric centre, with the Day Hospital at the Clinic, and residential facilities at Carmel.\(^{169}\)

It was at Carmel House, that Ada was prescribed anti-psychotic drugs, Stelazine and Melleril, for the first time in 1965. Ada admitted her auditory hallucinations were ‘like singing voices. Heart is not the best. I take tablets for my heart.’” (Melleril).’ The doctor later recommended Ada cease taking Melleril, and after a year Ada requested she have her ‘old heart’ tablets back.\(^{170}\)

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\(^{168}\) Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
Graeme recalled that he and our family would collect Ada from Carmel House, and take her on outings.

We would go and watch the planes come and go at Essendon Airport, other times we took Mum for drives and had family picnics. When we went to pick her up from Carmel House, she was always late and I remember waiting in that timber panelled foyer, lookingsearchingly at the stairs, until she made her entrance.

When I was working in the city, Mum used to go and get her hair done on her days off, and we would meet afterwards at the Town Hall corner, and go off to Coles Cafeteria, her favourite eating place. But then she would go into the toilets and wash her hair out, so sometimes when I met her, she looked a bit wild and woolly, like she had been diving in the Yarra River. She certainly had her eccentricities, Graeme said, in undoing her ‘hair do.’

The first time Mum stayed at our place for the weekend, mum turned to Graeme and said ‘Tell me, do you still use your title?’ ‘Er, what title’s that, Mum?’ Graeme asked surprised. ‘Lord Graeme,’ she replied, as if everyone knew. ‘No Mum. People don’t use their titles much these days.’ ‘What a pity,’ she said and dropped the matter.

From that time on, the story entered family folklore, whenever Graeme got indignant about anything, his wife would say: ‘Now, now Lord Graeme, get off your high horse!’

I was a young child when Ada came to our home. My memories are few and more like single snapshot visuals. Waiting in the foyer at Carmel House to take Ada with us on an outing, I remember my older two brothers being scolded for their noisy behaviour. Another memory is of Ada, sitting in the lounge room of our suburban family home, smoking cigarettes endlessly, her face not smiling, impassive and to me impenetrable.

Following Ada’s death in 1973, I went to Carmel House with my father and waited for him in the car. He returned with Ada’s small brown suitcase, it contained all her

171 Graeme, Personal Communication (27 July, 2008).
172 Ibid.
possessions. He placed it on the back seat and said ‘not much for a life, is it?’

**Conclusion**

Ada’s patient clinical notes show that the diagnostic category of puerperal insanity was still in use in the twentieth century. The family was often the site of problems for many mothers committed to the mental institution in the interwar years. For Ada, the isolation of nursing two babies in a rural town, and her illness, played its part in the marriage breakdown. In addition, there were many other factors that worked against her, including medicalised birth, risk of infection, the experimental procedures of ICT, abortion and sterilisation. The changes in her diagnoses illustrated the challenges psychiatry faced in understanding, classifying and treating mental disorders in twentieth century, Victoria. The broader social circumstances of the economic depression, the conditions and expectations of the good wife and mother, combined as dynamic features that led to Ada’s committal as insane in 1936. Her delusions of grandeur and voices persisted over a long period of time, but did not interfere with her strong work ethic, her participation in the Donnan’s family life and her reconnection with her family.

The personal family history approach, in this chapter, is a unique contribution to patient and institutional histories. Oral history interviews provide unrivalled access to the informant’s lived experience that would otherwise remain hidden. Sally’s oral testimony added depth and quality to the research, yet memories recalled from childhood, as oral historians acknowledge are partial and risk distortion and omission. Memory

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and the process of remembering shape Sally’s narratives from her childhood. The unusual location of the mental institution offers rare insights into what it was like growing up amongst the insane. Sally’s recollections remind us that staff and their families were provided housing within the institutional grounds and utilising patient labour for the efficient running of those households was a common practice. It is this mental institutional space and Ada’s patient labour that helped shape Sally’s early childhood memories of family life at Mayday Hills, Beechworth.

This chapter also opens the silences held within the family itself. I shared the details of Ada’s files with a few relatives, curious about the nature of her diagnosis, the treatments and the eye opening abortion and sterilisation not known to the family before. In the spirit of sharing, reciprocity and trying to match memories with Ada’s patient files, the family has pieced together, what was once disparate, fragmented and scant memories of their mother and grandmother. Bringing together Graeme, Sally and myself, however briefly, allowed us to share very different experiences of Ada, creating a common bond, and a sense of joint heritage and roots. It was like being with long lost family, or lost parts of ourselves.

The next chapter uses the emergent themes from this chapter on Ada’s life as the framework for investigating the further women’s files. It draws on all thirty-one mother’s patient clinical notes, gathered from across the time period of 1920–1934. All of these women were committed with birth-related insanity, defined in the Annual Reports as pregnancy, parturition and the puerperal state, as causes of insanity. The key areas

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addressed in the following chapter include: employment prior to committal, marriage, family and the unmarried, the role of husbands and relatives’ testimony in committal, mothers’ refusal to speak, threat and fear of violence and patient religious expression. The policing of mothers’ behaviour through institutional committals, the institution of marriage and the power of husbands is examined. The discussion is set within cultural and medical anxieties concerning maternal mortality, infant health and the domestic science discourses that reflected the drive to modernise motherhood.
**Chapter Five: Insane mothers in modernity 1920–40s**

**Introduction**

The changing role of women within the family over time has been of particular interest to feminists. The meanings of motherhood in Victoria in the early twentieth century concerned women’s capacity for reproduction with a focus on populating white Australia.¹ Specific domestic training for mothers focused on ideas that it was their civic duty to raise future generations of citizens.² Mothers were increasingly subject to state authorities and experts in modern scientific standards of domestic cleanliness and family management in order to become exemplars in scientific housewifery and modern mothercraft.³ Advice books and manuals on mothercraft and child-rearing practices proliferated.⁴ The state-led infant welfare movement grew out of notions that mothers lacked the necessary skills of parenting, and were in need of education and training in the care of their children.⁵ These ‘respectable’ mothering practices in the interwar period set up stereotypes of the ideal mother, constrained to reproduce within marriage and responsible for both the physical and social well-being of her children and family. The move to modernise motherhood reflected the rise of education in domestic science and scientific mothering that effectively policed mothers’ behaviour. The wage structure consolidated women’s economic dependence on their husbands and firmly tied mothers to the home and their families.⁶ By the First World War, mothers and their pregnancies were increasingly under a regime of surveillance by doctors through increased

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medicalised birth and the emergence of antenatal care.\textsuperscript{7} Despite women’s social advances in Australia such as achieving the Federal vote (1902) and maternity allowance (1912), nineteenth-century sexist attitudes towards mothers still prevailed in the interwar period, 1920 to 1936.

Gendered power socially constructed ‘good’ and ‘bad’ mothers. Women were considered ‘bad’ or ‘unfit’ mothers when they diverged from, or challenged gender norms. When suspected of being bad mothers, these women risked being cast insane and committed to the mental institutions. Scholars have suggested that puerperal insanity had been dropped from usage in Britain and America by the twentieth century. As Ada’s patient notes indicate, mothers in Victoria continued to be subject to nineteenth-century asylum practices, confined with puerperal insanity and birth-related insanity well into the twentieth century. In fact, the terms ‘pregnancy, parturation and the puerperal state’ were used by the Victorian psychiatric profession from 1905 to 1950 in the yearly reports to parliament.\textsuperscript{8} It wasn’t until Eric Cunningham Dax, Director of the newly formed Mental Hygiene Authority, that psychiatric terms were updated in his first annual report in 1951. ‘Pregnancy, parturation and the puerperal state’ were dropped. The term ‘insanity’ disappeared too, and schizophrenia appeared for the first time.\textsuperscript{9}

This chapter is an in depth examination of the patient clinical files of the thirty-one mothers committed with maternal insanity. The previous chapter, on Ada’s

\textsuperscript{7} Featherstone, 'Surveying the Mother' (2004).
\textsuperscript{8} \textit{Reports of the Inspector-General of the Insane, 1905-1933}. \textit{Reports of the Director of Mental Hygiene, 1934-1936. Reports of the Director of Mental Hygiene 1937-1950}.
institutionalisation, established that puerperal insanity continued to be used as a diagnosis to commit mothers in the early twentieth century. It also examined her treatments, her delusions and transfers to various institutions in Victoria. This chapter studies the same themes in the examination of the patient histories of females committed to the same institution with maternal insanity in the same interwar period as Ada. This chapter illustrates that psychiatry continued to link female insanity with women’s reproductive processes, as it had done in the past.

The historical developments of the new nation, in which the mothers’ files were created are inextricably linked to the ways mothers’ mental instability was observed, and described. Doctors and experts were influential in the shaping of ideas about race, population, degeneration and whiteness, and represented themselves as experts in white citizenship and national destiny. In this way, medical power extended beyond the scientific, and into the social sphere. This legitimised medicine as the authority over women’s bodies and their reproduction, central to the construction of femininity and maternity. Puerperal insanity as a diagnosis exemplifies gendered bias in psychiatry, in the committal of ‘bad’ and ‘unfit’ mothers into the institutions.

First, this chapter outlines the lack of uniformity in the various terms psychiatrists used to describe insanity in the postpartum period. Then, it will make an in-depth examination of each patient’s file, grouped into emergent themes: prior employment, unmarried mothers, the role of husbands’ and relatives’ testimony in committal, mothers’ refusal to speak,

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destructive, dangerous, violent and suicidal actions, threats and fears and patient religious expression. These themes are set within the context of mothering in interwar years, following the massive loss of life in WWI, and the effects of the Great Depression. The examination of these emergent themes indicates that the nineteenth-century ideas of female insanity as innate to women’s reproductive bodies persisted in undermining mothering well into the new century. In the next section, the gendered psychiatric language concerning insane mothers is examined in depth.

**Insane mothers in twentieth-century Victoria**

In this section, the emergent themes are examined through a deep reading of the women’s patient clinical notes. It investigates the varied psychiatric and lay language used to define these women as insane ‘unfit’ mothers. It also takes on a patient-centred approach which sees puerperal insanity as the expression of despair over the constraints of motherhood and women’s role within the family. These approaches reveal puerperal insanity reflected families’ and psychiatry’s need to institutionalise perceived unstable mothers. In this way, psychiatric power and the power of husbands and families conspired to commit ‘bad and unfit mothers’ when they could no longer cope at home.

An overview of the patient data helps to paint a picture of the whole group of maternally insane patients examined in this chapter. All the women were admitted to Royal Park Receiving House as involuntary patients. Their admission warrants each included the legally required two medical certificates from qualified practitioners that agreed on insanity as the diagnosis. Part of these official documents included the private request
from any friend, relative or acquaintance for admission. Their ages ranged from the youngest at twenty through to forty-four years. The majority of mothers were in their twenties and married, while five were unmarried mothers. Their length of stay ranged from five weeks to fifty-one years. Eleven mothers entered the institution after their first baby. One expectant mother was diagnosed with insanity of pregnancy, another two mothers entered the institution after experiencing miscarriages. No patients were identified by their race, ethnicity or skin colour. In this way, it could be presumed that these mothers were of white, ‘Anglo’ descent, as it was not otherwise stated. Twenty-eight women were born in Australia, with the majority having resided in Melbourne suburbs. Three were born overseas, in both Scotland and England. All identified as Christian from various denominations, the largest group belonged to the Church of England. Ten of the women died in the institution.

Generally, women also were committed as insane for other reasons such as: melancholia, confusional insanity, and insanity of epilepsy, for example. In many cases available in the archive a diagnosis was not given and the ‘cause of attack’ listed a range of life events. These included financial loss, love affair, loss of sons to the war, husband killed in war, anxiety over buying property, jealousy, diabetes, domestic worries, overwork, climacteric (menopause), menstruation, death of child, alcohol, death of husband, husband’s ill health and love disappointments. These descriptions indicate how the common language used by medical professionals incorporated the personal experiences of patients into the diagnostic language of symptoms. However, James Moran argues that these

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13 Admission Warrants, Male and Female Patients: VPRS 7680 (Public Record Office Victoria).
descriptions are indicators of insanity rather than actual symptoms, sourced from lay
observations recorded by the psychiatrists.\textsuperscript{16} Whether symptoms or indicators of insanity,
the devastating effects of World War I and the Great depression are evident in the
experiences of these female patients. Personal accounts of suffering were recorded in
everyday language in their patient clinical notes. Within the patient files the lay language
of family members, the patient’s own voice combined with clinical observations were
recorded.

The exploration of colonial patient records indicate that the family members’
understandings of mental disorders and their language used to describe changed
behaviour of sufferers were integrated by medical professionals into the clinical patient
records.\textsuperscript{17} Therefore, that both laypersons and medical professionals played a major role
in the total experience of sickness, particularly in the act of diagnosis, had huge
ramifications for all concerned. ‘Once articulated and accepted, disease entities become
‘actors’ in a complex network of social negotiations.’\textsuperscript{18} In particular, puerperal insanity in
the nineteenth century was a phenomenon of complaints from both patients and their
friends and families that were incorporated into clinical observations to ascertain the
symptoms and diagnosis of puerperal insanity.\textsuperscript{19} Furthermore, Marland argues, in her
extensive work on puerperal insanity in nineteenth century Britain, that case notes were
mediated accounts ‘largely reliant on details given by those closest to the patient –

\begin{itemize}
\item[\textsuperscript{16}] James E. Moran, ‘The Signal and the Noise: The Historical Epidemiology of Insanity in Ante-Bellum
\item[\textsuperscript{17}] Coleborne, \textit{Madness in the Family} (2010).
\item[\textsuperscript{18}] Charles Rosenberg and Janet Golden, \textit{Framing Disease: Studies in Cultural History} (New Brunswick and
\item[\textsuperscript{19}] Nancy Theriot, ‘Women’s Voices in Nineteenth-Century Medical Discourse: A Step toward
\end{itemize}
Maternal Insanity in Victoria, Australia

Chapter 5: Insane mothers in modernity

family, friends and neighbours. This practice continued into the twentieth century.

The various testimonies in the files of this present study, reveal a complex set of social negotiations. Perceived unmotherly behaviour was linked to insanity by patients’ husbands, relatives, and in some cases the women themselves and mediated through the psychiatrists. Women were seen to fail the assumed ‘naturalness’ of motherhood and transgress the ideal of the ‘good mother’, necessitating their removal from their families and children.

The use of a variety of terms reveal little uniformity or consensus among psychiatrists. Six of the thirty-one cases used the full term ‘puerperal insanity.’ Various other terms were used to indicate problems following childbirth: thirteen cases listed as ‘childbirth’, five cases listed as ‘puerperal’, three cases listed as ‘puerperium’, one case listed as ‘confinement’ and one case listed as ‘parturition’. This variation in language indicated physicians were not unified in the use of terms concerning mental illness thought to be related to childbirth. This meant that doctors’ views about women and mental health continued to link childbirth with instability and disease within the individual woman.

The practice in dividing puerperal insanity into either mania or melancholia continued to be applied to the insane mothers in this present study. In the nineteenth century, physicians generally agreed that: ‘the one attended with great excitement and furious delirium, the other characterised by the features of low melancholy’. Past physicians

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found that mania was the most common symptom in puerperal insanity. Of the six cases where the full term ‘puerperal insanity’ was used (Ada, Olive, Janice, Frances, Jennifer and Suzanne) two describe manic symptoms, two describe depressed or melancholic symptoms and two were left unstated. The puerperal insanity patients with manic symptoms were Ada and Janice. Ada’s files stated: ‘The patient is cheerful and talkative, her answers to questions are quite irrelevant and she smiles cheerfully for most of the time.’ In Janice’s case: ‘Since birth of child patient has been very excitable.’ The two patients with depressed or melancholic presentations are Suzanne and Frances. Suzanne’s files stated: ‘She has a depressed affect, is mildly resistive, and speaks with apparent reluctance and in low tone.’ In Frances’s case: ‘she is melancholic.’ For the two remaining puerperal insanity patients, Olive and Jennifer, it remains unclear whether manic or melancholic symptoms were present. In Olive’s files, the psychiatrist recorded: ‘Refuses to answer questions,’ and the doctor observes: ‘confused, fearful, aimless movements, faulty habits.’ In Jennifer’s case: ‘Patient had a breakdown following the birth of her first child & was very seriously ill for a long period. She again broke down with the birth of her second child.’ These six cases reveal a wide range of behaviour and symptoms used to diagnose puerperal insanity.

Other files use the term ‘puerperal’ in various ways, such as in Joanne’s and Edith’s cases. Joanne was committed in 1920 diagnosed with mania puerperal when her second child was twenty-one months old. Joanne’s file stated: ‘disoriented, talks incessantly,
incoherent, flight of ideas, noisy, restless. Edith was committed in 1931, aged twenty, when her first baby was eleven days old, her files stated: ‘Patient on admission is excitable, apprehensive and emotional.’ No diagnosis is provided and the cause of attack is listed as *puerperal* & *adolescence*.

Some files provided a different diagnosis, others avoided assigning a diagnosis altogether but described melancholic symptoms, caused by a childbirth event. Iris was committed after the birth of her third baby in 1932, her files stated: ‘Depressed, sits idle all day in chair. Will not do anything for herself.’ No diagnosis was provided in Iris’s files but the cause of insanity listed as *puerperal*. Freda was examined after the birth of her second child in 1924, her files stated; ‘dazed look, cannot or will not answer questions.’ The diagnosis assigned to Freda was ‘recent melancholia’ with the cause of insanity assigned to ‘puerperal’. Rachel was examined after the birth of her third child in 1931 and the psychiatrist recorded: ‘Depressed. Worried. People talk about her. Threatened to injure herself with a bread knife. Unable to concentrate.’ Rachel was given the diagnosis of ‘acute melancholia’ with the cause of insanity as ‘puerperal and heredity’.

The range of terms used to describe insanity related to maternity and childbirth indicate little consensus within the one institution over this period of mothers’ committals. This usage, however varied, continued long after postpartum insanity was omitted as a separate and distinct category in Europe, by Kraepelin’s re-classification compendium in 1899. This continued usage illustrated that psychiatrists in Victoria, continued to use

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27 Joanne Mont Park Clinical Patient Notes, DHS, AS/1994/00104/0021
28 Edith Kew Mental Hospital Patient Clinical Notes, PRO-V, VPRS: 7693/P1/45
29 Freda Royal Park Patient Clinical Notes, DHS, AS/1997/93/085.
30 Rachel Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0048
nineteenth-century diagnostic terms that connected women’s reproductive processes as the cause of illness, disease and insanity, as having relevance to their twentieth-century clinical observations.

**Emergent themes**

The thirty-one women in this study were committed in the interwar period of 1920 to 1936, it is therefore important to situate the impact World War I had upon women in Australia who remained behind at the home front. When Britain entered World War I against Germany in 1914, Australia enthusiastically committed troops to the cause. The ideology at that time was that the motherland was under threat and required Australia to assist and lend support. The impending war was seen by some as an opportunity to break from the oppression of modernity, a war that offered renewal, revitalised nationalism with a discourse of heroism and victory. However what actually occurred was a seminal event in terms of alienation and nihilism with the massive loss of life and horror of the trenches. The collapse of civilisation was implied; it changed the course of history and set the scene for the changes to the rest of the twentieth century. The surrounding issues of a post-war society also set the scene for women’s mental illness and distress, as well as the psychiatric profession’s development and medical progress.

The impact of the war is relevant to the Melbourne women described in the following section. Some women experienced the loss of their sons and husbands and grieved, while others joined the paid work force in increasing numbers. At the same time some could participate in the cultural shift for women that bought wider expression of feminine identities and visibility that modernity offered them. The themes which emerge from a deep reading of the files include: women’s prior employment, unmarried mothers, the
role of husbands’ and relatives’ testimonies in committal, refused to speak, threat and fear of violence and patient religious expression.

**Women’s employment**

In Britain during WWI women’s employment increased dramatically in munitions production and maintaining essential services. However, Australia’s commitment to war supply production was small and did not mobilise women into the workforce.\(^{31}\) Prior to WWI women’s employment in Australia had steadily increased in domestic service, industrial, factory and office work.\(^{32}\) Women took up paid labour, to provide for their own economic independence, or as a necessity in supplementing the family income, and in many cases as the sole breadwinner to support their families.\(^{33}\) In this study, eight female patients’ files indicated that the women were in paid employment prior to entering the institution. The remaining twenty-three recorded either ‘home duties’ or ‘housewife’. In the broader society, the majority of women ended employment once they wed. Married mothers who continued employment were condemned for neglecting their children. This rhetoric soon changed in WWII when married women were employed to meet the labor shortages in munitions factories and essential services.\(^{34}\)

Olive and Suzanne listed domestic service as their occupation, and both were unmarried mothers.\(^{35}\) Domestic service was seen to provide ideal training for their future roles as

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\(^{33}\) Kay Daniels and Mary Murnane, *Uphill All the Way* (Brisbane, University of Queensland, 1980), pp. 161-163.


wives and mothers and in fact the best servants made the best wives.\textsuperscript{36} Domestic servants were employed by private families, boarding houses and hotels, and, in large upper-class homes, many servants were hired. By the beginning of WW1 households often employed only one servant to attend to all the household chores of cooking, cleaning, laundry and child-care.\textsuperscript{37} The status of the domestic servant as an occupation was declining by the 1920s especially for those working in private homes. Private domestic work conditions involved loneliness, monotonous long hours, often ‘living in’ at the household, and was subject to the specific requirements of the mistress or lady. One of the most arduous chores was that of tending the wood fires for cooking in the hot Australian climate, until the gas stove became affordable.\textsuperscript{38} The well organised domestic work in hospitals and commercial establishments was preferred to private service as workers could return to their homes at the end of their shifts.\textsuperscript{39} Whereas servants in private households were aligned to slavery in some cases, subject to employer-employee relations set out by the wife in charge.\textsuperscript{40} Olive and Suzanne both worked as domestic servants and became unmarried mothers.\textsuperscript{41}

Another unwed mother, Hazel, listed her occupation as ‘twine worker.’\textsuperscript{42} Following WWI, manufacturing expanded, and in Victorian factories women’s numbers outweighed those of men.\textsuperscript{43} Factory work became increasingly more appealing for young women, rather than domestic service, due to the shorter hours which allowed evenings and

\textsuperscript{36} Kingston, \textit{My Wife, My Daughter} (1975), p. 49.
\textsuperscript{37} Ibid.
\textsuperscript{38} Ibid. p. 36.
\textsuperscript{39} Ibid. p. 54.
\textsuperscript{40} Ibid. p.54
\textsuperscript{42} \textit{Hazel Kew Patient Clinical Notes, PRO-V, VPRS: 7693/P1/29}
weekends free, a freedom not experienced by domestic servants or housewives. Hazel worked in a rope and twine factory, which was an industry that employed forty percent of women in Victoria. Hazel entered the mental institution at age twenty-seven in 1922 with pregnancy listed as the cause of her insanity.

Of the eight mothers who listed employment in their files four (Ada, Sandra, Catherine and Frances) worked in clerical positions, and one had worked as a nurse (Helen). The influx of women into office work is well described in Ada’s chapter. Women employed in office work had steadily increased before the war, then in the 1920s new areas of clerical work opened to women including banking, insurance and the public service. Sandra, aged twenty-six in 1922, listed her occupation as clerk and typist. Her mother said: ‘she is a bright and intelligent girl employed as lady clerk at a large shoe shop.’ Catherine’s occupation was listed as ‘home duties’ and she tells the doctor she ‘was a typist before marriage.’ Frances spoke openly about several aspects of her life and her files entry declared: ‘she stole some money – not a large amount – at about age twenty; was a bookkeeper and falsified the books. She insists this was deliberate, not accidental.’ Frances was aged thirty-one, committed in 1927, and while her occupation was listed as ‘home duties’, her confession of stealing money was recalled from ten years before. Last is Helen, a married woman with ‘home duties’ as her occupation, however, Helen tells her doctor she ‘had been a nurse at Beechworth.’

44 Kingston, My Wife, My Daughter (1975), p.58
46 Hazel Kew Patient Clinical Notes, PRO-V, VPRS: 7693/P1/29.
48 Sandra Kew Patient Clinical Notes, PRO-V, VPRS: 7676/R1/260
49 Catharine Sunbury Patient Clinical Notes, PRO-V, VPRS: 8245/P1/4
51 Helen Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0007
Generally, many women worked until they were married, others continued to work as married women out of necessity. Interest in domestic service declined, creating a shortage of domestic servants, as women found the set hours and free weekends in factory, retail and office work far more desirable.\textsuperscript{52} Employed unmarried and married women were seen as a threat to men’s waged labour, particularly during the depression.\textsuperscript{53} Fears concerning low birth rates and high infant deaths held working mothers responsible for a host of society’s ills including: contraception, neglect of home, children and husbands, abandonment of breastfeeding and the farming out of babies.\textsuperscript{54} Working mothers in paid employment challenged the entrenched tradition that women’s place was in the home. Unmarried mothers, were considered particularly abhorrent and caste as the bad mothers.

**Unmarried Mothers**

The dominant ideology for women contained their sexuality and reproduction within the institution of marriage: the ‘good mother’ was the married mother. Once unmarried women became pregnant their sexuality was seen as abnormal and stigmatised by their perceived lack of respectability and morality. The stigma was reinforced by the language used, as ‘illegitimate’ had negative connotations.\textsuperscript{55} Single, unmarried motherhood met with strong disapproval by both the church and the state. Unmarried mothers tried to avoid the shame and stigma by concealing their pregnancy within Melbourne institutions, maternity homes or living with distant relatives to await the birth.\textsuperscript{56} Four unmarried mothers entered the mental institution: Hazel, Olive, Suzanne and Sandra.

\textsuperscript{54} Grimshaw, Swain, and Warne, ‘Constructing the Working Mother’ (2005), p. 23.
\textsuperscript{56} Ibid. pp. 60-90.
Hazel, aged twenty-seven, was employed as a twine factory when she entered the institution in 1922, seven months pregnant. Hazel’s mother provided her testimony, recorded by the doctor:

Is restless at night and says she has been worrying about her pregnant condition. Tried to keep it from her mother as she feared she would be turned out. Is afraid of people who know of her condition.57

By July, 1922, Hazel was transferred to Kew Asylum and in the same month gave birth when on trial leave with her mother. No information concerning the nature of the birth, or the health and sex of the baby was recorded in Hazel’s files. Two months later Hazel returned to the institution, and within four months the doctor noted Hazel was improving and had insight into her condition. Hazel left on trial leave with her mother and was discharged by July 1923, thirteen months after her original committal.

Olive was a twenty-year-old unmarried mother who had worked as a domestic servant. Her baby was five days old when Olive was committed with puerperal insanity to the mental institution in January, 1921.58 Olive’s mother provided her testimony and stated Olive’s father was serving time in prison for carnal knowledge against his daughter. It is likely Olive’s baby was the result of her father’s incest. Rape, carnal knowledge and incest were major areas of male criminality, not always policed and generally under-reported, which resulted in low conviction rates.59 Incest in particular, remained hidden, when few women were willing to risk exposing sexual offences that occurred within the

57 Hazel Kew Patient Clinical Notes, PRO-V, VPRS: 7693/P1/29.
58 Olive Yarra Bend Patient Clinical Notes, PRO-V, VPRS: 7417/P1/14.
family.\textsuperscript{60} In Olive’s case, her pregnancy would have attracted notice and exposed the father, especially when her pregnancy could not be attributed elsewhere.\textsuperscript{61}

Olive’s mother further added: ‘Since 16 years she has been sexually “forward”! Frequent escapades with men with no further predilection for any of them.’\textsuperscript{62} Premarital sexual activity or promiscuity indicated sexual knowledge, and was found to be particularly abhorrent in an era that valued virginity, morality and the sanctity of sex within marriage.\textsuperscript{63} Olive’s mother could be seen to be blaming her daughter’s sexual activity for her husband’s prosecution, and continued to state: ‘Olive was sent to Riddell Home and escaped at age sixteen.’ The Riddell Creek Girls Home was a residential and reformatory institution for girls run by the Salvation Army, situated approximately seventy kilometers north-west of Melbourne. Originally reformatories were intended to separate children with criminal convictions from adult prison populations. In Australia reformatories were also for children deemed in need of strong discipline.\textsuperscript{64}

Olive’s mother played a complex role, and it is not known how much she was integral to her husband’s prosecution. In court, rape cases scrutinised the sexual history of victims. It was seen as a young woman’s responsibility to protect herself by not arousing or encouraging, what was accepted as men’s uncontrollable sexuality.\textsuperscript{65} It appeared that

\textsuperscript{62} \textit{Olive Yarra Bend Patient Clinical Notes}, PRO-V, VPRS: 7417/P1/14.
Olive’s mother was willing to place blame on her daughter, by providing Olive’s history, while her husband’s history of behaviour was not accounted for.

Within one month of her committal, Olive was transferred from the Receiving House to Yarra Bend hospital for the insane. It was there that Olive was assessed as suffering puerperal insanity. Olive died six months later, no autopsy file was included and the cause of her death remains unclear. Olive had a terrible life apparently having suffered at the hands of an incestuous father, and having being committed to two institutions: the reformatory girls’ home and later the mental institution.

Suzanne, aged twenty-three, worked as a domestic servant, and was committed to the mental institution with puerperal insanity in 1929 after birthing an illegitimate baby six weeks before. The psychiatrist noted: ‘she has a depressed affect, is mildly resistive, speaks with apparent reluctance and in low tone.’ 66 Suzanne managed to cultivate some family support from her brother and his wife. The doctor’s notes stated: ‘patient is very well and about 2 weeks ago wrote a letter to her sister-in-law and has since conversed quite rationally, when previously was mute.’ 67 This observation was noted in December 1930, and then four days later Suzanne left the institution for trial leave. It is not noted where Suzanne went for trial leave, but considering the previous correspondence, it is likely Suzanne was able to stay with her brother and his wife. As a single woman with domestic service experience, Suzanne may have become a female companion for her sister-in-law, assisting with the household chores, cooking and taking care of any children in the family, and possibly her own baby.

67 Ibid.
Sandra, aged twenty-six, worked as a clerk in a shoe shop, birthed an ‘illegitimate’ child in the Receiving House in 1922. Her mother explains Sandra’s situation:

The patient may have been married to a G. Thompson but says a solicitor annulled the marriage which apparently took place a few weeks before the birth of the child who was not the offspring of Thompson.68

The annulment of Sandra’s marriage would have come as a huge shock. To birth out of wedlock would have created much stress and anxiety for Sandra. There was no welfare support for unmarried mothers during this period which meant Sandra faced an unknown future. For many women, a prenuptial pregnancy could lead directly to marriage, but in Sandra’s case concerns over paternity gave cause to annul the marriage, and left Sandra to give birth as an unmarried mother. Potential fathers like Mr. Thompson rarely incurred legal responsibility or censure, and many had the financial resources to start their life again elsewhere.

Sandra’s records show she had been committed to the mental institution five years before in 1917, when she was twenty-one. The doctor recorded Sandra’s concerns:

Says mother and father are plotting to ruin her life by stopping her marriage for some time. Says her family persecute her, follow her about and interfere with her at her place of occupation.69

The doctor recorded Sandra’s mother’s testimony:

She has been visiting friends’ houses in the small hours, and accuses her [Sandra’s mother] of persecuting her. She left home and wanders about at night visiting friends before daylight.70

The doctor released Sandra after a three week stay:

She is very plausible and behaves well and conducts herself normally. She persists in the statements as to the cruelty and persecution of her parents and says they

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68 Sandra Kew Patient Clinical Notes, PRO-V, VPRS: 7676/R1/260.
69 Sandra Royal Park Patient Clinical Notes, DHS, AS/1997/093/24
70 Ibid.
come to her business any time and make charges about her, which seem true to fact.71

The conflict with her parents indicated the struggle for Sandra to assert her independence and make her own decisions. In Sandra’s later committal, after giving birth as an unwed mother:

Mother asserts mental breakdown at 21 had 2 causes: A death of a fine friend who was about to be married. The patient at the time was preparing to be her bridesmaid. The patient’s own lover went to the front and married another girl in England.72

This was a major life crisis for Sandra who suffered grief for the loss of her friend and lost the opportunity to marry. Sandra made no reference to her lover going to war, but did state her parents had stopped the marriage. The knowledge of this previous committal may have affected Mr Thompson’s decision to annul their marriage in 1922, rather than risk a future with a wife who had been previously committed as insane. The issue of the paternity of Sandra’s baby suggests premarital sex was acceptable to Mr Thompson, as long as he was the only one. His attitude and behavior represents men’s control over womens’ bodies, and their unborn children, as their exclusive property that ensured paternity. No note of her baby’s welfare was recorded, and having lost the opportunity to marry twice, Sandra remained in mental institutions for the rest of her life until her death in 1974 aged in her late seventies.

Olive’s, Hazel’s and Sandra’s mothers each provided testimony in their daughter’s committals. They may have decided committal to the institution was in their daughter’s best interests when alternative options were extremely limited. It would have been

71 Ibid.
72 Sandra Kew Patient Clinical Notes, PRO-V, VPRS: 7676/R1/260.
difficult for these four unwed mothers to continue their employment after giving birth, unless family members were willing to take care of the child. Without a breadwinner or welfare for financial support, it was highly likely these unmarried mothers were forced to relinquish their children for adoption. Separation from their children served as a punishment for their transgression and survival depended on their silence. Forced adoption was a hidden, and yet a common practice that ensured unmarried mother’s invisibility, and deepened their shame. Relinquishing mothers were expected to surrender, in many cases were forced, to give up their ‘illegitimate’ children to married mothers, who were seen to be more deserving of children.

Alternatively, it is likely some children were taken in informally by their mothers’ own families, as had occurred with Graeme, Ada’s youngest son, who was raised by his grandmother following his mother’s committal. In Suzanne’s case her sister-in-law may have taken the child into her care, whereas both Hazel’s and Olive’s babies may have been taken into both their mothers’ care. However, the mothers’ patient files are silent on their children’s welfare. Therefore, it is impossible to estimate how many families took care of the children or how many were adopted or placed in orphanages, while their mothers were in mental institutions.

By 1921, the number of single women reached a peak in Victoria, the proportion rose from 7 per cent in 1891 to 21 per cent in 1921, and then began to steadily decrease. Prospects for marriage were diminished by the First World War’s severe death toll, and

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among the soldiers who did return some were considered unsuitable for marriage due to injuries, and the trauma of shell shock. At the same time, the discourses of freedom and independence for the modern girl, competed with expectations of marriage and motherhood. These social changes shaped and influenced the low status of unmarried mothers. Their very status as unmarried was the key factor in their institutionalisation. Given their diverse circumstances, their unmarried status was the only point of commonality among them. What these women’s stories do illustrate is men’s sexual behaviour. In many ways men could avoid responsibility for their biological offspring, and in Olive’s case, some men felt they had a right of access to sleep with their own daughters and the daughters of others. For Hazel, Olive, Suzanne and Sandra unmarried motherhood was not of their choice. The unmarried mother was the antithesis of the true housewife, silenced, hidden and shut away into the mental institution.

**Husbands’ and relatives’ testimonies in women’s committals**

Families had always played a key role in identifying madness in the nineteenth century. The testimony of husbands was highly prominent in committal certificates, as they had been in nineteenth-century women’s cases. There were no new diagnostic tools in the twentieth century for psychiatrists to assess their patients for insanity. They relied on their own observations of patients’ behaviour and the testimony of others close to the patient. Husbands were often the first to notice their wives’ behaviour, and it is their testimony that was pronounced in the patient clinical notes. Husbands remained central in the decision to commit their wives. It is worth

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noting that the husband’s role in committal started before the institution’s psychiatric assessment, often featuring in the two GP committal certificates, completed and submitted prior to the psychiatrist first notes and assessment quoted in this section. Nancy Tomes argued that it was relatives that determined insanity, rather than doctors. Family assessment was usually based on the family’s limited financial and emotional resources when they were no longer able to cope at home with the stresses caused by mental breakdown.77

Patient clinical notes reveal the lay language used by families. The emotional expressions of both families and patients in nineteenth-century patient casebooks has been well-documented.78 Similar expressions can be found in these twentieth-century files. They illustrate family’s responses, and husbands in particular, to their wives’ insanity. Catharine’s doctor noted: ‘Husband says she has torn up nearly all her clothes.’79 Janice’s husband said ‘she lies in my arms with her head on my shoulder, eyes closed and mouth clenched.’80 In Pauline’s case, her husband stated: ‘she is using very bad language which she never uses; is quite opposite to herself in this way.’81 Helen’s husband gives a little more detail, by providing family concerns other than giving birth: ‘husband states that wife was somewhat depressed during her pregnancy. She has had a lot of worry lately – mainly relatives’ illnesses & accidents.’82

79 Catharine Sunbury Patient Clinical Notes, PRO-V, VPRS: 8245/P1/4.
80 Janice Sunbury Patient Clinical Notes, PRO-V, VPRS: AS/8245/P1/15.
81 Pauline Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0010
82 Helen Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0007.
Husbands’ testimonies provide insights into domestic circumstances. Issues over household management and the standards of housework were sources of conflict and disagreement between husbands and wives. From Ada’s files her husband complained that she neglected her housework: ‘She never washes up the ordinary household dishes and neglects her housework.’ Ada’s husband expressed his authority and policed his wife’s housework by measuring it to his expected standards. Conflict over housework characterised as neglect or refusal to perform wifely duties were considered as a deficiency inherent in her personality. Husbands performed a social role for policing women’s behaviour. They regulated housework standards and the priorities of expenditure required for a wife, as a financial dependant, to maintain a home.

Worries over money proved too much for Dora, who had five children to care for. Committed in 1928, Dora’s doctor stated: ‘3 weeks ago at first began to worry about house linen going, no money to replace it. Gradually became worse.’ Inability to stretch the family budget for new linen for her family reflected the effects of poverty upon families during the Great Depression. Her husband stated: ‘depressed for no apparent reason for past fortnight. Neglects home duties. Walking aimlessly from room to room. Sleeps poorly.’ Dora’s husband failed to understand the level of his wife’s stress, and the difficulty to care for her family when lacking household essentials. At the request of her husband Dora was discharged a year later.

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85 Dora Chief Psychiatrist Index Card, AS/1993/292/0042.
The pressure for mothers to make ends meet through the depression years on extremely limited resources proved too much to bear for Rachel, committed in 1931. Her files stated: ‘husband unemployed for 17 months was on sustenance & occasional relief work.’ Unemployment in Victoria reached 26.8% in the September quarter, 1931 as a result of the world-wide economic depression. With three children to care for and her husband unemployed, Rachel was committed when her third child was three months old. The government sustenance scheme provided financial relief for individuals willing to work but unable to find employment. Payments were 8s 6d per week for man and wife with an additional 1s 6d per week for each additional child up to a maximum of 20s 6d per week. For Rachel’s family with three children this payment amounted to fourteen shillings per week. The third child may have been too much a financial burden the family could ill afford, contributing to Rachel’s stress and anxiety. Families on sustenance could receive groceries, meat, bread and milk for a four-week period. Stretching supplies over one month would have been problematic. Rachel’s family was not alone in this situation of high unemployment in 1931 as ‘there were 43,000 families in the metropolitan area and large provincial towns receiving sustenance and 5,000 families in the remaining districts of the State. The total number of persons receiving the benefit of sustenance on the date mentioned was approximately 170,000.’ The doctor recorded Rachel’s husband’s testimony:

22.11.31: She has taken out 7 different policies in her own name. She has insured the 3 children herself and her husband 3 times. Her husband disapproves of this.

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88 Ibid. p. 220.
89 12 pennies in one shilling and 20 shillings in one pound. Therefore 8s 6d, for the husband and wife, plus 3s 18d for their three children= 12 s 24d = 14 shillings in total.
90 Laughton, Victorian Year Book: 1930-31 (1932), p. 221.
91 Ibid.
and says all his savings had gone into insurance instead of into bank.92

In the depression era a wife’s frugality and resourcefulness was most highly valued, however Rachel’s insurance policy activities proved too much of an extravagance for a family on an extremely tight budget. As the country faced economic collapse Rachel hit a psychological low point. She and her children were financially dependent upon an unemployed husband within a failing economic system. Rachel spent fifteen months in the institution, the final entry by the psychiatrist illustrated she was well oriented and ready for release on trial leave:

Asking to go out on trial leave and stay with aunt in the country. Talks sensibly and has some insight – ‘her children have not visited her since she has been here, as she did not want them to know she is in a mental hospital.’ Has 3 children – one year between 1st and 2nd, eight years between 2nd and 3rd. States she became ill 7 weeks after the last baby was born.”93

Rachel’s insight into her illness, and the ability to recall the ages of her three children, qualified her to go on trial leave. It is important to note here that Rachel went on trial leave to her aunt’s home. It is not known whether she reconnected with her husband or her children and the fate of her family remains unknown.

In Catharine’s case, her file showed her husband’s Melbourne address was crossed out and replaced by his new Tasmanian address. After over a year in the institution Catharine was released on trial leave with her mother. It remains unclear whether Catharine rejoined her husband. Both Rachel’s and Catharine’s cases offer the possibility that husbands could relieve themselves of the burdens in supporting their families, could move away and start new lives elsewhere, leaving their wives with relatives.94

93 Ibid.
Divorce could be obtained on the grounds of lunacy if the patient had spent five years out six in a hospital for the insane and was considered unlikely to recover. The issue of divorce appeared in Ada’s and Vivien’s files. Ada stated: ‘she says he keeps taunting her about her mental illness. They are on the verge of divorce but husband wants to claim the children.’ Her husband’s taunts may have been intended to demoralise Ada, possibly to prompt her negative reactions and her return to the institution. There is no evidence to suggest they did divorce. However, spending the rest of her life in mental institutions achieved the same level of separation as divorce. Vivien entered the institution in 1925 when her first baby was fourteen days old. By 1933 her files simply recorded the word ‘divorced’. Vivien spent the rest of her life in various Victorian institutions, and died at Beechworth in 1970. A similar case reported the divorce granted to Mr Woolf on the evidence given by the superintendent of Yarra Bend Asylum that Mrs Woolf was hopelessly incurable and the (ex) husband given custody of their two children.

In summary, husbands tied their wives’ value to their domestic duties. Husbands lacked tolerance for their wives, unable to forgive their eccentricities, fatigue, inattentiveness, unhappiness, poverty and overall inability to cope, however temporary. Committal, however ill conceived, was a coping mechanism when financial and emotional resources were drained, and relieved husbands of their burden. Wives were responding to the day-to-day pressures and stresses in keeping house and caring for their children and husbands while recovering from childbirth and tending babies. However, it was a sign of the times

97 Vivien Mayday Hills (Beechworth) Patient Clinical Files, DHS, AS/1995/00055/0091
that husbands found the individual mother at fault, rather than the, often difficult, context within which she mothered. In the next section, many mothers refused shed light on their circumstances by refusing to speak to their doctors.

**Mothers’ refusal to speak**

Silence as discussed in this section was an integral part of madness, insanity and institutional practices. The fear, stigma and suspicion of the psychiatric hospital were used as warnings against irregular behaviour. Evident in Ada’s case, families silenced the fact that a relative or spouse was instituted into a psychiatric hospital. In other cases, families silenced the knowledge that their family members were victims of incest, rape or premarital pregnancy by placing them into the mental institution. This effectively protected the family’s reputation from the shame of perceived transgressions. Diana Gittins persuasively argues that ‘the whole institution, at least until 1960, was about silence. Madness itself was a silence and something to be silenced.’ The records in this study indicate fourteen women refused to speak when examined by the institution’s doctor.

Fear, trauma, disapproval, resistance, contempt and sheer exhaustion may have been some of the emotions and reasons in understanding why these women maintained their silence. Birthing can be traumatic and as post-birth women some were likely to be in a vulnerable physical and emotional state. Sleep deprived and overwhelmed from the hard work of their household demands, their muteness may have been due to exhaustion, depression, stress and anxiety. The fear of a negative evaluation by the doctor, sensitivity

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100 Ibid. p.49
to judgement and further punishment would lead some women to remain silent. For others, remaining mute was a self-preservation mechanism when all else was lost. Too terrified to speak and too scared that they would make things worse, women were exercising the last point of agency and control left to them. Veronica’s records stated: ‘will not converse or reply to questions’ after being committed to the mental institution following a miscarriage in 1921. Her records noted the diagnosis of ‘acute melancholia’, and stated ‘worry over miscarriage and attempted suicide’, Veronica may have felt too grief-stricken to speak.

In Freda’s case, it was recorded that she ‘has a dazed look. Cannot or will not answer questions’ and she ‘lies in silence, eyes closed, nods when spoken to but will not speak. Puts out tongue when asked to [speak].’ Freda’s silence gave the doctor very little to go on, especially when no other testimonials from her husband or others were provided. The diagnosis was recorded as ‘recent melancholia’ with the supposed cause of insanity given as ‘puerperal’ which related to Freda’s recent birth four months previously. The melancholia diagnosis may relate to Freda’s refusal to speak and could be read as a sign of depression. Even so, it was expected that patients give an account of themselves.

Rachel admits she had much to disclose, but initially refused to do so: ‘She is very resistive to questioning. Says there is a lot to tell but she could not tell me.’ Rachel was aged twenty-two, her notes stated: ‘says little’ followed by several entries that stated; ‘no change’. Six months later Rachel was transferred from the Receiving House to Mont Park

101 Veronica Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0049
102 Freda Royal Park Patient Clinical Notes, DHS, AS/1997/93/085.
Mental Hospital. Here, the doctor noted: ‘she is quiet and restrained in manner. Her expression does not vary. She admits she is depressed and wishes to do harm to herself. She was very resistive to questioning. Says there is a lot to tell but she could not tell me.’ Rachel admits she has a lot to say, but refuses to disclose the reality of her life. This kind of self-censorship preserved the private nature of her family life. Rachel’s silence kept both the family, and her own respectability, intact. Her refusal to speak reflected a lack of trust and rapport with the doctor and by controlling their exchange through resistance and silence, Rachel exercised a level of agency.

By March 1932, Rachel underwent a tonsillectomy, recovered well, had insight into her illness and left on trial leave with her husband. After three months, Rachel returned from trial leave ‘mute and in a stuporous state’. By January 1933, seven months later, Rachel remained mute yet ‘has promised to speak soon.’ The next month, the doctor recorded Rachel’s reasons for her silence:

Tells me she had to keep silent otherwise ‘they’ would have set the dogs on her. She has been afraid of these men setting the dogs on to her children. However, they won’t do it now as they are known.

The doctor did not pursue Rachel’s statement with any further questions. Her disclosures appear to have been taken as proof of her unstable mind and cast as ‘hallucinatory’ by her doctor. The possibility is that Rachel had reason to fear for the safety of her children.

Victims of abuse were silenced by their families and unlikely to talk to the doctor. The experience of trauma, the feeling of shame and guilt and the risk of being re-victimised found women resistant to talking about their experiences. Janice’s records noted she: ‘is resistant in all ways.’ Janice married two months before she gave birth and her mother
expressed concern of Janice’s ill-treatment by her husband.\textsuperscript{104} Catharine was a married woman committed as insane in 1923. Her case notes stated: ‘bruises on both hips, small bruises all over body and limbs.’\textsuperscript{105} It is difficult to ascertain exactly how Catharine received the bruises, but if she was the victim of domestic violence, her refusal to talk may have been out of fear of her abuser’s retaliation and further reprisals.

The victim of incest, Olive’s files noted: ‘patient is resistive, maintains silence with questioning and will not give an account of herself.’\textsuperscript{106} A father having sex with his daughter is one of the most transgressive of all sexual relationships.\textsuperscript{107} Olive’s silence reflected the horror of her circumstances, the shame of her father’s sexual abuse, the humiliation in birthing a baby to him and the stigma of birthing an ‘illegitimate’ child as an unmarried woman. Being placed into the institution by her mother, effectively shut up into the mental hospital and locked safely away from society was a powerful silencing strategy.\textsuperscript{108} While her father served gaol time for the offence, Olive was also penalised for her perceived transgressions, in being sent to the mental institution. This hid Olive from public scrutiny and silenced her as the victim of incest. For Olive, the process of giving birth could have triggered memories of her sexual abuse, and at risk of being re-traumatised, silence was preferable than reliving her abuse by talking to another man, the doctor.\textsuperscript{109}

\textsuperscript{104} Janice Sunbury Patient Clinical Notes, PRO-V, VPRS: AS/8245/P1/15.
\textsuperscript{105} Catharine Sunbury Patient Clinical Notes, PRO-V, VPRS: 8245/P1/4.
\textsuperscript{106} Olive Yarra Bend Patient Clinical Notes, PRO-V, VPRS: 7417/P1/14.
\textsuperscript{107} Featherstone, Let’s Talk About Sex: Histories of Sexuality in Australia from Federation to the Pill (2011), p. 44.
Some women did conform to what was expected of them by answering questions, others answered in the briefest way. The doctor noted that Sylvia ‘has a depressed aspect; looks down; speaks no more than ‘yes’ or ‘no’ – mostly only nods or shakes her head, or gives no sign.’\textsuperscript{110} If some women were not informed of the processes involved in committal by their husbands and families they may have been surprised to find themselves in the institution, and found themselves speechless and confused through shock and disbelief. The doctor observed Lucy: ‘she is confused and restless. She is unable to give an account of herself and keeps muttering, I can’t understand what is wrong. At times seems apprehensive.’\textsuperscript{111}

The nature of the patriarchal family created unequal power relations where the women’s subordination to the male head of the family was paramount. The economic dependence on their spouse for their provision and survival meant that women, while attending to unpaid domestic labour, submitted themselves in obedience to their husbands’ authority. Power lay in the hands of the husband who possessed the right; to paid employment, to speak for and control his wife’s production in the home, to ownership of her reproduction and sexuality within a monogamous marriage. All the wife’s energies went into producing children and maintaining the home, often work that was were largely unnoticed and unrewarded, to the point where her identity as an individual was subsumed into the demands of family life. The taken-for-granted nature of mother’s work, restricted her into a narrow field of experience, risked alienation from others and erosion of her personality. Bowing and constantly deferring to her husband’s authority, which could be at times powerful and overbearing, would diminish a wife’s confidence in speaking for

\textsuperscript{110} Sylvia Royal Park Patient Clinical Notes, DHS, AS/1997/093/68
\textsuperscript{111} Lucy Royal Park Hospital Patient Clinical Notes, DHS, AS/1997/093/050
herself. Such dependence on others for survival could result in no sense of self and no autonomy. Silenced by their husband’s power and silenced by their own fear in losing everything: children, home and livelihood, or even worse enduring retribution, these women felt they had no rights, and no right to speak. For women who suffered abuse from male family members, the nature of patriarchal control and the family as private business, any disclosure from the woman could be tantamount to betrayal or disbelief.

Despite the emergence of psychoanalysis and engagement in talking and listening with patients, few doctors adopted this kind of individualised treatment with their patients at this time in Victoria. This was due to the chronic understaffing, the sheer numbers of patients in their care, the labour-intensive nature of one-to-one treatments and the lack of training in psychology and psychoanalysis.\textsuperscript{112} Doctors considered silent patients as depressed or melancholic, or suicidal. Most doctors did not have the time or expertise to draw out unsociable and withdrawn patients. Those mothers who did speak freely risked incriminating themselves further. Some of the unique experiences of individual lives were lost through the silences in these records.

Given the dominance of men in the psychiatric profession at the time, would female patients develop greater trust and rapport with female doctors? Would mothers share the intimate details about giving birth and the state of their marriage with another woman? Yet there were so few women trained in medicine and psychiatry in the interwar period.\textsuperscript{113} The lack of patients’ own voices in so many of these records, whether through

poor record keeping, or being silenced by their mental condition, class, limitations to communicate through fear and shame, only few could speak through their records and offer some explanation for their predicaments.

**Destructive, dangerous, violent and suicidal actions, threats and fears**

A range of destructive, dangerous, violent and suicidal behaviour is discussed in this section. It includes mothers’ violent acts against others and themselves. It also reports threats and fear of violence perpetrated against them. The violent and destructive behaviours of mothers were strong indicators of insanity and possibly the final straw for families, hastening entry into the institution. Mothers’ violent behaviour was a strong societal taboo. It transgressed society’s expectations of the ideal mother, as it had in the nineteenth century. When the birth of a child was perceived as the ultimate fulfilment of women’s happiness, anything that fell short led all concerned including the mother herself, to question her maternal abilities and her sanity. There was very little space for mothers to voice their disappointments, ambivalence or anger towards their children or the circumstances of their mothering. It was not until 1977 that Adrienne Rich’s landmark book *Of Woman Born* acknowledged that a mother’s anger towards her children could sit side by side with her intense love for them. However, verbal expressions of anger, that Rich gave relief to, are very different to threats and acts of violence perpetrated against family members described in the following section. Drawing from Ada’s files, destructive behaviour and violence was described in her 1940 re-committal, but not in her original committal in 1936. Ada’s doctor recorded her husband’s allegations in 1940:

> That for the last four months there has been an alteration in her usual habits. That she has thrashed her children unnecessarily and that she has burnt some of the

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furniture and all his clothes.\textsuperscript{115}

These remarks indicated a dramatic change uncharacteristic of her usual demeanour. Ada’s destructive behaviour and anger occurred after a long trial leave period at home and prompted her re-committal. Upon her re-entry to the institution, a question mark was entered into Ada’s patient notes as to whether she was considered dangerous or not.

Five other women were considered dangerous, with a further two listed as possibly dangerous when committed. However, others developed violent behaviour after their committal. For example, Pauline was not considered dangerous when first committed in January 1928. Three months later her doctor noted: ‘is still in padded cells at intervals owing to her outbursts and violence during which she attacks anybody.’\textsuperscript{116} Similarly, Phillipa was not considered dangerous at first, then her notes indicated she developed violent behaviour later in her stay, having attacked several patients and ‘strikes and spits, and uses filthy language.’\textsuperscript{117} It appeared that, for Pauline and Phillipa, being restrained within the institution led to their increased violent behaviour. It is likely they were both angered by the situation they had found themselves in, and were striking out against their exclusion and separation from their usual lives. For others, it was their families’ and husbands’ experiences of mothers’ violent behaviour, whether out of character, sudden outbursts, or escalation which initiated a mother’s committal.

Familial accounts alleging that mothers had harmed their children, or threatened to harm them, or risked their children’s safety, reveal much about their domestic circumstances.

\textsuperscript{115} Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
\textsuperscript{116} Pauline Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0010
\textsuperscript{117} Phillipa Kew Patient Clinical Notes, PRO-V, 7693/P1/33
Descriptions of harm and risk to children were sufficient proof of insanity and reason to commit mothers. Once in the institution, mothers, including Ada, were rarely questioned about the allegations of harm against their children. The testimony from Ruth’s relative’s stated that she tried to throw her child into the fire. Her files indicated Ruth was dangerous, but the incident was not referred to again. Janice’s certificates stated: ‘ill-treats baby and assaults those attending her when possible. Has taken a dislike to husband and mother.’ Janice was questioned further and denied the allegations.

Marion was committed after a police constable found her outdoors at midnight wandering with her baby. Marion offered: ‘that taking the baby out in heavy rain would make it grow up strong and healthy. Said she had the baby covered with a waterproof so that it could have a shower bath.’ It is likely a report from her husband or neighbours alerted the police, or Marion had come to police attention by a concerned member of the public. If mothers’ disturbed behaviour could be kept within the boundaries of the home, it could be overlooked for long periods of time. Otherwise, once such behaviour became public, like Marion’s, women were subject to police intervention. Child mistreatment carries a particularly emotionally charged quality. The violent and dangerous mothers who abused and neglected their children were the worst kind, as stated by Marland, the antithesis of the loving mother. The removal of the mother into the institution was thought to be the best outcome to protect the children. The alternative was provided by

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118 Ruth Royal Park Hospital Patient Clinical Notes, DHS, AS/ 1997/093/044
120 Marion Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0029
child welfare services who would remove children from their mothers. Children could be either made wards of the state, placed in orphanages, or adopted to other families.\textsuperscript{122}

For other mothers, husbands were the focus of their violent threats. Audrey threatened and attempted to kill her husband. While the details are scant Audrey argued she was provoked by her husband’s infidelity. She feared her husband had been poisoning both herself and her children and feared for her life. Audrey repeated these statements, and then later retracted them: ‘she denies having actually wanting to kill him and has been very fond of him.’\textsuperscript{123} Marion also threatened to murder her husband and the doctor recorded: ‘she was entitled to punch her husband’s head off because he was cruel to her and kicked her.’ Marion told her husband she has a paramour and he punched her and has bruises to prove it.\textsuperscript{124} Infidelity and accusations of infidelity led to violence in both Marion’s and Audrey’s marriages. Women’s economic dependence on men, meant that some husbands, in effect, could treat their wives as they pleased. In many cases a wife had to accept her husband’s treatment if she did not want to be deserted. Therefore, wives were reluctant to report cases of violence. Police have been historically reluctant to get involved in domestic violence, as it was seen to be a private family matter. This left women in a vulnerable position which could lead to ‘symptoms of fear, anxiety and paranoia, often developed in a context of long-term ill treatment at the hands of adult male relatives.’\textsuperscript{125} For both Audrey and Marion, attempted murder and the threat to murder were indicators of insanity, rather than criminal acts for court proceedings.

\textsuperscript{123} Audrey Mont Park Index Card, AS/1994/0093/0012.
\textsuperscript{124} Marion Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0029
Frances was considered dangerous upon entry to the institution in 1927 and expressed impulsive outbursts of violence throughout her three-year stay.\(^{126}\) No account was provided by Frances’s husband. Instead, she frames herself: ‘that she can never be anything but insane.’ Within three months of her arrival Frances threatened another patient with a piece of fire wood. Her doctor noted she said: ‘Can I have a revolver? I want to shoot Mrs __ and Mrs __ (patients). They are both tired of life. If I were not married to that unfortunate creature, my husband, I’d kill everybody I could get my hands on.’\(^{127}\) Frances’s expression of feeling murderous is alarming. Her doctor recorded Frances was calm except for occasional irrational outbursts ‘expressing the wildest delusions which vary from day to day.’ As a result of her violent behaviour, ‘she is not allowed to do other work, as she must be looked on as dangerous’ and occupied herself with sewing.

Other mothers feared violence being perpetrated against them, and in some cases relatives expressed concern of their ill treatment. Catharine’s files stated: ‘bruises on both hips, small bruises all over body and limbs.’\(^{128}\) Neither Catharine nor her husband was questioned about how she attained these bruises. If he was beating his wife, it showed collusion within the system: that the husband was without blame and not reported to the police. Their children were protected from their mother, as she entered the institution, but it is not clear that the children were safe from their potentially violent father. Catharine’s doctor indicated that she was both destructive and dangerous. Janice’s mother stated she

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\(^{126}\) Frances Mont Park Patient Clinical Files, DHS, AS/1994/00104/0002.  
\(^{127}\) Ibid.  
\(^{128}\) Catharine Index Card, DHS, AS/1993/0292/0254.
was worried about her daughter’s treatment by her husband, and further stated it was a forced marriage only two months before Janice gave birth.\footnote{Janice Sunbury Patient Clinical Notes, PRO-V, VPRS: AS/8245/P1/15.}

Women also feared that they were being poisoned. Beatrice stated: ‘they tried to poison her by giving her too much medicine’ yet it remains unclear who ‘they’ might be. Her fear of poison continued as she complained of poisoned food in the institution.\footnote{Beatrice Sunbury Patient Clinical Notes, PRO-V, VPRS: 8236/P1/4.} Joanne accused certain persons of poisoning and murdering many children in her committal certificates, but no further references were made to this claim.\footnote{Joanne Mont Park Index Card, DHS, AS/1994/00093/0010.} Rosanna, a thirty-five-year-old married and following the miscarriage of her first pregnancy, feared she had been poisoned, by taking Aspros instead of Aspirin, despite being the same thing.\footnote{Rosanna Royal Park Patient Clinical Notes, DHS, AS/1997/93/037}

Six women were classified as suicidal; either they survived a suicide attempt, or threatened to end their life. Ruth and Veronica both attempted to commit suicide. Ruth, a twenty-seven-year-old married mother of three children, was suicidal following the birth of her last child four months previously. Her doctor noted: ‘frequently felt like destroying herself, and attempted it twice during the week prior to admission, on both occasions with Lysol.’\footnote{Ruth Royal Park Hospital Patient Clinical Notes, DHS, AS/ 1997/093/044.} Lysol was an over-the-counter household antiseptic and insecticide. In 1912, poisoning by drinking Lysol was the most common means of suicide for women and men in Australia.\footnote{‘Lysol Poisoning. Fashions in Suicide’, The Argus, 10 January 1912, p. 11, <http://nla.gov.au/nla.news-article11644980> [Accessed 8 February, 2015].} By 1939, following the large number of cases of Lysol poisoning, the
National Safety Council of Australia recommended safe use and storage of poisons in the household.135

Veronica was a married woman, aged twenty-eight, when she was committed following ‘attempted suicide this morning by jumping off bridge.’136 The doctor noted that following her recent miscarriage, Veronica had fallen twenty feet and sprained both wrists. Over the next few months, she remained very depressed and resisted being spoon fed. Veronica was transferred to Mont Park, where she spent the following two years, until she left for trial leave with her husband in 1923. Hazel, an unmarried factory worker, threatened to poison herself when she was eight months pregnant.137 Rachel, a married woman with three children, threatened to kill herself with a bread knife or drown herself.138 Sylvia had threatened to end her life by throwing herself under a tram. Her husband said his wife has been unwell for the last three years, since the birth of her last child.139 Sandra was also considered suicidal, following the annulment of her marriage and having given birth as an unwed mother.140 Marion’s husband stated she went to the medicine cupboard trying to obtain poison, which she later denied.141

In summary, women were subject to domestic violence by their husband in their homes. Psychiatrists did not respond to male violence by reporting it to the police, but instead placed wives into the institution for their own protection. Women were also violent,

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137 Hazel Kew Patient Clinical Notes, PRO-V, VPRS: 7693/P1/29.
139 Sylvia Royal Park Patient Clinical Notes, DHS, AS/1997/093/68.
140 Sandra Kew Patient Clinical Notes, PRO-V, VPRS: 7676/R1/260.
141 Marion Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0029
dangerous and suicidal. Poison featured in several patients’ statements and has emerged as a common theme. Housewives could easily accessed poisons, purchase being freely available of over-the-counter products. These were often decanted into unmarked containers and kept in families’ medicine cabinets, before strict regulations were introduced. Mothers experienced internal conflict with the mother and housewife role, particularly in a time of high scrutiny, poverty and husbands’ and in-laws’ strict demands. Finding themselves disempowered and under high pressure, mothers were striking out against others, their children or themselves, as they were caught in impossible situations.

The next emergent theme discussed is the various ways patients used religious expressions.

**Patients’ religious expressions**

In this section, the focus is on how patients used religious expressions to make sense of their predicaments in the mental institution. Christian beliefs were expressed through the patients’ language, and in some cases, religious ideology played a strong role in women’s identity, sexuality and motherhood. All thirty-one mothers in this research identified as Christian: fourteen identified their religious affiliation as Church of England, seven as Roman Catholic, five Methodist, with the remaining identifying themselves as Presbyterian, Congregational, and Church of Christ. Nine mothers presented delusions of a religious nature.

Upon committal, ‘Sylvia feared the devil is chasing her, is hysterical and throws herself about’. After he had further examined her, her doctor noted: ‘Slow to reply to question.

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142 Poisons Must Be Guarded (1939).
Breaks into prayer; The Father, Son and the Holy Ghost etc.\textsuperscript{143} Later, Sylvia claimed her husband was the Devil. Vivien was elated, exalted and heard God speaking to her and believed she was chosen by God. Her doctor noted:

\begin{quote}
She is talkative, noisy and speaks in a theatrical manner. She puts her conversation into song form. She holds conversations with God, asking him questions and apparently receiving replies.\textsuperscript{144}
\end{quote}

The doctor’s notes on Gayle, a married woman committed after the birth of her third child, stated: ‘she sees visions, and says Jesus is looking at her.’ After Gayle was transferred to Mont Park, her doctor recorded: ‘her conversation is irrelevant and inconsequential. In answer to a question, she replied “Jesus Christ let me out the window.”’\textsuperscript{145}

Other patients’ religious delusions were more of a persecutory nature. Edith, a young married woman, was ‘scared for her baby and hears the voice of the Devil saying they are going to kill her baby’.\textsuperscript{146} A note from the Women’s Hospital stated Edith’s labour was normal, the baby healthy and had been on the breast until sent to the Receiving House. There, she had been receiving paraldehyde and morphia at night time.\textsuperscript{147} Freda was committed when her youngest of two children was four months old. Her doctors recorded that her delusions were of a religious nature and she said the Virgin told her she would lose her baby.\textsuperscript{148} Marion’s doctor stated: ‘she keeps referring to God and hears the voices of God & Devil who command her to do things. Starts singing in the middle of conversations.’\textsuperscript{149}

\textsuperscript{143} Sylvia Royal Park Patient Clinical Notes, DHS, AS/1997/093/68.
\textsuperscript{144} Vivien Mayday Hills (Beechworth) Patient Clinical Files, DHS, AS/1995/00055/0091.
\textsuperscript{145} Gayle Mont Park Clinical Patient Notes, DHS, AS/1994/00104/0003
\textsuperscript{146} Edith Kew Mental Hospital Patient Clinical Notes, PRO-V, VPRS: 7693/P1/45
\textsuperscript{147} Ibid.
\textsuperscript{148} Freda Royal Park Patient Clinical Notes, DHS, AS/1997/93/085.
\textsuperscript{149} Marion Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0029
Pauline calls herself “Therese – the Little Flower” and curses the Catholic Church.\(^{150}\)

Pauline, was a Roman Catholic, and may have embraced the canonisation of St Therese of Lisieux in 1925. St Therese was a nineteenth century French Catholic nun belonging to the Carmelite order and known as the ‘Little Flower’.\(^{151}\)

Husbands made comments about their wives’ religious behaviour. In Joselyn’s case, she embarrassed her husband, as he complained ‘she stood up in front of the church aisle, during church services.’\(^{152}\) With Audrey and her husband, their religious differences appear more serious:

Is suspicious. Sexual and religious trend in her ideas. Says her husband has talked about leaving her altogether. She wonders if he is a Roman Catholic, because his ideas on religion differ from her own. He must be C of E. If he were a Catholic she would be able to understand his attitude and his statements. For example, if one made a confession he can start a new life, also his coldness may be due to his religion, and if he is a Catholic he could be separated from her, as she is not a Catholic. She states also that she believes that the Catholic religion is the only one. He has told her that he believes in free love. She has not had coitus lately. She does not believe it is a wife’s duty to make herself attractive to her husband, as he should be fond of her naturally, and also because she has given him three children.\(^ {153}\)

Audrey and her husband had religious differences, particularly around the issues of separation, monogamy, free love and the Catholic faith, which forbids divorce.

These religious themes used in patients’ expressions can be seen as a vocabulary that helps to describe their fears, confusion and emotions.\(^ {154}\) Elspeth Knewstubb argues that psychiatrists dismissed religious expressions as delusions, which can betray patients’

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\(^{150}\) Pauline Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0010


\(^{152}\) Joselyn Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0047


engagement with scripture and religious practice as an important part of their identity. For these mothers, giving birth appeared to stimulate fears of wrongdoing and sinfulness, yet at the same time fulfilling the Christian expectation that their vocation was in motherhood.

**Conclusion**

This chapter has illustrated how Anglo-Christian mothers came from a wide variety of backgrounds with wide-ranging experiences with symptoms connected to maternal-related insanities. The decision to commit rested with the women’s families, evidenced by husbands’ and their own mothers’ testimonies which dominate these patient files. Families considered the seriousness of behaviours, whether, destructive, violent, suicidal or deluded, and their own social and economic circumstances in their final decision to commit. Once the admission warrants were complete, which, originated with and were determined by the families’ initiative, institutional psychiatrists had little choice other than admit the patient.

This chapter also illustrated that women were not allowed to not cope. Their mother work was policed, and scrutinised by husbands, families and in-laws, producing high pressured environments in which they were expected to mother. The lack of tolerance and forgiveness by their loved ones added to the pressures when no other social support and welfare services were available. Violence and suicide can be seen as striking out, either against others or themselves when at their wits end, when all else was felt to be lost and hopeless.

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The variety of psychiatrists’ diagnostic terms in the use of puerperal and maternal insanities did represent the biomedical focus psychiatrists continued to maintain. Once the patient was recognised as a mother, the diagnosis of puerperal, in all its guises and variations, was the hook upon which psychiatrists hung all mothers’ problems. This chapter highlights poor record keeping, the privileging of husbands facts, and the lack of fact checking, as the diagnosis of puerperal insanity gave doctors a way out of looking any deeper. Mothers were not their biology, nor were they, in any way, a uniform group. This is evidenced in their wide-ranging circumstances, behaviours and marital status. Women’s silence around and fears of desertion, family breakdown, pregnancy, poisoning, Christian sin and male violence were common. These issues provided the social context of their breakdown. Yet doctors continued to find that mothers’ mental problems were a direct consequence of their biological functions following childbirth, rather than seeing the individual mother within her social context.
Chapter Six: Gendered treatments in twentieth-century Australia

Introduction

This chapter investigates the management of the insane, the treatments and the doctors, set within the changes to the Victorian Lunacy Department in the first half of the twentieth century. It places Melbourne as a central site in the development of new psychiatric discoveries, physical treatments and the formation of professional groups. This period marks an important shift for psychiatric doctors and their patients, as doctors moved from keepers or custodians to modern clinicians.1 The main focus in this chapter is the gendered treatments that doctors applied to maternally insane women in Melbourne mental institutions. It draws from mothers’ clinical patient files and illustrates the ways doctors grappled with various new treatments and expanded clinical practices set within the over-arching context of eugenic and mental hygiene strategies. Efforts to modernise psychiatry and increase doctors’ influence can be seen in the transformations from the Lunacy Department, to the Department of Mental Hygiene in 1933, through to the much needed reformations brought about in the 1950s with Eric Cunningham Dax, the Director of the new Mental Hygiene Authority.

Mental institutions provided doctors’ access to a large population of insane patients to observe, to record their symptoms, and to test remedies.2 Treatments that offered any kind of relief for mental patients, and reduce overcrowding, attracted doctors’ interest. In the early twentieth century, insanity was thought to be a physical disease of the body. Doctors applied medical treatments to the bodies of insane patients for the conditions of their minds. The 1920s and 30s marked a new era in the approach to treating patients’

insanity and is known as the somatic era, where the body was the primary site for treating psychiatric distress.\textsuperscript{3} Melbourne was a central site in the development of new physical treatments applied to patients from the interwar period onwards. Doctors tried and tested various treatments on patients including malaria treatment in the 1920s, insulin-coma therapy in the 1930s and electroconvulsive therapy (ECT) in the 1940s. By the 1940s both lithium and penicillin were applied therapeutically and by the 1950s psychotropic drugs were being used.\textsuperscript{4} These developments advanced the medical model of mental disorder, and for many patients the relief of symptoms and hope of recovery and release was made possible. A treatment’s success lay in its early application to patients still considered curable, and therefore preventing the patients’ decline.\textsuperscript{5} For patients considered incurable, it was widely accepted that they suffered a predisposition to heredity deficiency through their family lines.\textsuperscript{6} Doctors had a powerful influence upon patients, particularly in the types of patients to whom they administered new, and at times, controversial treatments. Science, medicine and psychiatry were male-dominated professions, and in this way, doctors and their treatments tell us much about psychiatry’s approach to maternally insane women and the gendered nature of psychiatry in early twentieth-century Victoria.

This chapter addresses two kinds of gendered treatments applied to mental patients within institutional regimens: experimental medical treatments and social therapeutics. Both are set within the context of the eugenic and mental hygiene movements and the doctors who advocated strategies to assess and limit mental deficiency and mental disease. The first

\textsuperscript{3} Joel Braslow, \textit{Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century} (Berkeley, University of California Press, 1997).
\textsuperscript{5} Garton, 'Sound Minds and Healthy Bodies' (1994), p. 175.
\textsuperscript{6} Ibid. p. 174.
section examines germ theories, expanded laboratory practices, and doctors’ various experimental approaches in developing medical treatment for their maternally insane patients. These include the Wassermann test for syphilis, typhoid inoculation for puerperal patients, malarial treatment for neurosyphilis (GPI), insulin-coma, sterilisation, and therapeutic abortion. Insulin-coma had short-term good results, but by the 1950s it was discredited and discontinued.\(^7\) Other treatments such as malaria and lithium treatments were highly successful for particular kinds of patients. This discussion illustrates doctors’ endeavours in fostering new treatments, however experimental, to increase their status and return the mother to her ‘rightful’ place, within her family.

The second kind of treatment for patients examined in this chapter is social therapeutics which include employment, trial leave, occupational therapy, leisure activities and religious practice. These were twentieth-century extensions of nineteenth-century moral management and shaped by the physical environment, which separated the gendered spaces of female wards from the male wards and gender-specific workspaces and duties.\(^8\) Mothers who could cultivate and maintain support from home and from other family members, as evidenced in patients’ and family letters, could return to their families with regular trial leave, which increased their chances of securing their eventual release from the institution.

Both sections in this chapter draw from examples of the gendered treatments found within the thirty-one mother’s clinic notes. The examination of individual doctors, their biographies and their career trajectories, reveal the masculine hegemony and the gendered

\(^8\) Coleborne, ‘Space, Power and Gender in the Asylum in Victoria, 1850s-1870s’ (2003), p. 53.
nature of early psychiatry in the twentieth century. In particular, this chapter illustrates the ways doctors enforced cultural norms of the ‘good mother’ and appropriate maternal behaviour. It illustrates the ways these norms were used in the provision of gendered treatments prescribed to maternally insane women in the twentieth century. The gendered treatments, both medical and social, attempted to procure recovery and return the mother to her family to assume her domestic responsibilities. Psychiatrists believed insane mothers were ‘unfit’ as they risked passing deficiency on to their offspring, as well as producing degenerate children through their maternal environment. In the next section, specific experimental medical treatments are examined with a particular focus on individual doctors’ biographies as the elite male authority governing female mental patients’ bodies, minds and their behaviours.

**Gendered treatments as experimental medical therapies**

This section maps the various experimental treatments applied to insane patients, and the doctors who developed and applied them in institutional settings. Stephen Garton reminds us that the difference between experimentation and necessary treatments was not always clear.\(^9\) The testing and refining that took place in the development of treatments in Melbourne from the 1920s onwards illustrates the advances and setbacks that shaped twentieth-century Victorian institutions, doctors, their patients and the department responsible for modernising psychiatry. Melbourne was the center for major psychiatric breakthroughs and new professional groups. Dr Reginald Ellery, a prominent Melbourne psychiatrist, developed malariotherapy in 1925 for treating patients suffering

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neurosyphilis (GPI) at Sunbury and later Mont Park. Dr John Cade’s original discovery of lithium salts in the successful treatment of manic patients (later bi-polar) in 1949 attracted world-wide attention and he was awarded the Office of the Order of Australia in 1976. Other experimental treatments discussed in this section include the Wasserman test, used to identify syphilis, typhoid vaccine for puerperal insane sufferers, insulin-coma therapy, sterilisation and ultraviolet ray treatment.

Melbourne was also the center for two new professional groups. The Melbourne Institute of Psychoanalysis, established in 1940, began with a group of doctors supporting analyst Clara Geroe’s migration to Melbourne, she having escaped war-torn Europe. By 1946, the Australasian Association of Psychiatrists held its first official meeting in Melbourne, chaired by its founder Dr. Henry (Hal) Maudsley. These were the highlights that mark the modernisation of Victorian psychiatry. Yet at the same time, as Dr William Ernest Jones found, the early twentieth century was an era of an underfunded Lunacy Department and overcrowded asylums.

Dr William Ernest Jones was appointed as the Inspector-General of the Insane, the head of the Victorian Lunacy Department in 1905. Dr Jones was an experienced English
psychiatrist and found the six asylums in his charge in Victoria were in a bad state of neglect: overcrowded, lacking ventilation, the kitchens disgraceful, no telephone systems, and in some cases the upstairs dormitories were a fire hazard.\textsuperscript{14} He opened the Receiving House at Royal Park in 1907 to function as an observation ward to the main hospital for short term stays.\textsuperscript{15} In 1909, the government purchased land at Bundoora for the new Mont Park Hospital for the Insane, to replace the oldest asylum at Yarra Bend.\textsuperscript{16} By 1913, Dr Jones received the first one hundred and seventy patients to Mont Park from Yarra Bend and Kew that year.\textsuperscript{17} Dr Jones was head of the Victorian department for over thirty years, and during this time he continually made requests for the most basic requirements. His yearly reports, accompanied by the smaller superintendents’ reports from individual institutions, had a pleading tone as he entreated for funding. Long periods of stagnation saw the older mental institutions of Beechworth, Ballarat, Ararat (all three opened in 1867), Kew (opened in 1871), and Sunbury (opened in 1879) fall into disrepair; in need of electric lighting, heating and sewage, for example. Except for the newer Mont Park (opened in 1912) and Royal Park Mental Hospital (opened in 1907), the older institutions were dilapidated and in need of constant repair, overcrowded and understaffed in all areas. After thirty years as the department head, Dr Ernest Jones wearily stated the burdens of his responsibilities in the administrative care of approximately 8,000 patients accommodated across twenty institutions was too much to bear. In his 1935 annual report Jones stated his work became more and more impossible as ‘the responsibility thrown on the shoulders of one man is growing too great to be borne with equanimity by one

\textsuperscript{14} Iliya Bircanin and Alex Short, \textit{Glimpses of the Past: Mont Park, Larundel, Plenty} (Melbourne, Vic, 1995), p. iii.
individual.\textsuperscript{18} There were no votes in mental health, and the government provided only the barest minimum to avoid the destitution of mental patients.\textsuperscript{19} In many ways, the government’s parsimony in its refusal to provide from the public purse reflected the social stigma attitudes towards mental illness in the wider community.

The high pressures placed upon doctors to produce cures came from desperate mental patients and their families. The superintendents of public mental hospitals were charged with the professional responsibility for treating patients and enabling their recovery and discharge and return to their families. Doctors did not dispel the public belief in their ability to cure, despite few effective treatments available to doctors, other than segregation. Research into the development of new therapies was severely hampered by the continued lack of research funds and clinical facilities affecting clinical trials among mental patients.\textsuperscript{20} Facing overwhelming numbers of mental patients in their institutions, doctors were willing to try and risk any therapeutic possibility to restore mental health and stability.\textsuperscript{21}

Under restrictive financial conditions, the small group of Victorian medical and psychiatric elite professionals had limited resources and equipment to devote to developing treatments for the insane. Dr John Cade’s lithium treatment was an original discovery and the exception. Others had to abandon patient trials due to lack of funding.

\textsuperscript{19} Ash et al, ‘Mental Health Services in Australia’ (2001), p. 53.
\textsuperscript{20} Ann Westmore, ‘Reading Psychiatry’s Archive’, in Madness in Australia: Histories, Heritage and the Asylum, ed. by Catharine Coleborne and Dolly MacKinnon (St Lucia, University of Queensland Press, 2003), pp. 214-216.
\textsuperscript{21} Elliot Valenstein, Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness (New York, Basic Books, 1988), p. 44.
otherwise psychiatrist’s primarily borrowed and replicated treatments from overseas studies.22

From the 1920s onwards, psychiatrists drew upon scientific methods and medical developments which linked institutional laboratory practices with patient care. In adopting the medical model, the psychiatry profession was keen to lose its custodial past and marginalised status.23 Ann Westmore argues that as psychiatry sought greater alignment with medicine, the struggle for science’s imprimatur was crucial to psychiatry’s transition and modernisation during the twentieth century.24

The germ theory of disease, and the development of bacteriological knowledge, Mokyr argues, must be regarded as the most significant technological breakthroughs in history.25 From the late 1870s, the work of experimentalists including Louis Pasteur, Robert Koch, John Tyndall and Joseph Lister identified distinctive species of microorganisms that caused human and animal diseases.26 The discoveries of the bacteria responsible for cholera, tuberculosis, gonorrhoea, typhoid and scarlet fever were identified in quick succession.27 Doctors gained greater confidence and diagnostic power in the successful development of tests for syphilis, typhoid and diphtheria.28 Joel Mokyr argues the link between microbes and disease ‘provided an entirely new concept of what disease was,'

22 For information on Trautner and Gershon having to abandon their work on treating schizophrenia with succinic acid due to the lack of government support and funding see Westmore, ‘Reading Psychiatry’s Archive’ (2003), p. 214.
24 Ann Westmore, Mind, Mania and Science: Psychiatry and the Culture of Experiment in Mid-Twentieth Century Victoria (PhD Thesis, University of Melbourne, 2002).
27 Ibid. p. 6.
28 Ibid. p. 239.
how it was caused, how to differentiate between symptom and cause, and how infection occurred.\textsuperscript{29}

The new science of bacteriology expanded laboratory practices as a scientific discipline.\textsuperscript{30} Urine and blood tests were performed for mental patients in this current study. This illustrates that psychiatry adopted medical clinical practices in the use of pathology testing in the laboratory. Psychiatrists also undertook basic physical examinations of their patients upon their first reception. The condition of patients’ heart and lungs were recorded in most cases.

In Victoria, Dr Lind was appointed in 1912, as the pathologist of the newly established pathology laboratory located at Royal Park Hospital for the Insane. The majority of Dr Lind’s work involved performing post-mortems on patients who had died in the institutions. The connection between pathology testing, biological causation and insanity in the early twentieth century is exemplified by the diagnosis of syphilis and its treatment. All stages of syphilis, were treated by psychiatrists in the hospitals for the insane.\textsuperscript{31} From the early psychiatric symptoms of mania, through to the advanced infection that spread through the central nervous system to the brain, known as neurosyphilis or general paralysis of the insane (GPI). The identification of the syphilis spirochete and the subsequent Wassermann test of patients’ blood used to diagnosis the presence of syphilis in 1910 expanded the role of pathologists in the Victorian Lunacy Department.\textsuperscript{32} Elizabeth Lunbeck argues the Wassermann test substantially advanced psychiatry’s

scientific status in its alignment with medicine in the early twentieth century. This medical advance was made in the psychiatric field. It supported psychiatry’s long held tradition that linked behaviour with a parallel physical illness.

In 1912, Dr Lind reported that 450 insane patients were tested for syphilis using the Wasserman test which resulted in 152 positive results with a further 234 significant reactions. By 1923, Dr Lind complained that more advantage was not taken of his pathology services. After performing 180 post-mortems, 106 showed evidence of syphilis, with only twenty-nine Wasserman tests from this post-mortem group performed. For cases of syphilis, segregation was the only treatment offered until Dr Reg Ellery successfully treated the advanced stage of neurosyphilis (GPI) with malariotherapy in 1925. Ellery effectively adapted this treatment pioneered by the Viennese psychiatrist Dr Wagner-Juarreg.

Eight women in this present study were tested for syphilis with the Wasserman blood test. The results found seven negative and one woman, Suzanne, tested positive for syphilis in 1929. Transferred to Mont Park, Suzanne underwent treatment for some months, began to converse rationally and was released on trial leave for three years, then finally discharged.

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39 Suzanne Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0027
40 Ibid
Reg Ellery introduced malariotherapy to Mont Park patients in 1927 and was appointed as neurologist following Dr Lind’s unexpected death.\textsuperscript{41} For Suzanne, the type of treatment that led to her recovery was left unstated, but it is highly likely she successfully completed a course of malariotherapy at Mont Park. On the efficacy of malariotherapy, Ellery reported that of ninety patients treated, forty-two per cent were discharged in remission, thirty-four per cent improved but were not discharged and twenty-three per cent showed no improvement.\textsuperscript{42}

Other psychiatric treatments given to the insane were largely experimental in the 1920s and 1930s. Psychiatrists used laboratory practices to experiment with ideas, methods or material not tried before. Medical experiments followed the chain of evidence, linking the laboratory with the bedside, in testing on mental patients. The therapeutic success and side effects of insulin-coma treatment, ultraviolet rays and sterilisation, were unknown or short term. The typhoid vaccine and its application in treating maternally insane mothers demonstrates an experimental use of the vaccine. Fortunately for the patients, it was a harmless one.

In 1929, Dr John Kellerman Adey, the superintendent in charge of Sunbury Hospital for the Insane, published successfully treating women suffering puerperal insanity with typhoid vaccine. In the \textit{British Medical Journal}, Dr Adey stated: ‘in all, twenty cases have been treated; of these fifteen have improved sufficiently to leave the hospital and


have since remained out with their friends.\textsuperscript{43} The work was undertaken by Dr Peter Lalor, senior medical officer at Sunbury, but was unable to be completed due to his unexpected death in 1927.\textsuperscript{44}

Both Lalor and Adey studied medicine at the University of Melbourne and graduated together in 1909.\textsuperscript{45} Dr Adey went on to complete his postgraduate study in Britain.\textsuperscript{46} With the outbreak of war he served as a medical officer in Gallipoli and France from 1914 to 1918.\textsuperscript{47} Typhoid was one of the many factors that diminished the fighting strength of the soldiers in Gallipoli, and became an epidemic due to polluted water, fly swarms and overall severe unsanitary conditions.\textsuperscript{48} Working in the Medical Corps in Gallipoli, Dr. Adey would have dealt with the typhoid epidemic first hand. To stem the typhoid emergency, the War Office ordered a conference of naval, military, and civilian specialists in pathology to clinically analyse the test results from Gallipoli typhoid cases.\textsuperscript{49} The triple typhoid vaccine (TAB) was approved in 1916 by the British army after careful consideration given to the specific ratio of the three types of typhoid in the experimental inoculations given to troops.\textsuperscript{50} It was highly likely Dr Adey participated in

\textsuperscript{49} Ibid. p. 457
\textsuperscript{50} Ibid. p.457
the systematic inoculation of soldiers with TAB vaccine at Gallipoli, and witnessed its effectiveness in the dramatic reduction of typhoid fever.⁵¹

Following his return from war service, Dr Adey, promoted to superintendent at Sunbury in 1922, supervised his two medical officers Dr Ellery and Dr Lalor. By this time, Dr Adey well understood that TAB vaccine was proven safe for human use. Ellery stated: ‘anything which promised betterment to the patients he [Adey] welcomed with enthusiasm.’⁵² Dr Peter Lalor’s use of TAB vaccine as an experimental treatment for insane mothers showed patients improved sufficiently to leave the hospital and resume their lives outside. In the publication of Lalor’s work, Adey provided the exact measures for each of the three types of typhoid prescribed in this triple vaccine and to increase the dosage over the first course, then double the dosage on the second course of vaccine. In his final statement, Adey recommended that the good results show all cases of puerperal insanity be given at least two courses of TAB vaccine.⁵³ This was a gendered treatment specifically aimed at women suffering maternal insanities.

Despite Dr Adey’s recommendation that TAB vaccine be administered to all puerperal mothers, only three women selected for the present study received this treatment: Catharine, Joanne, and Vivien. Catharine was transferred to Sunbury in December 1923, following her committal to Royal Park Receiving House three weeks before. She was at Sunbury in time for Dr Lalor’s TAB experiment with puerperal insane mothers. Following the completion of a second course of TAB vaccine, Suzanne’s doctor

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⁵² Ellery, The Cow Jumped over the Moon (1956). p.150  
⁵³ Adey, ‘Protein Therapy in Puerperal Insanity’ (1929).
recorded: ‘is definitely brighter; no longer sits with head on her chest, but erect, & will reply in subdued tones, & of her own accord will ask for her discharge.’ Where for Vivien and Joanne, the TAB vaccine appeared to be more a part of their general health programme. Vivien had fallen ill with typhoid after four years at Mont Park, and was then transferred to Beechworth in 1929 to convalesce. By 1943, she was given two courses of TAB vaccine, and again in 1953. Joanne had broken her thigh and was given three courses of TAB vaccine in 1952 and placed in the isolation ward. The nursing notes indicated Joanne was vomiting, her foot was swollen and she suffered high temperatures. She was issued with a series of penicillin and another course of TAB vaccine in 1954. Joanne died in her sleep in 1954 aged fifty-four. Inoculation against typhoid went towards eliminating any further health complications in patients.

This evidence suggests that women admitted with maternal-related insanities had several health issues in need of medical attention. For example, Suzanne, committed with puerperal insanity as an unwed mother, tested positive for syphilis, and was also diagnosed with pyelitis, an inflammation of the bladder. At Mont Park, Suzanne underwent ultraviolet (UV) ray treatment for several months. Phototherapy was enthusiastically embraced by the medical profession in the 1920s for both the prevention and cure of a wide range of illnesses. It was pioneered by the Danish physician, Niels Finsen after he successfully treated the skin rash produced by the tuberculosis bacteria.

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54 Catharine Sunbury Patient Clinical Notes, PRO-V, VPRS: 8245/P1/4.
58 Ibid.
with ultraviolet radiation, in the 1890s.\textsuperscript{59} By 1915 phototherapy was believed to prevent gout, Bright’s disease of the kidneys, diabetes and obesity.\textsuperscript{60} Around the same time, the harmful effects of sunlight exposure associated with skin cancer in the Australian conditions was studied, mainly in the dermatological field, but received little attention from the medical profession.\textsuperscript{61}

Ernest Jones reported on the progress of establishing the new Ultraviolet Ray Plant at Mont Park, in his 1928 annual report.\textsuperscript{62} By 1929, Dr Catarinich, the medical superintendent at Mont Park, said that Dr Rogers was treating patients twice a week with the ‘rays’. This justified the expense of its installation. Catarinich endorsed the therapeutic value of the rays and added that this ‘treatment by suggestion is intensified when the ultraviolet rays are also added to the patients’ general treatments.’\textsuperscript{63} Here, Catarinich suggested that patients felt the psychological benefit in being prescribed the ‘rays’. Suzanne, after completing months of UV ray treatment, left for her first trial leave in 1930 and was later discharged in 1933.\textsuperscript{64}

Lalor’s typhoid vaccine experimentations, Ellery’s successful treatment of neurosyphilis and ultraviolet ray treatment went towards closing the gap between mental hospitals and the medical profession. These approaches assumed that mental illness was a chemical

\textsuperscript{60} Ibid. p. 933.
\textsuperscript{61} Paul Charles Norman, \textit{The Influence of Sunlight in the Production of Cancer of the Skin} (London, H. K Lewis, 1918).
\textsuperscript{64} Suzanne Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0027.
imbalance in the body, and that these somatic treatments restored mental health in patients. As psychiatry sought greater alignment with medicine, these therapies described above illustrate how the struggle for science’s endorsement and approval was crucial to psychiatry’s transition and modernisation during the twentieth century. With these new developments in mind and despite Adey’s recommendation that all puerperal women receive TAB vaccine, only three mothers of the sample received it. The same can be said for ultraviolet ray treatment. Although Catarinich believed in its therapeutic benefits, only one patient underwent the ‘rays’ from this group. This evidence illustrates that TAB vaccine, the ‘rays’ and insulin-coma treatment were not consistently administered across this whole group of patients but only applied in particular individual instances.

The medical developments in the 1920s described above had strong connections to the theories of heredity and eugenics, prominent in the field of psychiatry. Physical illness affecting behaviour was thought to be both incurable and inherited through genetic transmission. The incarceration of insane mothers was a eugenic gendered strategy used to prevent mental deficiency in populations believed to be carried through the female line. In the nineteenth century heredity was thought to be one of the major causes of insanity. By the early twentieth century heredity theories expanded as germ theories and bacterial microbes were thought to be responsible for many types of mental illness. As the new science of bacteriology took decades to become a coherent body of knowledge, it remained unclear why some infected people did not get sick. Psychiatrists believed heredity explained why only some people succumbed to toxins such as syphilis and

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alcohol while others did not.\textsuperscript{68} Heredity insanity was a physical, or organic, condition, and psychiatrists recommended early treatment, so patients with heredity insanity could avoid risking the predisposition to defectiveness in their offspring.\textsuperscript{69} These ideas fed into eugenic concerns of good and bad breeding within human populations, believed to affect the future health of the nation.\textsuperscript{70} Yet there was no scientific proof or exact means of how hereditary deficiency was transferred through families.\textsuperscript{71} Despite this vagueness, heredity theory was a dominant rationale that helped to explain the causes of insanity in early twentieth-century discourses. For example, Dr Lind devoted several pages to ‘heredity’ in his 1912 report. He examined the ‘pedigrees’ and genealogy of mental patients and found that various combinations of feeble mindedness, alcoholism, insanity and tainted stock in patients’ family bloodlines produced defective children. The female line was held responsible for hereditary transmission in Dr Lind’s findings. He stated that ‘in female patients, I find the mother and sisters are insane much more often than the fathers and brothers’ and in male patients the issue of heredity was smaller in number than the females.\textsuperscript{72} Heredity theories fitted the pre-existing medical bias against women due to their role in reproduction.

Hereditarianism was an integral part of eugenic discourses that found the female line at fault. The segregation of maternally insane patients was used as a means to isolate those deemed unfit for reproduction.\textsuperscript{73} In this way, Mark Finnane argues the asylum was a

\textsuperscript{69} Ibid.
\textsuperscript{73} See Finnane, ‘From Dangerous Lunatics to Human Rights? The Law and Mental Illness in Australian History’ (2003), p. 28.
eugenic strategy; it limited procreation through detention of those considered undesirable.\textsuperscript{74} The eugenic movement was always concerned with reproductive sex and the need to intervene in the reproductive lives of particular groups. In this way, eugenics was also always about gender.\textsuperscript{75} Due to women’s key role in reproduction, pregnancy and birthing, hereditarianism in eugenic theories was gendered. Although the body of the woman was absent from eugenic discourses and publications, eugenics was often code for blaming ‘unfit’ mothers for passing on mental deficiency in their children.

Eugenicists, in the interwar years, were concerned for the decline of the white race through insanity, mental defectives, and racial mixing. They believed heredity deficiency was responsible for the degeneration of populations.\textsuperscript{76} Dr Ernest Jones, the then Inspector-General of the Insane, was a prominent and influential eugenicist. He headed the national survey into mental deficiency in 1928, and found that three per cent of Australia’s school children were mentally deficient.\textsuperscript{77} Dr Jones believed these results were of supreme national importance and posed a serious danger to the country’s prosperity and national efficiency.\textsuperscript{78} His report recommendations were eugenic in tone: ‘the detection and segregation of the unfit, marriage bars, sterilisation, elimination of syphilis, the control or prohibition of alcohol and the establishment of psychological clinics for mentally defective children and adults.’\textsuperscript{79} These proposals represented

\textsuperscript{74} Ibid.


\textsuperscript{77} William Ernest Jones, \textit{Report on Mental Deficiency in the Commonwealth of Australia} (Melbourne, Australian Department of Health, 1929), p. 3.


psychiatry’s keen interest in coercive and intrusive state action in people judged to be deficient and unfit for reproduction. Dr Jones was instrumental in placing the Mental Deficiency Bill before Victorian parliament. The legislation proposed the permanent segregation of the unfit and their sterilisation to secure the future of a healthy white race in preventing procreation and passing on their mental deficiency. But the bill was thwarted twice in 1926 and 1929, and in 1939, after Dr Jones’s retirement, the bill was passed but not enacted. Despite the difficulties to implement this legislation, it does indicate the strength of heredity in eugenic ideology. As Rob Watts argues, the first half of the century was the ‘age of eugenics’. By 1934 Dr Jones had backed down on the sterilisation of the ‘unfit.’ He knew the ‘public outcry would make it impossible’, when sterilisation needed to be applied to such a very large number of people to be totally effective.

The difficulties in implementing reproductive intervention legislation meant that sterilisation was not prescribed uniformly across maternally insane women or the mentally deficient in Australian institutions. Yet Garton suspected some sterilisations did occur. He found that the NSW Crown Solicitor advised psychiatrists that sterilisation had to be for the ‘benefit’ of the patient, and permission must be sought from parents and guardians. In Ada’s case, both sterilisation and the termination of her third pregnancy were performed privately, outside the institution when on trial leave. In comparison, no

81 Ibid. p. 322.
82 Ibid. p. 319.
86 Ibid. See footnote 6
sterilisation or termination was performed or recorded for patient Sylvia, who returned to
the institution several times following the births of her second, third and fourth babies.87
The different outcomes for Sylvia and Ada illustrate the complexity in establishing
grounds for the psychiatric benefit of reproductive intervention in individual mother’s
cases. The eugenic undertones of these permanent procedures intended to limit potentially
mentally deficient children being born to ‘unfit’ mothers and to prevent any possible
further episodes of insanity connected to the patient’s reproduction. Ada’s case illustrated
an individual instance, and at a time without legislation, where the gendered and eugenic
interventions of sterilisation and ‘therapeutic’ abortion were secured outside mental
institutions and performed in a private medical setting.88

Environmentalism, alongside hereditarianism, formed part of the persuasive eugenic
discourses that emerged throughout the interwar period.89 Poor environments and social
ills including poverty, crime, illness and delinquency were thought to play a role in
mental deficiency and the degeneration of populations.90 The mental hygiene movement
recognised the importance of good environments for ‘sound minds’ necessary to
strengthen individuals to cope with the fast pace of the modern world.91 Dr Jones was one
of the leaders in the mental hygiene movement, which was principally a preventative
campaign in advocating social reforms.92 His earlier reforms in prevention can be found
in the changes to legislation for voluntary committal (1914) and the establishment of two

87 Sylvia Royal Park Patient Notes, DHS, AS/1997/093/68.
88 For gendered eugenic policies internationally see: Veronique Mottier, 'Eugenics and the State: Policy-
Making in Comparative Perspective', in The Oxford Handbook of the History of Eugenics, ed. by Alison
Bashford and Philippa Levine (New York, Oxford University Press, 2010).
92 Ibid. p. 177.
Receiving Houses (Ballarat and Royal Park) for early treatment, observation and short term stays.\textsuperscript{93} These two initiatives attempted to minimise and prevent long term disease and decline into incurability. However, Dr Jones desired to go much further in psychiatry’s role in preventative strategies for mental health and hygiene.

Social reforms were part of Dr Jones recommendations in his national report on Mental Deficiency, 1929. Jones outlined the need for psychological clinics, attached to children’s courts, attended by paediatricians, educators, psychiatrists and social workers to treat mentally deficient children and younger adults.\textsuperscript{94} This approach indicated Jones’s interest in preventative measures and environmental concerns as a mental hygienist. His recommendations combined the two types of eugenic strategies: hereditarianism (sterilise the unfit) with environmentalism (social reforms). Stephen Garton reminds us that these eugenic ideas were not polar opposites or mutually exclusive positions, but part of a singular discursive formation.\textsuperscript{95} Dr Jones’s recommendations represented this fusion of eugenic approaches in the mental hygiene movement. By 1930, Dr Jones had helped to establish the Victorian Council of Mental Hygiene.\textsuperscript{96} It was supported by professionals in psychiatry, medicine and education, to address the strains of modern life and tackle weakness believed to be set down in childhood and to find means to prevent them.\textsuperscript{97} The Council represented the growth in understanding the role that the environment played and

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\item \textsuperscript{93} Lewis, \textit{Managing Madness} (1988), p. 36.
\end{itemize}
recognition that insanity and deficiencies could be overcome when they were social, economic or psychological in origin. This was a significant shift and hallmark of mental hygiene in the interwar period. It provided the impetus to rename the government department in 1933 from the Lunacy Department to the Department of Mental Hygiene, which Dr Jones had successfully advocated. The Mental Hygiene Bill also changed Dr Jones’s title from the Inspector-General of the Insane to the Director of Mental Hygiene and institutions for the insane were updated to mental hospitals. This signified the move from heredity to environmental reforms, in an effort to remove stigma and improve community attitudes in the modernisation of psychiatry in Victoria.

The recognition that the environment played a role in human deficiencies gained currency in the early twentieth century in many areas other than psychiatry. Hygiene was a concept of cleanliness and purity, where government initiatives placed rigid responsibility upon the practices of individuals in the interwar years. Poor mothering was believed to be responsible for the high infant and maternal mortality rates and the supposed declining birth rate. Mothers were thought to be inadequate, ignorant and neglectful. In order to produce citizens who best served the nation, the mother and her maternal practices were scrutinised by new professionals. The social force of doctors, nurses and experts asserted their authority in instructing mothers on all aspects of motherhood: from

102 Ibid.
pregnancy, infant care and child-rearing practices. In an era of maternalism and pronatalism, professionals enforced norms and standards in mothering and infant care through scientific mothering, domestic hygiene and the science of child care. This new emphasis on the increased responsibilities of good motherhood was a key factor in eugenic ideology. Professional instruction had demoralising effects, and mothers who failed to meet enforced norms may have felt inadequate, anxious and depressed. These were key factors in mothers’ mental breakdown. Mothers committed to the institution found themselves caught in these new pressures, as maternal practices were increasingly policed. Mothers were blamed for both heredity and environmental deficiencies, in both their breeding and child-rearing practices. Mother blame and perceived bad mothers revealed the gendered nature of mental hygiene, psychiatry, public health and wider social reforms.

Psychiatrists entertained a whole host of eugenic ideas as to the causes of insanity in mothers. Both heredity and environmental causes found that the fault lay with each individual mother. Within the mental institutions, psychiatrists continued to experiment with treatments in an effort to cure the maternally insane. Following the retirement of Ernest Jones in 1937 after thirty-two years of service, the position of Mental Hygiene Director was taken up by Dr John Catarinich. He had been the superintendent of Mont Park since 1919. By 1939, Dr Catarinich boasted to the Argus newspaper that ‘Victoria leads the world in successful experiments in the use of insulin and cardiazol treatments

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106 Ibid.
and that recoveries are substantially higher than in any other country in the world.  

Both treatments bolstered the psychiatric profession’s much needed objective and scientific status and renewed confidence in their ability to produce cures for insanity.

Insulin-coma was an experimental treatment with short-term success. It was discredited and outmoded in Australia by the 1950s and 1960s following the deaths of some patients. For example, two patients died when they could not be revived from their insulin-induced coma. Stephen Garton reminds us that the boundaries between experimentation and essential treatments were not clear. Both the side effects and therapeutic success of new treatments were uncertain and yet to be proven. Ada was the only patient in this present study who underwent insulin-coma treatment at Mont Park. This was probably due to the change in her diagnosis from puerperal insanity to dementia praecox (schizophrenia). Insulin was injected into schizophrenic patients to induce daily comas, and heralded as a cure for schizophrenic patients. However, there was no scientific rationale for why or how insulin worked. Despite this, the high percentage of improvement in patients encouraged others to take up this new remedy. It was an experimental treatment and enthusiastically put into practice, with initially good results, as Catarinchichs’ claims attest. By 1956, Superintendent Dr

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114 Ibid. p. 98.
J. F. J. Cade announced Royal Park opened its new twenty-three-bed insulin ward. This new ward was part of Eric Cunningham Dax’s larger reforms as the new chairman of the Mental Hygiene Authority. Dax promoted the importance of insulin treatment in 1955:

You give this to your patient every morning and keep him busy for the rest of the day carpentering, tailoring, sculpturing, and on other forms of occupational therapy for two to four months – depending on his condition.

Then you abruptly stop the insulin. Each day after this insulin treatment his brain suddenly gets a swamp of food and by the end of the course, if you have built up his interests and activities, then he can go out to a normal, fuller life with his brain working properly again.

At the same time, 1950s medical researchers discredited insulin-coma treatment as having no therapeutic benefit for schizophrenic patients. In Ada’s case, the positive effects did not last. The treatment led to her discharge, but her recovery was short when she was readmitted with similar symptoms six months later.

This section has shown that the physical treatments applied to the maternally insane, prior to the pharmaceutical revolution in the 1950s, were not consistently prescribed across the whole group of mothers in this study. Only two individuals underwent insulin-coma and ultra-violet ‘rays’ therapies, which were later discredited when adverse effects were identified. Whereas TAB vaccine and Wasserman testing for syphilis were proven safe for human use, neither were prescribed uniformly as a standardised treatment to the

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116 Ibid.


118 Ada Mont Park Patient Clinical Notes, AS/1994/508/129. For information on the short-term effects of ICT for patients at Devon County Lunatic Asylum, United Kingdom see Nicole Baur, 'Family Influence and Psychiatric Care: Physical Treatments in Devon Mental Hospitals, C. 1920 to the 1970s', Endeavour, 37, 3 (2013).
maternally insane in this group. In addition, the failure to enact the eugenic legislation for the sterilisation of the insane meant that it could not be adopted in mental institutions as a common and systematic treatment for insane mothers. As a result, this evidence indicates maternal insanity did not elicit greater incidence of any type of physical treatment, other than incarceration. The gendered treatments specifically aimed at women were more evident in the realm of social therapeutics, discussed in the next section. In particular, the domestic duties expected of female patients were seen to be one of the major factors in patient recovery and potential release. Patients who demonstrated good behaviour are discussed, as well as the importance in maintaining family connections to secure their trial leave and eventual discharge.

**Gendered social therapeutics: work and trial leave as therapy**

This section covers the gendered power in social therapies within the institutions, and the ways insane mothers could secure their release. The gendered divisions within the mental institution between male and female work saw women expected to be usefully employed in the sewing room or cleaning wards. This resembled the gendered division of labour in broader society. The study of patients’ appearance was measured as a sign of insanity and for women to uphold assumed gendered attributes of femininity was expected.\(^{119}\) The assessment of patients’ willingness to manage their own dress and appearance, their productivity in work, and good behaviour was seen as an indicator of mental improvement, and a measure for possible future release.\(^{120}\) Mothers who could cultivate and maintain support from family members or friends, as evidenced in patient and family...

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\(^{119}\) Coleborne, 'Space, Power and Gender in the Asylum in Victoria, 1850s-1870s' (2003). p.53
\(^{120}\) Ibid. p.53
letters, could return to their families with regular trial leave, appearing, in most cases, to have had greater chance of securing their release.

The nineteenth-century Australian asylum culture reflected British reforms regarding the appropriate treatment of the insane. Instead of imposing the physical restraints of chains and handcuffs, the moral management approach encouraged patients to learn and exercise self-control in the moderation of their feelings and behaviour.\textsuperscript{121} For mothers who entered the nineteenth-century asylums in Britain, treatment consisted of respite from the family and their newborn. This break from both mothering and household duties provided the opportunity for mothers to recuperate their strength through rest, a nutritious diet and encouragement to occupy themselves.\textsuperscript{122} Patient occupations, work and employment activities formed part of the nineteenth-century moral management treatment of the insane. Such activities were considered therapeutic, but at the same time it reinforced the gendered division of labour. Female patients were given domestic work in the laundry, the sewing room and in cleaning wards. For male patients, outdoor manual labour and physical exercise were deemed more necessary therapies.\textsuperscript{123}

These gendered activities extended into the twentieth-century mental hospitals. For example, Ada’s files stated she ‘occasionally does some ward work’ and a month later ‘now works willingly in the ward.’ Later, in 1954, Ada ‘works daily in B ward which she calls going to the office.’\textsuperscript{124} This comment indicated that Ada gained satisfaction from working and the productive use of her time may have increased her self-esteem and

\begin{footnotesize}
\begin{enumerate}
\item Lewis, \textit{Managing Madness} (1988). P.8
\item Marland.
\item Showalter, \textit{The Female Malady} (1985), p. 82.
\item Ada Mont Park Patient Clinical Notes, AS/1994/508/129.
\end{enumerate}
\end{footnotesize}
humour. By the time Ada worked in Dr. Donnan’s superintendents’ residence at Beechworth Mental Hospital her self-belief was that of staff status, not a patient. Patients’ willingness to take up female work was used to measure their ‘improvement’. For Beatrice, her files stated: ‘does some work, well behaved, assists in sewing room’.

And in Rachel’s case: ‘is working well in the ward and kitchen.’ As for Frances, she was restricted to the sewing room only: ‘is calm (except for occasional outbursts) and occupies herself with sewing. She is not allowed to do other work, as she must be looked on as dangerous.’ For most female patients, their willingness to work reflected an effort in their own reform. It was used to measure ‘improvement’ and could lead to eventual recovery and discharge. Such is the case for Phillipa, who was ‘working usefully in the laundry,’ and was discharged as recovered a year later. Yet for others like Ada, whose consistent work indicated improvement, it did not lead to her discharge. As for Catharine, the sewing room held little interest for her: ‘was taken to the sewing room, but does nothing there yet,’ and again one month later ‘has been taken to the sewing room without much success.’ Catharine’s lack of interest in the sewing room may have been more about not knowing how to sew or not being willing to learn. Her doctor noted, a year later, Catharine’s improvement: ‘is brighter, sits erect & of her own accord and will ask for her discharge.’ For women like Catharine who remained unoccupied, whether refusing to work or who did not have the required skills, did not limit their opportunity for discharge.

125 Beatrice Sunbury Patient Clinical Notes, PRO-V, VPRS: 8236/P1/4.
128 Coleborne, ‘Space, Power and Gender in the Asylum in Victoria, 1850s-1870s’ (2003).
129 Phillipa Kew Patient Clinical Notes, PRO-V, 7693/P1/33.
130 Catharine Sunbury Patient Clinical Notes, PRO-V, VPRS: 8245/P1/4.
131 Ibid.
Mothers who remained unoccupied may have felt their institutional stay was an opportunity for rest, recuperation and respite from their domestic responsibilities at home. For mothers who were assessed, their willingness to successfully undertake domestic tasks in the institution was incongruent to the discourses of respite and rest. The irony in being given a break from their household duties while expected to undertake them within the institution remains. This is an example of how gendered work in the institutions reflected the gender order of the broader social world. While some female patients’ sanity was measured by their ability to assume appropriate gender attributes of femininity and gendered work in institutional household tasks, others like Catharine could procure their release without undertaking work therapy. In Ada’s case, her labour did not secure her release. This indicated a complexity of elements at play, beyond work therapy, which influenced her chances of recovery and subsequent discharge from the institution.

Patients like Ada depended on someone on the ‘outside’ being willing to receive them on trial leave or their discharge. In the next section, the discussion of patients’ trial leave, was another approach in their social therapy. Trial leave could lead to discharge in many cases, yet it depended on the communications and relationships between female patients and their husbands, families and the institution.

Patients were assessed for trial leave according to the doctors’ criteria: the patients could demonstrate insight into their condition, were correctly oriented in time and place, and be well behaved.132 In addition to these criteria, the patient needed someone to sign them out for trial leave, collect and transport patients from the institution, and house them. Not only were patients required to have insight, be well behaved, and be usefully employed or

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occupied, they crucially needed to cultivate and maintain support from home, relatives or friends. An examination of the correspondence between patients, families and institutional officials reveal how trial leave was negotiated through letter writing.\(^{133}\)

For example, Lucy’s brother sent three letters to the superintendent to enquire about Lucy’s present condition, arrange his visits, and asked about the procedure to take his sister home.\(^{134}\) Lucy had been committed with puerperal insanity by Dr Adey in 1933, following the birth of her first child. In his first letter sent in March 1942, Lucy’s brother asked if it would be advisable to bring Lucy’s daughter, aged eight, to see her mother on his next visit. The doctor noted his reply one week later, although the details of this return correspondence were unknown. In Lucy’s bother’s next letter, he stated that ‘I am now able to provide a home and care for her’ and asked could arrangements be made for Lucy’s trial leave on his next visit. The final letter instructs the superintendent that Lucy’s brother will be collecting her on the following Sunday for her first trial leave and that ‘her daughter is very happy here and wants her mother to come.’\(^{135}\)

Lucy remained out on trial leave until she was discharged in the following year.

Several women were released on trial leave with their mothers including Joanne, a married women, who was committed in 1920 with puerperal mania. By 1922, Joanne’s mother took her home on trial leave and by 1924 Joanne was discharged as recovered. Recommitted in 1934 with acute mania, Joanne was visited by her sister in 1949. This was followed by a letter sent to the superintendent to ‘meet and explain the whole of her

\(^{133}\) Ibid. p. 91.
\(^{134}\) Lucy Royal Park Hospital Patient Clinical Notes, DHS, AS/1997/093/050.
\(^{135}\) Ibid.
circumstances more fully.\textsuperscript{136} The doctor discussed Joanne’s case with her sister on the telephone, but no notes were kept of their conversation.

Patients on trial leave were expected to remain in contact with the mental hospital.

Pauline wrote a letter of thanks to her doctor at Mont Park, from her mother’s home:

\begin{quote}
Dear Dr Wood
Just a few lines as promised to let you know I am feeling well and settling down again to home life. Elaine our little baby is lovely, she has blue eyes and fair hair. I think she is like her father. I have not been to the doctor yet about my tonsils but I will go along to see him one of these days. I suppose you are still very busy at Mont Park.

I think I will stay with mother for about two months before I go up to Ballarat. We intend boarding for a while before taking up housekeeping again. Hoping you are well and thanking you for all you did for me whilst I was ill in hospital. I will now say goodbye.
Yours sincerely.
[Patient’s full name]\textsuperscript{137}
\end{quote}

After spending eight months in the mental institution following the birth of her first child, Pauline’s letter provides us with rare insight into her plans for the future. Her tender reference to her baby, and having the opportunity to take her time in setting up house indicated how crucial her mother’s support was to Pauline’s recovery and subsequent release. It is one of the very few examples that represent the patient’s point of view, particularly in the crucial transition between the institution and family life that trial leave represents.\textsuperscript{138} Pauline remained on trial leave and was discharged as recovered in 1930.\textsuperscript{139}

\begin{itemize}
\item \textsuperscript{136} Joanne Mont Park Clinical Patient Notes, DHS, AS/1994/00104/0021.
\item \textsuperscript{137} Pauline Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0010
\item \textsuperscript{138} Coleborne, Madness in the Family (2010), p. 132.
\item \textsuperscript{139} Pauline Mont Park Patient Clinical Notes, DHS, AS/1994/00104/0010
\end{itemize}
In Sylvia’s case, she returned to the institution following the births of her second, third and fourth babies. On all three occasions, Sylvia’s husband insisted in taking his wife home on trial leave. In the first instance, a short two-month stay in 1925 occurred following her second child. Sylvia’s doctor notes: ‘Her husband insists on taking her out on full responsibility and against advice and signed to that effect.’

By November the following year, Sylvia was committed after giving birth to her third child five days before at the Women’s Hospital. At the request of her husband, Sylvia was discharged after a two week stay. Three years later, Sylvia was committed in March 1929, then discharged at her husband’s request one month later, having no menses for four months. Sylvia gave birth to her fourth child in August 1929 and committed the day after. Against doctor’s advice, Sylvia’s husband signed for her early trial leave after a two month stay. This time, Sylvia remained out of the institution and discharged by 1930.

Sylvia’s husband’s continued insistence to take his wife home reflects his dire need for her to return to her domestic responsibilities in caring for their young family and to run the household. He demonstrated his intimate knowledge of the mental hospital’s system by the sequence of births, committals and trial leave against doctors’ advice. It may be appropriate to question whether this married couple had an agreement between them to use the system to their advantage. It is a plausible idea that would allow Sylvia to rest following each birth, knowing her husband would actively seek her leave each time. Either way, Sylvia’s many committals illustrated the burdens mothers faced. Her case highlighted the issues of family size, and whether the use of contraception to space pregnancies was known and personally morally acceptable. Additionally, the possible

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140 Sylvia Royal Park Patient Clinical Notes, DHS, AS/1997/093/68.
141 Ibid.
lack of family support, social networks and domestic help, may have contributed to Sylvia breaking down under the sheer weight of her domestic responsibilities following childbirth, as the mother of a young family.

For both Beatrice and Sandra, no trial leave was granted and both spent decades in the institution. Beatrice was committed in 1920, aged forty-two, following the birth of her seventh child. A letter sent to Beatrice’s husband was returned to the institution in 1942. He was no longer at the same address, but the letter intended to inform him his wife had been boarded out at the benevolent home in Castlemaine. Whether Beatrice’s husband had died, forgot to notify his change of address, or intentionally shirked his responsibilities to his wife in order to start a new life elsewhere, is difficult to know. Beatrice later died at Castlemaine in 1952. For Sandra, committed in 1922 aged twenty-six, no trial leave was granted at all. She died in 1974, having spent over fifty years in various Victorian institutions. One of the last doctors’ notes states: ‘This patient is almost totally deaf elderly person, and as a chronic schizophrenic is completely inaccessible.’ The loss of family ties for Beatrice and Sandra meant they had no opportunity for trial leave or release, and were left to decline and eventually die after many decades in the institutions.

In summary, the women’s success in social therapies of work and trial leave did not always lead the patient to recovery and release in every case. Some women worked consistently in their occupations, like Ada, but without a family member to take

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142 Beatrice Sunbury Patient Clinical Notes, PRO-V, VPRS: 8236/P1/4.
143 Ibid.
144 Sandra Kew Patient Clinical Notes, PRO-V, VPRS: 7676/R1/260.
responsibility for her welfare on the outside, could not secure release. For those who were released, the files show it was less dependent on occupying themselves inside, or recovery as the result of physical treatment. Instead a patient’s discharge depended on cultivating outside support and having a family member willing to sign their release and provide for their future welfare.

**Crises and reform**

Three highly critical reports in the 1940s and 1950s exposed the long-term inadequate care of patients in Victorian institutions. The first inquiry responded to allegations made by the clergy reported in the press that ‘patients were herded together with few staff to care for them’ and ‘some male patients were bedded down like dogs.’

The then Health Minister for Victoria, Mr Barry, denied these allegations as lies and exaggerations and claimed ‘mental patients had never been harshly treated in this state.’ However, Barry agreed to investigate the state of Victorian mental hospitals and appointed Dr Ernest Jones as chairman of the Mental Hospitals Inquiry Committee. In his 1949 final report, Ernest Jones agreed the ‘press allegations were true.’ Jones clearly blamed the government for not allocating adequate financial resources, as he had done for many years in his annual reports as Director of Mental Hygiene and as the Inspector-General of the Insane:

> Most of the older institutions were out of date, that insufficient money for maintenance, equipment, and advancements has been provided, and this parsimony is of many years. Overcrowding does exist and considerable clothing,
feeding and amenities is imperative.\textsuperscript{148}

Professor Alexander Kennedy, from Durham University, England, conducted the second report on Victorian mental health services, also in 1949.\textsuperscript{149} It was unclear why a second report was needed so soon. Whether Jones’s report humiliated the government, particularly in light of Barry’s vigorous denials, or whether there was concern over Jones’s objectivity, having headed the department for so long, an international expert was sought. Professor Kennedy, the Chair of Psychological Medicine at Durham University, spent six weeks in Australia to investigate the state of Victorian mental hospitals and delivered a lecture tour.\textsuperscript{150} His key recommendation was to establish the new Mental Hygiene Authority. This would achieve, Kennedy argued, the much needed improvements in the quality of staff training, postgraduate qualifications and close co-operation between universities and medical agencies.\textsuperscript{151}

At the same time, Kennedy publicly criticised Dr Catarinich, the director of the Mental Hygiene Department. The headline: \textit{Expert condemns our asylums: Mental homes ‘inhumane and backward’} covered the front page of \textit{The Argus} newspaper in 1950.\textsuperscript{152} This, and other newspaper articles, slammed Catarinich for failing to keep informed of recent developments in psychological medicine; remaining isolated from the Australasian Association of Psychiatrists and not attending scientific meetings, were among

\textsuperscript{148} Ibid.
\textsuperscript{150} Ibid. For information on Professor Kennedy’s academic and sporting career, see ‘Professor Kennedy Visiting Canberra’, \textit{The Canberra Times}, 7 October 1949, p. 4, \url{<http://nla.gov.au/nla.news-article2746416>} [Accessed June 11].
Kennedy’s complaints. In response, Catarinich did not defend his leadership publicly. Instead, in a small newspaper notice he briefly stated he would reply to Kennedy’s allegations in a report to the health minister, Mr Gartside. In 1950, the government acted upon Kennedy’s recommendations and legislated for the new Mental Hygiene Authority. It was responsible for managing the public psychiatric system, replacing the existing Mental Hygiene Department. The new Director would report directly to the Health Minister, establishing greater autonomy than the former Mental Hygiene Department. For Catarinich, there was no role in the new structure. He completed the terms of his appointment and retired in 1950. In his final annual report, Catarinich cautiously defended his leadership:

The difficulties at present confronting the Department are not the result of indifference or lack of appreciation of the many issues involved. They are the inevitable results of the many urgent and essential activities which had preference over the claims of the mentally ill. In my opinion, it will be wrong to expect the new Authority to perform miracles in the way of altering existing conditions. The Authority will have an uphill task to fulfil, but I trust that with the increasing demand by the public for better treatment and supervision of the mentally ill, it will be enabled to do much to remove the difficulties which have hitherto blocked the progress which is so urgently necessary.

Three men were appointed to run the new Mental Hygiene Authority in 1952: Dr Eric Cunningham Dax, chairman, Dr Charles R. D. Brothers, deputy chairman and Mr E. R. B. Ebbs, administrator. Cunningham Dax, a British psychiatrist, emigrated to take up the

new appointment. His skills in public relations, government administration and his personal energy and charisma gained legendary status as the reformer who modernised Victoria’s neglected mental health system. Dax’s leadership was a turning point that came to be known as the ‘Daxian era’. His reforms were wide ranging:

The reformation of a service becomes a fascinating exercise in the raising of the standard of patient care and in public relations, in personal recruitment, training and management, in communication, in architectural design, in the use of social welfare services, in industrial activities and in community welfare.

One of the Authority’s first concerns was the recruitment of student nurses. Seven new nurses’ quarters were commenced at Sunbury, Larundel, Warnambool and Royal Park, and modernising the nurses’ home at Kew. Nurse training and facilities were improved and examinations were reorganised through the Nurses Board. The traditional authoritarian and custodial approach began to disappear as the shift to patient welfare and rehabilitation took place. With the backlog of over 3,000 public works requisitions yet to be completed, Dax found some easy remedies for raising the living standards and patients self-esteem. For example, worn out institutional attire was replaced by clothing from the stores and donations from the public. Dax also called on the public to donate books for recreational, rehabilitative and educational activities when he discovered four mental hospitals were without patient libraries. The Red Cross

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161 Ibid. p. 79.
166 Ibid. p. 45.
167 Ibid. p. 25.
168 Ibid. p. 27. See also p. 25 where Dax acknowledged the stores were well stocked in bedding, linen and clothing, but were not issued in the past to save money.
volunteers coordinated the collection of donated books and helped establish patient libraries.¹⁷⁰ Voluntary community organisations, including the Mental Hospital Auxiliaries, Melbourne Rotary Club, Victoria’s Aid to the Mentally Ill, the Red Cross and the Country Women’s Association, played an important role in Dax’s reforms for improving patient welfare.¹⁷¹ For example, the Mental Hygiene Auxiliaries opened new kiosks at Beechworth, Ararat, Larundel and Sunbury where patients could purchase an assortment of consumable items.¹⁷² The Melbourne Lions Club and master painters donated many Saturdays to paint all the exteriors of Kew cottages.¹⁷³ Dr Grantley Wright, Superintendent of Mont Park, reported:

The patients’ happiness and well-being were specially catered for in the many social and recreational activities and events arranged for them by the hospital and various interested bodies. Picture shows, dances, and community singing were held weekly and greatly appreciated; concerts, bus drives, special teas, Christmas treats, all helped to bring pleasure to the patients.¹⁷⁴

The Annual Fancy Dress Ball, sponsored by the Riversdale Mental Hospital Auxiliary, bought pleasure to over 500 patients in attendance.¹⁷⁵ Dax spoke highly of these volunteer groups’ activities in the Mental Hygiene Authority’s annual reports, adding the Authority was ‘most indebted for their unlimited kindness.’¹⁷⁶ The involvement of volunteer organisations, Dax acknowledged, worked in two ways: volunteers aided patients with practical support and at the same time served to educate and de-stigmatise community attitudes towards mental illness.¹⁷⁷

¹⁷¹ Cunningham Dax, Asylum to Community (1961), pp. 87-94.
¹⁷³ Ibid. p. 33.
¹⁷⁴ Ibid.
¹⁷⁵ Ibid.
¹⁷⁶ Ibid. p. 13.
¹⁷⁷ Cunningham Dax, Asylum to Community (1961).
The Authority worked hard to recruit medical and professional staff. Between 1951 and 1968, psychiatrists increased from ten to ninety-seven, and medical officers from twenty-eight to ninety-six.\textsuperscript{178} Medical officers were encouraged to undertake postgraduate study offered by the University of Melbourne in the Diploma in Psychological Medicine.\textsuperscript{179} Social workers increased from eight to forty-nine, responsible for recording patients’ social history and liaising with family members and relatives.\textsuperscript{180} Occupational therapists increased from ten to fifty-five, in the same period.\textsuperscript{181} Dax encouraged creative activity in patients, having previously used art therapy in the treatment of mental illness at Netherne Hospital, Surrey.\textsuperscript{182}

In Victoria, art therapy units were set up in several hospitals, including a studio, workroom and gallery at Royal Park.\textsuperscript{183} The psychiatrist referred specific patients to art therapy and their paintings were retained and stored.\textsuperscript{184} By 1961, Dax recommended that occupational therapy provided different functions for short-term and long-stay patients.\textsuperscript{185} Art therapy promoted a sense of positive achievement, restoring patients’ self-esteem and giving them assurance in their abilities, especially for short-term patients in the early stages in their illness. For long-stay patients, Dax outlined that occupational activities were directed in industrial activities for rehabilitation.\textsuperscript{186} Dr Roberts, superintendent at Ballarat, reported that a group of regressed patients formed two small manufacturing

\textsuperscript{179} Cunningham Dax, \textit{Asylum to Community} (1961), p. 31.
\textsuperscript{182} Cunningham Dax, \textit{Experimental Studies in Psychiatric Art} (1953).
\textsuperscript{185} Cunningham Dax, \textit{Asylum to Community} (1961), p. 36.
\textsuperscript{186} Ibid.
units in the successful production of usable and saleable products included: ‘marionettes, children’s furniture and toys, party decorations and hats, place mats, theatre properties, game sets, paper bags, mops and brushes and the packaging of stamps.’

At the same time, improvement to buildings and facilities commenced. Mont Park opened a new operating theatre and renovated the female wards. From the superintendent annual reports throughout the early 1950s capital works were slow to progress. Dax addressed this problem, in part, by increasing the artisan staff to attend to small job maintenance in the wards. It wasn’t until the federal government rolled out funding, following the 1955 Stoller report, that Dax could address building accommodation and facilities at all Victorian institutions. Dr Alan Stoller was appointed to the Mental Hygiene Authority as Chief Clinical officer in 1953. In this role, he was responsible for research, teaching of medical staff and general provision of treatment. By 1954, the federal government commissioned Dr Stoller, and administrative assistant Mr K. Arscott, to investigate the mental institutions in all Australian states. Their 1955 final report found that all mental hospitals ‘were hopelessly overcrowded, poorly maintained and short-staffed.’ Victoria was the best equipped in the commonwealth, yet still fell short of desirable standards and overcrowding still occurred.

189 Cunningham Dax, Asylum to Community (1961), p. 44.
193 Ibid. p. 92.
Once the report was released to the public, the press seized the opportunity with headlines such as: *A report that shames us all* and *Mental report ghastly*. The neglect of the nations’ mental institutions became politicised. The state and federal governments argued over jurisdiction and responsibility, while the Labor opposition attacked the federal government for its failures. The Menzies government finally responded to the Stoller and Arscott report with a capital grants program to modernise the facilities, and as Dax points out it was the first time federal funding was made available for capital works. 842,000 pounds was devoted to the Royal Park rebuilding programme. In 1955, a year after Stoller investigated the conditions of Victorian hospitals, he acknowledged ‘there has been a marked improvement in mental hospital conditions and great projects in treatment, cure and prevention are going ahead. Under Dax’s leadership, the increased funding saw Victoria as the first state to address the legacy of neglect and parsimony.

Dax continued the medicalised approach in the form of physical treatments in malaria for general paralysis (syphilis), insulin comas and leucotomy within institutions. The advent of pharmacology, gave Dax the opportunity to create fundamental changes in the mental health care. Medication allowed patients to leave hospital and access the new out-patient clinics Dax had initiated. Psychiatrist J.F.J. Cade, known for his discovery of lithium for manic depression, saw the introduction of Largactil for schizophrenic patients as ‘the miracle drug that was destined to change the whole practice of hospital

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197 Shame Story Can't Be Written Today (1955), p. 3.

198 Ibid.


psychiatry.' The therapeutic benefit of Largactil allowed schizophrenics to leave the institutions and be maintained in the community with regular out-patient attendance and assessment. Cade argued that this was a positive alternative to the multitude of schizophrenics doomed to spend the rest of their lives as chronic patients in mental institutions.

Dax’s optimistic plan for the future in community-based, mental health services would replace the old mental institutions, effectively moving from asylum to community. His vision of a complete mental health service for Victoria would provide the promotion of mental health, the prevention of mental illness, out-patient care, day hospitals, in-patient early treatment, in-patient rehabilitation, and community after-care services and follow up organisations. In many ways, Ada benefitted from Dax’s move to community-based, mental health care, particularly when she could not return home. However, medication did not enable Ada to leave the institution, as Cade argued, but in her case, it worked the other way around. In Ada’s last assessment at Mont Park, when arrangements were finalised for her to be boarded out at Carmel House, her doctor noted Ada was not on medication at present. Instead, once living at Carmel House in 1964, a hostel dedicated to female out-patients, it was through Ada’s attendance to the nearby Preston out-patient clinic, that she was first introduced to anti-psychotic medication in the form of Stelazine and Melleril, in 1965.

202 Ibid. p. 50.
203 Ibid.
205 Ibid. p. 100.
Updating psychiatric terminology was among the many notable changes Dax instituted. The terms ‘pregnancy’, ‘parturation’ and the ‘puerperal state’ were dropped from the classification of mental disorders in Dax’s first report in 1952. These terms were used by the Victorian psychiatric profession from 1905 to 1950, as evidenced in the yearly reports to parliament.\(^{206}\) Other obsolete terms such as ‘insanity’, ‘hygiene’ and ‘lunacy’ were removed and schizophrenia appeared for the first time.\(^{207}\) In 1959, the Mental Health Act, formally modernised terminology and removed out-dated terms, changed the name of the department to Mental Health Authority and simplified the process of admission and discharge.\(^{208}\) The move from ‘mental hygiene’ to ‘mental health’ illustrated psychiatry was willing to leave behind the eugenic connotations of population degeneration that ‘mental hygiene’ broadly encompassed. Instead, the move to ‘mental health’ was an integral part of Dax’s reforms. He recognised certain social factors as the genesis of psychiatric disorders: old age, alcoholism, migration, housing and marriage breakdown, and the need for further social research to remedy these issues.\(^{209}\) Mental health reforms shifted away from institutional settings with decentralised programs for prevention, public education, early detection and treatment, rehabilitation, day hospitals and in and out-patient clinics in both city and regional settings.\(^{210}\)

The cycle of crises and reform illustrated how Victoria struggled to care for the mentally ill, particularly in the second half of the twentieth century. As the practice of psychiatry moved towards community-based facilities, Janice Chesters argues, the institutional

\(^{206}\) Reports of the Inspector-General of the Insane, 1905-1933; Reports of the Director of Mental Hygiene, 1934-1936; Reports of the Director of Mental Hygiene 1937-1950.


\(^{208}\) Cunningham Dax, Asylum to Community (1961), p. 142.

\(^{209}\) Ibid. pp. 204-205.

\(^{210}\) Ibid. pp. 200-205.
medical model of mental illness continued in smaller, and fragmented public mental health services, usually in close proximity to major hospital precincts.\(^{211}\) This diversification of mental health services, increasingly burdened families to care for their mentally ill family members.\(^{212}\) The 1993 Burdekin report exposed the failure of deinstitutionalisation and that people were denied the rights and services they are entitled to, suffering widespread and systematic discrimination.\(^{213}\) In launching the report Burdekin stated: the inadequate provisions in mental health facilities, welfare services, and secure housing violated the human rights of people with mental illness [and] is a national disgrace.\(^{214}\) By the year 2000, all the old psychiatric hospitals in Victoria were closed and the recurrent funding was redirected into alternative services.\(^{215}\) Housing people with highly complex needs, was just one of the multiple issues in need of attention. Some could access community sector supported groups homes, but were hindered by problems with the supply of housing in general.\(^{216}\) By 2005, the Not for Service report stated increased homelessness remained a key issue amongst people affected by mental illness.\(^{217}\) The lack of housing options, the high cost of private rentals, long waiting lists for both public housing and supported accommodation still needed to be addressed in Victoria.\(^{218}\) The deinstitutionalisation of patients meant that families of


\(^{216}\) Ibid. p. 64.

\(^{217}\) Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia, (Mental Health Council of Australia, 2005).

\(^{218}\) Ibid. pp. 390-391.
the mentally ill and the community were expected to absorb the shortfall in caring for their mental ill family members, but were not equipped for the task. Burdekin, in his 1993 report, stated women were amongst the most vulnerable citizens left to suffer without any appropriate services. He acknowledged that women who had endured childhood abuse, sexual assault or domestic violence were more likely to experience mental illness.

Asylum superintendents continued to recognise puerperal insanity as distinct from other mental disorders. It therefore serves as the historical forerunner to today’s postpartum mental disorders. Baby blues, postnatal depression (PND) and puerperal psychosis are three distinct categories specific to the postpartum period. The baby blues are common affecting seventy per cent of postpartum women and characterised by mood changes. Usually short in duration, baby blues or maternity blues in general, do not require medical attention. Postnatal depression (PND) affects 10 per cent to 15 per cent of women in Western society. The early editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I, DSM-II and DSM-III), did not classify PND as a distinct mental disorder until 1994. This revised edition of the DSM-IV included PND as the same

221 Ibid.
224 Ibid.
depressive symptoms as a major episode of depression. It identified the onset in pregnancy or a ‘postpartum onset specifier’ within four weeks after the delivery of the child. In the subsequent editions of the DSM, the classification for PND has remained unchanged. John Cox argued that without a specific diagnostic classification in international definitions of mental disorders, postnatal depression could be misconstrued as not to exist. This led, Cox argued, to the failure to identify depressed mothers in Edinburgh, Scotland in the 1980s, with the majority not receiving any treatment. His development of the *Edinburgh Postnatal Depression Scale*, a ten question, simple method of assessment, has greatly assisted the detection of mothers with postnatal depression.

Puerperal psychosis, differs from postnatal depression, as it is a rare condition that occurs in only two episodes per one thousand deliveries. It has a rapid onset, characterised by hallucinations and delusions and is linked to mothers with a pre-existing bipolar disorder and family history of psychotic disorders.

The medical model uses pharmacological interventions in the form of antidepressants to treat women with PND. This biomedical approach ignores social, cultural and personal factors contributing to postnatal depression. Researchers have identified a multiple set of causes for postnatal depression that include both biological and psychosocial risk.

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The risk factors include: depression or anxiety in pregnancy, past history of psychiatric illness, stressful life events, lack of social support, relationship problems and breakdown, and obstetric complications. A holistic, biopsychosocial approach to treatment is recommended for postnatally depressed mothers, tailored to the individual.

**Conclusion**

It is hard to see that mental hospitals offered much to the insane other than providing bare refuge from the outside world. Cure was such a problematic concept. For example, manic patients under Dr Cade’s care, improved with lithium treatment, but it did not cure bipolar, instead it evened out their moods. The psychiatric profession relied on the public’s belief in their ability to cure the insane, yet cure remained a false promise in many cases. However, women did recover, but it is difficult to point to one single approach or treatment that lead to their release. Some worked and may have gained new skills and confidence in themselves. While at the same time the institution relied heavily on patients’ employment for the smooth running of the place, when the government continually refused the necessary resources for improved care. Others that did not participate in work but could still procure their release.

The various experimental treatments described in this chapter illustrates psychiatrists were desperate to produce cures, to heal and restore their patients to normalcy and lead

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productive lives. But many treatments, as this chapter has shown, led both doctors and patients down blind alleys in terms of cure. What did lead to a patient’s recovery and release was an eclectic combination of all the above. Some worked, like Ada, but that did not lead to her recovery or release. Others managed to maintain or reconnect with those on the ‘outside’ willing to take responsibility for them upon their release and that appears to be the key. The difficulties in maintaining their networks from inside the institution proved problematic particularly when relatives appeared to have ‘moved on.’ Others remained in touch and actively sought their family members’ release. Communication appears more powerful than any other cure or treatment for patients to procure a place to go, whether through either letter writing or phone calls. Although this was not foolproof for patients like Ada, who had regular contact with her husband and brother, but neither were willing to take responsibility for her outside the institution. A combination of circumstances, particularly being a hard worker without medication, allowed Ada to live in the community at Carmel House.

In many ways, doctors in the early twentieth century focussed on the perceived unbalanced behaviour of mothers and lost sight of the person. The context and circumstances of her childbirth experience, her family’s circumstances and how she felt were of little concern to psychiatrists. Mothers were constrained by their compulsory committal and the power inequality between themselves and their doctors and husbands. Within the hegemonic power structure of the institution, a few women managed to express their agency through the power of resistance by remaining silent. Differences between the sexes mattered and the medicalisation of mothers’ bodies and minds powerfully influenced the gendered roles in domestic duties assigned to female patients as work therapy. The cultivation of family support and the ability to maintain it from
within the institution appears more integral to recovery, discharge and release, than medical or social treatments for mothers in the institution.
Chapter Seven: Conclusion

This thesis has shown how the legacies of uterine theories continued to powerfully influence the gendered practices of psychiatry and framed Anglo-Christian mothers as maternally insane in the early twentieth century. Doctors persistently saw puerperal insanity, and its variations, as a useful and distinct diagnostic category to commit mothers perceived as ‘unfit’ by their families. Although ‘maternal insanities’ were poorly defined and omitted from classification systems, doctors found childbirth as the key event for instability in mothers, as they had done so in the past.

Maternal insanities involved a complex web of medical and social assumptions and prejudices concerning women’s reproductive health and ill health, and childbirth. Doctors saw mothers as a uniform group, in which their social and biological roles were tightly bound together as one. When doctors identified and socially positioned women as mothers, they confidently labelled childbirth as a psychiatric problem. This led them to apply the diagnosis of maternal insanity as reason for committal. The files show a diversity of mothers, experiences and backgrounds, but doctors showed little interest in individual, cultural and social influences. Any social or personal problems that mothers experienced following childbirth, such as poverty, violence, suicide or fear of poisons were reduced to psychiatric problems. This exposes the contradictory meanings of motherhood that often blamed the individual for their situations, rather than understanding the difficult conditions mother’s laboured under as the dependants of men, and their difficult family circumstances within an unequal gendered society.

Families had plenty to say about mothers behaviours and reported a whole host of dysfunctions and symptoms that clearly marked out what was acceptable and
unacceptable motherly conduct. Mothers of unmarried women played a key role in their daughter’s committals, keen to avoid the public stigma concerning their unmarried and pregnant status. Husbands described their wives’ insanity in domestic terms. A woman’s value was reduced to her domestic ability and inability. Families initiated committal, often ill-conceived, when the emotional and financial resources of the household were drained. The families’ and husbands’ role began by attaining committal certificates from general practitioners, often when mothers could no longer fulfil their domestic responsibilities. Husbands’ complaints ranged from the trivial through to acts and threats of violence, while mothers, on the whole, denied the more serious allegations. Overall, the majority of mothers remained silent, unable to express their concerns and fears of desertion, family breakdown, pregnancy, poisoning, Christian sin and male violence to their male psychiatrists.

Institutional psychiatrists could not turn away involuntary patients. Doctors were legally bound to admit the patient once the family successfully gained two admission certificates. Committal was historically, and continued to be a *fait accompli*. Doctors tended to favour husbands’ versions of the facts, but there was no effort to substantiate their claims through fact checking. These points, along with fragmented note taking, culminated in what we could term the collusion of the system. For example, husbands were not questioned about their role in their wives’ problems. Given that institutional doctors had to comply with the committal process, their power lay in assigning diagnoses, which, in turn, determined the kinds of treatments recommended for patients.

For the vast majority of psychiatric patients, counselling, and Freud’s talking cures were not yet a routine part of the doctor’s therapeutic repertoire, at least not inside the public
institutions such as those described in this study. Australian women’s individual experiences of childbirth and mothering, their family’s circumstances, social problems and how the mother felt about these were pathologised into psychiatric categories no longer in use. Psychiatry’s understanding of mental illness at the time meant that treatments focused on mothers’ bodies. The experimental treatments examined included the ‘rays’, insulin coma, typhoid inoculations, sterilisation and abortion illustrated the belief that maternal insanities was an organic, physical disease within the individual mother, triggered by childbirth. Differences between the sexes mattered, and the male dominated profession failed to recognise their deeply embedded male bias that reproduction, pregnancy and childbirth explained perceived psychological dysfunctions.

Historians have successfully argued that families had faith in psychiatry’s ability to cure their relatives, and held hope that patients would be ‘fixed’ in the institutions. At the same time, institutions tended to reinforce the idea of the dysfunctional family. Psychiatry did not dispel the myth of cure, when medical, physical treatments for insanity on the whole, were unsuccessful. This thesis has shown how physical treatments had mixed, and in some cases devastating, results for patients. Release could be achieved, but rarely due to experimental physical or gendered social treatments alone. The patient’s fate depended on someone willing to have them released into their care. This research has illustrated the strength and pervasive power of families, both in initiating committal and taking responsibility for their family member’s release.

This thesis is a significant contribution to knowledge through its chronicling of the cases of women committed to institutions with maternal insanities in the twentieth-century, Australian context. Few studies have been able to assess the twentieth-century evidence.
It has illustrated the pressures and social issues mothers faced, whether poverty and illegitimate birth, and argues that maternal insanities were not always linked to a recent birth. Instead, this work has shown that puerperal insanities and its maternal variations were widely applied to mothers distressed by their mothering and domestic roles. The nature of the twentieth-century psychiatry and treatments changed dramatically from the nineteenth century, but the linking of reproduction, pregnancy and childbirth with psychological problems remained the same.

Several methodological innovations have been introduced. One contribution to methodologies is illustrated by the descendant’s ability to access their relative’s patient clinical files through Freedom of Information Units, if they wish to. This method of access for next of kin has shown FOI’s capacity to draw patient information from a wide range of archival spaces that included admission warrants and notice of transfers, as well as the individual patient files. A further methodological contribution is demonstration by the ability for researchers to request and gain access to restricted files held by the Victorian DHS, not always permissible in other states.

The examination of patient files illustrated some distinctive patient journeys, particularly in the unmarried mothers group. This collection allowed comparisons to be drawn with Ada’s patient history, which illuminated her institutional journey as highly unique. It is through Ada’s passage that major twentieth-century psychiatric developments were revealed. For example, her diagnostic changes from puerperal insanity to schizophrenia, experimental treatments including ICT, abortion and sterilisation, eight years of domestic work in the superintendents home, her persistent delusions of grandeur, the move into the community by boarding at Carmel House, the hostel dedicated to ex-female patients
instituted by Cunningham Dax and lastly, the prescription of anti-psychotic drugs in the mid-1960s. All these points serve as major markers of twentieth century psychiatry found in one patient’s institutional journey. But these discoveries were serendipitous. It could very well have been another mother’s files that provided such a wide variety of treatments and institutions. In this way, it is through Ada, that a narrative for twentieth-century psychiatry has been mapped and marked out.

The final contribution to original methodologies lies in the multiple qualitative methods used to narrate Ada’s story. The combination of patient files with oral histories and family stories compliment and complete the triangle of data. All three methods substantiate the internal validity of this research. The qualitative research strategy in matching and checking information in data triangulation has strengthened this work. The documentation of method procedures and declaring my feminist insider position, as researcher and family member, has consolidated the reliability of this research. Oral history approaches in family recollections and interviewing staff descendants provided a personal richness and depth in Ada’s patient story not available through an analysis of her files alone. Furthermore, Ada’s story has gone towards completing our family story, in removing the shroud of mystery, silence and stigma that once rendered her invisible.

The limitations of this study concern the small collection of mothers’ mental patient clinical notes. This study is therefore not representative of all female insane patients admitted with maternal insanities in early-twentieth century Victorian institutions. The selection of maternally insane women was not exhaustive, and while this study provides in-depth insights into some patients, it is not representative of all maternally insane patients in this time period. However, the methods presented here have allowed for a
deeper analysis of a selection of cases. The thesis makes no claims for a representative sampling technique.

The opening of the twentieth-century archive would provide greater opportunities for researchers to deeply investigate the successes and pitfalls of psychiatry in the twentieth century. Further studies of patients, treatments, doctors, pharmacology, institutions, psychiatry and community care before and after de-institutionalisation would allow a more indepth narrative of twentieth-century psychiatry to emerge. Given the low percentage of women committed with maternal related insanities, an exhaustive collection of the cases of all mothers with same diagnosis would be possible. Research that is larger in scale, concerning mothers committed to institutions, could further unpack assumptions about women and reproduction in psychiatry. This could also feature differences and commonalities in family stories, treatments and pathways to release for institutionalised mothers.

This work importantly serves as the forerunner in understanding mother’s mental health in a cultural and a biomedical perspective. It offers opportunities to research progress from the biomedical model to incorporating psychosocial approaches in treating mothers. Further research could be undertaken on the services available to mothers experiencing baby blues, postnatal depression and puerperal psychosis before and after de-institutionalisation. Whether these services were free from moral and sexist assumptions and if separating mothers from their children was necessary in all cases, warrant further investigations.
The exposure of past abusive institutional practices bear further study. The removal of mothers to the institution is identical to the child-removal policies that forced separation of babies and children from their mothers. In cases of maternal insanities, separation at the earliest sign of instability was standard practice. Mother’s committals intended to save children from mothers identified as ‘unsound’ and ‘unfit’ whether black, poor, and single and in these mother’s cases, insane. Children were deprived of their mothers, and in turn mothers deprived of their children. On the one hand, committal was seen in the best interests for the protection of their children and on the other hand in protection of the mothers themselves. However, these files were notably silent on the welfare of insane mother’s babies and their children. The note taking was poor, and the lack of information stemmed from the belief that the welfare of babies and children were beyond the psychiatrist’s responsibilities. The secrecy and erasure of children’s family of origin embedded in the bureaucracy of child removal policies bear strong similarities to the lack of information on children’s welfare in this study.

Child-removal policies and past abusive institutional practices have come to light in three Australian public inquiries that investigated the Stolen Generations, Former Child Migrants and Forgotten Australians. Survivors and their families’ testimonies provided evidence that extensive institutional abuse occurred in the hands of state, medical and church organisations.

The widespread removal and forced adoption of babies born to white, unmarried mothers (Forgotten Australians) occurred in Victoria from 1870s and was formalised in legislation
These unmarried mothers were deemed ‘unfit’ and were forced to relinquish their babies for adoption has strong links with unmarried mothers in this study. This research has exposed issues of child welfare, wrongful committal, intrusive and experimental treatments, and deprivation of liberty. These vexed problems indicate the necessity of a public inquiry into Australian mental institutions past activities and abuses. Restorative justice and reparation are some of the outcomes from the three public inquiries, currently in progress for the survivors of child-removal practices. In the same vein, public apologies, memorials and in some cases schemes of redress and compensation could be appropriate outcomes of such an inquiry for psychiatric survivors and their families.²

Alternatively, litigation has precedence in international cases. Psychiatric survivors have pursued individual and class actions for compensation and recognition of abuse while in institutional care. In the case of Leilani Muir, she successfully sued the Alberta government (Canada) for wrongful sterilisation and wrongful confinement. Muir’s case elevated the issue of human rights abuses concerning individuals in the mental health system, the legacy of eugenic practices, and their rights to make decisions about their reproductive futures.³

In making some final reflections, the three Australian Royal Commissions and international litigation cases have ramifications for Australian institutional practices,

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patients and their families. Individuals like Muir, mental patient consumer groups, their families and advocates continue to drive major change in the reform of the mental health system. The present government continues to delay the investment of funds and the re-structure of mental health services, as it has done in the past. Opportunities for further studies on institutional human rights abuses hold hope in achieving positive rights for people with mental illness.
Epilogue: The researcher’s journey

2007

I began by asking G about any of Ada’s records or documents he knew about? He told me about the bundles of letters and cards Ada had sent to both her children from the institution over a twenty year period. This got my hopes up!

G recalled the events leading up to discovering Ada and her letters. As a young married man in his twenties G was celebrating his birthday. He received a birthday card signed love from mum. G was outraged, and accused his cousin R of sending the card, as a bad practical joke. R denied it and suggested G better talk to P about his mother’s whereabouts. P confessed and said yes, Ada was living in, and always has been, in a mental institution. P then produced, the bundle of cards and letters from Ada, and proceeded to burn them there and then in front G. I can sense that G experienced a great sense of betrayal and hurt.

Between G and myself, we figured that prior to G moving towns, the local postmaster had been sending the letters from Ada, but P had been intercepting them. Once G moved house, as a newlywed, the post master simply forwarded the card onto G’s new address, as is the case in small towns. There began the process of rediscovery and re-connection with Ada.

12 December

I did some research online in an effort to find information about Ada. I found that the Public Records Victoria website held Beechworth female patient files up until 1912. But this was far too early a time period. I found that some files are closed for 75 years and requests can be made through the Freedom of Information Unit. I talked to G about
making the request for Ada’s files. He was okay with it, but didn’t want the files sent to him.

**28 December**

I purchased both Ada’s marriage and death certificates, from Victoria’s Registry of Births, Deaths and Marriages. Her occupation on the 1934 wedding certificate said ‘comptometer operator’ and Ada was twenty-four when she married. I have no idea what a comptometer is and will need to research that later.

I recall some of the family stories I heard growing up that Ada’s condition was connected to her periods. I’m not sure what effect this had on me as a young girl or whether I knew what menstrual cycles were. I remember someone in the family saying that when Ada became unwell she would be put into hospital for rest and that she was well for three weeks out of the month. As a child I remember thinking that being sick one every month was very often.

**2008**

**17 May**

G had reconnected with Ada in the 1960s, when she was living at Carmel house. They met once a week in the city and had lunch together. From these chats, G knew Ada had worked in the boss of the institutions’ home, at Beechworth, Victoria.

With the details from Ada’s marriage certificate, like her date of birth and correct spelling of her maiden name, I filled out the forms for the FOI request, with as much information as I could. I requested her mental patient files from Beechworth and any other institutions she had possibly been in. A phone call from FOI said they could not release Ada’s files to me as I hadn’t proved I was her next of kin. I spoke to G and he signed the permission
request. G also verified with FOI, that Ada’s files were to be sent to me, as G didn’t want
to see them. Quite a process. Within three months, Ada’s files arrived

10 July

I received Ada’s records from Freedom of Information Unit, Melbourne by post. The
records are A4 photocopies, not in chronological order and the hand-writing is difficult to
read. Her first committal was to Royal Park Receiving House in 1936. No diagnosis on
committal certificates. One of the early doctor’s entries stated ‘puerperal insanity’.

I searched online for the meaning of ‘puerperal insanity’ and found several publications
by Hilary Marland. Marland’s focus was on puerperal insanity in nineteenth-century in
Britain and explained that it was insanity caused by recent childbirth. This led me back to
check Ada’s files. Her most recent birth was two weeks before her committal. Which
means G was a newborn baby. I was very saddened by this. It’s hard to express how
devastating it is to find that G lost his mother so soon after being born.

I went to the last section in Marland’s book Dangerous Motherhood searching for
information on the condition in the twentieth century. Marland argued puerperal insanity
began to be written out of psychiatric textbooks and out of asylum records from the late
nineteenth century onwards. I was disappointed there was little information beyond the
nineteenth century. It did give me the beginnings of my thesis argument. Ada’s files
illustrated the diagnosis of puerperal insanity was still in use in Australia in the twentieth
century.

August

I’ve started to transcribe Ada’s files into a word document, attempting to place transfers
to other institutions in chronological order. This immersed me deeply in her institutional
life. Ada was only twenty-four years old when she was first committed. She was just so young.

I’m struck by the voice of Ada’s husband as prominent in her committal certificates. I am also struck by the photograph of Ada, a small black and white portrait pasted into the first page of her clinical notes. Her physical resemblance to myself is strong. Small eyes, fair skin and wavy hair. The wavy hair is such a signature feature in the whole family. Ada is looking away from the camera and smiling.

While transcribing I found Dr Booth notes on Ada undergoing a therapeutic abortion and sterilisation. It is shocking and I am very saddened that Ada had been through such an ordeal. I wondered if this was standard procedure for all mothers in the institutions. The understanding that Ada had become unwell following her second birth, was a very different illness to the one the family had thought that was connected to her periods. Yet both scenarios were related to her reproductive functions and somehow the link to her womanhood was made.

July

I made contact with supervisor C, having purchased her book *Madness in Australia*. There were no references to puerperal insanity, unfortunately. C is keen to supervise my PhD. I then searched SCU academic register, and found supervisor A and made arrangements to meet. I told A about Ada’s records, and about my discussions with C and her interest in supervising my PhD.

I started writing the research proposal for enrolment. Good feedback from both supervisors. But they critiqued my use of old refs such as Ann Summers and Miriam Dixson. I like them as they talk about women and mothers as victims, within Australian
masculine society, which I perceived relevant to Ada’s life. The argument has moved on and I needed more current references.

October
I submitted my applications for APA Scholarship. Fingers crossed.

15 December
Good news. I received an offer from SCU for admission into PhD. Then I arranged meeting with A this week to sign Supervisor/Candidate Agreement form.

16 December
More good news. After a day of moving house, and relaxing with friends at my new place surrounded in boxes I opened the mail. Wow, I received notice that I have been granted the APA scholarship commencing early in the 2009.

2009
January
I met with supervisor A, who suggested I undertake the Research Methods unit offered in the Honours program in this first semester. She felt it would be useful as I am jumping disciplines, from my media Honours to history PhD. A friend of mine thought it was insulting to be put in with the Honours group as a PhD. I did not feel this way at all.

February
I attended the two day Postgraduate Orientation for research students. I really enjoyed meeting the group of candidates across all the disciplines. One presentation on the importance of study groups got me networking with T and M. We exchanged contact
information, formed a study group together, and planned to meet once a month in the University library.

**February**

I enrolled in the PhD program and started attending the Research Methods class every Monday morning. It was great. I loved being a student again and attending class. There were no other social science or history students, unfortunately. The class are mainly creative students, painters and writers, who were struggling with the idea of writing an exegesis. I well understood their frustrations, as I had done creative work and exegesis for my Honours.

There is no history major or history undergraduate degree taught at SCU. There are only two history units offered within the Bachelor of Arts. Other PhD students may relocate or enrol in another University to be supervised by an expert in their field of study. I chose to enrol in SCU, the university in my home town. This allowed my son to continue high school without the disruption of relocating, and it also avoided the expense of regular travel to receive supervision.

**May**

I completed all assessments for Research Methods unit okay. The last assessment was a 6,000 word research proposal that included methodology, and methods etc. I am aiming to do Ada’s biography, set in context to the rich tradition of women’s madness.

**July**

I attended the Fifth Australian International Academic Conference on Motherhood. Titled: *The Mother and History: Past and Present*, at University of Queensland in Brisbane. A wonderful conference, and attended by some prominent international
motherhood researchers including Andrea O’Reilly. Andrea runs the MIRCI (Motherhood Initiative for Research and Community Involvement) out of University of York, Canada. MIRCI publish a Journal of Motherhood (JMI) and Demeter Press. I found MIRCI website, and became a member, and started to receive call for papers etc.

**August**


**October**

I presented at the Praxis conference, an internal SCU conference for postgraduate students, at the Coffs Harbour campus. In the discussion that followed my presentation a senior academic told the group about her mother’s committal in NSW following the birth of eighth or ninth child. We later had an email exchange concerning how she could access her mother’s files, like I had done.

While in Coffs Harbour I visited Aunty Val, G’s cousin. Val was great, very interested in my project, and had some recollections. She recalled her parents talking with P, when she was a child, that he should visit Ada more often in the institution.

**October-November**

I did three weeks casual teaching in Tianjin, China as unit assessor and lecturer with tutor and fellow PhD buddy T. I read Matthews, Garton and Coleborne books and took copious notes while away.
December

I took my son with me to China and taught at Shanghai. I wrote the Demeter press book chapter before the teaching day began. Very busy.

Back in Australia, I talked to a family member, K, a trained as a nurse and midwife, about Ada’s files and whether they could assist me in understanding some of the medical terms. K is interested and agreed to assist. Within the same month, G complained to me, that an old family friend and local shop retailer, talked to him and knew I had Ada’s files and was working on them as a PhD project. He was very upset that this information was leaked from K to the local community. I was told in very certain terms not to talk to K about Ada, or the project, as they were a ‘gossip’. I then refrained from sharing any further information with that first K. I raised this family upset with my supervisor.

2010

January

I finished and sent 5, 500 word book chapter to Demeter Press: I wrote it with a particular emphasis on blaming men, Ada’s husband, and her psychiatrists. I felt very outraged and indignant that so many awful things had happened to Ada.


22 March

I talked to several family members who were keen to be interviewed and be involved in the project. I worked hard with both supervisors to write and complete the full NEAF Ethics application to do interviews with family members. It was tough writing it. It
included the outline of research design, interview design and questions, and informed consent forms and information sheet for participants.

10 April
I presented my Confirmation presentation to the School, as per requirements at the end of the first year of candidature. It was attended by both Supervisors, C on the phone, Head of School, several senior academics and a couple of friends of mine in support. One year has passed already.

16 April
I received response from HREC on NEAF App. They’ve queried six points concerning the interviews with family members. I felt frustrated after working hard on it, but it still needed more work.

15 July
I worked with supervisor A on responses to HREC and re-submitted it today. I addressed the issues HREC raised concerning risk to myself and family members, how these risks would be managed, ensuring anonymity of family members. It was intense and gruelling work.

19 August
Both supervisor A and I were asked to meet with the Chair of HREC (Human Research Ethics Committee) to discuss ethical issues of family interviews in NEAF Application. He was generous with his time, and spent about an hour and a half with us. The Chair suggested I needed to provide stronger evidence that demonstrates awareness of the risks to myself and outline strategies for my emotional management. He recommended I needed to read up on insider research, as a family member and researcher. We talked
about accessing further mental patient files, which C had recommended, and we agreed was possible. The Chair recommended I could do a phased approach with the methods, and ethics applications. To start with applying for further files, and if family interviews were still important to do a Full NEAF App for family interviews at a later stage. The Chair asked that I withdraw or put a hold on NEAF app, for now. There was something said about problems with a previous family research project. Then I was asked to leave the room so the Chair and A could talk privately.

After all the hard work I had put into the NEAF application, the Chair was asking me to put the interviews on hold. I was confused, disappointed and frustrated as to why this was seen to be the best approach. I began writing my reflective journal to record my achievements, disappointments and reflections.

25 August
I met with both supervisors with C on Skype. There was much discussion about the shock and surprise in not getting ethical approval to interview family members. It had me spinning. Supervisor A said it would make a good journal article one day, on issues of family research and the concerns of university ethics committees. Supervisor C said her University had approved a candidate’s work with their own Mauri family. Whether that project was a more sensitive family project than my own is hard to say.

I felt my thesis title was enough to scare the Ethics committee: *Releasing the Unreleased: An historical study of mothers’ insanity in Victoria Australia: 1920-1936*. In placing both ‘insanity’ and ‘mother’ together in the title may have conjured a social taboo and proved too much of a risk for the Ethics committee. I have spent the last six months on the NEAF application. I felt I did not have much to show for eighteen months of study.
The discussion with my supervisors returned to collecting further files. Supervisor C had raised this method earlier this year. I felt that my unique access to Ada’ files, within the closed file embargo of 75 years, meant that I had effectively excluded myself from accessing any more files in the same time period. I felt I had backed myself into a corner methods wise. Supervisor C was encouraging, and said I might be surprised and approval may be possible. We planned the strategy to request further files by applying to the Health Minister, Victoria and request change of protocol from SCU Ethics committee first.

5 September

Despite several family members being on board to participate, I advised both of my supervisors I would not pursue interviews with my family members. I submitted the Expedited Ethics application outlining my request to collect further mental patient files from Victoria. I also made it clear I did not intend to pursue family interviews in this application. It has been far too stressful and difficult. This change to the data collection would allow me to progress the research and avoid further delays. But I now had a fear of the Ethics committee and was very worried about this application, however low-risk and straight forward, I feared it too would be rejected. I began to see ethical dilemmas everywhere, and it highlighted the problems in doing family research and protecting family identities.

15 September

I received notification from Division of Research that I had formerly progressed my candidature, following my confirmation presentation. It took five months from my presentation in April to received notice. I hope that if I had not progressed, I would have
received notice far earlier. There were no issues raised at my confirmation presentation concerning the ethical issues in interviewing family members.

13 October

Good news. The Expedited Ethics Application was approved to access thirty files.

15 October

I presented at the annual SCU postgraduate conference Praxis: *Fractured Motherhood* based on Ada her files. I feel my presentation style is poor. Even though I have been teaching undergraduate students for a couple of years now, I just simply read from my notes when presenting my research. The information in Ada’s files are distressing and it is compounded by my family’s secrecy concerning her whereabouts, I get emotional when presenting Ada’s story. The audience are supportive, thank goodness and the following discussion was very stimulating. During the lunch break a senior academic confesses to me that his mother was committed to a mental institution in New Zealand years ago.

30 October

I sent the request letter sent to the Health Minister of Victoria Hon. Daniel Andrews to access further files, with support letters. I am worried that Victoria is in the middle of state elections, and could delay the decision about my request until new government had taken office. A friend advised me that my application had little political motivation or ramification, and if rejected it would not be due to change in government.

24 November

I presented to the School’s Annual Colloquium, along with my PhD peers. Titled: *Fractured Motherhood* based on Ada’s story. It was a full room of academic staff and
PhD candidates. My presentation style continues to be poor in my eyes, and as usual I just read from my notes. I get all wobbly, and a shaky voice when presenting my research. It’s such a painful story, and extremely difficult to tell. It did stimulate interesting questions and discussion, the audience seem to be carried by the story. But frankly, I am a mess during it and afterwards. This is the third presentation this year and it does not get any easier. Too sad, too personal, too hard.

It is the talking of Ada’s story out loud in formal settings that I become a little emotionally unsteady. There is something about verbalising the story that the impact of her life really hits me. I can only hope the audience sees my emotional connection to the research as a positive thing. After my presentation, a staff member confided in me that their mother had periods of time in a mental institution. This is happening very often. People are willing to disclose to me about their own family members committed to mental institutions. By presenting Ada’s story it seems to give people permission to reflect on the circumstances of their own relatives committals. Perhaps my presentations removes or, at least, lessens the social taboo and provides a space to air the issue of committed family members, previously only talked about in hushed tones and behind closed doors. People’s disclosures gave me an understanding that insanity affected many families, other than my own.

November

Supervisor A received a phone call from the Victorian State Psychiatrist, who received my request that had been forwarded on from the Health Minister’s Office. The discussion concerned how much work was involved for Dept. of Human Services, Victoria, where the files are held. I think the department were worried that by giving me access it would
add to the department staff workloads. It was made clear, once access was approved, I would attend the office of the DHS and undertake the work of collecting the files.

**December**

Supervisor A received approval from Chief Psychiatrist Victoria to access mental health records. I then had an email exchange with the Manager of Information & Records Services (Dept. of Human Services, Vic) in Lonsdale St, Melbourne to arrange my visit to their office in January 2011. I booked my flights for January 2011.

**2011**

**11-28 January**

I travelled to Melbourne to work in the DHS archives and collect further mothers’ patient files. The staff were very helpful and gave me a desk and computer. I started working through the Admission books for Royal Park Receiving House and was given white cloth gloves and a nose/mouth guard to protect me from the dust.

I totally underestimated the time needed to collect thirty files. I booked four days accommodation in Melbourne CBD, and optimistically thought I could spend the rest of the time with family and continue to work on the project. I soon realised I needed more time in the archive and rebooked new accom for another week.

From the admission books, I took notes of patient names who were committed with birth-related insanities. There were so many terms used: puerperal, parturition, childbirth, and post-partum. I had collected over fifty patient names from the admission books. Next, I found forty-four patients index cards, and photocopied them. The information on the
index cards provided the last institution the patients resided, which then lead to finding the full patients clinical notes.

The archive itself was the size of a huge aircraft hangar with compactor shelves on rollers. A staff member showed me the filing system and the protocol necessary before one starts to move and roll a row of shelves. Which is to call out ‘moving row L’ for example, and waiting to see if anyone hollers back. Fortunately, I did not squash anyone.

The moment of discovering a file was exciting. I had to tag the place where the file was removed and return the box to the shelf. Then leave the archive to photocopy the file in the office area, and then return the file to its rightful place. As paper files, I photocopied them all at their original, which fitted nicely on A3 size paper. They were far easier to read at this size than Ada’s, which had been reduced to A4 by FOI.

All the index cards were held in this archive, but not all the patient files were held there. For patients that were transferred to Kew their files were ordered from the Public Records Office, with the help of the staff. I optimistically bought 30 A3 plastic covers for each to get them home safely. A very helpful staff member offered to scan all the photocopies to pdf, and then save them to my USB. It was simply a terrific backup to the paper versions.

I had trouble finding the minimum of thirty files and spent a hurried day at Public Records Victoria, where some files are open to the public.

I had too little time with family. I did manage time to have lunch and a few hours with G, who caught the train into the city to meet me. He was concerned the project had moved away from the focus on Ada. I tried to explain why I needed further thirty files, as it was basically a way to sure up the thesis, now that interviews of family members had gone. It
is not easy to explain the decisions of University Ethics committee to those outside the university system.

21-24 January

I travelled to Beechworth, about a three hour drive from Melbourne, in country Victoria. I visited the Mayday Hills Mental Hospital where Ada had spent eight years in the 1950s and 1960s. It is a very eerie place. I walked around the grounds, and took many photographs. I looked for the Superintendent’s residence, where Ada worked as a domestic servant, but I could not find it. Some of the buildings serve as La Trobe University’s Beechworth campus, while the rest appears abandoned. I was advised by Beechworth historical society of a Book available on the mental hospital The Lion of Beechworth by D.A. Craig and purchased it.

I had a sleepless night, felt flat, sad and bereft and I chose not to return to the Institution the next day. I contacted the tour guide who ran Ghost Tours through the mental hospital. I did not want to do the tour, I thought it far too creepy. Instead, I thought they might know some information about superintendent’s residence. The tour guide was away at the time of my visit, and a later email exchange confirmed the superintendent’s residence had been demolished in the 1970s.
Figure 16: Various photographs of the grounds and buildings at Mayday Hills Mental Hospital, Beechworth, Victoria. Photographed by the researcher
25-27 January

In my last few days in Melbourne, I found the Melbourne Health Science Library, situated in the Royal Melbourne Hospital, but unfortunately, it was closed due to renovations. So I then headed to the Ballieu Library, at the University of Melbourne. There I found volumes parliamentary papers, and spent a day photocopying the Annual Reports from psychiatrists. I located the former Royal Park Mental Hospital, now converted to luxury apartments known as the ‘Parkville Gardens’ housing estate, which was refurbished as accommodation for the Commonwealth Games Athletes Village, 2004. I also located the Cunningham Dax Centre in Parkville that houses thousands of psychiatric patient’s art, which has since been relocated to the University of Melbourne.

![Figure 17: The Cunningham Dax collection located in Parkville. Photographed by the researcher](image)

February

Back home I began collating the files I had collected and realised I was still a few short of thirty. I contacted a private historian to collect two more files from PROV, and they arrived by post on CD disk.
March

I presented at the school’s Annual School of Arts and Social Sciences Colloquium, which was tele-conferenced across all three SCU campuses. The title is: ‘Mother’s interrupted: puerperal insanity in early twentieth century Australia’. It focused less on Ada and incorporated some information from the other mother’s files. This approach worked for me, as I was less emotional and shaky, and a little more confident in my presentation style. I used it as a practice run for next month’s international conference. It was well attended by PhD students and academic staff, and an interesting discussion followed which provided some good feedback to rework the presentation for next month’s conference.

27-30 April

I travelled to Brisbane and presented at my first International Conference: Mothers at the Margins, the Sixth International Conference on Motherhood at The University of Queensland in Brisbane. My title is: ‘Mother’s interrupted: puerperal insanity in early twentieth century Australia’. It drew from both Ada and the further files collected. The presentation before mine was about the bad mother in Japanese fiction and referred to specific Japanese authors and their texts. The audience was predominantly Japanese. I was then introduced and got up to do my presentation. There was no discussion and no questions asked from the audience. I think they were mystified about my topic. I ran off with my tail between my legs. I cheered myself up by purchasing many finding Hecate Journals from the campus bookshop.

I figured that by bringing in the further files, and not concentrating on Ada’s story, I would be more confident and less wobbly and emotional. I started to refer to Ada as a female relative. This worked for me personally, but of course I was delivering to the
wrong audience. Back in Lismore and discussed the conference with supervisor A. I figured by putting ‘puerperal insanity’ in the title must have confused the organisers as to know where to place me in their sessions. Supervisor A encouraged me that in the future, scrutinise the program beforehand and argue to be better placed in an appropriate session. Such is the benefit of hindsight.

29 September

I flew to Sydney to attend a one day symposium: Histories of Motherhood in Australia held at the NSW State Library, hosted by Macquarie University. Some excellent presentations from Australian feminist luminaries. I tried to circulate and chat with presenters at morning tea, lunch and afternoon tea. It was hard to break the ice and join the conversations. I lurched in and introduced myself and felt I was politely tolerated. I had the same ‘outsider’ feeling at the meet and greet drinks that evening. I suppose I need to submit and publish and earn my stripes as a researcher. It does beg the question why I think I need to attend conferences, especially when it feels there is a lack of inclusiveness.

2012

March

My three years of APA Scholarship is finished. I applied for six months extension to the scholarship citing the protracted NEAF process, which resulted in changes to methodology, methods, and considerable revision to draft chapters. I argued that conducting interviews with my family members was an approach that was not questioned in my confirmation documents and presentation. The Full NEAF Application in 2010 was a stressful process, the concerns of the Chair of HREC were unforeseen and considering the fraught nature of the process it was unlikely to achieve approval for the full NEAF
application to interview family members quickly. Supervisor C wrote a very strong letter of support to extend the scholarship.

7 March

Good news. The six month APA scholarship extension was approved. I continued to write the thesis chapters. I completely revised the chapter on puerperal insanity in the nineteenth century. It felt like every sentence typed in that chapter needed to be referenced, as there is so much research material on the topic to understand, incorporate and acknowledge.

16 August

The APA scholarship extension is finished. This which prompted me to change my enrolment to part time and self fund the remainder of my PhD studies through casual teaching.

October

I had my lap top stolen from home! There was much confusion over who was the last to leave and didn’t lock the backdoor! Thank goodness for regular back-ups to external hard drive. I lost about three weeks of thesis writing. Bought a cheap Toshiba laptop.

November

G had been reminding me about whether I had found anything about the Donnan’s and Ada’s work with their family at Beechworth. This curiosity had stemmed from Ada’s stories she told him on their weekly catch-ups in the 1960s. But the files said so little about this time. I decided to join ancestry.com to see if I could find anyone from the Donnan family. It cost $21.99 per month to be a paying member, which allowed a deeper
level of access, including the ability to email other members. I decided I would give it a go for a limited time of three months paid membership.

December

I just received my two copies of book from Demeter Press: Moms Gone Mad: Motherhood and Madness, Oppression and Resistance. Here’s the timeline: I wrote it in 2009, peer reviewed in 2010 and 2011, final edits completed in late 2011. Published with printing errors in 2012 (not my chapter). Republished (without typos) in late 2012. What's the lesson? Publish journal articles, as they are the same university bonus payment, but a much quicker publishing process.

Some reflections on writing the Book Chapter:

The book chapter was drawn from Ada’s files, before I obtained the remainder of mental patient files. In Ada files, the voice of her husband’s testimony, the doctor’s notes and treatments illustrated to me how men had dominated her life. Upon reflection, this book chapter focused on her powerlessness and subordination by all kinds of patriarchal power. The radical feminist writers were so enchanting and deliciously appealing to me, strident in their smashing of patriarchy. I felt it was true that Ada was a victim to all kinds of male power, and my feminist outrage seeped into the text.

After the book chapter was published, I was disappointed to read feminists have argued against research that posited women as victims. Feminists argue the field of scholarship needs more positive stories about women’s roles in history. But what if the data, like mine, doesn’t show the key points of the women’s liberation movement of female agency, emancipation, liberation or empowerment? Most of the files are sad stories. The empowerment element in this research, may not be for the women in the files themselves,
but for women of today. Western Women who have managed to access education, health care, employment, and good ante and postnatal care may see this research as a lens into the historical treatment of women and mothers and reflect on how far women have come.

2013

January

On ancestry.com I found there was a Donnan family tree posted online and I made contact through the site. They confirmed that their relative was Dr Donnan who had been Superintendent Psychiatrist at Beechworth. This family member facilitated my contact with other family members. Sally emailed me her telephone number if I wanted to call her and chat further. My first telephone call with Sally was extremely rewarding. Sally talked easily and openly about Ada’s appearance, her work and general family life. It was this kind of personal element I had been hoping for. I informed Sally the work was part of my PhD research and she was happy to participate.

4 February

A change of protocol and low-risk ethic application was submitted to HREC to interview Sally was approved. Sally and I talked on the phone several times and exchanged emails regularly. We talked about my visiting her in Melbourne, and Sally invited me to stay with her at her home. We started to plan a time towards the end of the year that would best suit us both.

April

I registered my book chapter publication with SCU, applied for the publication bonus and obtained a Researcher Profile page at http://works.bepress.com/alison_watts/
September

I received my first publication bonus of $600 from the Demeter Press book chapter. This money would assist in the travel costs to visit Sally in Melbourne and interview her in person.

18-28 November

I travelled to Melbourne and stayed in the CBD. The first week I spent every day at the Health Sciences Library, situated within the Royal Melbourne Hospital. On my last visit the library was closed for renovations, and as they do not allow requests or interlibrary loans, it was excellent to be finally here. I collected loads of references written by Ellery, Cunningham Dax, and volumes of Medical Journal of Australia.

On Friday I travelled by train to stay with Sally. She met me at the train station and took me to her lovely home. We talked all weekend and I took copious notes. Together we had coffee by the sea and walked along the beach. I found that her father Dr Donnan had worked at Mont Park first, following the family’s migration from England. It was at Mont Park Sally first met Ada. I didn’t know this before. Somehow I thought Ada was transferred to Beechworth independently from the family. Instead, the Donnan family took Ada with them, travelled in their car and no doubt helped Mrs Donnan set up the house for the family. The transfer documents in Ada’s files match the dates of Dr Donnan’s new position as Superintendent Psychiatrist at Mayday Hills, Beechworth.

Sally was very open and generous and together we looked through her family photo albums. She told me about her brother’s wedding at their home in Beechworth. This matched Ada’s anecdotes with G, who said Ada spoke of the excitement of a wedding. G also knew of the Donnan’s transfer to Warnambool from these chats with Ada, which
Sally was able to confirm.

It was arranged for G to collect me from Sally’s home on Sunday and stay with him for the remainder of my trip. G was anxious and did not want to meet Sally. G and I checked in with each other a couple of times over the weekend, and I tried to assure him Sally was a gentle person and she invited him to come in and have morning tea. Sally was a bit confused as to whether she would get to meet G or not. It required a fair bit of emotional labour from me to put both Sally and G at ease. I decide it was best not to have any expectations, and that either way would be okay and I would let G decide.

As Sally and I set the table for morning tea I reminded her G was probably nervous because Sally had childhood experiences with Ada, whereas G was deprived of Ada’s mothering from birth. She understood his sensitivity. Morning tea was ready and we still unsure whether G would toot the horn from the driveway or come in. We were all nervous. G arrived and he was happy to come in and met Sally and together we had morning tea. I was much relived. I left them together briefly as I went to collect my bags and their conversation lightly touched on Ada and our physical resemblance to her. As we were preparing to leave G thanked Sally sincerely for helping with my research.

The next day G and I drove to a family lunch. On the way, G wanted to drop into Sally’s and give her a gift. She was home and was visibly moved by G’s present. Sally said we were like lost family arriving. We took photos together in Sally’s front garden, then we left for lunch.
The whole experience was so powerful, deeply moving and healing. All three of us had parts of Ada within us. The lived experience of childhood memories, adult reconnections and anecdotes and the family likeness. We attended the lunch with the family. H and G, brother and sister, and were happy to share their recollections of growing up. There was a gorgeous interaction between them. Both, in their mid to late 70s, sharp minded and quick witted. Sometimes they had conflicting memories, other times they shared a laugh.

2014

January

I have about 70,000 words for the thesis, but much refining is needed. My candidature ends in August this year and I will need to go into lapse to get it ready for submission.

2 May

I was invited to present at the Psychology Colloquium, at SCU Coffs Harbor campus. In my role as both president and secretary of the Southern Cross Postgraduate Association over the years, I met many students from the large cohort of higher degree psychology students studying at Coffs Harbour campus at our social functions. One of these students recommended to their convenor I present my research at their weekly colloquium. The title: Insane mothers: an historical approach. It was recorded and can be viewed on the internet at: http://scu.edu.au/health-sciences/index.php/163

Following the presentation, one of the students asked whether I had sought redress and reparation for wrongful committal. I hadn’t thought of this before. It did get me thinking about the parallels to the three royal commissions into historical child welfare practices and their approaches to restorative justice and reparation. The recording of my
presentation served as a very useful tool for reflecting on the quality of my presentation style and content, which I think has much improved.

7-11 July

I presented at the Australian Women’s History Network Symposium as part of the Australian Historical Association 33rd Annual Conference. It was held at the University of Queensland, St Lucia campus. The title of my presentation: Unfit Mothers in the Archive: Female Insanity in Twentieth Century Australian Mental Institutions. The presentation went well and a very good discussion followed.

30 July

My candidature has gone into lapse, which means my end date is now 30 July 2015.

2015

Thesis title change to: Maternal Insanity in Victoria, Australia: 1920-1973

As I work through the final editing of this thesis, I recognise the difficult journey I have travelled. When I began this project, I did not realise I would spend six years on very sad stories, particularly Ada’s. The work has haunting qualities as I came to terms with my legacy as Ada’s descendant and attempted to face our family’s past. I have mourned and grieved the circumstances of Ada’s life, the effects upon her children and the disempowerment that leapt out from the other mother’s files. My family’s secrets and lies, once necessary to protect Ada’s children from the truth of their mother’s whereabouts and mental illness, now have been revealed and released. Its power lies in its redemptive qualities, where any unconscious trauma that may have passed down the generations has dispersed. Ada is no longer locked in the attic of my psychic life, but has joined her rightful place as my materfamilias.
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Maternal Insanity in Victoria, Australia

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Appendix A

Fact Sheet: Closure of Public Records under Section 9 of the Public Records Act 1973,
Public Records Victoria
Appendix B:
Appendix B:

Decision

On the basis of your request, the department conducted a search and located the documents relevant to your request. The documents were then assessed by a freedom of information officer in accordance with the FOI Act to determine whether they could be released to you in full or released to you in part, or whether they were fully exempt from release. It is the department’s decision that no material is exempt from release and the documents that you requested can be released to you in full. Please find these documents enclosed. The table below provides details regarding the documents that have been released:

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Charges

All access charges of $22.40 (112 pages x 20 cents per page) in relation to your request have been waived.

If you have any questions in relation to this decision, please contact me on 9096 7538.

Yours sincerely,

Katrina Pantazopoulos
Senior Freedom Of Information Officer
Appendix C:
Hon Daniel Andrews Request, Nov 2010. p 1

Alison Watts, B of Arts (Hons),
PhD Candidate,
Arts and Social Science, Southern Cross University
PO Box 257, East Lismore, NSW, 2480
Ph: (02) 66219443 M: 0413326504
Email: alison.watts@scu.edu.au

The Hon. Daniel Andrews MP
Minister for Health, Victoria
Level 22, 50 Lonsdale Street,
Melbourne, Victoria, 3000

RE: Request for female mental patient files from Victorian mental institutions 1920-1934

Dear Honourable Daniel Andrews,

I am currently a PhD research student with Southern Cross University, Lismore, NSW (and a former resident of Victoria). The research focuses on an analysis of one female family member’s mental patient case files from Victoria, which were made available to me as next of kin through the Freedom of Information Unit. My aim is to contribute to knowledge regarding the diagnosis and treatment of women’s post-birthling Insanity’ in the early 20th century.

In order to make a more valid interpretation of my relative’s situation, I am requesting access to a small number of other women’s case files. I would like to select a between of 20-35 female mental patient records from the period 1920-1934 from any of the Victorian mental hospitals and institutions. This time period (1920 to 1934) aligns with the era of my family member’s confinement and sits outside the 75 year closed-file policy of Public Records Victoria. In order to undertake a comparative study, the files I select are of women with similar post-partum diagnoses, as my family member, in which various terms were used including Puerperal Insanity, Postpartum Psychosis, Puerperal Psychosis and Puerperal Mental Illness.

I would attend the premise where the files are held, photocopy them and de-identify the copies immediately, and not remove any original files from the premise. I am familiar with and abide by, the ethical standards governing the secure storage of sensitive material. Privacy and confidentiality are essential considerations when writing the thesis and other publishing of the research. This research has secured ethical clearance from Southern Cross University dated 13 October, 2010, Ethics No: ECN-10-175

The benefits of this research for the wider community lie in the telling of these previously unheard stories, which help us to understand our history, and more specifically the history of Australian women.
Appendix C:
Hon Daniel Andrews Request, Nov 2010, p. 2

I will acknowledge your ministerial offices’ role in assisting my access to the files requested, in both the thesis and any further publishing, if this meets with your approval.

If you have any further enquiries, please do not hesitate in contacting me or my principal supervisor Dr. Angela Coco, whose contact details I have provided below.

Yours sincerely,

Alison Watts

Dr Angela Coco
Principal Supervisor
School of Arts and Social Sciences
Southern Cross University
PO Box 157
angela.coco@scu.edu.au
Ph: (02) 6620 3035

Enclosures:
Two supporting letters from
Dr Cathy Coleborne
(Associate PhD Supervisor)
University of Waikato, New Zealand

AND

Dr Philip Hayward
Director, Higher Degree Research Unit
Southern Cross University, Lismore, NSW
Appendix D:
Interview Consent Form

CONSENT FORM

Title of research project:
Releasing the Unreleased: An historical study of mothers’ insanity in Victoria Australia: 1920-1936.

Principal Researcher: Alison Watts  Supervisor: Dr. Angela Coco

I agree to take part in the Southern Cross University research project specified above. 

I have been provided with information at my level of comprehension about the purpose, methods, demands, risks, inconveniences and possible outcomes of this research. I understand this information. 

I agree to be interviewed by the researcher. 

I agree to allow the interview to be audio-taped.

I understand that my participation is voluntary. 

I can withdraw from this research at any time without consequence. 

I understand that any information that may identify me, will be de-identified at the time of analysis of any data. Therefore, I, or any information I have provided cannot be linked to my person. (Privacy Act 1988 CN)  

I understand that neither my name nor any identifying information will be disclosed or published. 

I understand that all information gathered in this research is confidential. It is kept securely and confidentially for 7 years at the University. 

I give permission for information provided by me to be used in publications. 

I am aware that I can contact the Supervisor or other researchers at any time with any queries. 

I understand that the ethical aspects of this research have been approved by the SCU Human Research Ethics Committee. 

This research has been approved by the Southern Cross University Human Research Ethics Committee. The approval number is:  ECN-13-118

If you have concerns about the ethical conduct of the research, you should contact the following: 
The Ethics Complaints Officer 
Southern Cross University 
PO Box 157 
Lismore NSW 2480 
sue.kelly@scu.edu.au

All information is confidential and will be handled as soon as possible.

Participant’s name: 
Participants signature: 
Date: 
Contact Phone: ( )