EPILEPSY IN THE LUNATIC ASYLUMS OF SOUTH AUSTRALIA (1852 – 1913)

MARGARET BOULT

A thesis submitted in fulfilment of the requirements

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Department of History, Faculty of Arts,

University of Adelaide

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CONTENTS

ABSTRACT

Epilepsy is a common and sometimes life-threatening condition that can have profound physical, psychological and social consequences. Whilst much has been written about how the medical understanding of epilepsy changed during the nineteenth century, little is known of the individual experiences of people. This thesis addresses this by questioning why people with epilepsy were placed in lunatic asylums. In so doing it engages with the scholarly debate about whether the purpose of lunatic asylums was for cure or custody. Some scholarship describes asylums in humanitarian terms, stressing the importance of 'moral treatment' and situating it as a forerunner to psychiatry. This view was challenged by Michel Foucault who contended that moral treatment merely replaced physical restraints with another form of repression, imposed by power-seeking doctors. Materialist scholars also reject the idea that asylums were curative, describing them as places of social control and citing low cure rates and the accumulation of 'hopeless' cases. Using a 'bottom-up' approach, social historians regard families as central to the admission and discharge process. Opinions vary however, as to whether families sought cure or custody. In this study, patient information obtained from two South Australian lunatic asylums has been used. South Australia provides a useful case study as there were no private lunatic asylums, union workhouses or poor law. Nevertheless, as with asylums elsewhere, epileptic patients accounted for nearly ten percent of the asylum population between 1852 and 1913. Only the worst cases were admitted; the majority of people with epilepsy remaining in the community. Those admitted posed a significant burden to poorer families as they exhibited difficult behaviours and had little or no capacity to look after themselves. However, their families (if indeed they had families) did not readily relinquish their epileptic charges to the asylum, typically only seeking admission after years of home care. My thesis argues that the asylum was used for three purposes: respite care, palliative care and long-term care. The argument proposed is that moral treatment benefitted incurable patients, such as those with epilepsy. Families did not place kin in the lunatic asylum for custodial purposes. Instead they recognised that it provided a safe and caring environment for those debilitated by the condition.

DECLARATION

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Date: *3 December 2018*

ACKNOWLEDGMENTS

I dedicate this thesis to the memory of my great-uncle Sydney Duckworth (b. 1901), who developed epilepsy and was committed to a Yorkshire lunatic asylum in 1916. He remained there until his death in 1938. May this thesis serve as a small reminder of his life, which has otherwise been too easily forgotten.

ABBREVIATIONS & NOTES

ABBREVIATIONS

SRSA   State Records of South Australia

SAGG   South Australian Government Gazette

PPSA   Parliamentary Papers of South Australia Lunatic Asylums published in the Government Gazette of South Australia

NOTES

- Shortened references have been used for all footnotes in this thesis, as recommended by the *Chicago Manual of Style, sixteenth edition*.
- A complete list of all patients described in the thesis is included in Appendix 2. The entire Microsoft Excel spreadsheet can be downloaded from FigShare at:
  https://figshare.com/articles/EPILEPSY_IN_THE_LUNATIC_ASYLUMS_OF_SOUTH_AUSTRALIA_1852_1913_/7263476

TABLES AND FIGURES

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INTRODUCTION

There are many epileptic cases in this asylum, and all attendants are trained to be specially careful with these people, and to pay particular attention to them in case they are taken in a fit. Anyone who is accustomed to go through an asylum must have noticed that when an epileptic is seized with a fit he turns round and round. The attendant's duty is to seize him and lay him down on the ground and kneel at his side, undo his necktie, and send anyone, even a patient, for a pillow to put under his head. When this is done it may look like an assault, and patients have told me that an attendant is assaulting another patient when I have seen the whole thing myself. Look through all the patients in this institution and see if there is a man marked by a fall except one, and that man will not permit any man to go near him.[1]

This information was provided to a Royal Commission held in South Australia during 1884. It is unusual because it offers a rare glimpse into the lives of people with epilepsy inside nineteenth-century lunatic asylums. The commissioners learned that there were many people with epilepsy in the asylum and that attendants enacted special routines to prevent physical harm in the event of seizures. In 1900, Frederick Norton Manning, the (former) Inspector General of the Insane in New South Wales, also referred to the care provided for epileptics at two lunatic asylums. He noted that they were looked after in 'special wards' where 'thought, care and money have been expended to good purpose on behalf of this class, and that for the confirmed and insane epileptic no better or more suitable provision could be made'.[2] However, Manning also emphasized that only epileptics who were 'really insane' should be 'sent to hospitals devoted to the care and treatment of insane persons'. Evidently not all people with epilepsy were 'really insane'. Even so, to modern ears, the idea that *any* person with epilepsy was insane strikes a discordant note. The fact remains that a considerable percentage of residents in lunatic asylums were epileptic. According to Norton Manning, around ten percent of

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1 PPSA, No 136, (Adelaide, SA, 1884), q5726.
2 Norton Manning, 'The Epileptic,' 219.

lunatic asylum admissions in Australia, Britain and America had epilepsy.[3] Nevertheless, whilst the phenomenon of nineteenth-century lunatic asylums has continued to excite intellectual curiosity, the history of the many people with epilepsy who resided in them has been largely forgotten, absorbed into the larger history of institutionalisation.

This thesis seeks to redress the silence that surrounds the confinement of people with epilepsy by disentangling their stories from those of other patients who occupied lunatic asylums. However, before extricating the epilepsy narrative, in this introduction I first explain where the thesis is situated in the historiography of asylum theory and the colonial experience of insanity. I then explain what the care of epileptic people in South Australian asylums reveals about the evolving role of asylum care in the nineteenth and early twentieth century. A methodology section follows which describes the historical sources used and the development of a large South Australian dataset. The chapter concludes with an outline of the thesis structure.

THE USE OF LANGUAGE

The language in this thesis is not intended to offend, although many of the words used are now associated with language that stigmatises mental illness. The terms lunatic, mad, insane, idiot, and imbecile were commonly used in newspapers, correspondence, legislation and medical documents to describe mental impairment during the eighteenth and nineteenth centuries. The same terms are used in this thesis; however a distinction has been made when describing institutions. Those dating from the eighteenth century are referred to as mad-houses, whereas those of the nineteenth are called lunatic asylums, also in keeping with contemporary terminology. The language of insanity did not change significantly until the twentieth century. This change was apparent in South Australia when the nineteenth-century *Lunatics Act* was replaced by the *Mental Defectives Act 1913*. Lunatic asylums became 'mental hospitals' and patients 'mentally defective'. Another area where terminology is problematic relates to the doctors who worked in these institutions. In current parlance they are called psychiatrists, doctors who practice psychiatry. This terminology was not in use during the nineteenth century,

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[3] Norton Manning, 'The Epileptic,' 218.

although in instances the title 'alienist' was. As neither title was applied to the doctors in South Australia, in this thesis they are referred to as Colonial Surgeons, medical superintendents, resident medical officers, or simply doctors. The term 'mad-doctors' has not been adopted, although this wording did appear in some nineteenth-century literature. Finally, the word 'epilepsy' was in current usage during the nineteenth century, as was the description 'epileptic'. The Oxford English Dictionary dates their first appearance in the English language to the sixteenth century, with old French (*epilepsie*) and Latin (*epilēpsia*) precursors. These had origins in Ancient Greece where ἐπιληψία meant 'to seize'.[4] In England, epilepsy was also known as the 'falling sickness'; however this term does not appear in the South Australian archival records.

HISTORIOGRAPHY

Until the mid-twentieth century, historical narratives of lunatic asylums portrayed the nineteenth century as a time of humanitarian concern for the insane and the birthplace of psychiatry.[5] This view was revised during the 1960s, when historians started to contextualise the purpose of lunatic asylums within the rapidly changing social and economic circumstances of the nineteenth century. Rather than being places of humanitarian concern, the revised view maintained that they were centres of state-sanctioned custodialism and 'professional imperialism'.[6] The doctors who would come to be known as psychiatrists were not curing madness; as Foucault put it, they were inventing and subjugating it, becoming instruments in their own professional aggrandisement.[7] Following on from the revisionists came the post-revisionists. These social historians examined 'history from below', reconstructing patients' experiences of lunatic asylums from asylum records.[8] They created a different perspective of the

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[4] Temkin, *The Falling Sickness,* 21; 'epilepsy, n.'. OED Online. June 2018. Oxford University Press. http://www.oed.com.proxy.library.adelaide.edu.au/view/Entry/63398?redirectedFrom=epilepsy (accessed July 18, 2018).

[5] Examples of psychiatric histories include: Walk, 'Aspects of the "Moral Treatment" of the Insane,' 807-34; Leigh, *The Historical Development of British Psychiatry*; Berrios, *One Hundred and Fifty Years of British Psychiatry*; Zilboorg, *A History of Medical Psychology*; Hunter *Three Hundred Years of Psychiatry*.

[6] Scull, *Museums of Madness*; Scull, *Decarceration*; Scull, 'Madness and Segregative Control'; Rothman, *The Discovery of the Asylum.*

[7] Foucault, *Madness and Civilization*, 241-278.

[8] Early examples include: Porter, 'The Patient's View,' 175; Porter, 'Madness and Society in England,' 275-90; Digby, *Madness, Morality and Medicine*; Finnane, 'Asylums, Families and the State,' 134-48. In Australia see, Garton, *Medicine & Madness*. For a description of Whig, revisionist and post-

lunatic asylum, identifying collaborations between patients and their families, asylum doctors and government authorities. Aspects of each of these asylum histories are further elaborated in order to establish a conceptual framework within which the institutionalisation of people with epilepsy can be understood.

'Traditional' or 'progressive' linear histories of nineteenth-century lunatic asylums maintain that improvements in the treatment of the insane were a result of growing humanitarian concern.[9] This concern was seen to be part of a broader philanthropic movement which included in its purview the abolition of slavery, school and prison reforms, improvements in the working conditions of women and children and concerns about cruelty to animals. In what historian Kathleen Jones describes as 'the triumph of legalism', reformers such as Lord Ashley-Cooper, the seventh Earl of Shaftsbury successfully campaigned for a change in the laws pertaining to lunacy.[10] Their goal was achieved by raising public awareness of the cruel and dehumanizing treatment perpetrated against the insane in 'mad-houses'.[11] This led to a number of legal reforms between 1808 and 1845 which first enabled and later mandated the building of lunatic asylums in English counties.[12] The 1845 Lunacy Act ensured that all asylums would be subject to oversight by a public body called the 'Commissioners in Lunacy'. Most proponents of this view acknowledge that humanitarian reform of lunatic asylums did not arise *de novo* in the 1800s. There had already been proposals to regulate private mad-houses by 1754, and the Madhouse Act was passed in 1774.[13] It was, however, weaknesses in this Act that roused the concerns of reformers. Nevertheless, a mature legal framework was established by 1845, which ensured that asylums would be built, regulated and administered through a centralised state body.[14] Whether or not these changes were evidence of humanitarian reform has been challenged. Legal historian Clive Unsworth explicitly describes these changes as ushering in an era of custodialism. The wide-scale construction of lunatic asylums, coupled with the ability to legally detain patients, meant that 'the mentally disordered were subjected to a modified status

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revisionist arguments see: Brown, 'Dance of the Dialectic?' 267; Porter, 'Introduction,' in *Confinement of the Insane,* 1-5.

[9] An overview of the 'progressive' position is provided by: Garton, *Medicine & Madness*, 2-3; Porter, 'The Historiography Reconsidered,' 275-6.

[10] Jones, 'Triumph of Legalism' in *Asylums and After*, 93-111.

[11] Jones, 'The Parliamentary Reformers' in *Asylums and After,* 41-49.

[12] Unsworth, 'Law and Lunacy,' 479-485; Wright, 'Getting out of the Asylum,'138.

[13] Unsworth 'Law and Lunacy,' 482-3.

[14] Unsworth 'Law and Lunacy,' 481-5.

of subcitizenship'.[15] Thus, as Lyn Crowley-Cyr notes, 'the connection between reform and progress has come to be questioned'.[16] This however assumes that the aim of reformers was to subjugate the insane, an argument that risks associating good intentions with poor outcomes.

Alongside fundamental changes in the legal and administrative processes affecting the insane, another controversial aspect of humanitarian discourse is the system of care known as 'moral treatment' and 'moral therapy'.[17] In the 1970s, medical historian William Bynam stated that 'the development of "moral therapy" … is of course one of the high points in the history of psychiatry'.[18] In Britain, this approach was pioneered by William Tuke who famously designed and ran his Quaker mad-house on these principles. The York Retreat opened in 1796, and operated on the basis that a 'kind and conciliating treatment is the best means to promote recovery … and the use of chains is never resorted to'.[19] Moral treatment was embodied in all aspects of the asylum, according to Tuke's ideal of the middle-class family home.[20] The insane were to be treated as 'moral' beings; people who could understand and respond with reason if treated appropriately.[21] Significantly, much of the Retreat's fame resulted from publications written by Tuke's descendants over the course of the nineteenth century. His grandson Samuel, for instance, stated that the ideal design of the Retreat had 'met with the approbation of many judicious persons', and suggested that others should copy its 'internal economy and management' in other similar institutions.[22] A century later, Tuke's great grandson Daniel lauded the Retreat and the role it played in the 'reform in the treatment of the insane'. His book was dedicated to William, 'whose courageous humanity a century ago is recognised at home and abroad'.[23] Although the self-publicising Tukes were perhaps the most effective promoters of the system of care used at the York Retreat, John Conolly, an asylum reformer, also described moral treatment as an 'enlightened principle of treatment' in his 1856 book *The Treatment of the Insane*

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[15] Unsworth, 'Law and Lunacy,' 481.
[16] Crowley-Cyr, 'The Incarceration Archipelago,' 37.
[17] The two terms are used here interchangeably, although some scholars, such as Anne Digby, distinguish between the two: Digby, *Madness, Morality and Medicine*: chapters 3 & 4.
[18] Bynum, 'Rationales for Therapy in British Psychiatry,' 318.
[19] Daniel Tuke, *Reform in the Treatment of the Insane,* front quote.
[20] Edginton, 'The Design of Moral Architecture,' 103.
[21] Digby, *Madness, Morality and Medicine*, 33-34; Walk, 'Aspects of the "Moral Treatment",' 808.
[22] Samuel Tuke, *Description of the Retreat,* v.
[23] Daniel Tuke, *Reform in the Treatment of the Insane*, Dedication.

without Restraints.[24] However, by the twentieth century, critics questioned the likelihood that moral treatment was practiced, positing it would not have been possible to recreate such a system in large and overpopulated lunatic asylums.[25] One of the most strident critics of moral therapy was the French philosopher, Michel Foucault. Foucault did not question the use of moral treatment; rather, he asserted that it was a new system aimed at controlling, rather than curing the insane.[26]

Foucault's criticisms of the humanitarian model were published in the 1960s and would have an enduring influence on asylum theory. He declared that 'no medical advance, no humanitarian approach was responsible for the fact that the mad were gradually isolated'.[27] He famously challenged all of the underlying assumptions of the humanitarian model, in particular the meaning and construction of madness.[28] Tracing a linear history from the Middle Ages, Foucault argued that before 1656 the mad had not been ostracised from society.[29] Rather, they contributed a tragi-comic reflection of people's 'follies' and the 'dark necessity of the world'.[30] This view changed during the seventeenth century, according to Foucault, when the 'socially unproductive' were segregated *en masse* from the rest of society.[31] The mad were imprisoned with the sick, destitute, beggars and criminals, in a movement Foucault called the 'Great Confinement'.[32] By the nineteenth century, the mad were further segregated, and became the 'silent object of medical science shut away and invisible in institutions'.[33] Asylum-doctors did not need to use physical restraints, as they could control their patients with 'surveillance and judgement', the process Foucault envisaged to be at the heart of moral treatment.[34] He was particularly interested in the imposition of a new medical authority which based its moral imperatives on what he termed the 'fiction of the family'.[35] Thus, the mad, could be 'sequestered, and in the fortress of confinement,

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[24] Conolly, *Treatment of the Insane without Mechanical Restraints,* 17.

[25] Scull, *Most Solitary of Afflictions*, 198-201; Leonard Smith, *Cure, Comfort and Safe Custody,* 4; Adair, 'A Danger to the Public?' 1-2.

[26] Foucault, *Madness and Civilization*, 241-278.

[27] Foucault, *Madness and Civilization,* 224.

[28] Foucault, *Madness and Civilization,* 23, 243, 276-277.

[29] Foucault, *Madness and Civilization*, 39. The symbolic landmark date was the founding of the Hôpital Général in Paris.

[30] Foucault, *Madness and Civilization*, 13.

[31] Foucault, *Madness and Civilization,* 38-64.

[32] Foucault, *Madness and Civilization* , 47; Porter, 'Foucault's Great Confinement,' 47.

[33] O'Farrell, *Michel Foucault,* 36.

[34] Foucault, *Madness and Civilization,* 251.

[35] Foucault, *Madness and Civilization,* 254.

bound to reason, to the rules of morality'.[36] The lunatic asylum cut communication between 'modern man' and the madman, and replaced it with the 'abstract universality of disease', a language mediated by doctors which 'confines insanity within mental illness'.[37] Thus, according to Foucault, madness became the prerogative of doctors, whose knowledge would serve to legitimise the purpose of the lunatic asylum as well as their own professional status.

Foucault's ground-breaking work overturned the orthodoxy that asylum reform was a victory of humanitarian principles over an unenlightened past. Rather, he created an intellectual space in which new ways of thinking about lunatic asylums and madness could flourish. The scholars who followed Foucault faulted many aspects of his work, not least his 'Great Confinement', for which little historical evidence existed outside of France.[38] According to the medical historian Roy Porter, in England the insane had only been confined by parish boundaries under the Old Poor Law.[39] Indeed, until the nineteenth century, any move to exclude the insane in England was 'gradual, localised and piecemeal'.[40] Porter also criticised Foucault's assertion that moral treatment could be regarded as an 'authentic break', noting the contributions of English philosopher John Locke in 1700 and physician William Battie in 1758 to theories of the mind.[41] According to Porter, it was Locke, not Tuke, who was the actual pioneer of a 'moral' or 'mental' approach to madness.[42] Locke argued that reason was made by the mind, not 'divinely illuminated'.[43] The historian Andrew Scull also drew attention to the fact that William Tuke was a layman and not a doctor. He highlighted that it was therefore inappropriate for Foucault to attack the role of asylum doctors based on the work of a layman.[44] Rather, moral treatment could be regarded as 'a threat to pre-existing medical involvement in the mad business'.[45] Hence, Foucault had failed to provide a 'persuasive account of how professional control over madness was secured by physicians'.[46]

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[36] Foucault, *Madness and Civilization*, 64.
[37] Foucault, *Madness and Civilization,* xii
[38] Porter, 'Foucault's Great Confinement,' 47-50; Scull, *Most Solitary of Afflictions*, 7.
[39] Porter, 'Foucault's Great Confinement,' 48.
[40] Porter, 'Foucault's Great Confinement,' 48.
[41] Porter, 'Foucault's Great Confinement,' 50; Regarding the contribution of Locke see: Charland, 'John Locke on Madness,'137-53.
[42] Porter, *Mind-Forg'd Manacles,* 188-93; Hunter, *Three Hundred Years*, 236.
[43] Porter, *Mind-Forg'd Manacles*, 189.
[44] Scull, *Social Order,* 19.
[45] Scull, *Social Order*, 19.
[46] Scull, *Social Order*, 19.

Further, the historian David Rothman criticised Foucault's work as unhistorical. It could not be regarded as a work of *historical* analysis because he 'eschewed archival research … and had little respect for the nuances of time …or the nuances of place'.[47] Despite these criticisms levelled at Foucault, his 'dazzling originality' served to influence the way in which lunatic asylums were imagined and studied.[48] As one reviewer noted, the 'medical triumphalism that celebrated the courageous efforts of early insanity reformers' was overturned, and asylums became the subject of much creative re-evaluation during the twentieth century.[49]

The revisionist scholars who followed Foucault increasingly described lunatic asylums in custodial terms, environments used for the 'social control' of undesirable people.[50] This trend was strongly driven by 'materialist' scholars such as Scull and Rothman, for whom Foucault had failed to explain the 'social organisation of insanity in the nineteenth century'.[51] Scull framed his theory of custodialism within the 'broader changes in English society's political, economic and social structures and in the intellectual and cultural horizons of the English bourgeoisie'.[52] The need for this interpretation was premised on the 'sudden eruption onto the nineteenth-century scene' of the lunatic asylum. Rothman described this as an 'effort to ensure the cohesion of the community in new and changing circumstances', an effort to re-establish equilibrium on a destabilised population.[53] Scull believed this argument lacked nuance and looked to the effects of broader social changes wrought by industrialisation. Thus, he suggested, in older agricultural societies, 'nature, rather than man [was] the source of activity'.[54] Man's activity was central to the industrialised, market-driven workforce, but could not be harnessed with physical threat.[55] Evoking Foucault, Scull suggested that instead of threat, 'men have to be taught to internalize the new attitudes and responses, to

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[47] Rothman, *Discovery of the Asylum*, xix.

[48] Porter, 'Foucault's Great Confinement,' 47.

[49] Eigen, 'The Confinement of the Insane (Book Review),' 618.

[50] For example, Garton, *Medicine & Madness*, 2; Scull, 'Madness and Segregative Control,' 337; Scull, 'Psychiatry and Social Control,' 149; Szasz, 'Psychiatry and Social Control,' 24.

[51] The term 'materialist' is used to reference Marx's methodological 'historical materialism'. Quote by Scull, 'Rethinking the History of Asylumdom,' 296.

[52] Scull, 'Rethinking the History of Asylumdom,' 298; Scull, *Social Order*, 43.

[53] Rothman, *Discovery of the Asylum,* xviii; Scull, *Social Order*, 35-36.

[54] Scull, *Social Order*, 91.

[55] Scull, *Social Order*, 91.

discipline themselves'.[56] Social control was achieved though self-control, a necessary trait in the new economy, and lack of self-control required additional measures.

These measures included the various forms of institution that arose during the nineteenth century. All nineteenth-century institutions have been described in terms of social control, or *pace* Scull, centres where people went to learn self-control.[57] Hence, children, prisoners, indigents and the insane were herded into schools, prisons, workhouses and lunatic asylums to be socialised.[58] Scull argues that 'warehousing' the mad was the only option open to reformers due to the 'imperatives of the New Poor Law'.[59] A home-based system would have involved 'supplying relatively generous pensions or welfare benefits' for people to look after insane relatives, at a time when the indigent were otherwise subject to the workhouse.[60] As a consequence, lunatic asylums were established and took the place of family-based care. Scull suggests that families chose to relinquish their role because

> The poor … had little alternative but to make use of the asylum as a way
> of ridding themselves of what, in the circumstances of nineteenth-century
> working class existence was undoubtedly an intolerable burden, the caring
> for their sick, aged, or otherwise incapacitated relatives.[61]

He has also suggested that 'families sought to hide what was unquestionably a source of profound shame and potential disgrace from public view and knowledge'.[62] Further, the availability of lunatic asylums served to reduce 'family and community tolerance'.[63] As evidence of this, Scull highlights the increasing use of asylums by the poor, expanding definitions of insanity, and an upsurge in the number of 'harmless' patients.[64]

Another type of history that embeds the lunatic asylum within its narrative is the one written by psychiatrists about psychiatry. Such narratives are almost always written in

[56] Scull, *Social Order/Mental Disorder*, 91-92.
[57] Scull, *Social Order/Mental Disorder*, 91-94.
[58] Scull, *Social Order/Mental Disorder*, 92.
[59] Scull, *Social Order/Mental Disorder*, 49.
[60] Scull, *Social Order/Mental Disorder*, 49.
[61] Scull, 'Madness and Segregative Control,' 347
[62] Scull, *Most Solitary of Afflictions*, 310.
[63] Scull, *Most Solitary of Afflictions,* 353.
[64] Scull, *Most Solitary of Afflictions,* 353.

progressive terms.[65] The use of moral treatment is absorbed into psychiatric history, helping to explain the process by which doctors, working in lunatic asylums, developed a 'psychological approach' based on a mixture of 'moral, educational and behavioural methods'.[66] They identified madness as a 'disease' and as such, it became the 'proper object of medical description and treatment'.[67] These narratives were challenged in what came to be known as the anti-psychiatry movement.[68] The scholars Thomas Szasz, David Cooper and R. D. Laing, who were themselves psychiatrists, expressed scepticism about the reality of psychiatric conditions.[69] Szasz in particular described mental illness as a socially constructed myth and lunatic asylums as places to 'dispose of unwanted persons'.[70] Interestingly, Szasz also included epilepsy within this view, stating that epileptics were placed in asylums because 'people found it intolerable to witness a person having a seizure … the public wanted to be spared this spectacle'.[71] Szasz's views were influential, and received both praise and opprobrium. Some psychiatrists criticise his 'fulminations against psychiatry', suggesting that there is solid evidence of brain pathology in some cases.[72] Nevertheless, even psychiatrists agree that some psychiatric diagnoses were socio-political (e.g. sexual disorders), and currently regard the label 'mental illness' as inappropriate (preferring psychiatric disease 'to suggest brain illness').[73] However, medical historians have been more receptive: for instance Porter suggests that Szasz's work helped to move the discussion away from anachronistic, hero-focussed and triumphalist psychiatric histories.[74] The new 'sociological-cum-ideological insights' of the anti-psychiatrists were readily incorporated into new historical narratives.[75] The materialist theorists, for instance, extrapolated from the anti-psychiatry theories, projecting them into the wider social

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[65] As described previously, early examples include: Leigh, *Historical Development of British Psychiatry*; Berrios, *150 Years of British Psychiatry*; Zilboorg, *History of Medical Psychology*; Hunter, *Three Hundred Years of Psychiatry*. A recent study: Bewley, *Madness to Mental Illness.*

[66] Bewley, *Madness to Mental Illness*, 6.

[67] Bewley, *Madness to Mental Illness*, 7; Bynum, 'Rationales for Therapy in British Psychiatry,' 317.

[68] Porter, 'Madness and Society in England,' 276-7; Laffey, 'Antipsychiatry in Australia,' 17-36; 'Anti-psychiatry,' Wikipedia.

[69] Szasz, *The Manufacture of Madness*; Cooper, *Psychiatry and Anti-psychiatry*; Crossley, 'R. D. Laing and the British Anti-psychiatry Movement,' 877-89.

[70] Szasz, *Cruel Compassion*, 9.

[71] Szasz, *Cruel Compassion,* 61.

[72] Shorter, 'Still Tilting at Windmills,' 183.

[73] Shorter, 'Still Tilting at Windmills,' 183.

[74] Porter, 'Madness and Society in England,' 277.

[75] Porter, 'Madness and Society in England,' 277.

context, describing psychiatry as part of a broader effort to enforce state control in order to maintain the 'capitalist social order'.[76]

The view that nineteenth-century lunatic asylums should be understood within the context of psychiatry and social order continues to exert a powerful challenge to social historians. However, during the 1980s there was a shift away from the custodial model with its over-emphasis on the power of the state, towards what Porter called the 'patient's view'.[77] Following the example of other social historians who had begun to focus on microhistories told 'from below', the post-revisionists closely examined the records of lunatic asylums to uncover the 'experience of peoples whose lives intersected with the asylum world'.[78] According to Porter, they discovered that 'the asylum was neither just a site for care and cure, nor just a convenient place for locking up inconvenient people'.[79] Indeed, the post-revisionists began to regard lunatic asylums as places that served multiple purposes, which were 'subject to continual negotiation amongst different parties including families and the patients themselves'.[80] They were not without their critics, however. Scull noted that this 'fascination with details' was often too narrow in perspective to enable the lunatic asylum to be examined within a broader historical framework.[81] To be of any use, Scull argued, the 'micro-researchers' needed to demonstrate how they could be used to test 'larger theoretical issues'.[82]

Despite considerable academic interest in the power relationship between doctors and patients, many revisionists and post-revisionists have asserted that power did not lie solely with the medical profession, if indeed it did at all. Historian Peter Bartlett, for instance, describes the English lunatic asylum as 'an institution legally based in the Poor Law, administered primarily by Poor Law officials, and directed at paupers'.[83] It was, in other words, a legal and administrative approach to controlling the insane poor. In the courtroom, the sociologist Joel Eigen has emphasised the importance of the judge in cases where the legal defence was based on insanity and required decisions to be

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[76] Garton, *Medicine & Madness*, 3.
[77] Porter, 'The Patient's View,' 175. Also see: Levi, 'On microhistory,' 93-113.
[78] Quote from: Wright, *Mental Disability in Victorian England*, 1.
[79] Porter, *The Confinement of the Insane*, 4.
[80] Porter, *The Confinement of the Insane,* 4.
[81] Scull 'History of Asylumdom,' 298.
[82] Scull 'History of Asylumdom,' 299.
[83] Scull, 'History of Asylumdom,' 300; Bartlett, 'The Asylum and the Poor Law,' 63.

made based on medical testimony.[84] In her analysis of Australian colonial asylum admissions, Catherine Coleborne notes that often the police in Victoria were expected to 'perform a role that was both medical and legal in nature, and were thus intimately involved in the forging of the asylum population'.[85] Other scholars describe how the admission process was one of negotiation between local administrators and families. Elaine Murphy, for instance, highlights that the process of committal was 'the outcome of contractual and bargaining negotiations between family, poor-law officials and doctors, between the "community" and "authority" [rather] than an imposed medical solution'.[86] Some scholars have focussed more closely on the agency of the family when gaining access to care and custody of difficult relations.[87] John Walton and David Wright both look at patterns of admission and discharge in English asylums, and demonstrate the power of the family rather than medical authority in the process. Both argue that the asylum was not a 'dustbin for the useless and unwanted of industrial society'.[88] Their evidence for this is based on the fact that most patients remained in the asylum for relatively short periods of time and families were 'willing and able to receive ex-patients back into the household'.[89]

One area where legal, medical and administrative decisions intersected during the nineteenth century concerned dangerous lunatics. Foucault suggests that the idea of the psychiatrically dangerous individual originated once the medical profession was able to assert its understanding of such behaviour during legal proceedings.[90] Foucault argued that this constituted a process whereby doctors initially asserted that some monstrous (but motiveless) crimes were evidence of diseased minds, a pathological state which they named 'homicidal monomania'.[91] Perpetrators were a danger to society, but could not be held *legally* responsible if, as the doctors claimed, they were insane. Thus they belonged in the lunatic asylum, rather than the gaol, under the supervision of the

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[84] Eigen, *Unconscious Crime*, 160-163; Eigen, *Mad-doctors in the Dock,* 140-3.

[85] Coleborne, 'Passage to the asylum,' 129-148.

[86] Murphy, 'The administration of insanity in England,' 336.

[87] See for instance: Suzuki, 'Madness at Home,' 179-183; Suzuki, 'Closing and Disclosing Lunatics within the Family Walls,' 115–31; Finnane, 'Asylums, Families and the State,' 134-48; Tomes, *A Generous Confidence*,' 123-127; Prestwich, 'Family Strategies and Medical Power,' 799; Cathy Smith, 'Family, Community and the Victorian asylum,' 109.

[88] 'Dustbin' quote from Porter and Wright, *The Confinement of the Insane*, 9.

[89] Walton, 'Casting Out and Bringing Back,' 132-46; Wright, 'Getting out of the Asylum,' 137; Wright, 'The Discharge of Pauper Lunatics,' 106.

[90] Foucault, 'About the Concept of the "Dangerous Individual",' 3.

[91] Foucault, 'About the Concept of the "Dangerous Individual",' 6.

medical profession.[92] Over time, the 'notion of psychiatric *dangerosité* [dangerousness] became more and more familiar … and less and less related to any kind of monstrosity'.[93] Indeed, the knowledge (or 'trained eye') of asylum doctors, enabled them alone to recognise 'dangerous individuals before they acted and thereby prevent unthinkable crimes'.[94] According to Foucault, knowledge about dangerousness helped to aggrandize the role of doctors.

Without doubt, many of the people admitted to lunatic asylums during the nineteenth century were identified as dangerous. In Irish lunatic asylums, in 1888 for example, around ninety percent of their admissions were described as dangerous.[95] The historians Mark Finnane and Pauline Prior both argue that it was easier for families to gain access to asylums using 'dangerous lunacy procedures'.[96] Some have interpreted the consignment of dangerous individuals to asylums in terms of gender, race, and economic imperatives. South African historian Harriet Deacon for instance notes that in the early twentieth century, eighty percent of lunatics consigned to Robben Island were black and 'dangerous'.[97] In Scotland, where a broad network of informal relief existed alongside formal structures, the (mainly male) dangerous lunatics were increasingly institutionalised having 'exceeded the boundaries of family care and community tolerance'.[98] Despite differences in the economic cost to the community, the (more expensive) lunatic asylum was where the dangerously insane were sent. Chapter 1, examines the legal, medical and social factors that explain the connection between dangerousness and epilepsy in the South Australian lunatic asylums.

As will be shown throughout this thesis, the majority of epileptic patients admitted to the South Australian lunatic asylums were highly disabled, often physically and mentally. For this reason, the scholarship pertaining to disability and the associated issue of care warrants review. Whilst some historiographic treatment has focussed on reformers (biographical) and care strategies, many recent scholars have examined the

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[92] Bennett, 'Historical Notes on the Law of Mental Illness in NSW,' 53.
[93] Foucault, 'Danger, Crime and Rights,' 5.
[94] Taylor, 'Infamous Men, Dangerous Individuals,' 426.
[95] Prior, 'Dangerous Lunacy,' 531.
[96] Finnane, *Insanity and the Insane*, 94; Prior, 'Dangerous Lunacy,' 534.
[97] Deacon, 'Insanity, Institutions and Society,' 8.
[98] Houston, 'Poor Relief and the Dangerous,' 467.

issues from the perspective of social exclusion and oppression.[99] Thus, in her close examination of the history of disability in Britain from 1750, Anne Borsay states that patients in lunatic asylums were 'denied political citizenship for the duration of their confinement [and] inadequately protected against squalid or abusive conditions by paternalistic inspection systems that showed no awareness of social rights'.[100] Borsay's view that lunatic asylums were places of incarceration echoes Scull as both argue that people were incarcerated because 'their behaviour contravened social norms'.[101] Hence, segregation of any kind, or treating the disabled as 'special cases', only served to 'isolate and weaken' people by exiling their bodies from social, political and physical spaces.[102]

Rather than describing responses to disability solely in terms of isolation and exile, some scholars examine it through the framework of ethics and the provision of care. Definitions of care are varied, and scholarly debate continues to challenge its meaning.[103] Warren Reich describes two conflicting and ambiguous meanings of care:

> On the one hand, it meant worries, troubles, or anxieties, as when one says that a person is 'burdened with cares'. On the other hand, care meant providing for the welfare of another; aligned with this latter meaning was the positive connotation of care as attentive conscientiousness or devotion.[104]

Reich shows that these two contradictory meanings were understood throughout history, mythologised and personified in ancient Roman literature as the goddess 'Cura'.[105] Whilst worry could drag a person down, as a virtue it could elevate humankind and be seen as a 'precondition for the whole moral life'.[106] Other definitions incorporate different aspects of care, describing it in terms of labour, relationships, dispositions and values.[107] As with debates about disability, some discussions about care focus on the importance of rights and autonomy.[108] Thus care can result in a loss of

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[99] Borsay, *Disability and Social Policy;* Longmore. *Why I Burned My Book*; Hughes, 'Social Model of Disability'.
[100] Borsay, *Disability and Social Policy,* 93.
[101] Borsay, *Disability and Social Policy,* 93.
[102] Hughes, 'Social Model of Disability,' 6.
[103] Tronto, 'Care Ethics,' 496-7; Sander-Staudt, 'Care Ethics'.
[104] Reich. 'History of the Notion of Care,' 476.
[105] Reich, 'History of the Notion of Care,' 477-8.
[106] Reich, 'History of the Notion of Care,' 487.
[107] Sander-Staudt, 'Care Ethics,' (Section 2 Definitions of Care)
[108] Sander-Staudt, 'Care Ethics,' (Section 3 Care ethics as theoretically indistinct)

independence, devaluing the existence of the disabled person. According to this view, care is only useful if it facilitates independence. A different argument is presented by the feminist philosopher Eva Kittay who highlights that this 'emphasis on choice leaves out many people with disabilities for whom making choices is problematic as their cognitive function may be severely impaired'. According to Kittay, the denigration of care and dependency is itself a form of oppression as it denies the value and work of carers, 'thus creating one oppression in the effort to alleviate another'.[109] Nevertheless, 'power' narratives are deeply entangled with the ethics of care. The philosopher Joan Tronto describes 'the tendency of women and other minorities to perform care work in ways that benefit the social elite', coining the phrase 'privileged irresponsibility' to explain how those with sufficient wealth can purchase 'caring services'. In Chapter 2, narratives of care are framed within the context of lunatic asylums when examining the role of doctors, attendants and nurses alongside the requirements of the epileptic patients.

Few historians have directly studied the experience of people with epilepsy in institutions, although there has been some discussions about the role of the 'epileptic colony'.[110] In England, America and Australia, a number of such colonies were established, primarily during the late nineteenth and early twentieth century, based on a German model.[111] One was established in Australia in 1907, its origins described (somewhat inaccurately) in 2006 by the then Chief Executive Officer of the Epilepsy Foundation as follows:

> Australia was one of a handful of places leading the world to a more compassionate and reasoned view of epilepsy and its management. A Victorian governor's wife, Lady Alice Talbot, appealed directly to the public and raised huge sums of money to establish the Talbot Epileptic Colony and Farm in Clayton. No longer would people with seizures have to face being chained to asylum walls. Doctors, teachers, and other staff were able to help

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[109] Kittay, 'The Ethics of Care,' 51.
[110] Dwyer, 'Stories of Epilepsy,' 248-70; Szasz, *Cruel Compassion,* 43-62.
[111] The Bethel Epilepsy Colony opened in Bielefeld, Westphalia, Germany in 1863. Hermann, '100 Years of Epilepsia,' 1110.

people living with epilepsy have a real chance at a decent life, even if the seizures were not fully controlled.[112]

The fate of epileptic colonies was similar to that of lunatic asylums; they either were closed or became specialised centres or hospitals. In England, for instance, the Epilepsy Society, a charitable organisation, is currently housed on the site of the former Chalfont Colony in Buckinghamshire, where it continues to provide supported living accommodation for people with epilepsy.[113] The Talbot Colony in Australia transitioned slowly to become a rehabilitation centre. The *raison d'être* of epileptic colonies is controversial. Some scholars consider that they provided the 'best possible methods of caring for the epileptic and epileptic insane'.[114] Others regard them as a means of segregating a problematic group of people.[115] Szasz, as has been noted, thought the public found it intolerable to witness epileptic seizures, suggesting that doctors sought to accommodate this view because 'the myth of the dangerous epileptic justified a popular social policy'.[116] However, Ellen Dwyer argues that families who placed epileptic relatives in colonies had 'a perspective on epilepsy far different from the one that prevailed in the medical and legal literature'.[117] As she claims, families were looking for treatments, whereas doctors wanted to provide explanations located within a framework of moral judgement. Clearly, the use of epileptic colonies raises questions as to whether their use was premised on humanitarian concerns or custodialism. The same question is examined throughout this thesis regarding the use of the lunatic asylum for people with epilepsy.

Although Dwyer argues that families and doctors approached epilepsy and epileptic colonies from totally different perspectives, the problem of explaining what motivated families to use institutions remains. When examining (but not answering) this question, David Wright outlines several concepts grounded in the historiography.[118] These range from families having lower tolerance for unproductive members consequent to 'indoctrination in the new market-driven society'.[119] An alternative suggestion was that

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[112] Pollard, 'Rediscovery of the Australian Epilepsy Movement,' 25, 30.
[113] Anon, 'The History of the Epilepsy Society,' *Epilepsy Society*. (online)
[114] Kissiov, 'The Ohio Hospital for Epileptics,' 1524; Bladin, *Century of Prejudice and* Progress, 147.
[115] Szasz, *Cruel Compassion,* 61.
[116] Szasz, *Cruel Compassion*, 58.
[117] Dwyer, 'Stories of Epilepsy,' 264.
[118] Wright, 'Getting out of the Asylum,' 152.
[119] Scull, 'Most Solitary of Afflictions,' 352; Dorner, *Madmen and the Bourgeoisie,* 59, 67-71.

families felt able to use lunatic asylums for their unwanted relatives as they started to be regarded as a 'culturally acceptable locus' of care.[120] From the perspective of gender theory, female incarceration can also be explained as the enforcement of patriarchal bourgeoise ideologies.[121] Lastly, some scholars interpret institutionalisation as a consequence of the breakdown of kinship and community values as families moved towards smaller family units during the nineteenth century.[122] Evidently, views that aim to ground asylum theories within the 'macrostructures of the nineteenth-century social world' place little emphasis on emotional intimacy within familial relationships.[123] Michael Ignatieff questions this 'social control' argument, suggesting that not all 'social relations can be described in terms of power and subordination'.[124] Hence, rather than exploring the extrinsic factors that 'pushed' families towards using lunatic asylums, it is also worth examining whether intrinsic factors associated with the asylum exerted a 'pull'. Attempts to do this are frequently situated within the humanitarian model and focus on the role of the emergent medical profession. As shown, revisionists criticise this due to the obvious failure of doctors to cure patients, and the build-up of 'hopeless cases' in lunatic asylums. The medical view also precludes the possibility that other attributes of the lunatic asylum contributed to familial decisions.

The problem with triumphalist accounts of lunatic asylums is that they are premised on the growing expertise of doctors. Nevertheless, it is generally acknowledged that doctors employed in nineteenth-century lunatic asylums were primarily managers and administrators.[125] Scull suggests they assumed this role to conceal their professional incompetence.[126] This claim seems unlikely, however, as their terms of employment were based around the provision of medical care and administrative oversight, whilst most of the day-to-day care of patients was provided by attendants and nurses.[127] Some scholars describe the asylum workers as the 'unemployable of Victorian Society' and

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[120] Suggested by Scull in: Scull, *The Most Solitary of Afflictions*, 352-5.
[121] Examples include: Showalter, *The Female Malady;* Chesler, *Women and Madness*; Ussher, *Women's Madness*; Ussher, 'Women and Madness,' 288-92.
[122] Scull, *Museums of Madness*, 47; Wright also cites: Shorter, *The Making of the Modern Family*; Stone, *The Family, Sex and Marriage*.
[123] Brown, 'Dance of the Dialectic?' 282.
[124] Ignatieff, 'State, Civil Society, and Total Institutions,' 153.
[125] Wright, 'Getting out of the Asylum,' 139.
[126] Scull, *The Most Solitary of Afflictions*, 244-251.
[127] Monk, *Attending Madness at Work,* 149; Wright, 'The Dregs of Society?' 5.

their jobs as the 'occupation of last resort'.[128] Others, such as David Wright in England and Lee-Ann Monk in Australia have challenged this stereotype. Wright has shown that attendant's jobs were often sought after, and although levels of pay were average, the positions were associated with useful benefits such as meals and board.[129] Monk describes how attendants forged a 'specific occupational identity' based on a shared understanding of their role and the wide range of skills required.[130] Much of the attendant's work was 'domestic' and many interactions with patients were intimate, involving washing, dressing, feeding and shaving patients, all performed without recourse to restraints.[131] It is likely that the provision of nursing care, a beneficial environment, and management by trusted professionals did much to encourage the use of lunatic asylums by the local community, a possibility that is discussed further in Chapter 2.

In Australia, there has been considerable debate amongst post-revisionists regarding the intersection of colonialism and asylum theory. Scholars have examined it from various perspectives, including gender, migration, ethnicity, aboriginal psychiatry, and criminality, thus allowing them to provide some unique contributions to the historiography. From the 1980s onwards, interpretations were grounded in social history, superseding earlier accounts that tended to focus on the 'progressive' nature of psychiatry. In 1951, for instance, John Bostock wrote:

> The record of psychiatry in Australia must be studied as a story of progress
> along the pathway to modern mental hygiene. Impartial analysis reveals
> that Australia has a laudable record of achievement in this important field.
> It adds lustre to the reputation of its original British stock and to the
> Australian initiative and common sense in overcoming the hardships of
> the pioneer. [132]

Whilst Bostock's admiration for the achievements of Australian psychiatry might appear to over-inform his work, in fact he also provides an illuminating and detailed

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[128] Scull, *Most Solitary of Afflictions,* 173, 26; Leonard Smith, 'Behind Closed Doors,' 305–13, 326; Jones, *Asylums and After*, 96–7; Nolan, 'Nineteenth-Century Mental Health Care,' 263.
[129] Wright, 'The Dregs of Society?' 9.
[130] Davis, 'Attending Madness (Review),' 137.
[131] Monk, *Attending Madness at Work*, 13.
[132] Bostock, *Dawn of Australian Psychiatry,* 14.

analysis of the early Australian response to madness. By carefully reconstructing events between 1836 and 1850, he shows, for instance, how political forces in South Australia opposed the establishment of private lunatic asylums. This opposition occurred, despite strong criticism that the Adelaide Gaol was being used to house the insane throughout the early years of settlement.[133] For this reason, Bostock's work retains some relevancy, and his use of records parallels those of social historians thirty years later, albeit without any contextualisation in social theory.[134]

Stephen Garton was one of the first social historians to critically examine responses to colonial insanity. His analysis of thousands of asylum records in New South Wales allowed him to demonstrate a gendered shift in the construction of insanity between 1880 and 1940. During the 1880s, inmates were typically 'single, male, rural, itinerant laborers, apprehended by the police', whereas by the 1930s they were 'suicidally depressed domestic servants or housewives living in a Sydney suburb'.[135] Garton's work contributed to the debate about gender and insanity, building on the arguments of feminist scholars who wrote about the colonial period.[136] Hence, Ann Summers' view that 'women [in Australia] are divided according to whether or not they are prepared to uphold the colonial order' can be seen reflected in discussions about gendered responses to insanity.[137] Feminist scholars argue that the control of disordered females was based on socio-medical assumptions about the female body, and their symptoms were read differently to those which defined male madness.[138] Coleborne highlights how doctors asserted their knowledge of the female body in this legal arena, which resulted in female transgressive behaviour being preferentially interpreted in terms of insanity rather than criminality.[139] Mark Finnane, however, observes that the lunatic asylum could be a refuge for some women, particularly from domestic violence and sexual abuse.[140] In these cases, the 'asylum … was acting quite simply as the protector of the abused and intimidated'.[141] However, unlike some forms of gendered insanity, such as

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[133] Bostock, *Dawn of Australian Psychiatry*, 144.
[134] Bostock, *Dawn of Australian Psychiatry*, 14.
[135] Garton, *Medicine & Madness*, 187.
[136] Summers, *Damned Whores and God's Police*; Matthews, *Good and Mad Women*; Reiger, *Disenchantment of the Home*); Deacon, 'Taylorism in the Home,' 161-73.
[137] Summers, *Damned Whores and God's Police,* 248.
[138] For the Australasian context on gender and madness see: Coleborne, *Reading Madness*; Labrum, 'Boundaries of Femininity,' 59-77; Rychner, 'Murderess or Madwoman?' 91-104.
[139] Coleborne, *Reading Madness*, 37-55.
[140] Finnane, 'Asylums, Families and the State,' 138.
[141] Finnane, 'Asylums, Families and the State,' 139.

puerperal insanity and hysteria, epilepsy was not *per se* a gendered construct. Nevertheless, aspects of gender discourse are examined in Chapter 3 with regards epilepsy associated with alcoholism and General Paralysis of the Insane. These illnesses affected men more than women and the lunatic asylum provided an environment for their care and treatment.

Another contentious historiographic area in the history of insanity in Australia surrounds social concerns about 'evolution, hereditary, and social progress'.[142] Responding to fears about the degeneration of the human race, Francis Galton coined the word 'eugenics' in 1883. His idea that the 'human race' could be improved by 'breeding the best with the best' was codified into a 'scientific' discourse by the early twentieth century.[143] Galton also popularised the phrase 'nature versus nurture', to describe two philosophical positions used to explain human 'degeneracy'. Those who thought *nurture* more important (also described as 'environmentalists' or 'positive eugenicists') believed that human behaviour was contingent on environmental influences.[144] Advocates were more inclined to suggest that 'the procreation of people with desirable characteristics' should be actively encouraged.[145] Those who held the opposing view that the *nature* of an individual was predetermined (often called negative eugenicists) advocated that it was necessary to avoid 'undesirable parentage strains' by preventing procreation.[146]

That both schools of thought existed in Australia is not a controversial claim; however, scholars are divided on the relative influence of each. Carol Bacchi, the first to investigate eugenics in the Australian context, argued that 'the political and social climate in Australia suited the more optimistic environmental theory'.[147] Diane Wyndham supported this view, stating that 'hereditary determinism found fewer adherents in Australia than in England or America'.[148] Other scholars have criticised this, suggesting that the position occupied by the social-reforming elite was more

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[142] Garton, *Medicine & Madness,* 56.
[143] Watts, 'Beyond Nature and Nurture,' 318; Wyndham, *Eugenics in Australia*, 351, 354; Lemar, 'Locating Adelaide Eugenics,' 50.
[144] Locke, *An Essay Concerning Human Understanding*, 1690. In Book 1, 'Neither Principles nor Ideas are Innate', Locke describes the mind at birth as a blank slate (*tabula rasa).*
[145] Lemar, 'Locating Adelaide Eugenics,' 50.
[146] Lemar, 'Locating Adelaide Eugenics,' 50.
[147] Bacchi, 'The Nature-Nurture Debate in Australia,' 199.
[148] Wyndham, *Eugenics in Australia*, 344.

ambiguous, with most finding 'themselves on a continuum upon which, depending on the context and contingency, they could occupy more than one position'.[149] 'Negative' eugenicists had the greatest potential to affect the lives of people with epilepsy, and were undoubtedly active in South Australia at the start of the twentieth century.[150] Susan Lemar notes that in 1911, a scientific sub-committee recommended that people with epilepsy should be classified as 'eugenically unfit' and barred from marrying or having children.[151] Whilst their report was ultimately rejected by others who favoured positive eugenic principles, Lemur supports the view that a range of opinions existed in South Australia. The opinions of doctors certainly contributed to the eugenic debates, as will be shown in Chapter 1. However, the limited extent of this influence on the epileptic patients in lunatic asylums shall be demonstrated in Chapter 2.

Finally, the motivation for grounding this thesis in South Australia requires some clarification, particularly as it is risks what Scull describes as the 'particularities of person and place'.[152] Nevertheless, the colonial outpost of South Australia provides an opportunity to test legal, economic and social considerations about lunatic asylums. The origins of South Australia are unusual as it was a colony established by a British act of parliament.[153] The terms of the South Australian Act 1834 set it apart from other parts of Australia because it banned the transport of convicts to the settlement. It aimed to attract young, 'respectable' settlers whose civil rights would not be limited by the religion they practiced. In addition, many settlers were Protestant 'dissenters' who would be integral to developing and administering the colony's welfare system.[154] Whilst the settlers accepted most aspects of British rule, they rejected others, including the new Poor Law of 1834.[155] Hence, unlike their counterparts in England, the destitute were not pauperised in order to obtain financial relief or enter a lunatic asylum.[156] This challenges the views of Scull and Bartlett who describe lunatic asylums as institutions 'legally based in the Poor Law … and directed at paupers'.[157] Another difference lay in

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[149] Watts, 'Beyond Nature and Nurture,' 319; Lemar, 'Locating Adelaide Eugenics,' 49-60; Garton, 'Sound Minds and Healthy Bodies,' 181.
[150] Susan Lemar, 'Locating Adelaide Eugenics,' 49-60.
[151] Susan Lemar, 'Locating Adelaide Eugenics,' 53.
[152] Scull 'History of Asylumdom,' 299.
[153] Sendziuk. *History of South Australia*, 13.
[154] Sendziuk, *History of South Australia*, 12.
[155] Dickey, *Rations, Residence, Resources,* 1-3.
[156] Dickey, *Rations, Residence,* Resources, 1-16.
[157] Scull, 'History of Asylumdom', 300; Bartlett, 'The Asylum and the Poor Law,' 48-67.

the fact that South Australia did not industrialise to any great extent; its economy remained resource-based well into the twentieth century.[158] This brings into question Scull's early assertions that it was 'urban-industrialised society' that gave rise to institutionalised responses of social control.[159] South Australians were not dislocated by industrialisation, rather they were isolated by distance and at a remove from old community ties. Another difference lay in the fact that all South Australian welfare was administered by the state. As noted by historian Brian Dickey, in South Australia 'voluntary agencies were slow to emerge and weak in effect'.[160] This resulted in a very different care model to any developed in other states, where state funding was administered in tandem with non-governmental institutions.[161] Likewise, the insane were not 'boarded out' with community members.[162] There were no cottage homes, private lunatic asylums or charitable institutions for the insane. Indeed, the value of studying South Australia lies in the absence of these institutions. Its origins were contemporaneous with the emergence of the state funded lunatic asylum, but unlike its counterparts elsewhere, the system was uncomplicated by other forms of assistance.

SOURCES

SOUTH AUSTRALIAN PATIENT RECORDS

Records from the Adelaide and Parkside Lunatic Asylums are held by the State Records of South Australia (SRSA).[163] Information about whether a person was epileptic appeared in a number of asylum records including admission forms, case books, patient registries, death registries, head attendants' journals, and seclusion books. Although epilepsy was not routinely recorded in South Australia until 1865, some older cases were recorded when long-term patients had their information transferred to the new books. A fuller description of the SRSA records used in this thesis is provided in Appendix 1. Each of the patients described in this thesis are listed in Appendix 2 and Appendix 3 shows examples of casebook forms to show the information collected when

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[158] Shanahan, 'Personal Wealth in South Australia,' 55; Sendziuk, *History of South Australia*, 130.

[159] Scull, *Social Order*, 216. Note that Scull later broadens his argument by suggesting institutional responses were due to the 'commercialisation of existence'. Scull, *Most Solitary of Afflictions*, 29.

[160] Dickey, *Rations, Residence, Resources*, xx.

[161] Dickey, *Rations, Residence, Resources*, xix.

[162] Sturdy, 'Boarding-out the Insane,' i ; Houston, 'Poor Relief and the Dangerous and Criminal Insane,' 453-76.

[163] A full list of all folios used is provided in the Appendix 1.

people were admitted to asylums. One question specifically asks 'whether subject to epilepsy'; however, the possibility that a patient had epilepsy was not limited to this field. Each casebook included a question about the 'supposed cause of admission', and epilepsy was sometimes recorded in this field.[164] In the 'notes' section at the bottom of the record, the patient was sometimes also described as epileptic. The death registries recorded whether death was caused by epilepsy. The seclusion books and head attendant's journals also noted whether someone was isolated or treated for epilepsy in the asylum infirmary. The forms used in South Australia were not unique, sharing similarities with those used elsewhere.[165]

During the collation of data for this study a total of 631 admissions for 578 people with epilepsy were identified in the South Australian records between 1853 and 1914.[166] All information was photographed, and the relevant information entered into a Microsoft Excel Spreadsheet. The original phrasing of records was maintained, although some new fields were added, such as length of stay, days to discharge, and days to death. All notes or letters enclosed with the original record, were photographed and their existence recorded in the spreadsheet. The spreadsheet has been used throughout this thesis to illustrate specific arguments, and to examine patterns and trends.[167]

A CAUTIONARY NOTE ABOUT USING ARCHIVAL MATERIAL

Using archival asylum records is generally considered a valid means of performing historical research, however it is also associated with a degree of uncertainty.[168] It is perhaps worth remembering that the French deconstructionist Jacques Derrida held that 'archiving represents both attempting to preserve something to be remembered and leaving out something to be forgotten'.[169] Another cautionary note was sounded by librarian Marlene Manoff who pointed out that the 'interpretation of the archive always

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[164] This field also provides a window into the beliefs of families, friends and admitting officers, at the time of admission. Typical reasons included sunstroke, injury to head, fright before birth and religious excitement. For one person, witchcraft was provided as the cause.

[165] Examples of an English form is shown in Appendix 3. For Scotland see Millar, *Hints on Insanity*, 95. See also: Coleborne, 'Reading Insanity's Archive,' [online resource]; Bartlett, *Poor Law of Lunacy*, 281.

[166] Only records older than 100 years could be searched.

[167] The spreadsheet is available on Figshare. Boult, 'Epilepsy in the South Australian Lunatic Asylums,' https://doi.org/10.25909/5bd542c52b409.

[168] Coleborne, 'Reading Insanity's Archive,'; Manoff, 'Theories of the Archive,' 9.

[169] Derrida, 'Archive Fever,' 9; quote from: Rose, 'Archive Fever: A Freudian Impression,' 66.

depends on the perspective of its interpreters'.[170] Amongst the South Australian records, most of the recorded material was minimal, often incomplete, and written by the asylum staff. Not all records survived, and although the remaining South Australian asylum records are substantial, there are gaps and missing pages. Australian historian Catharine Coleborne highlighted this problem, reminding historians that 'even where official records have been kept in a relatively meticulous fashion, there are gaps in the record'.[171] However, she was alert to the promise of the asylum record, suggesting that 'closer, qualitative readings' can provide ways of constructing 'patient identities, power relations … and emotions'.[172] Evidently the archive can be read, but with caution.

OTHER MATERIALS

Various local materials were used to augment the asylum records from South Australia. The annual reports, written by the Colonial Surgeon, and published in the *South Australian Government Gazette*, provided narrative and statistical information about the administration of the two South Australian lunatic asylums throughout the latter half of the nineteenth century and the early twentieth. The *Statistical Register* also published official government figures, including types of illnesses and causes of death in South Australia. A substantial amount of information about the South Australian lunatic asylums was found in the transcripts of three government inquiries, published in the *Parliamentary Proceedings of South Australia* (PPSA). Further details were obtained from contemporary newspaper articles, using the online data resource, Trove.[173] This resource was also useful for acquiring information about individual patients, either through news reports, or via death and funeral notifications. In a similar vein, information about burials was obtained directly from Adelaide Cemeteries Authority, using their online resources and via email.

Some of the nineteenth-century medical publications were available at the Barr Smith Library, University of Adelaide. A few, such as those by Henry Maudsley, Eric Gowers and John Reynolds, had been part of the library collection for over a century. A copy of

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[170] Manoff, 'Theories of the Archive,' 16.
[171] Coleborne, 'Reading Insanity's Archive,' 2.
[172] Coleborne, 'Reading Insanity's Archive,' 2.
[173] 'Digitised Newspapers and More,' *Trove*. Accessed July 26, 2018. https://trove.nla.gov.au/newspaper/.

the 1884 *Handbook for the Instruction of Attendants on the Insane* in the rare books collection had been the property of the Adelaide Lunatic Asylum according to a library stamp in its frontispiece dated the 15 April 1886. Other important texts, such as those by John Conolly, William Ellis, T.S. Clouston, E. Esquirol, were downloaded from a various online repositories. Copies of digitised nineteenth-century South Australian laws are available online through the Australasian Legal Information Institute (AusLII).

CHAPTERS

The three chapters in this thesis follow the administrative cycle of asylum use: admission, residency and discharge. Chapter 1 examines admissions from the legal, medical and social perspectives. Most of the patients who were admitted with epilepsy were described as dangerous. Using this as a focus, the chapter describes how the legal machinery to deal with dangerous lunacy arose in England during the eighteenth century. This machinery was used in South Australia until 1844 after which the government enacted its own legislation. Like its English precursor, this also aimed to control dangerous lunatics. Nevertheless, it is clear that as early as 1846, the lunatic asylum was used to house people with epilepsy who did not pose a threat to others, but who were unable to care for themselves. More complex legislation followed in 1864, which served to fragment the notion of dangerousness between the medical and legal domains. During the same period, asylum doctors in Europe and Britain were writing about epilepsy in increasingly stigmatising terms. Doctors described how it was associated with unconscious acts of murder and crime which they associated with hereditarian concerns. Nevertheless, in South Australia this did not increase admissions and most people with epilepsy remained in the community. Indeed, the decision to seek admission for an epileptic person was largely premised on the needs of families, as shown in the final section of the chapter. In the event that a person did not have family, similar negotiations were conducted by state authorities, including the destitute asylum, or in the event of vagrancy, the police. Whilst descriptions of epileptic patients as dangerous did sometimes equate with difficult and erratic behaviours at the time of seizures, in the main, admission was premised on their inability to care for themselves.

The notion of care forms the central theme of Chapter 2. Many descriptions of lunatic asylums in the nineteenth century focus on the origin of 'moral treatment' as a curative therapy for the insane. This chapter will argue that despite the idea that moral treatment was a precursor to psychiatry, in fact its adoption by asylum doctors resulted in their role becoming largely managerial. Associated with this change was the development of auditing, introduced to ensure that the standards of moral treatment were met. The physical environment was assessed, including a requirement that restraints not be used. This affected epileptic patients who had previously been shackled. Outside the asylum, the use of restraints continued at other institutions and in some domestic situations. In their absence, the asylum environment was modified to minimise danger occurring during seizures. Some epileptic patients who became violent at the time of their seizures were placed in seclusion until the episode passed. Finally, the chapter shall describe the provision of care by attendants and nurses. It shows how this became increasingly codified and professional, based initially on the establishment of rules and regulations. Whilst there was some evidence of abuse by asylum attendants, this was limited in extent. In the main, the staff were valued and thought to perform their duties well in South Australia.

Chapter 3 describes under what circumstances people with epilepsy left the asylum. From this perspective, it is evident that the lunatic asylum was used in three different ways. Some patients were admitted in very poor health. Their use of the asylum is described as palliative, as their deaths followed shortly after their admission. This corresponded with a period when attitudes towards the locus of dying were beginning to change and the community was becoming more accepting of institutional care. Not all deaths of epileptic patients took place quickly. There was a second group of patients who resided in the asylum for very long periods of time. They were unable to care for themselves but generally lacked familial support. The third group has been described in this thesis as receiving 'respite care' based on relatively short stays in the asylum. This group was not dissimilar to the 'long-stay' group in terms of their care needs, however they were more likely to have families in the colony.

CONCLUSION

Scholars have examined the use of lunatic asylums in the nineteenth century from many different angles, but never specifically from the perspective of epileptic patients. In general, explanations for asylum use have been contentious, particularly with regards whether they were used for custodial or humanitarian reasons. By closely examining why people who were physically and mentally damaged by the effects of epilepsy were placed in South Australian lunatic asylums, it is possible to provide an alternative explanation for their use. Thus, it is hoped that this thesis offers a more nuanced way of understanding the use of lunatic asylums that will contribute to future historical understanding.

CHAPTER 1

ENTERING THE LUNATIC ASYLUM

> The most dangerous cases with which those who take care of insane persons have to do are those of persons suffering from epileptic mania. Sometimes after one fit, more often after a succession of fits, an attack of furious and destructive mania supervenes, marked by blind and reckless violence.[1]

There were a number of reasons why people with epilepsy were admitted to lunatic asylums in South Australia and elsewhere, but it was seldom, if ever, predicated solely on their seizures. One explanation, as illustrated in the quote (above) by Henry Maudsley, was that doctors believed some to be extremely dangerous. Whilst the majority of epileptic patients admitted to lunatic asylums were described as dangerous, this chapter demonstrates that it was rarely due to 'blind and reckless violence' and neither was it premised on the opinions of doctors. Dangerousness was used to describe many asylum patients, and as noted in the introductory chapter, scholars have proffered a number of theories to explain the link between dangerousness and lunacy.[2] Michel Foucault asserts that it enabled asylum doctors to further their professional interests by describing the 'dangerous individual' as a medical, rather than a legal problem.[3] Indeed Maudsley's quote provides a prime example of Foucault's argument. Conversely, historical materialists such as Andrew Scull place dangerousness within the broader social context of poverty and the purported need for greater social control during the nineteenth century.[4] Danger provided an acceptable justification for confining lunatics away from the rest of society.[5] Peter Bartlett shifts the debate back towards the legal sphere, stating that 'danger' was 'just as much a legal as it was a medical construction'

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[1] Maudsley, *Responsibility in Mental Disease,* 169.

[2] See for instance, Foucault, 'About the Concept of the "Dangerous Individual",'; Prior, 'Dangerous Lunacy'; Finnane, *Insanity and the Insane*; Deacon, 'Insanity, institutions and society'; Houston, 'Poor Relief and the Dangerous and Criminal Insane'; Cathy Smith, 'Insanity and the Civilising Process'; Bartlett, *The Poor Law of Lunacy,* 174-7.

[3] Foucault, 'About the Concept of the "Dangerous Individual",' 6; Taylor, 'Infamous Men, Dangerous Individuals,' 425.

[4] Scull, 'Convenient Place to Get Rid of Inconvenient People,' 50; Also discussed in Scull, *Most Solitary of Afflictions*, Ch. 6.

[5] For a discussion see: Smith, 'Insanity and the Civilising Process,' 253; Adair, 'A Danger to the Public,' 2-3.

due to certification requirements for pauper lunatics.[6] Under the New Poor Law, dangerous pauper lunatics had to be removed from workhouses within fourteen days.[7] Cathy Smith describes this as a 'guaranteed fast track into the asylum'.[8] Smith and other social historians have consequently speculated that dangerousness was used by family, friends and poor law officials to provide a 'much needed solution' for the 'care of difficult and dangerous family members'.[9] Close reading of various asylum records demonstrates that the meaning of danger was flexible and often used to describe people who clearly posed no danger. Hence it is suggested that dangerousness was rhetoric frequently used to secure the admission of paupers to the lunatic asylum.[10]

Asylum records from Britain, America and Australasia generally show that around ten percent of people admitted to lunatic asylums had epilepsy, the majority of whom were described as dangerous.[11] It has never been satisfactorily established why so many people with epilepsy were admitted, nor why they were so often described as dangerous. When Cathy Smith examined the records of dangerous lunatics at the Northampton General Lunatic Asylum, she specifically excluded cases of epilepsy stating they were 'invariably classified as dangerous because of their fits'.[12] This chapter demonstrates that 'fitting' does not explain their admission nor their classification as dangerous. Nor can explanations be grounded in the administration of a Poor Law, as Peter Bartlett suggests was the case in Britain.[13] Whilst the majority of people admitted to South Australian lunatic asylums could not pay fees, the institutions were never administered as part of a centralised Poor Law.

In contrast, this chapter argues that the admission of people with epilepsy to the South Australian asylums resulted from the combined effect of legal and medical precedents intersecting with social needs. The first section shows how laws developed for the detention of dangerous lunatics and how these were used during the nineteenth century

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[6] Quote taken from: Melling, 'A Proper Lunatic for Two Years,' 372. Based on Bartlett, *The Poor Law of Lunacy*, 174-7.

[7] Bartlett, *The Poor Law of Lunacy*, 179.

[8] Cathy Smith, 'Insanity and the Civilising Process,' 254.

[9] Smith, 'Family, Community and the Victorian Asylum,' 121; Also described in: Prior, 'Dangerous Lunacy,' 525-41; Melling, 'A Proper Lunatic,' 371-405; Adair, 'Danger to the Public,' 1-25.

[10] Smith, 'Insanity and the Civilising Process,' 254-7, 263-4.

[11] Smith, 'Insanity and the Civilising Process,' 255-6; Bartlett, *The Poor Law of Lunacy*, 179. Up to 82% of admissions at Northampton Lunatic Asylum and 70% at the Leicester Asylum were dangerous to themselves or others.

[12] Smith, 'Insanity and the civilising process,' 257.

[13] Bartlett, 'The Asylum and the Poor Law,' 48-64.

for people with epilepsy. The second section demonstrates how the creation of the category of the 'dangerous individual' by influential medical men came to include epilepsy. Lastly, adopting a wider, social perspective allows exploration of how families and other state-organisations manipulated the legal and medical systems, often using dangerousness to gain access to the asylum, despite the absence of a Poor Law.

THE LAW, THE ASYLUM AND EPILEPSY

Until 1844, the Province of South Australia used English law to detain people who were considered dangerous by virtue of insanity.[14] For instance when Huntley McPherson was held on suspicion of arson in 1841 the Advocate General called for his detention under Act 29 & 30 Geo III c. 94, on the grounds that his peculiar state of mind was a danger to public safety and to himself.[15] This early nineteenth-century law had evolved from the Vagrancy Act of 1714, which was the first legal instrument to include a provision for the detention of people judged too 'furiously mad and dangerous to be permitted to go abroad'.[16] Indeed, during the eighteenth century control of 'dangerous lunatics' could require them to be 'safely locked up' or 'chained'.[17] Hence, the use of restraints for lunatics was legally acceptable during the eighteenth century, and, as will be shown in the following chapter, this had particular relevance for people with epilepsy. In 1844, the government of South Australia enacted its own legislation to deal with lunacy.[18] As demonstrated by its title *An Ordinance to make provision for the safe custody of, and prevention of offences by, Persons dangerously Insane, and for the care and maintenance of Persons of Unsound Mind*, the focus remained firmly on the need

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[14] Under the *Criminal Lunatics Act 1800* 39 & 40, Geo. III. c. 94. Described in Bennett, 'Historical Notes on the Law of Mental Illness,' 60-61; Garton, *Medicine & Madness*, 17; Lewis, Managing Madness, 1.

[15] 'The Late Case of Mr. Huntley McPherson and the Supreme Court,' *Southern Australian*, 12 March 1841, 3.

[16] Garton, *Medicine & Madness,* 12. *Vagrancy Act 1714* 12 Ann c. 23.

[17] The relevant section of the *Vagrancy Act* states: 'And whereas there are sometimes in parishes, towns and places, persons of little or no estates, who, by lunacy, or otherwise, are furiously mad, and dangerous to be permitted to go abroad, and by the laws in being, the Justices of Peace and officers have not authority to restrain and confine them; be it therefore enacted by the authority aforesaid, that it shall and may be lawful for any two or more of the Justices of the Peace … where such lunatic or mad person shall be found … directed to the constables, church-wardens, and overseers of the poor of such parish, town or place, or some of them, to cause such person to be apprehended and kept safely locked up in such secure places within the county … and … to be there chained.'

[18] *An Ordinance to make provision for the safe custody of, and prevention of offences by, Persons dangerously Insane, and for the care and maintenance of Persons of Unsound Mind, 1844* No. 10 (SA).

to control the 'dangerously insane', thus showing continuity with the act's origins in earlier English statutes.

Under the 1844 legislation, people thought to have 'a derangement of mind and a purpose of committing suicide or some crime' could be brought before Justices of the Peace and examined by 'legally qualified' medical practitioners. Terms used in the legislation were not defined, so the precise meaning of 'derangement of mind', 'dangerous lunatic', 'dangerous idiot' and 'insane' depended on the opinions of the medical practitioners. Most of the dangerous lunatics were either suicidal or exhibited behaviours that could endanger the lives of others. However, there were also examples of people who posed little risk to others, but who were unable to look after themselves. Mary H was a young epileptic woman who appeared in court in 1846 and 1848.[19] At the time of her first appearance she was seventeen and had been working as a servant. The medical practitioner who attended her at the urging of her employer reported to the court that Mary was 'quite insane' as a result of epileptic fits. He also stated that she was incapable of taking care of herself and 'although he had not personally known her to do anything dangerous, it would be wrong to suffer her to be at large'. Evidently, she was not detained long, because at her second court appearance in 1848, the Colonial Surgeon, James Nash, stated that 'the prisoner had formerly been under his care', noting that Mary was

> subject to epileptic fits, which left her very weak, and brought on insanity. It was not safe to leave her. She was an only child; and he understood that her father, who was working as a gardener in the country, took no notice of her, and did nothing towards her support.[20]

At both appearances the medical view was that Mary's insanity was linked with the after-effects of her epileptic seizures. During her second court appearance she was found to be without support and weakened by the effects of her illness. Hence, the legal determination that Mary should be charged as a dangerous lunatic was largely based on her state of mind after seizures and the medical view that she could not look after herself. Thus, after 1844 the legal instrument designed to control dangerous lunatics

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[19] 'Police Commissioners Court,' *Adelaide Observer*, 12 September 1846, 2; 'Tuesday, 28th November,' *South Australian Register*, 29 November 1848, 3. Name appears as 'Eastall' in 1848.
[20] 'Tuesday, 28th November,' *South Australian Register*, 29 November 1848, 3.

was modulated by medical opinion which 'softened' the meaning of dangerousness to include the management of people who could not look after themselves.

After 1864, the meaning of dangerousness fragmented following the introduction of new lunacy legislation in South Australia.[21] The legislation required all admissions to be classified according to whether they were 'criminal', 'dangerous', 'pauper' or 'private'.[22] The difference between criminal and dangerous lunatics was one of intent. 'Criminal' lunatics were those found to be insane following imprisonment, whereas 'dangerous' lunatics were persons 'discovered and apprehended under circumstances denoting a derangement of mind and a purpose of committing suicide, or some crime'.[23] The fragmentation of dangerousness arose because all patients could also be *described* as dangerous in their admission notes, regardless of whether they were *admitted* as dangerous lunatics. Hence, under the new South Australian legislation, dangerousness became both a legal designation and a medical description, representing a change from the previous 1844 act. The new legislation also required increased documentation. Subsequently, all admission forms recorded whether a patient had epilepsy. The effect of collecting more information was that it could be compiled and the statistics collated for reporting purposes.[24] As will be shown in the next section, the use of these medical statistics would contribute to public concerns about hereditarian degeneration.

The 1864 Lunatics Act remained in place until 1913 and provides the legal framework for most of the period under consideration in this thesis.[25] Between 1864 and 1913, only fifteen people with epilepsy were admitted under the *legal* category of 'dangerous lunatic', primarily because they had been observed attempting to commit suicide or they were excitable and erratic. Amongst the slightly larger group of people transferred

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[21] *The Lunatics Act 1864* No. 21 (SA), was passed and commenced on 9 December 1864. There were three amending acts: *Lunatics Amendment Act 1865*, No.3 (SA), *Lunacy Act 1866*, No.19 (SA), *Lunacy Act 1868*, No.1 (SA). As shown in Appendix 3, the admission forms were nearly identical with those required under the British law 1844.

[22] *SAGG*, 'Colonial Surgeons Office,' 2/5/1889, p1004.The designation of 'pauper' had a different connotation to that in England. Described by Paterson in 1889: 'The term "pauper" is somewhat misleading. It is used in the Act to designate persons who are maintained in asylums at the public charge. It does not, however, follow from this that the person so described have belonged continuously to the pauper class. What is implied is that, being incapacitated by their lunacy from earning a livelihood, and having no means to fall back on, they have been reduced to destitution, and have, when placed in an asylum, to be supported out of the public funds.'

[23] For examples of admission forms see Appendix 3.

[24] Asylum reports were published in the South Australian Government Gazette. Available at: http://www.austlii.edu.au/au/other/sa_gazette/

[25] Replaced by *The Mental Defectives Act 1913*, No 1122 (SA). Some information was provided for patients before 1864, if their notes were transferred to new case books.

from gaol, six had committed acts of violence, including one who had murdered his wife.[26] The misdemeanours committed by the remaining seventeen 'criminal' epileptic patients ranged from theft, vagrancy, attempted suicide, idle and disorderly behaviour, indecent exposure and prostitution; mainly crimes of poverty and desperation. It is significant that after the passage of the 1864 Lunacy Act, only seven percent of epileptic admissions were admitted as 'dangerous' or 'criminal' lunatics, and few had committed violent acts. From this point forward, most epileptic patients were merely described as dangerous, rather than legally committed as dangerous. Hence, the effect of the new legislation was to make dangerousness a medical rather than a legal concern.

In the years following 1864, eight-six percent of epileptic patients admitted to South Australian asylums were 'pauper lunatics', most of whom were described as dangerous. Determinations about their economic status did not depend on Poor Law administrators. Unlike Britain where 'the pauper lunatic was made by the Poor Law machinery at local level', South Australian paupers simply 'had no means to fall back on'.[27] They were not described as dangerous to 'fast track' their removal from the workhouse to the asylum, as has been suggested was the case in England.[28] Nevertheless, descriptions of dangerous patients in Britain and South Australia had many commonalities, mainly in terms of troublesome and disruptive conduct, and to a lesser extent violence and aggression.[29] Therefore it appears that dangerousness was understood to signify a wide range of behaviours. In South Australia, this understanding was shared by everyone responsible for the admission process, including magistrates (justices of the peace), medical practitioners, family members and police officers.[30] The police became involved when 'lunatics [were] wandering at large, not being properly taken care of, or being cruelly treated'.[31] Describing the situation in Victoria, the historian Catherine Coleborne notes that the police worked 'in conjunction with the asylum and its inmates and their families', and questions 'whether this might be understood as "welfare policing" or surveillance'.[32] Amongst the South Australian epileptic patients, police became involved when their illness left them 'at large', destitute and vulnerable. Hence,

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[26] The case of Charles D is described in the following section. Additional information about patients appears in the Appendix.
[27] Adair, 'A Danger to the Public?,' 3.
[28] Cathy Smith, 'Insanity and the Civilising Process,' 254.
[29] Described in greater detail in final section of this chapter.
[30] *The Lunatics Act 1864* No. 21 (SA).
[31] *The Lunatics Act 1864* No. 21 (SA), s13.
[32] Coleborne, 'Passage to the asylum,' 148.

their removal to the asylum served to remove a nuisance from the street, but also availed them of care, which will be explored in more detail in the following chapter.

In summary, the legal machinery that enabled epileptic patients to be admitted to South Australian lunatic asylums was founded on eighteenth-century legislation designed to control dangerous vagrant lunatics in England.[33] Nevertheless, as early as 1846, it is evident that committing a person as a dangerous lunatic did not necessarily imply that he or she was violent. In the case of Mary H, the damaging effects of epilepsy meant she was incapable of looking after herself and thus became a danger to herself. In England, scholars have linked dangerousness with the administration of the Poor Law, but this fails to explain its common usage in South Australia. It is significant that after 1864, most epileptics were described, but not legally defined, as 'dangerous lunatics'. This suggests that around this point in time, the legally-administered admissions process became more aligned with medical opinion. This enabled dangerousness to absorb a range of different meanings. Before examining how this terminology was used by families, the following section shows how asylum doctors contributed to the debate about dangerous epileptics.

THE MEDICAL VIEW OF THE DANGEROUS EPILEPTIC

Communications were slow between South Australia and Britain during the nineteenth century. Nevertheless, there was a regular exchange of information relating to the management of asylums and care of the insane. This was partly fostered in Britain through the *Association of Medical Officers of Asylums and Hospitals for the Insane*, which was formed in 1841.[34] From 1853 the association published *The Asylum Journal*, later renamed *The Journal of Mental Science*. Information about Australian lunatic asylums appeared sporadically in this journal, and a number of Australian doctors became honorary members of the British Association of Medical Officers.[35] Articles about asylums and insanity were published in *The Lancet* from 1823, copies of which circulated in Australia.[36] Several medical journals were published in Australia, the most

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[33] *Vagrancy Act 1714*, 12 Ann c.23 (UK).
[34] The Association later changed its name to the *Medico-Psychological Association* in 1865.
[35] Possibly the best known was Frederick Norton Manning, the Inspector General of the Insane in New South Wales.
[36] Due, 'Australian Medical Pioneers Index,'; Due. 'Early medical journals of Australia,' 340, 342.

successful of which were *The Australian Medical Journal* (from 1856) and *The Australasian Medical Gazette* (from 1881). The *Medical Gazette* was the 'official organ of the combined Australian Branches of the British Medical Association'.[37] In 1880, the British Medical Association ratified a South Australian branch and three of the Colonial Surgeons held honorary positions on the committee.[38] The South Australian branch also organised the first Intercolonial Medical Congress, which was held in Adelaide in 1887 and included a section on lunacy in Australia.[39] Thus, South Australian asylum doctors were beneficiaries as well as active players in the organisation of medical groups during the nineteenth century and they participated in the active exchange of information through meetings and journals.

The most influential doctors, however, were those who wrote books. Evidence of this is demonstrated by the wide availability of their publications in Australia and the frequent reference to the authors in commissioned reports and newspaper articles.[40] Information about asylum management was also widely reported, and two major surveys were conducted by Australian asylum doctors. In the 1860s, Frederick Norton Manning was commissioned by the Colonial Secretary of New South Wales to visit the 'chief asylums in the United Kingdom, on the Continent, and in the United States'.[41] The full report was published in 1868, based on the instructions given to Norton Manning and outlined in Figure 1:

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[37] Nage, 'The Beginning,' In *A History of the Australian Medical Association*, 17.
[38] The role of the Colonial Surgeons included supervising the lunatic asylums. A list of the Colonial Surgeons and the South Australian lunatic asylums they managed is presented in Appendix 4. William Gosse served as president and William Cleland as secretary.
[39] Nage, 'The Beginning,' 29-30; Cleland, 'Australian Lunatic Asylums,' 870-77.
[40] Doctors referred to in Australian reports, papers and news articles included John Conolly, W.A.F. Browne, William Sankey, John Thurman, Jean-Étienne Esquirol, Philippe Pinel, Robert Gardiner Hill, Thomas Clouston, and various generations of the Tuke family.
[41] Norton Manning, *Report on Lunatic Asylums*, 1868.

> "You will visit the chief asylums in the United Kingdom, on the Continent, and in the United States. You will direct your inquiries in these visits to the principles on which the buildings have been erected, and the sanitary precautions adopted in their construction. Yon will carefully observe the different methods of treatment, and obtain statistical evidence of the results in separate cases, so far as is practicable. You will examine the working of different systems of management and discipline, and endeavour to ascertain the effects of the different forms of administrative organization on the condition of the patients, and in relation to efficient supervision and economy of expenditure. In all cases it will be desirable to obtain plans as well as accurate descriptions of the buildings, particulars of the number of inmates allotted to rooms of a given size, and the quantity of pure air considered as indispensable to a given space."
>
> "You will obtain from the institutions you visit, copies of all regulations, dietary scales, and reports. It will also be within the compass of your duties to procure for the Government, copies of all recent and important statutes, state papers, and departmental reports relating to the treatment of lunatics; and the end to which all this information is to tend is "a re-organization of the lunatic asylums of the Colony on the basis of a correct knowledge of the improvements carried out under more favourable circumstances in other parts of the World."

FIGURE 1: INSTRUCTIONS TO FREDERICK NORTON MANNING[42]

In the 1880s, George Tucker, the owner of a private asylum in New South Wales, undertook a similar exercise. Tucker visited North America, Canada, North Africa, and Australasia as well as most countries in Europe. By his own estimate, he travelled around 140,000 miles, inspected over four hundred asylums and communicated with 'a hundred others'.[43] Copies of the Norton Manning and Tucker reports were widely circulated, and their contents précised in newspapers. In addition to journals, congresses, books, and reports, many Australian asylum doctors also had a direct working knowledge of lunatic asylums in other parts of the world, either from their

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[42] Norton Manning, *Report on Lunatic Asylums*, i.
[43] Tucker, *Lunacy in Many Lands*, 2.

early education, working lives, or subsequent visits.[44] Despite what has been called the 'tyranny of distance', the doctors associated with Australian lunatic asylums were not isolated: instead, they were well appraised of what their peers were doing elsewhere.

During 1873, a series of articles were published in *The Australian Medical Journal* that aimed to help doctors understand the legal requirements of certifying people as insane.[45] The author, Patrick Smith, explained that doctors had to be mindful of 'statute-book law' in order to avoid being 'made defendants in vexatious actions'.[46] Disputes could be avoided by writing better explanations about the 'causes, the duration, and the nature of attacks' on the certificates.[47] According to Smith 'professional' terms, such as 'monomania', 'melancholia', 'mania' or 'dementia', should be avoided. Rather, doctors should provide more descriptive information, such as 'she states she has been dead for a long time', or 'he does not remember the names of his wife and children'.[48] It is evident from Smith's articles that problems were arising where medical knowledge and the application of law intersected with public requirements for rigorous certification procedures. Whilst Smith's information was directed at the doctors responsible for supplying certificates of insanity, he also noted that they had to meet the standards of the medical superintendents of the asylums, who could refuse admission if they 'considered the facts adduced insufficient evidence of insanity'.[49] Various scholars have argued that in Britain, asylum superintendents had little to do with admissions into the asylums, but this appears not to have been the case in Australia.[50] And, as Smith himself was an 'asylum doctor', he was able to inform other 'medical men' about the standards expected of them through the medium of the new medical journal.

Smith also engaged actively in the debate regarding the admission of dangerous lunatics. Smith stated that 'all cases where a lunatic is dangerous to himself or others …

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[44] For instance, Robert Moore attended lectures by John Conolly and visited the Hanwell Asylum. Michael Downey studied under Thomas Clouston. The architect of the Parkside Asylum, William Hanson, had visited various British lunatic asylums.
[45] Patrick Smith, 'Hints on giving certificates,' Dec 1873, Jan 18 74 & Feb 1874.
[46] Smith, 'Hints on giving certificates,' Dec 1873, 357.
[47] Smith, 'Hints on giving certificates,' Jan 1874, 17.
[48] Smith, 'Hints on giving certificates,' Jan 1874, 18.
[49] Smith, 'Hints on giving certificates,' Jan 1874, 18.
[50] *The Lunatics Act 1864* No. 21 (SA), Melling suggests the power of 'psychiatric physicians' was minimal given they 'appeared only at the end of an often extended road to the county asylum'. Melling, 'A Proper Lunatic for Two Years,' 393. However, in South Australia, newspaper accounts show that the colonial surgeon (responsible the SA asylums), could give advice in some cases.

ought to be sent into an asylum'.[51] Amongst his examples of dangerous cases were 'epileptics in whom impulsive insanity has shown itself, as it often does after a fit. This class of cases is the most dangerous of any'.[52] There would, it appears, be no questions raised regarding the need to admit dangerous epileptics to the lunatic asylum. Smith's description of dangerous epileptics resonates throughout the medical literature of the nineteenth century. In the following section, I show that relatively few 'dangerous' epileptic patients were excessively violent. In order to frame that investigation, the medical notion of epileptic violence requires further explanation, as it formed part of the dominant medical narrative during the nineteenth century. The first scholar to examine the link between dangerousness, medical power and the medical subspecialty known as forensic psychiatry was Michel Foucault.[53] According to Foucault, forensic psychiatry had its origins in the early nineteenth century when asylum doctors started to use medical terms to describe spectacularly violent crimes committed by otherwise sane persons. In 1810, a French asylum doctor, Jean-Étienne Esquirol, coined the term 'monomania' to describe a pathological state where a person became highly fixated on some object. Describing it as a medical problem had repercussions in jurisprudence. If a person committed a crime whilst temporarily insane ('fixated'), they could not be held legally responsible.[54] It became, according to Foucault, 'a crime that is insanity, a crime that is nothing but insanity, an insanity that is nothing but crime'.[55] The diagnosis of monomania was widely accepted and used by doctors around the world. In an early South Australian lunatic asylum register, amongst forty-six patients admitted between 1846 and 1856, the word 'monomania' was applied to eight admissions, including one epileptic patient.[56] It is likely that William L was described as a monomaniac because he suffered from what were later described in his notes as 'petit mal' seizures (now known as 'absence seizures').[57] William had not committed any criminal offences; indeed his physical state was described as 'feeble, can hardly see', his mental condition was 'completely demented', and he was subject to severe epileptic fits. He had no next of kin and when he died it was recorded as resulting from 'epilepsy'. Evidently, by the

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[51] Smith, 'Hints on giving certificates,' Dec 1873, 369.

[52] Smith, 'Hints on giving certificates,' Dec 1873, 369.

[53] Foucault, 'Dangerous Individual,' 1-18. Forensic psychiatry links psychiatry and the law, specifically with regards assessments of whether or not criminals are mentally competent to stand trial.

[54] Goldstein, *Console and Classify*, 153; Bucknill, *Manual of Psychological Medicine*, 33.

[55] Foucault, 'Dangerous Individual,' 6.

[56] William L. GRG34-119/1, admitted 12/3/1853.

[57] Berrios, 'Epilepsy,' 148; Esquirol, *Mental Maladies*, 147-8; Hughlings Jackson, 'Diagnosis of Epilepsy,' 47-8.

middle of the nineteenth century, to be diagnosed with monomania did not necessarily imply that a person had committed inexplicable and horrendous crimes. However, it helped to justify the admission of many people to lunatic asylums around the world.

The link between epilepsy and monomania is stronger than might at first appear, mainly because both were described using broadly similar terms by a number of prominent asylum doctors.[58] As with monomania, epilepsy was a form of temporary insanity. A number of doctors argued that during epileptic seizures people could engage in a murderous frenzy, for which they could not be held legally responsible.[59] When Esquirol described 'dangerous epileptics', he drew on his experience at the Paris asylums:

> the fury of epileptics bursts forth after the attacks, rarely before, and is dangerous, blind, and in some sort, automatic. Nothing can subdue it, neither the appearance of force, nor moral influence; which are methods that are successful in other cases of mania.[60]

As noted by Foucault, the diagnostic term 'monomania' fell out of fashion in medical circles after 1870; however people with epilepsy continued to be described in increasingly stigmatizing terms.[61] In England, a report into the state of the nation's asylums noted that during seizures epileptic patients became

> irritable, morose, malicious and sometimes exceedingly dangerous. During these periods, Epileptics [are] prone to violence and sometimes perpetrate atrocious acts. Many instances [are] upon record of such persons … having been seized with a sudden impulse to commit homicide, infanticide, suicide, or to set fire to houses.[62]

Epileptic violence was also a topic frequently revisited by Henry Maudsley. He described how unconscious behaviour of an epileptic maniac could erupt in such 'blind fury and reckless violence' that [the epileptic] might kill, batter or mutilate himself or

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[58] Discussed by a number of doctors including: Jean-Étienne Esquirol, Jules Falret, M. G. Echeverria & Henry Maudsley.

[59] Foucault, 'Dangerous Individual,' 6-7; Masia, 'Epilepsy and Behaviour,' 32.

[60] Esquirol, *Mental Maladies,* 150.

[61] The works of criminal anthropologist Cesare Lombroso are particularly noteworthy. Discussed in; Monaco, 'Cesare Lombroso and Epilepsy,' 679.

[62] Lumley, *The New Lunacy Acts,* 226.

another person.[63] As late as 1900, Maudsley wrote: 'when a murder has been committed without apparent motive and the reason of it seems inexplicable, it may chance that the perpetrator is found on inquiry to be afflicted with epilepsy'.[64] He advocated that these people should be treated in the asylum rather than sent to the gallows.[65] Thus, using a pretext of humanitarian concern, Maudsley claimed the homicidal maniac as an object of medical concern. Foucault argued that this was how asylum doctors gained professional power: by attributing monstrous crimes to a state of temporary insanity.[66] Through their widely-disseminated publications, asylum doctors created the idea of the dangerous epileptic, making him or her an object of public anxiety and a medical responsibility.

The notion of the dangerous epileptic resonated in Australia. Evidence of one impulsive attack was recorded in a South Australian commissioned report into the state of the lunatic asylums.[67] The Colonial Surgeon, Alexander Paterson, had defended the use of force by some of his male asylum attendants, noting they were vulnerable to assaults from patients, 'sometimes of a very ferocious description':

> A few days ago attendant Woolcock was assaulted without the slightest provocation by an epileptic, who, before he could be overpowered, inflicted four incised wounds on the unfortunate man – one four inches long on the right arm; another blow intended for the eye would have blinded him for life, but missed its destination by an inch. The modern treatment of insanity forbids the use of all restraint or coercion. The only means of control, therefore, which the Surgeon-Superintendent has at this disposal, is his own moral ascendency.[68]

However, the only epileptic person accused of murder in South Australia spent most of his custodial time in gaol, rather than the lunatic asylum. Charles D was initially sentenced to hang, but this sentence was later commuted to life imprisonment.[69] After a

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[63] See for instance: Maudsley, *Body and Mind,* 64-65; Maudsley, *Responsibility in Mental Disease*, 165-170. Maudsley, *The Pathology of Mind*, 477-491.

[64] Maudsley, *Responsibility in Mental Disease*, 244.

[65] Maudsley, *Responsibility in Mental Disease*, p331.

[66] Foucault, 'Dangerous Individual,' 4-5; Taylor, 'Infamous Men,' 426.

[67] PPSA, *Management of Lunatic Asylum,* No 68, 1869.

[68] PPSA, *Management of Lunatic Asylum,* No. 68, 1869, Q. 1931.

[69] 'Supreme Court - Criminal Sittings – Murder,' *Evening Journal*, 18 May 1871, 3.

brief confinement in the Adelaide Gaol, the prisoner was transferred to the Adelaide Lunatic Asylum, where his 1871 admission notes record that he had: 'killed his wife at Nailsworth, a form of epileptic mania'.[70] This single entry suggests the doctor, at least, believed the murder had been committed in a state of epileptic frenzy. During Charles D's trial there was no mention of epilepsy; the focus had rested on his 'excited' behaviour before he killed his wife, 'wilfully and of malice aforethought'.[71] After three years in the lunatic asylum, Charles was transferred to Yatala Gaol, where he died four years later of 'epilepsy and liver disease'.[72]

The case of Charles is significant because he was described medically as having epileptic mania and had committed a murder, yet he was transferred back to gaol. In fact, the most likely explanation for this is that in 1874 there was no dedicated ward for the criminally insane in the South Australian asylums.[73] The Colonial Surgeon berated the government for many years about the absence of a secure facility and the 'necessity of placing [the criminally dangerous men] in a separate and detached building' until money was made available to build one.[74] In South Australia, the Colonial Surgeon had very wide-ranging medical responsibilities, quite different to those of asylum doctors elsewhere. They included (but were not limited to) the management of the lunatic asylums and the medical charge of the Gaol.[75] Hence, by returning Charles to gaol, he was not so much relinquishing authority; rather he was using his position to demonstrate the inadequacy of the lunatic asylum for the criminally dangerous individuals. Whilst he may have been considering the well-being of other patients, this seems unlikely. A coroner's inquest held after Charles' death in 1878 noted that he had been a *constant* inmate at the gaol's infirmary 'suffering from epilepsy and general debility'.[76] However, his treatment in the infirmary would have been similar to that provided at the lunatic asylum. Two English sisters who visited the prison during the period of Charles' confinement described it as a 'very comfortable room', visited daily

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[70] Charles D. GRS-14319/0/1, p23, admitted 19/10/1871.
[71] 'Law and Criminal Courts,' *Evening Journal* , 17 May 1871, 2.
[72] 'Coroners Inquests,' *South Australian Chronicle and Weekly Mail*, 23 March 1878, 18.
[73] Kay, *Centenary of Glenside Hospital*, 36. The ward for the criminally insane was completed in 1885
[74] SAGG, 'Colonial Surgeon's Office,' 22/2/1883, 742.
[75] Anon, 'Appointment Of Colonial Surgeon,' *South Australian Register*, 11/11/1858, 3.
[76] 'Coroners Inquests,' *South Australian Chronicle and Weekly Mail*, 23 March 1878, 18.

by a medical officer. [77] As advocates of prison reform, the sisters were evidently confident that the care administered in the Yatala Gaol was adequate.

The question of whether Charles murdered his wife whilst affected by epilepsy was never debated in the local press. Nevertheless, the abstract idea that such violence could erupt was aired by journalists. In 1888, an article drawing on the writings of George Savage appeared in the South Australian papers. [78] Savage was then the chief medical officer at Bethlem Royal Hospital in England and co-founder of the *Journal of Mental Science*. Writing about homicidal mania, Savage described 'the crimes of the epileptic':

> Probably some of the most brutal crimes have been committed by epileptics. In an asylum there are always patients who are dreaded on account of their objectless and murderous fury. A fit of fury may precede a fit of epilepsy, or, what is much more common, follow it, or, according to some, may take the place of the fit. In these cases apparently purposeless acts are done. The victim may be cunningly decoyed, and later, may be dismembered and mutilated. [79]

The willingness of editors to reproduce such material in newspapers suggests that the accounts appealed to public sentiment. One consequence was that these ideas were transposed into fiction, which undoubtedly served to embed the idea of the dangerous epileptic in public consciousness. Indeed, crimes committed by people with epilepsy became a recurring motif in a new genre of 'sensation novels' that appeared during the nineteenth century. [80] Thus, doctors were ultimately responsible for stigmatising epileptic people through descriptions that were embraced by writers of gothic-horror fiction.

Towards the end of the nineteenth century, doctors also started to associate dangerous insanity with crime and heredity. In Australia, newspaper articles appeared in which this was discussed, particularly in the 1890s following significant public interest in the 'Windsor murder' trial held in Victoria. [81] The accused, Frederick Deeming, was

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[77] Hill, *What We Saw in Australia*, 171.
[78] 'Homicidal Mania,' *Petersburg Times*, 21 December 1888, 3.
[79] 'Homicidal Mania,' *Petersburg Times*, 21 December 1883, 3.
[80] Examples include: Collins, *Woman in White*; Collins, *Poor Miss Finch*; Braddon, *Thou Art the Man*.
[81] 'The Windsor Murder,' Advertiser, 27 April 1892, 5. The case is also described on Wikipedia under the accused's name Frederick Deeming: https://en.wikipedia.org/wiki/Frederick_Bailey_Deeming.

charged with murdering his wife, but claimed to have been affected by epilepsy. Due to public interest in the case, various articles appeared in which 'instinctive crime' was discussed. In Adelaide, doctors were asked to provide their opinions about the legal culpability of such cases. Alexander Peterson 'preferred not to offer any remarks upon the matter'; however William Cleland provided a lengthy response in which he stated that 'the only question left for the Judge and Jury … to decide is as to the "dangerous" or "harmless" character of the accused, and his capacity for responding to the accentuated stimulus of an artificial environment'.[82] Interestingly, Cleland referred to the work of the 'criminal anthropologist' Cesare Lombroso, whose Italian publications had started to be translated into English at this time. Lombroso believed that 'the basis of criminal tendencies is always of an epileptic nature', something that was inherited.[83] Summing up his own position, Cleland stated:

> the question for society is to decide which is preferable:- (a) a lifelong imprisonment, hopeless and objectless from a curative point of view; or (b) a more liberal application of the principle of euthanasia.

What Cleland implies is that Deeming had an inherited 'instinctive' condition (epilepsy) that rendered him dangerous. Inherited conditions could not be cured and he was clearly dangerous; thus society would be better served by 'euthanising' him. Deeming was indeed swiftly dispatched to the gallows. The high-profile nature of his case indicates where the debate about dangerous epilepsy was heading in the late nineteenth century. As epilepsy was increasingly linked with hereditarian concerns and dangerous behaviour, doctors such as Cleland were beginning to argue that they did *not* necessarily belong in the lunatic asylum.

The Deeming case polarised public thinking in Australia because it revealed the gulf between what one contemporary newspaper article described as the 'orthodox legal and the advanced medical views of the responsibility of madmen'.[84] The author of the article suggested that attempts to 'get the prisoner off on the grounds that he was not in his right senses at the time of the deed was committed' were more common for capital offences than other criminal charges.[85] Such petitions for reprieve received

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[82] 'Instinctive Criminality: what some Adelaide doctors think,' *SA Register*, 21 April 1892, 6.
[83] Lombroso*, Crime: Its Causes and Remedies*, 24.
[84] 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.
[85] 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.

'considerable support among people whose sense of justice is temporarily obscured by feelings of pity or who object to capital punishment under any circumstances'.[86] The article further described the association of epilepsy and murder, noting that there were doctors who believed murder was committed 'in a state of great epileptiform furor [sic] or incontrollable impulse in a weakened brain'.'[87] Nevertheless, the author argued that it was the responsibility of the jury, not the doctors, to determine whether the accused could distinguish 'right from wrong', stating that 'it is perhaps a fortunate circumstance that the law is slow to fall in with the extreme ideas of medical science'.[88] Thus, it can be seen that by the late nineteenth century there was a tension between public opinion, medical power and the legal machinery regarding the treatment of murderers who claimed insanity as a defence. Whilst the position of medical 'experts' was understood, ultimately the final decision lay with the judge and jury. The fact that William Cleland argued in favour of execution rather than clemency suggests that he chose to align his medical opinion with those of the legal profession.

Not all doctors described epileptic behaviour in such extreme terms. In his book about epilepsy, Eric Gowers offered a more balanced description of impulsive behaviour.

> The subjects of epilepsy sometimes, *but rarely*, present sudden paroxysmal outbursts of mental derangement, often with violence and a tendency to injure others. The maniacal attack is usually brief, often lasting minutes only, sometimes for an hour or two.[89]

Thus, according to Gowers, people with epilepsy seldom posed a risk to those around them, and when they did, such events were short-lived. This was a better representation of the violent behaviour typically exhibited by epileptics in the South Australian lunatic asylums than the extreme examples provided by doctors such as George Savage and Henry Maudsley. David O, for instance, was only manic 'when the epilepsy is most in evidence' at which time he was 'inclined to become impulsively violent'.[90] The notes of William E, diagnosed with 'mania from epilepsy', record that he was 'very excited and violent in status epilepticus and quite unconscious of what he is about'. Between fits he

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[86] 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.
[87] 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.
[88] 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.
[89] Gowers, *Epilepsy,* 120. My italics
[90] David O. GRS-14317/1/2, p360, admitted 12/2/1902.

was deemed 'weak minded' and said to have a 'silly smile'.[91] Another epileptic, Michael O, was 'subject to maniacal outbursts of violence when he attacks those about him'.[92] None of these 'epileptic maniacs' were murderers. Rather, they had a short-lived tendency to strike out at others when affected by epilepsy. Thus, there was a large gap between public representations of dangerous epileptic mania made by doctors, and the actual symptoms exhibited by patients in lunatic asylums. Clearly epileptic patients were not described as dangerous to avoid capital punishment. Rather, the designation defined behaviours similar to those outlined by Eric Gowers, which he described as 'outbursts of mental derangement, often with violence and a tendency to injure others'.[93]

In conclusion, it can be seen that during the nineteenth and early twentieth century, doctors were instrumental in creating and exaggerating the idea of the dangerous epileptic through journal articles and books, and their ideas were frequently reproduced in newspapers. Hence, although asylum doctors had little control over the admission processes, they could assert their influence through the burgeoning new field of medical journalism. Evidence that they were influential can be seen in the way the notion of the dangerous epileptic became a plot device in Victorian gothic novels. Nevertheless, the medical view that people with epilepsy committed murder unconsciously, and thus were 'mad', was largely ignored when tested in the legal domain. Although some doctors did call for clemency during two high-profile trials in Australia, the legal view of culpability prevailed and the perpetrators were hanged.[94] Foucault has argued that doctors exploited the idea of the dangerous individual in order to elevate their professional standing. However, it appears that their 'knowledge' did not strongly influence legal judgements. Evidence from South Australia also demonstrates that asylum doctors were not necessarily against the death penalty, even if they believed that a crime was unconscious. Some epileptic patients exhibited occasionally violent behaviours; however these were generally short-lived episodes and easily managed in the asylum. Most of the epileptic patients were not violent but were described as dangerous. The following section therefore explains why families and other institutions

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[91] William E. GRS-14317/1/2, p93, admitted 21/1/1899.
[92] Michael O. GRS-14317/1/2, p546, admitted 1/1/1904.
[93] Gowers, *Epilepsy,* 120
[94] Two patients described were Frederick Deeming and Colston in, 'Insanity and Murder,' *South Australian Chronicle*, 9/4/1892, 4.

used the language of dangerousness when admitting epileptic patients into the lunatic asylum.

THE SOCIAL VIEW OF THE DANGEROUS EPILEPTIC

As demonstrated, lunatic asylums existed within the frameworks of the legal and medical systems, both of which linked lunacy to dangerousness. Thus, it could be argued that medico-legal explanations are sufficient to explain why so many epileptics were described as dangerous. Foucault clearly thought this, interpreting the admission of dangerous individuals solely in terms of 'power relations between violent men, medicine and the law'.[95] As noted in the introduction to this chapter, scholars of British lunacy history prefer to interpret dangerousness as evidence that families negotiated with Poor Law officials in order to gain admission for 'difficult and dangerous family members'.[96] The British process encouraged families to describe members as dangerous because the Poor Law explicitly required dangerous lunatics to be removed from the workhouse to the asylum within fourteen days. In Britain, harmless lunatics often remained in special wards in the workhouse. However, South Australia had a different administrative process where families had to negotiate admissions with magistrates and certifying doctors. This raises the question of why their charges were frequently described as 'dangerous'. Most were not particularly violent; indeed, relatively few exhibited seizure-induced aggressive tendencies. By reviewing narratives used by families, it is clear that when they described someone as dangerous, the term incorporated a range of meanings, as will be discussed below.[97]

Before examining the language of dangerousness, it is important to note that most people with epilepsy were *never* admitted to lunatic asylums. Evidence of the occurrence of epilepsy among those who remained in the broader community is only available when deaths attributed to epilepsy were reported in the newspapers. This was typically reported in family notices, but longer articles were written if circumstances

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[95] Taylor, 'Infamous Men,' 426.

[96] Smith, 'Family, Community and the Victorian Asylum,' Smith, 121; Also described in: Prior, 'Dangerous Lunacy,' 525-41; Melling, 'A Proper Lunatic,' 371-405; Adair, 'Danger to the Public,' 1-25.

[97] The same is suggested of dangerousness in Britain, see: Bartlett, *The Poor Law of Lunacy*, 62-64; Melling, 'A Proper Lunatic for Two Years,' 384; Smith, 'Insanity and the Civilising Process,' 253 & 260; Smith, 'Family, Community and the Victorian Asylum,' 116.

were unusual.[98] Thus in 1902, an inquest was held into the unexpected death of a man during a coach journey. The report concluded that he had two epileptic seizures and had not recovered from the second.[99] Whilst the true incidence of epilepsy at this time is not known, in 1898, the American neurologist Frederick Paterson noted that 'epilepsy is a wide-spread disorder and it has been calculated that one person in five hundred is thus afflicted'.[100] Peterson's estimate is less than half that found in contemporary populations.[101] However using his figures, when the population of South Australia was 279,865 in 1881, there would have been over five hundred people affected by epilepsy in the community.[102] The actual figure probably stood at over a thousand; however, there were only seventy epileptic patients in the two lunatic asylums at this time. Towards the end of the century, the number admitted, per head of population, increased slightly (see Table 1), but only from two to two and a half per 10,000 between 1870 and 1890. These figures demonstrate that epilepsy alone was not sufficient to warrant admission to the lunatic asylum. And despite the increasing tendency for doctors to link epilepsy with crime and danger, there is little evidence that this resulted in an increase in the number of people admitted. Hence, in order to understand why people with epilepsy were admitted, it is necessary to examine why so many were described as dangerous, and how this related to their physical and mental condition.

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[98] 'Death of Mr John Shannon,' *South Australian Register*, 3 January 1885, 5.

[99] 'Death on a Coach,' Adelaide Observer (SA: 1843 1904), Saturday 11 January 1902, 31.

[100] Peterson, 'On the Care of Epileptics,' 362.

[101] According to the World Health Organization, the proportion of the general population with active epilepsy (i.e. continuing seizures or with the need for treatment) is between 4 and 10 per 1000 people. Studies in low- and middle-income countries put the figure higher at between 7 and 14 per 1000 people. http://www.who.int/mediacentre/factsheets/fs999/en/

[102] 'Statistics of Population,' South Australian Register, 6 December 1881, 4. Census details are also available online through the Australian Data Archive: http://hccda.ada.edu.au/pages/SA-1881-census-02_3.

TABLE 1: NUMBER OF ASYLUM RESIDENTS WITH EPILEPSY PER HEAD OF POPULATION IN SOUTH AUSTRALIA

Year	1870	1880	1890	1900
Population of South Australia	184,546	276,393	318,947	362,107
Number of epileptics in the South Australian lunatic asylums	38	68	81	92
Number per 10,000	2	2	2.5	2.5

Most of the epileptic patients admitted to the South Australian lunatic asylums were 'paupers', defined under the 1864 Lunatics Act as 'any person having no income, property, or estate sufficient to provide for his maintenance'.[103] As noted previously, this differed from Britain where 'pauper' meant a person in receipt of relief administered under the Poor Law. In his annual report for 1899, the medical superintendent Dr Cleland recorded that only nine percent of residents in the state's two asylums contributed to their asylum fees.[104] In the same year, seven percent of the epileptic patients were fee-paying. What this shows is that there was little or no difference between epileptic patients and other 'ordinary' admissions in terms of their social status.[105] Wealthier members of the South Australian community were more able to provide home-based medical and nursing care. Epilepsy was not a class-specific condition, as it affected rich and poor alike. For instance, in 1889, the newspapers reported the death of 'John Shannon, of Warbreccan Station, Deniliquin'.[106] Shannon was married to the daughter of Sir John O'Shannassy and was the business partner of Sir Patrick Jennings. Nevertheless, he was reported to have 'died suddenly last night of epilepsy, aged 32 years'. His estimated worth was placed at around a 'quarter of a million sterling'. Whilst epilepsy affected people at every level of the socio-economic scale, admission to the lunatic asylum was largely premised on poverty. Hence

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[103] *Lunatics Act* 1864 (SA).
[104] *SAGG*, 'Report for 1898. Lunatic Asylums,' 22/6/1899, p1373.
[105] 'The Lunatic Asylums,' Adelaide Observer, 1 July 1899, 13.
[106] 'Death of Mr John Shannon,' *South Australian Register*, 3 January 1885, 5.

whatever led families to describe their charges as 'dangerous' needs to be framed within a context of poverty.

The link between epilepsy and poverty is most evident amongst the six percent of epileptic patients transferred from the destitute asylum.[107] Mostly these people had fallen into destitution when the long-term effects of their epilepsy rendered them unable to work. In the absence of financial support from families, they were admitted to the destitute asylum, but as their conditions deteriorated, they were transferred to the lunatic asylum. For example, Lily B had been a dressmaker but had become 'mind - weakened … evidently unable to take care of herself or earn her living'.[108] Samuel M had been a labourer, but on transfer it was noted he had 'dementia from epilepsy, the convulsive seizures are of very frequent occurrence and leave him in a very exhausted and bruised condition'.[109] At the age of twenty-nine, Samuel was also a widower and his four children were in state care. However not everyone affected by epilepsy was transferred from the Destitute Asylum.[110] Generally, transfer eventuated when the Destitute Asylum could no longer cope with their care needs and behaviour. Words that were used to describe transferred patients include 'uncontrollable', 'unmanageable', 'maniacal', 'excitable' and 'violent to others', suggesting that disruptive behaviour was a strong contributory reason. However, most transfers, such as Samuel M, also had dementia, which, as will be discussed further in Chapter 3, was frequently associated with epileptic admissions.[111] The association of epilepsy, dementia and poverty at the Destitute Asylum is most clearly expressed in the notes of Sarah F, who on transfer was described as having 'dementia from epilepsy. The convulsive seizures incapacitate her for work and thus gaining her living, at the same time she requires skilled attention during the attacks which could not be obtained in a destitute asylum'.[112] Clearly in order to remain in the destitute asylum, inmates had to be tractable and require little in the way of nursing care. Those whose needs were greater were invariably described as 'dangerous' and transferred to the lunatic asylum. Whilst the administrative process of

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[107] There were 41 epileptic patients transferred from the South Australian Destitute Asylum (10 were also transferred from the Industrial Schools).

[108] Lily B. GRS-14310/1/2, admitted 7/11/1905.

[109] Samuel M. GRS-14316/2/5, 521, admitted 14/8/1890 (also GRS-14317/1/1).

[110] 'Destitute Asylum Annual report,' Advertiser, 21 October 1905, 13. One death was attributed to epilepsy in this report.

[111] Caramelli, 'Dementia Associated with Epilepsy,' s195. Dementia and epilepsy are discussed in more detail in Chapter 3.

[112] Sarah F. GRS 14310/1/1, p321, admitted 4/10/1890.

transferring people from the British workhouse and the South Australian destitute asylum were very different, both it seems were attributed to dangerousness. In Britain, scholars argue that dangerousness helped families hasten the progress of relatives from the workhouse to the lunatic asylum. However, in South Australia epileptics in the destitute asylum lacked family support and the destitute asylum system was unable to provide the care that they required.

Unlike those transferred from the Adelaide Destitute Asylum, most epileptic patients admitted to the South Australian lunatic asylums had families. The admission notes allude to the reasons why their families were unable to keep them at home. Based on the words used, three different behaviours are apparent: mania, dementia and suicide. Some patients apparently exhibited all three types, others only one. 'Epileptic mania' was characterised by erratic behaviours after seizures. In this state, a few became aggressive and their descriptions mentioned that they were 'often violent, will strike anyone'; 'tries to injure those about her, uses a hatpin or knife or anything handy'; and 'maniacal outbursts of violence when he attacks those about him'.[113] One man had 'tried to shoot someone a week ago'.[114] In the main, aggressive actions were directed against family members ('violent to her mother and sisters', 'inclined to be violent with the other boys [his brothers]', 'attempted to stab her sister with scissors').[115] However, most described as having 'epileptic mania' exhibited behaviours that cannot be explained in terms of violent outbreaks. Typically their admission notes allude to difficult behaviours based on the use of words such as excitable, destructive, unmanageable, lacking self-control, noisy, talkative or rambling, restless, irritable, or removing clothing. Thus, the meaning of dangerous, even amongst 'epileptic maniacs' was nuanced and accommodated a range of meanings. When Cathy Smith examined descriptions of dangerous behaviours in the Northampton Lunatic Asylum, she suggested that the 'absence of violent actions in so many cases' might mean that those involved in the committal process were 'playing the system', by which she meant the Poor Law system.[116] However, it is possible that South Australian families also

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[113] Sarah S. GRS-14310/1/2, p362, admitted 23/10/1909; Susan Rebecca C. GRS-1410/1/2, p402, admitted 8/8/1910; Michael O. GRS-14317/1/2, p546, admitted 1/1/1904.

[114] William J. GRS 14324/1/2, p32, admitted 11/5/1911.

[115] Gertrude J. GRS-14324/1/1, p251, admitted 1/5/1914 George T. GRS-14317/1/2, p369, admitted 4/3/1905; Sophia M. GRS-14324/1/1, p31, admitted 2/5/1911.

[116] Smith, 'Insanity and the Civilising Process,' 261.

described their charges as dangerous in order to emphasise the seriousness of their problems and to gain admission.

Not all behaviours that were described as dangerous implied a threat of physical violence to others. Dangerousness was also evoked in situations where it was thought the person with epilepsy might be harmed. The admission notes of epileptic patients frequently described the scars, bruises, broken bones and burns that covered their bodies, caused by falling during seizures. However, it was *not* for these harms that families sought admission. Rather, some families found their abilities to cope were diminished when their charges started to roam, a behaviour associated with epileptic dementia. They attempted to prevent this from happening through surveillance, describing how their relative 'has to be watched else she would wander away and get lost', and 'has to be watched at home day and night', and 'requires constant supervision', and 'managed to escape from their supervision'.[117] Apart from the lunatic asylum, the only options available to families were either home nursing or restraints. Wealthier families could pay for nursing or spare a family member to provide the necessary attentive care. Some descriptions from the nineteenth century suggest that families also resorted to restraints or imprisonment.[118] Although placing people with epileptic dementia in lunatic asylums deprived them of their liberty, it simultaneously removed a burden from family members who could also expect their charge to be kept safe in the asylum. When Nancy Tomes describes familial expectations about treatment in a lunatic asylum, she suggests that

> Since loss of control over the patient's behaviour prompted most commitments, patrons naturally looked to the asylum to supervise the insane very closely. At the most elemental level, this supervision meant providing physical security for the inmates. Maniacal outbursts had to be subdued, suicidal patients constantly observed, *and peripatetic individuals kept from wandering off*.[119]

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[117] Sophia M. GRS-14324/1/1, 31, admitted 2/5/1911; William J. GRS-14324/1/2, 32, admitted 11/5/1911; Joseph S. GRS-14317/1/1, 694, admitted 5/8/1893; Joseph J. GRS-14316/2/5, 324, admitted 12/10/1888.

[118] Suzuki, *Madness at Home*, 116.

[119] Tomes, *Generous Confidence*, 114. My italics

Whether committing a person prone to wandering was evidence of social control or humanitarian concern is one of perspective. The family undoubtedly benefitted, but as will be shown in the next chapter, they could also reasonably expect that their relations would receive humanitarian 'care'.

Some families also had the responsibility of watching over epileptic relatives who were suicidal. Alexander H was thirty-seven when he was admitted to the lunatic asylum, his notes stating he 'wants to commit suicide, and has cut his throat – has threatened to jump down the well – refusing food – requires constant supervision'.[120] In fact, over a quarter of the South Australian epileptic cohort were described as suicidal, suggesting self-endangering behaviours or ideations contributed strongly to the reasons why families sought admission for their charges. Suicidality is discussed in more detail in Chapter 3; however the frequency with which it appears in the admission notes requires some explanation. Under the 1864 Lunacy Act, anyone 'discovered and apprehended under circumstances denoting a derangement of mind and a purpose of committing suicide' could be committed as a 'dangerous lunatic'. Nevertheless, few epileptic patients were actually apprehended attempting suicide. Some attempts had been made: Rose M had 'attempted to throw herself off the balcony', and Mary L had 'jumped into sea from the Penola', whilst John B had 'attempted to cut his throat'.[121] However for many of the epileptic patients identified as suicidal, this was premised on the threat to commit suicide rather than any actual attempt. Thus, admission notes speak of an inclination, rather than the actuality of suicide: 'threatens to commit suicide', 'threatened to cut throat', 'threatened to harm herself', 'disposed to suicide', 'threatened to drown herself'.[122] Little has been written about the link between suicidal behaviours and epilepsy, although some contemporary scholars have suggested it may be associated with the period following a seizure (post-ictal state).[123] When Esquirol described the epileptic patients under his care at Salpêtrière Hospital in Paris, he noted a correlation between the 'mental alienation' occurring after attacks and 'an inclination to suicide'.[124] Jules Falret, also at the Salpêtrière, similarly described suicide attempts

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[120] Alexander H. GRS-14324/1/1, p42, admitted 22/6/1911.

[121] Rose M. GRS-143227/1/3, p128, admitted 28/11/1884; Mary L. GRS-14227/1/1, p323, admitted 24/10/1875; John B. GRS-14317/1/1, admitted 28/7/1881.

[122] Sophia M. GRS14324/1/1, p31, admitted 2/5/1911; Margaret B. GRS-14310/1/1, p468, admitted 11/7/1895; Elizabeth R. GRS-14227/1/2, p48, admitted 5/10/1879; Margaret M. GRS-14310/1/1, p131, admitted 1/3/1881, Flora M. GRS-14323/1/4, p218, admitted 2/4/1890.

[123] Marsh, 'Aggression and Violence,' 160.

[124] Esquirol, *Mental Maladies*, 150.

during post-seizure delirium.[125] Suicidal ideation could be part of epileptic disorientation or unrelated to epilepsy. Nevertheless, the frequency with which it is mentioned in the admission notes suggests that this potentially dangerous behaviour both caused and enabled families to seek admission for their relatives.

Finally, the admission records show that most epileptic patients were also burdened with a substantial level of mental and physical disability. Many were 'unable to attend to themselves', and had 'wet and dirty' habits, which meant they were incontinent. Some could not feed or dress themselves. Within descriptions of such debility is a sense of each family's desperation particularly when they stated that their charges were 'unmanageable at home', 'a source of anxiety', 'requires much looking after', and 'more than his mother can manage'.[126] For families who existed at the edge of poverty, providing home-based care posed a threat to their economic survival. Thus, gaining admission to the lunatic asylum helped to relieve them of this burden. By describing people who were difficult as dangerous, those seeking admission were embracing and manipulating the medico-legal discourse for their own purposes.

CONCLUSION

It is unsurprising that families seeking admission to South Australian lunatic asylums typically described their epileptic charges as dangerous, as to do so was to frame their problem within the medico-legal discourse of insanity. Nevertheless, they were not admitted simply because fits were considered to be dangerous.[127] Some individuals *were* aggressive at the time of their seizures, although their behaviours did not match the exaggerated and stigmatising claims made by nineteenth-century asylum doctors. In this sense, Foucault accurately suggested that doctors used hyperbole to elevate their own status and power. However, it would seem that families also co-opted the notion of the dangerous epileptic by applying it to behaviours with which they had difficulty dealing, rather than those that strictly speaking were dangerous. Most of the people admitted with epilepsy were suffering from worsening health problems, difficult and disruptive

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[125] Quoted in: Temkin, *Falling Sickness*, 321.
[126] Comments applied to many patients – see Boult,. 'Epilepsy in the South Australian Lunatic Asylums (c.1850-1914),'. Figshare. doi:10.6084/m9.figshare.7176542.
[127] As suggested by Cathy Smith, 'Insanity and the Civilising Process,' 257.

behaviours, and physical and mental incapacity. Their need for constant vigilance and care differentially affected poorer families whose resources were already limited. What is evident in South Australia is that the push to gain admission came from 'below', mainly from families. In the absence of family members, however, this responsibility devolved to the police, doctors and administrators at the Destitute Asylum. It was rarely imposed through legal authority, except in a few cases where patients were admitted as criminal or dangerous lunatics. This is particularly evident in South Australia, where families did not have to negotiate through the administrative tier of the Poor Law. Despite this difference, South Australian asylums were very similar to those elsewhere, with around ten percent of patients having epilepsy. The question remains whether it is reasonable to describe the use of lunatic asylums as places where families discarded 'inconvenient people' into places that were 'little more than custodial warehouses for the chronically ill and dangerous' as described by Scull.[128] There is little doubt that epileptic patients were chronically ill and were sometimes dangerous. Equally evident is the custodial nature of the lunatic asylums, which was undoubtedly appreciated by families whose demented epileptic relatives had taken to wandering. This question is examined in greater detail in the following chapter, which evaluates what the provision of care meant for epileptic patients.

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[128] Scull, *Most Solitary of Afflictions* C6; Cathy Smith, 'Insanity and the Civilising Process,' 251, 253.

CHAPTER 2

EPILEPSY INSIDE THE ASYLUM

> In South Australia there is no hospital for people suffering from an incurable
> disease; and, as people of this class, particularly when their minds are
> affected, become a trouble to their friends and neighbours, the difficulty, in
> not a few cases, is solved by their being sent to end their days in the asylum.
> Whatever else may be the disadvantages of this plan, it at least secures for
> them the benefit of constant medical supervision and skilled nursing; and,
> when all circumstances are taken into consideration, this is, perhaps, the best,
> as it certainly is the easiest course to follow.[1]

In the absence of designated institutions for severely disabled and incurable epileptic
patients, it was inevitable that some would be placed in lunatic asylums. We cannot be
certain what Dr Paterson, the Colonial Surgeon for South Australia between 1867 and
1896, and medical superintendent of the Adelaide Asylum, meant when he referred to
'the disadvantages of this plan'. He may have been considering the disadvantages to
patients, such as stigmatisation arising from lunacy certification or the loss of personal
liberty incurred through admission to a lunatic asylum. He may have understood that
patients would miss their homes, family and friends, and would be affected by this
separation. Alternatively, he may have been considering the disadvantages to the public
purse and the additional expense required to pay for their treatment. Undoubtedly,
committal was not desired, as is shown in the next chapter, few people affected by
epilepsy *actively* sought admission to the two South Australian lunatic asylums between
1852 and 1913. Nevertheless, several hundred epileptics passed through the two lunatic
asylums. Little is known about the treatment which they received there, hence, this
chapter focusses on what Paterson described as the 'constant medical supervision and
skilled nursing'. Firstly, it examines how asylum doctors asserted their professional
authority over lunatic asylums by embracing the tenets of moral therapy. The chapter
then explores how descriptions of 'ideal' asylum environments compared with the real
environments that eventuated, with particular regard to the epileptic patients in the

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[1] SAGG, *Annual Report by Dr Alex S Paterson*, 28/3/1872, 400.

South Australian lunatic asylums. Thirdly, it investigates the development of 'skilled nursing' practices and their application to the treatment of epileptic patients. By examining the individual factors of care within the lunatic asylum, the chapter shows how they combined to benefit the epileptic patient.

MANAGING THE LUNATIC ASYLUM

By the mid-nineteenth century, the management of government-sponsored lunatic asylums had largely devolved to qualified doctors employed as 'medical superintendents' and 'resident medical officers'. This transition of power from lay-keeper to trained doctor has been described by various scholars.[2] Andrew Scull highlights how doctors usurped lay practitioners by adding moral treatment to their armamentarium.[3] Doctors asserted that the combined use of medical and moral treatment would only be successful in the hands of people who had a medical education and an extensive experience of the insane.[4] One such doctor was William Ellis, the medical superintendent at the Middlesex Asylum in England, who argued that an understanding of the 'dispositions, habits, and temperaments of individual patients' could only be achieved by those who were 'medically and morally qualified for the office'.[5] Moral qualifications were subjective and informal. When Charles Caldwell described moral medicine in 1833, he envisaged it would be undertaken by people who were agreeable, civil, affable, kind, courteous, attractive, dignified, calm and confident.[6] To this list, Ellis might have added qualities such as patience, hard work and temperance, based on his understanding of 'man's nobler faculties'.[7] Medical qualifications, on the other hand, were increasingly codified during the nineteenth century following legal changes, the creation of governance bodies, and the introduction of specialised university training. After 1838, there was a legal requirement for medical qualifications to be reviewed in New South Wales.[8] Henceforth a medical board took responsibility for assessing medical qualifications and

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[2] Foucault, 'The Birth of the Asylum,' in *Madness and Civilization,* 241-278; Scull, 'From Madness to Mental Illness,' in *The Most Solitary of Afflictions,* 175-216.

[3] Scull, *Most Solitary of Afflictions,* 228-230.

[4] Scull, *Most Solitary of Afflictions*, 230.

[5] Ellis, *Treatise on the Nature,* 210.

[6] Caldwell, 'Thoughts on Moral Medicine,' 415-6.

[7] Ellis, *Treatise on the Nature,* 14.

[8] *An Act to define the qualifications of Medical Witnesses 1838*, No 22 (NSW).

determining which doctors were allowed to practice.[9] A similar act followed in South Australia in 1844.[10] Further legislation followed, requiring state-funded lunatic asylums to be managed by medically qualified doctors. In South Australia, this was enshrined in the 1864 Lunatics Act which required qualified doctors to 'have control and management of such asylums'.[11] Unlike other Australian states, there were no private asylums or lay-superintendents in South Australia, and the state-funded asylums were always overseen by medically qualified doctors.

The control of the lunacy trade by doctors suggests that it was premised on their abilities to cure patients. Indeed, in 1844, a British report by the Metropolitan Commissioners in Lunacy noted that housing incurable patients in lunatic asylums would be a waste of doctors' time which was better spent trying to cure patients.[12] The Commissioners accepted that 'incurables' should be given refuge, but not in an institution that employed doctors, and thus would cost more.[13] Nevertheless, large numbers of people with incurable and chronic insanity were admitted to lunatic asylums during the nineteenth-century, generally because they were described as dangerous, and lunatic asylums were required to accept them.[14] Scull suggests that asylum doctors did not actually want alternative institutions to be established for incurable patients, as they argued that this would be the more expensive alternative.[15] He 'suspects' doctors were privately 'seeking to inhibit the construction of a set of organizations which might potentially compete with their own'.[16] Further, by allowing chronic cases to remain in lunatic asylums, Scull argues that doctors could also make a

> graceful retreat from the difficult and risky task of curing significant numbers
> of lunatics … and redefine success in terms of comfort, cleanliness, and
> freedom from the more obvious forms of physical maltreatment, rather than
> the … often unattainable goal of cure.[17]

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[9] Proust, *History of Medicine in Australia,* 63-65.
[10] *Ordinance to define Qualifications 1844*, No 17 (SA).
[11] *The Lunatics Act*, 1864, No 21 (SA).
[12] *Report of the Metropolitan Commissioners,* (1844) 92.
[13] *Report of the Metropolitan Commissioners* (1844), 6-7.
[14] As described in introductory chapter.
[15] Scull, *Most Solitary of Afflictions,* 270.
[16] Scull, *Most Solitary of Afflictions,* 270.
[17] Scull, *Most Solitary of Afflictions,* 271.

After 1844, doctors had successfully asserted their control over the lunacy trade and the British Commissioners in Lunacy no longer spoke in favour of separate institutions for incurables.[18] In addition to the outlay that would be required, doctors observed that it was not possible to know in advance which patients were curable; some who appeared incurable might be cured, whilst the supposedly curable might deteriorate. Evidently, most asylum doctors accepted that incurable patients would come under their remit. Although epilepsy was known to be incurable, Ellis thought that caring for epileptic patients might reduce their symptoms and enable them to 'enjoy a considerable share of comfort and happiness between the attacks'.[19] Thus in Britain, the lunatic asylum became the locus of care for some incurable patients such as epileptics. There they could expect to receive better care and protection than in institutions such as workhouses and gaols.

Managing lunatic asylums required a total commitment from the asylum doctors. According to W.A.F. Brown, in order to engage with moral systems of cure in the asylum, doctors 'must live among them'.[20] When the British Government sent a lay-person to run its first lunatic asylum in New South Wales, Ellis imagined this would lead to such asylums becoming 'rather as prisons for the safe custody of the insane, than as hospitals for their cure'.[21] Doctors such as Ellis, Browne and Conolly, convincingly argued that doctors were the ones who were best qualified to create a therapeutic environment. Under their remit they could ensure 'the recovery of the curable, the improvement of the incurable, the comfort and happiness of all the patients'.[22] Prescriptive accounts of the 'construction and government of lunatic asylums' were outlined by a number of doctors, including John Conolly who has been described as the 'most famous mad doctor of the age'.[23] Conolly provided details about where asylums should be located, their architecture and arrangement of internal and external spaces, and even which utilities they should provide. He also recommended the best clothing, exercise, recreation, food, and employment for patients.[24] His attention to details

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[18] Scull, *Most Solitary of Afflictions*, 270.
[19] Ellis, *Treatise on the Nature,* 246.
[20] Brown, *What Asylums Were*, 181.
[21] Ellis. *Treatise on the* Nature, 316.
[22] Conolly, *Construction and Government,* 1.
[23] Examples include: Browne, *What Asylums Were;* Clouston, *An Asylum, or Hospital-Home;* Burdett, *Hospitals of the World;* Hill, *Abolition of Restraints*. Conolly is described as the most famous mad-doctor of the age in, Monk, *Attending Madness at Work*, 7.
[24] Conolly, *Construction and Government.*

provided a useful template for others to utilise. Conolly also helped to define the treatment regimens and drug therapies, ensuring doctors maintained a medical presence in the asylum.[25] Such was the level of interest in formulating standards for lunatic asylums that by the 1850s there was a substantial body of published information to help doctors manage lunatic asylums and treat insanity.

Although asylum doctors became the primary administrators of lunatic asylums, they did not have complete autonomy. In light of well-publicised abuses in some asylums a system of oversight was deemed necessary in Britain. This became the responsibility of the Commissioners in Lunacy, a legally constituted and salaried body required to audit asylums. Their annual reports to government demonstrate an acceptance of the principles of moral treatment and also provide valuable insights into the expectations of what constituted a well-run asylum.[26] Leonard Smith describes how everything, including the 'location of lunatic asylums, their design, layout and furnishing, and the proper methods for managing and treating patients, had been reinforced by legislation', and were subject to scrutiny by the commissioners.[27] In South Australia and elsewhere in Australia there were no paid auditors, however antipodean legislation required asylums to be inspected by official visitors appointed by the government. These visitors were not required to meet, or report to the government, unlike their British counterparts. Indeed, their views were only officially recorded when state governments appointed 'Select Committees' to review lunatic asylums. The reports from these reviews demonstrate that Australian asylums were also expected to conform with the same standards of care as those in Britain.[28]

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[25] Conolly's lectures were all published in *The Lancet*, vol. 2 (1846); They were later compiled in: Conolly, *Treatment of the Insane* (1856).

[26] Jones, *Lunacy, Law, and Conscience,* 222. See also section in Introductory chapter re moral treatment.

[27] Leonard Smith, 'Lunatic Asylum in the Workhouse,' 227.

[28] Inquiries were published in Parliamentary Papers of South Australia (PPSA) in 1856, 1864, 1869 & 1884 (see bibliography).

Restraint	15
Neglect	1
Bedding and Clothing	20
Warming and Ventilation	8
Cleanliness	7
Attendance	7
Diet	9
Occupations and Amusements	10
Airing Courts	3
Furniture and Utensils	11
Baths and Lavatories	2
Drains	5
Excess of Number beyond Licence	1
Management and Treatment	4
Case-book and Medical Register	27

FIGURE 2: 1851 REPORT OF PROBLEMS OBSERVED IN ASYLUMS BY THE COMMISSIONERS IN LUNACY

The 1851 report to the British government described every asylum that the Commissioners in Lunacy had visited.[29] Figure 2 provides a summary of the number of places where they had observed problems. For instance, whilst the use of mechanical restraints had been discontinued in many asylums, the Commissioners noted their use continued in fifteen. They assessed the physical environment of each asylum in terms of cleanliness, warmth and comfort. It appears that few asylums were unclean (7), cold or badly ventilated (8), inadequately furnished or provisioned (11), or provided with insufficient baths and lavatories (2). Comfort was important, and the Commissioners examined this in terms of bedding, clothing, bathing and food. They also ascertained whether patients were provided with activities such as employment, amusements or other occupations. Each of these different aspects of the asylum checked by the Commissioners formed part of the therapeutic system known as moral treatment. However, Figure 2 also demonstrates that asylums were judged in terms of their record-keeping practices, which were apparently inadequate in twenty-seven asylums. This highlights the extent to which bureaucratic reporting was emerging as an important aspect of institutional management. Overall, Figure 2 demonstrates what Scull was referring to when he said that treatment success had been redefined 'in terms of

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[29] *Sixth Annual Report of the Commissioners,* 11. (British Reports)

comfort, cleanliness, and freedom from the more obvious forms of physical maltreatment'.[30] Elsewhere in the report, the Commissioners described the provision of 'cheerful' surroundings, a feature that would continue to be audited at lunatic asylums.[31] What is evident is that the Commissioners were able to audit asylums by comparing them against descriptions of 'ideal' asylums, the apparent 'gold-standard' indicators of quality.

In general, real changes in the way that lunatic asylums were managed did not become widespread until after the middle of the nineteenth century, and coincided with the period of asylum building in South Australia. Hence, South Australia never used 'lay superintendents', relying on qualified doctors from the outset to treat the insane. As will be shown, these doctors and the lunatic asylums that they managed were also expected to meet specific standards, defined under the rubric of moral treatment. Oversight, auditing and reporting became normalised aspects of asylum governance. In Australia, oversight was less regulated, asylum visitors were unpaid, and reporting requirements were less stringent than in Britain. Nevertheless, commissions of inquiry led by the government ensured sufficient oversight of the antipodean asylums. As the following sections will demonstrate, ideas about the ideal management of lunatic asylums influenced the provision of care in Australia from the mid-century onwards. This in turn led to improvements in the circumstances of patients with incurable diseases such as epilepsy.

ENVIRONMENTAL MANAGEMENT

In letters sent to John Bevans, the architect of the York Retreat in England, it is evident that William Tuke's ideas about treating insanity were 'folded into the material construction of The Retreat'.[32] Whereas the actual architecture of The Retreat was never copied, the belief that the 'built environment affected treatment' was widely embraced during the nineteenth century. As noted previously, several asylum doctors described how best to incorporate moral treatment into the buildings and architecture of the

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[30] Scull, *Most Solitary of Afflictions,* 271.
[31] *Sixth Annual Report of the Commissioners,* 35.
[32] Edginton, 'Design of Moral Architecture,' 103.

asylums.[33] In practice, most asylums fell short of such idealised principles. Hence, when Susan Piddock compared the architecture of South Australian and Tasmanian asylums with nineteenth-century descriptions of ideal asylums, she concluded that 'the worlds of the Adelaide Asylum and the New Norfolk Hospital for the Insane were custodial, with the Parkside Asylum offering a life only slightly less so'.[34] As will be shown, there are some reasons to agree with her conclusion. Nevertheless, it will also be argued that 'moral architecture' did improve the treatment of patients with epilepsy in South Australia. Whilst the resulting environments were never ideal, they provided more humane conditions than did anything that had existed previously.

One practice associated with environmental management was the use of restraints for people with epilepsy. In this section, the discontinuation of restraints is discussed in relation to how this affected the internal use of space in asylums.[35] Without doubt, restraints had been used for people with epilepsy. Jean-Etienne Esquirol described how epileptics were routinely chained to their beds at night in the hospitals of Southern France during the early 1800s.[36] Conolly described their use at the Middlesex County Asylum:

> Although restraints were especially and excessively abused in cases of epileptic mania, there are no cases in which they were really less protective or more annoying, or more hurtful to the patient. His days and nights were equally deprived of comfort by them. Many were bound hand and foot to the bedsteads during the whole epileptic period; the more imbecile and helpless were fixed in the coercion-chairs every day and all day long; and every epileptic patient, without distinction or exception, male or female, old or young, tranquil or restless, rational or irrational, was fastened to the bedstead at night by one hand, so as to be prevented from the possibility of lying comfortably either on one side or the other.[37]

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[33] See footnote 23, this chapter.
[34] Piddock, *Space of Their Own*, 2007, 222.
[35] The following section describes how restraints affected care practices.
[36] Esquirol, *Mental Maladies*, 150.
[37] Conolly, 'Insanity Complicated with Epilepsy,' 175.

There can be no doubt that during the early nineteenth century, epileptic patients were treated inhumanely. Little attention was paid to their needs because restraints provided a convenient solution.

In South Australian asylums, there is no direct evidence that people with epilepsy were tied to beds or chairs. However, in the early years of colonisation, the Adelaide Gaol was used to house the insane and there is evidence that strait-jackets were purchased and used.[38] Nothing about the enclosed environment of the gaol conformed with the principles of moral treatment. And later, when a small house was rented for use as an asylum, this too failed to meet expectations. In 1848, the head keeper of the new 'Colonial Lunatic Asylum' (1846-1852) alerted the South Australian Governor that some patients were 'all but naked for want of clothing' and complained that provisions that had been ordered never materialised.[39] The keepers at the Colonial Asylum wanted to use restraints but were limited by the small number of rooms. Hence, following a violent attack on a keeper, it was reported that 'as there were only two cells, it was not possible to secure patients effectively without all of them being under restraint'.[40] Articles appearing in the *Adelaide Times* were increasingly critical about the 'want of accommodation' for the insane. One suggested that if there was a 'large building and capacious rooms … there is very little doubt that many of the poor creatures confined in this colony for insanity, would ultimately recover'.[41] However it was several years before funding for a larger asylum was made available.

The Adelaide Asylum was the first purpose-built lunatic asylum in South Australia. It opened in 1852 and remained in use until 1902. Piddock's assessment of it as a custodial institution was based on the use of restraints, an absence of space for exercise and recreation, the incorporation of window bars, and no means of separating difficult patients from quieter ones.[42] Whilst the building had many inadequacies, it is, however, debatable whether it was designed to be purely custodial. For instance, in a report commissioned in 1856 into the treatment of lunatics in South Australia, it was stated that

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[38] Bostock, *Dawn of Australian Psychiatry*, 147; Kay, *Centenary of Glenside Hospital*, 8.
[39] Bostock, *Dawn of Australian Psychiatry,* 152.
[40] Bostock, *Dawn of Australian Psychiatry,* 152.
[41] 'Lunatic Asylum,' *Adelaide Times* (SA : 1848 - 1858), 26/2/1849, 2.
[42] Piddock, *Space of their Own*, 2007, 146.

> The first duty, as it appeared to your Committee, had reference to the treatment of those lunatics confined in her Majesty's Gaol; and, secondly to the treatment of those confined in the Lunatic Asylum. With regard to the former, it is a subject of extreme regret to your Committee that they must report very unfavourably; while it affords them some satisfaction to report favorably [*sic*] of the latter, with respect to order, cleanliness, and apparent kindness of treatment.[43]

Throughout the 1856 report, it is evident that committee members understood, although did not cite, the tenets of moral treatment. They asked about the use of restraints, availability of activities, the quality of food, bedding, clothing, cleanliness, and the use of space. Responses provided by several witnesses also demonstrated that they understood what was expected of asylum care. When discussing the use of a 'strait waistcoat' for a patient who persistently attempted to eat his blankets, a committee member asked: 'is not restraint abolished in the Lunatic Asylums of England now?'[44] The witness answered, 'not more than here'. When asked what could be done to 'better the conditions of the lunatics', the witness (a doctor) responded that he would situate the asylum in the country 'on the score of health', because 'anything tending to hurt the body tends to hurt the brain'.[45] Indeed, throughout the report it is clear that most people involved in the inquiry understood the asylum environment to be important. Although the Adelaide Asylum was imperfect, it was not, as Piddock suggests, *intended* to be custodial. Nevertheless, it was the continued use of the gaol as a lunatic asylum that drew most criticism and provides a better example of custodial treatment for the insane.

The 1856 report makes it clear that the male and female lunatics housed in the Adelaide Gaol were subject to appalling conditions. They were inadequately dressed, most only had boards on which to sleep, their night rooms were overcrowded and during the day there was only a small yard and no activities. An 'idiot' had badly blistered feet because the ground was hot and he had no shoes. Bedding was described as filthy, and one patient died due to neglect. Indeed, a witness was moved to state that this was 'the only country in the world where such barbarity is tolerated'.[46] Whilst the respondents

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[43] PPSA, No. 119, (1856) iii.
[44] PPSA, No. 119, (1856) Q.669.
[45] PPSA, No. 119, (1856) Q.711-5.
[46] PPSA, No. 119, (1856) Q.1040.

repeatedly declared that strait-jackets and other restraints were rarely used, it is evident that it was the physical environment of the gaol that was the problem. Interestingly, when the resident medical officer at the Adelaide Asylum was asked to comment on the number of deaths at the gaol compared with the asylum, he suggested it occurred because 'they have had a great many epileptic patients – they had four or five, while we had none'.[47] This was not entirely accurate, as there had been at least six epileptic patients in the Adelaide Asylum between 1852 and 1856.[48] However, the descriptions of the Adelaide Gaol in the 1856 report provide one of the earliest insights into the treatment of people with epilepsy in South Australia. It was a custodial environment that completely failed to treat them humanely.

Thankfully, the Adelaide Asylum was better provisioned than the gaol. When an official asylum visitor was asked during the 1856 inquiry, 'what kind of treatment the patients are subject to as respects food, clothing, moral, and other treatment otherwise than medical', he thought the 'general treatment' to be sufficient. However, he was highly critical of the shortage of space limiting recreational activities and the ability to classify patients.[49] This problem arose from insufficient funding and the decision not to raise additional capital from private subscribers.[50] Budgetary cut-backs meant that the built environment did not meet the expectations for the 'ideal' asylum.[51] The government not only reduced funding; they also co-opted part of the new Adelaide Asylum to house the destitute. This initiative did not last long as the two uses were antithetical, the noise and disruption of the destitute affecting the well-being of the insane.[52] Government ministers appear to have been less well versed in moral treatment, assuming the space could be used for both purposes. However, the decision to abandon this social experiment shows there was some understanding about use of space in lunatic asylums. In place of the destitute, the upper floors were used to accommodate the attendants, doctors, and their families. However, this was also criticised, as it

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[47] PPSA, No. 119, (1856) Q.718.

[48] William L. GRS-14311/1, p3 admitted 12/3/1853; William H. GRS-14311/1, p3, admitted 12/3/1853; Catherine H. GRG34-16, admitted 9/10/1854; Edward C. GRG34-5/1/1, admitted 25/8/1854; Henry G. GRG34-5/1/1, admitted 24/10/1854; Eugene H. GRG34-5/1/1, admitted 11/3/1855.

[49] PPSA, No. 119, (1856) Q.1046. Classification was the system used in lunatic asylums to separate patients. Criteria for separation included gender, behaviour and social class. In larger asylums epileptic and suicidal patients were classified separately based on their greater needs. York, *Suicide, Lunacy and the Asylum*, 196-201.

[50] Dickey, *Rations, Residence, Resources,* xix; Bostock, *Dawn of Australian Psychiatry,* 153-4.

[51] Piddock, 'Convicts and the Free,' 90; Shlomowitz, 'Treatment of Mental Illness,' 39.

[52] Shlomowitz, 'Treatment of Mental Illness,' 39.

limited the number of inmates who could be housed there, particularly those who remained in the Adelaide Gaol. Within two months of the Select Committee Report, twenty-six patients were transferred from the gaol to the asylum, including one man with epilepsy. It seems unlikely that the Adelaide Asylum was designed to be custodial, given its alternative uses, housing the destitute and asylum staff members. Rather, it was not ideal mainly due to limitations imposed by financial restraints.

As noted, most witnesses who gave evidence at the 1856 commission of inquiry stated that restraints were rarely used. Nevertheless, scholars of South Australian lunatic asylums suggest that moral treatment and non-restraint were not introduced until 1858.[53] This is based on the appointment of Dr Robert Moore as the new Colonial Surgeon. Piddock suggests that the transition to full non-restraints under Moore's direction was difficult and 'not welcomed by all attendants and some refused to work under the regime'.[54] In reality, Moore reported in 1864 that there had been few objections to its introduction; only one attendant had been 'discharged in consequence to his opposition to the non-restraint system'.[55] However, when asked whether the 'former mode of treating patients was different from the present', Moore was keen to assert his professional authority, responding that it was 'very much different'.[56] Moore's expertise drew on a direct connection he had with John Conolly, having attended his lectures and visited the asylum at which Conolly worked, during his medical training in England.[57] However, Moore's claim to have single-handedly reformed the South Australian asylums was not entirely accurate as there is clear evidence that the use of restraint had already been largely discontinued before he arrived. He actually pioneered a transition to full non-restraint, which had implications for the way in which the asylum space was used. In the absence of strait-jackets, refractory patients were confined in seclusion rooms. Such spaces, or what Moore called 'close rooms', began to feature prominently in the treatment of some epileptic patients.[58]

South Australia was not unusual in the move towards eliminating restraints. Piddock notes that at the New Norfolk Asylum in Tasmania, the use of restraints was

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[53] Piddock, *Space of their Own*, 2007, 146; Shlomowitz, 'Treatment of Mental Illness,' 47.
[54] Piddock, *Space of their Own*, 2007, 146.
[55] PPSA, No 30, 1864, Q.34.
[56] PPSA, No 30, 1864, Q.146.
[57] PPSA, No 30, 1864, Q.82.
[58] PPSA, No 30, 1864, Q.2.

discontinued after 1860.[59] Similarly, when George Tucker visited Australian lunatic asylums in the 1880s, he saw little evidence of seclusion and restraints. Even at the Newcastle Asylum for Idiots and Weak Minded Children, where nearly thirty percent of the children had epilepsy, seclusion was 'rarely resorted to'.[60] There is some evidence, however, that the practice continued in a lunatic asylum in Victoria. Under the pseudonym of 'The Vagabond', journalist Julian Thomas wrote about his experiences working at the Kew and Yarra Bend Asylums, Melbourne's principal state lunatic asylums.[61] Thomas described the Kew Asylum as more like a gaol than a hospital. Nevertheless, he admired the practice of using restraints stating that 'it is better too, I think, to tie an epileptic in his chair, as is done at Kew, than to let him continually fall out and bruise his face'. [62]

The use of restraints for people with epilepsy outside the lunatic asylums continued throughout the nineteenth century. A report from the Adelaide Destitute Asylum in 1884 stated that 'a girl suffering from epilepsy had had to be tied down. She was tied with sheets across her to keep her from knocking herself about'. The girl was one of several epileptics at the Destitute Asylum, a situation that its Superintendent considered highly unsuitable. In response, the Resident Medical Officer at the Parkside Asylum (Dr William Cleland) stated 'the Lunatic Asylum was the best place for them ... they were not tied down in the asylum, but mattresses were put on the floor and the furniture removed.'[63] There is also some evidence in the asylum admission records that restraints were used in the domestic sphere. When Michael B was brought to the asylum in 1894 having travelled over two hundred kilometres, it was noted he was 'handcuffed and 'moaning on admission, his father says this is caused by his being tied down'.[64] Compared with these practices, the lunatic asylum was a place of relative freedom. Nevertheless, the seclusion room was increasingly used for managing difficult patients within the environment of the asylum, including some people with epilepsy.

The records for the seclusion room at the Adelaide Lunatic Asylum demonstrate the frequency with which it was used for epileptic patients. During an inquiry into the

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[59] Piddock, *Space of their Own*, 2007, 176.
[60] Tucker. *Lunacy in Many Lands*, 646.
[61] Thomas, 'Month in Kew Asylum #6,' *Argus*, 26 Aug 1876, 9.
[62] Thomas. 'Month in Kew Asylum #3,' *Argus*, 5 Aug 1876, 4.
[63] 'The Destitute Act Commission,' *Express and Telegraph* 1884, 2.
[64] Michael B. GRG34-118/0/1, admitted 20/7/1894.

management of the Adelaide Asylum in 1869, it was noted that seclusion was used to prevent violence, particularly if other patients had been assaulted, or someone had 'disturbed the quiet of three or four patients'.[65] It appears that relatively few epileptic patients were difficult to manage. Over a twenty-five year period (1870-1895), only thirteen were secluded, mainly for short periods of time, suggesting that it was primarily used as a tool for managing specific behaviours, rather than to protect people during seizures.[66] Generally epileptic patients were isolated because of 'excessive excitement and violence *at the time of their seizures'*.[67] Unusually for epileptic patients, Alexander C spent a great deal of time in the seclusion room.[68] When 'under the influence of epileptic fits', his behaviour became maniacal and violent, and he would attack other patients and attendants.[69] Between 1874 and 1881, he spent more than 121 days in seclusion, sometimes up to twelve hours a day.[70] These episodes recurred every couple of months, and lasted for about a week, after which he would become 'much improved' and 'very much better'. Explanations for his seclusion cycled between 'epilepsy', 'excited and violent', 'excited and epilepsy' and 'violent epileptic'. In 1889 Alexander was released into the care of his brother-in-law who 'signed a guarantee form that he should be properly looked after'.[71] However, he was readmitted and discharged five times before his subsequent death in the asylum from epilepsy at the age of fifty-five. The use of the seclusion room in Alexander's case appears excessive and suggests that his treatment was custodial. Nevertheless, the control of violent patients in the era of non-restraint meant that seclusion from other patients was the only option. On occasion Alexander was allowed to remain in his room. In his lecture on epilepsy, Conolly mounted a case for the calming benefits of seclusion for epileptic patients who were too excited and had become dangerous.[72] Even so, others questioned its use. In the 1864 inquiry into the lunatic asylum, one of the visitors stated that 'it is of course, a debateable question, whether the restraint of a close room is not as objectionable as that of a strait waistcoat'.[73] For the patient, both would have been

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[65] PPSA, No 68, 1869, Q. 18.
[66] SRSA GRG 34/17/1/V1&2 (Record of Seclusions 1870-1897).
[67] Stated for many patients, see Boult, 'Epilepsy in the South Australian Lunatic Asylums'.
[68] Alexander C. GRS-14320/1/1 p31-2, (admitted 10/10/1875).
[69] Alexander C. GRS-14320/1/1 p31-2.
[70] GRG 34/17/1/V1&2. 12 hours was the maximum period spent in seclusion.
[71] Alexander C. GRS-14322/1/1. p32.
[72] Conolly, *Treatment of the Insane*, 42-43.
[73] PPSA, No 30, 1864, Q.314.

objectionable, but they were used in order to make the environment safer for other patients.

Criticisms made about the environment at the Adelaide Asylum in 1856 were evidently not quickly remedied. In an 1864 inquiry, it was noted its ventilation was poor, and drainage inadequate; windows were small and badly situated, and there was still insufficient space to separate different 'classes' of patients. Altogether the building was 'unsuitable for the purposes to which it is applied'.[74] The ideal asylum evidently required more than cleanliness and the removal of restraints. Moral treatment required buildings to be light and airy with ample spaces within which the quiet patients could be separated from the refractory.[75] In theory, when the Parkside Asylum opened in 1870, it should have been better than it turned out to be. The architect's brief was to build an asylum that 'should combine all the excellencies and latest conveniences of the best English Asylums'.[76] However, financial constraints again resulted in a building that was one-fifth of its original design and lacked many important features.[77] Some of these features would have helped to minimise harm to epileptic patients during seizures. Conolly stated that it was better for epileptics if there were wooden floors, and 'there should be no sharp corners or edges in the furniture, or in the railings, or steps, or stone-work; the door-posts should be rounded, the fire-places guarded'.[78] For sleeping, the 'old-fashioned crib bedstead made of deal [soft-wood], and varying in depth from six to twelve inches, and very little raised from the floor' would provide safer night care.[79] If epilepsy was associated with mania, the 'tranquillity of his own bed-room' could help.[80] Conolly also noted that when epileptics had been 'fixed into coercion chairs … (or) bound hand and foot to bedsteads, they had been irritable, noisy and dangerous. The removal of restraints, and the modification of nursing practices had made them 'peaceful and cheerful'.[81] Whilst Conolly recognized that epilepsy was 'incurable by human means', he hoped that their circumstances could be modified and their lives rendered tolerable 'even in this hopeless form of affliction'.[82] However, few of

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[74] PPSA, No 30, 1864, p iii-iv
[75] Conolly, *Construction and Government,* 8; Ellis, *Treatise on the Nature,* 274.
[76] Kay, *Centenary of Glenside Hospital*, 13.
[77] Piddock, 'Space of Their Own,' 2002, 174-176.
[78] Conolly, 'Insanity Complicated with Epilepsy,' 174.
[79] Conolly, *Construction and Government,* 101.
[80] Conolly, 'Insanity Complicated with Epilepsy,' 175.
[81] Conolly, 'Insanity Complicated with Epilepsy,' 175.
[82] Conolly, 'Insanity Complicated with Epilepsy,' 175.

Conolly's recommendations were adopted when the Parkside Asylum was built. As far as the many epileptic patients were concerned, 'all the excellencies and latest conveniences of the best English Asylums' did not apply to them.

Some of Conolly's ideas were considered too dangerous to be implemented in the Parkside Asylum. For instance, although wooden floors and wood bed frames were softer, they were known to be a fire risk. Hence, the new asylum at Parkside was built with stone floors and furnished with iron bed frames. However the bed height was adjusted, a visitor noting that 'some of the bedsteads for the epileptic patients are within an inch or two of the ground, so that in case of fits or frenzy the patient is not likely to do himself much harm by falling off the bed'.[83] Likewise, mattresses and padding were available for epileptics.[84] The hospital ward was another space that was frequently used by epileptic patients.[85] However, the suggestion that people with epilepsy should remain on the ground floor may have been ignored, as blood seen on a staircase at the Parkside Asylum was reported to be from an epileptic patient, as such patients often 'bloodied their noses'.[86] Some attempt was made to separate the different 'classes' of patients across the two asylums, placing chronic patients in the Parkside Asylum and acute ones in the Adelaide.[87] After 1875, the majority of epileptic patients were housed at the Parkside Asylum, alongside the other 'chronic' patients.[88] Within the financial constraints imposed on the South Australian lunatic asylums, some consideration was given to the environmental needs of epileptic patients, but less than some authorities on the subject recommended.

The only other evidence of architectural modifications for epileptic patients in South Australia occurred towards the end of the period under investigation. In 1909, William Cleland asked for additional money to build a cottage for epileptic patients at the Parkside Asylum. In his memo he stated that the epileptic patients would be provided with 'more immediate supervision'; however the main thrust of his argument was premised on the welfare of his other patients. He noted that the 'occurrence of the convulsive seizures has a very disturbing effect on the ordinary ones [patients]'.[89]

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[83] 'Visit to the Parkside Lunatic Asylum,' *Adelaide Observer*, 1876, 10.
[84] PPSA, No 136, 1884. Q. 4292.
[85] PPSA, No 136, 1884. Q. 7414.
[86] PPSA, No 136, 1884. Q. 2457-60; Piddock, *A Space of Their Own*, 2007, 123.
[87] Piddock. *Space of Their Own*, 2007, 128-9; 'The Lunatic Asylum,' *Express and Telegraph,* 1877, 2.
[88] Based on aggregated details of epileptic patients between 1870 and 1913.
[89] GRG34-72/21.

Likewise, when epileptic patients were housed at the Adelaide Asylum, they were given single rooms for sleeping, so they 'could be looked after at once', and to avoid disturbing other patients if they were likely to be noisy.[90] Cleland was also echoing the views of Etienne Esquirol who, seventy years earlier, had claimed that 'they [epileptics] ought not to live together in the same wards with the insane' maintaining that it was detrimental to other asylum patients to witness an epileptic seizure.[91] According to this view, the ideal asylum design was one which housed epileptics but prevented others from observing their fits. However, in South Australia there was never any serious consideration given to establishing separate institutions for people with epilepsy, although calls for such became common during the late nineteenth and early twentieth century.[92]

It is evident that the physical environment and the use of space was integral to the implementation of moral treatment. The main effect of this for epileptic patients was the removal of restraints, meaning they were no longer tied to chairs or beds. As a consequence, the spaces, rather than the patients, had to be modified, in order to minimise harm during seizures. In South Australia, the only material change was the provision of lower beds and mattresses on the floor. Much later, separate accommodation was considered advisable, but the majority of the asylum's epileptic patients remained within the main body of the asylum. The space provided by the seclusion room was used to control some epileptic patients. Whilst some thought that seclusion produced a calming effect and hence encouraged its use, it appears in South Australia that these rooms were mainly used to safeguard other patients and staff. The environment, however, was only one aspect of moral treatment that affected people with epilepsy. What follows next is a description of 'ideal' care compared with its actual provision in the asylum.

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[90] PPSA, No. 30, 1864. Q. 42.
[91] Esquirol, *Mental Maladies,* 168.
[92] See introductory chapter on epileptic colonies, 15-16.

CARING RELATIONSHIPS AND CARE PRACTICES

Amongst the 1856 admission papers for the Adelaide Lunatic Asylum were some hand-written instructions for staff members, including the following:

> Keepers and Nurses
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> The keepers and nurses are to be under the immediate control of the Headkeeper. They are to watch vigilantly over the patients under their care, and are on no account to leave them without permission, except under the most imperative necessity. They must be most careful to avoid hardship both in conduct and language towards the patients, they are on the contrary to treat them with as great gentleness as is compatible with the due enforcement of discipline. They are to use all their best endeavours to keep the patient under their charge employed and amused. The nurses assisted by such patients as are able to attend to the washing.[93]

During an 1856 inquiry into the treatment of lunatics in South Australia, the document from which these instructions were taken was referred to as the *Book of Rules and Regulations*.[94] When the Select Committee summarised their findings, they were evidently satisfied that the ancillary staff at the Adelaide Asylum provided appropriate and 'kind treatment'. They regretted that the same could not be said about the treatment of lunatics at the Adelaide Gaol. As noted earlier, although there is little direct evidence of cruelty at the gaol, the report described patient neglect and inadequate resources. Clearly good patient management required both an appropriate environment as well as good nursing care. Hence, the contribution of 'skilled nursing' to the treatment of people with epilepsy in lunatic asylums warrants consideration.

The daily supervision and guardianship of people with epilepsy in lunatic asylums lay almost entirely in the hands of the nonprofessional asylum staff who, Leonard Smith notes, were important intermediaries between the patients and the asylum management.[95] Anne Digby highlights the importance of their role, noting how descriptions of their 'ideal' character 'reached the heights of rhetoric' in the asylum

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[93] GRS-15230/1/1 1856 #16.
[94] PPSA, No. 119, 1856, Qs. 97, 762-763, 738, 806.
[95] Smith, *Cure, Comfort and Safe Custody,* 131.

literature of the 1850s.[96] Digby suggests that the relationship that existed between asylum carers and the cared-for was 'key' to the effective implementation of moral treatment.[97] This was made evident in 1856 and 1864, during inquiries into the treatment of the insane in South Australia. Expectations about nursing care were also codified in South Australia in 1868 when the *Book of Rules and Regulations of the Lunatic Asylum* was published in the *Government Gazette*.[98] In all instances, it is apparent that attendants were expected to treat patients with 'great gentleness', and were commended for providing 'kind treatment'. At the 1868 inquiry, the Commissioners, expressed their 'unqualified commendation of the general management of the institution, and the kind treatment of the patients by the Colonial Surgeon, the Master Attendant, and the Matron, as well as by the subordinates of the establishment'.[99] Nevertheless, accounts of the absence of care at the Adelaide Gaol indicate that attitudes had changed by the 1850s as to what comprised appropriate care for lunatics.

In the 1850s, the job of overseeing the lunatics housed in the Adelaide Gaol was conducted by 'keepers'. Leonard Smith suggests that it was not a coincidence that their title mirrored that of gaolers and emphasised their custodial role.[100] In South Australia, keepers were helped by prisoners; on the women's side the helpers were, 'all previously considered respectable servant girls who have conducted themselves well whilst in gaol'; on the men's side, the helpers were described as a runaway sailors.[101] It can only be wondered how this arrangement worked in practice, as the insane were entitled to better provisions than the prisoners. They were, for instance, supposed to have proper beds, although many slept on boards 'just the same as the common prisoners'.[102] Whilst the conditions for the insane held in the Adelaide Gaol were grim, descriptions of 'madmen' held in the Western Gaol in Victoria appear worse. Francis Smith describes how they were left unattended and many died 'huddled together on the bare ground'.[103] Between 1856 and 1864, the titles of the South Australian asylum staff changed. Rather

[96] Digby, *Madness, Morality and Medicine*, 140.
[97] Digby, *Madness, Morality and Medicine*, 140.
[98] SAGG, 'Rules for the Government,' 1868, 1011
[99] PPSA, No. 30, 1864, Q.3.
[100] Smith, *Cure, Comfort and Safe Custody*, 131.
[101] Bostock, *Dawn of Australian Psychiatry*, 147. PPSA, No. 119, 1856. Q.285.
[102] PPSA, No. 119, 1856. Q.699.
[103] Smith, *Illness in Colonial Australia*, 321.

than 'keepers', they began to be referred to as 'attendants' and 'nurses'.[104] Leonard Smith suggests this helped shift the custodial image to one more in tune with the curative principles of moral treatment.[105] Much later, the title 'attendant' would be dropped in favour of 'psychiatric nurse' during the 'hospitalisation of lunatic asylums'; however, this was a phenomenon of the twentieth century and beyond the scope of this thesis.[106]

Some scholarly accounts of asylum attendants describe them, somewhat unfairly, in terms of an absence of qualities.[107] Scull states that attendants were 'recruited from the dregs of society', taken from 'the unemployed of other professions'.[108] He emphasised their low wages, low intelligence and low social status, and used this to describe the provision of poor and potentially brutal care, high staff turnover, and difficulty in employing good staff. Other scholars have been more forgiving, and argue that the job of attendant provided security and prospects. They show that far from there being a high turnover of staff, many attendants remained in their positions for extended periods.[109] In South Australia, the asylum attendants shared little, if anything, in common with Scull's harsh assessment. Indeed, at the Adelaide and Parkside Asylums, the workforce was stable. Those occupying senior positions often remained in them for decades. The Morris family provides one extreme example, working in the South Australian asylums for nearly fifty years. William Morris had worked in two Irish asylums prior to his appointment in South Australia in 1844. Initially he was employed as Head Keeper at the Colonial Lunatic Asylum and later became Head Attendant at the Adelaide Asylum until his death in 1857. His wife, Julia Morris, also worked at the two asylums from 1846 until her death in 1884, occupying the role of matron. Their daughter, Celia, having been raised in the asylum, also took employment there from 1884 and 1892. In 1899, William Cleland noted that there was a 'lengthy waiting list' of people seeking employment at the asylums.[110] Salaries were slightly lower than

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[104] See 'Council Papers,' *South Australian Register*, 1856, 3; PPSA, No 30, 1864. The language in the Government Inquiries changes between 1856 and 1864.

[105] Smith, *Cure, Comfort and Safe Custody*, 131.

[106] Walk, 'The History of Mental Nursing,' 12; Smith, *Illness in Colonial Australia*, 329.

[107] Scull, *Most Solitary of Afflictions,* 173; Smith, *Cure, Comfort and Safe Custody,* 152-3. Dingwall, *A Social History of Nursing*, 127.

[108] Scull, *Most Solitary of Afflictions, 173, 263.*

[109] Monk, *Attending Madness at Work*, 9. Wright, 'The Dregs of Society?' 16-17.

[110] 'The Staff of the Lunatic Asylums,' *Adelaide Observer* 1899, 14.

elsewhere in Australia, but staff had more leave entitlements.[111] The general level of pay was comparable to that of servants and tradesmen but was augmented with daily allowances and 'apartments, rations, fuel, and light'.[112] The staff-to-patient ratios in South Australia were also much better than elsewhere. Leonard Smith describes ratios in England ranging from one keeper per fifteen patients to one for every twenty-four patients.[113] John Conolly recommended a ratio of one attendant to seventeen patients.[114] Evelyn Shlomowitz estimates that South Australian ratios varied between one in four and one in twelve, which she describes as 'enviable'.[115] It appears that in South Australia, the attendants were not, as Scull described them, the 'dregs of society'. With high numbers of staff, reasonable working conditions and a stable and experienced work force, this perhaps explains why the South Australian lunatic asylums were considered to be well-run.[116]

Although there is some evidence that attendants were familiar with written instructions in 1856, these rules were not overhauled and officially published in the *Government Gazette* until 1868.[117] From this point onwards, attendants had a protocol to follow when epileptic patients were 'taken with a fit'. The attendant was instructed to place a pillow under the patient's head and slacken all fastenings 'about the dress'.[118] It is probable that this rule had originated from Conolly's prescriptive instructions for the treatment of 'insanity complicated with epilepsy'. In his published lecture he stated that it was normal 'for the attendants [at the Hanwell Asylum in Middlesex] to place a pillow under the head of a patient seized in a fit … and to loosen the cravat, or any tight part of the dress'.[119] Conolly had experimented with soft caps for the 'protection of the [epileptic] patient's head', but as patients found them irritating he did not recommend their use.[120] To reduce the likelihood of harm, he said that attendants should be more vigilant with epileptic patients than with other patients. At the time of the 1884 inquiry into the South Australian lunatic asylums, it was noted that 'all attendants are trained to

[111] Forbes, *From Colonial Surgeon to Health Commission*, 93-94.
[112] 'The Staff of the Lunatic Asylums,' *Adelaide Observer*, 1898, 14; Sinnett, *Account of the Colony*, 34; Kay, *Centenary of Glenside Hospital,* 67.
[113] Smith, *Cure, Comfort and Safe Custody*, 133.
[114] Conolly, *Construction and Government,* 83.
[115] Shlomowitz, 'Nurses and Attendants,' 48.
[116] PPSA, No 136, 1884, iii.
[117] GRS-15230/1/1 1856 #16; SAGG, *Rules for the Government*, 1868, p.1011.
[118] SAGG, *Rules for the Government*, 1868, p.1011.
[119] Conolly, 'Insanity Complicated with Epilepsy,' 174.
[120] Conolly, 'Insanity Complicated with Epilepsy,' 173.

be specially careful with these [epileptic] people, and to pay particular attention to them in case they are taken in a fit'.[121] This included the night attendants, one of whom had to occupy 'a room in the ward where all the epileptics and sick are … she gives them special supervision and feeds them at night and attends to them in any way they require'.[122] Close attention was not always successful in South Australia. In 1885 Agnes N 'sustained a traverse fracture of left tibia and fibula immediately above ankle by falling off bench where she was sitting, in a fit'.[123] Epileptic seizures frequently resulted in injuries, and patients had to be watched carefully, not just to prevent bruises, abrasions or burns. There were fears that they might choke on food at meal times or suffocate in their pillows at night.[124] Several patients did die unexpectedly in their beds at the asylum.[125] When their deaths were reported to the coroner, they were attributed to epilepsy. When 'The Vagabond' Julian Thomas recommended restraints for epileptics at the Kew Asylum in Victoria, he noted that without them 'the wearers would have either to be confined to a padded room or have an attendant specially engaged to watch each, an arrangement manifestly impossible'.[126] Clearly, watching epileptics placed an additional burden of care on attendants; however according to Conolly, this helped them to learn respect and 'humane regard' for the patients.[127]

We cannot be certain whether asylum attendants did learn respect and humane regard for the epileptic patients in their charge, nor whether the patients and their families understood this to be the case. However, in 1884 the committee responsible for investigating the general management of the two asylums noted that 'most of the attendants, both male and female, are not only humane and considerate, but are much respected by the patients'.[128] This statement followed inspections of the asylums 'without notice' and the questioning of many witnesses. Several complaints that had caused the inquiry to be convened were discussed at length. One particular episode that

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[121] PPSA, No 136, 1884. Q. 5726.
[122] PPSA, No 136, 1884. Q. 7414.
[123] Agnes N. GRS-14310/1/1, p38, admitted 9/3/1883.
[124] Royal Medico-psychological Association, *Handbook,* 30-31; PPSA, No 136, 1884. Q. 7414.
[125] Elizabeth B. GRS-14310/1, p210, 16/3/1885; Mary Ann K. GRS-14310, p119 20/2/1885; Arthur M. GRS-14317/1/1, p180, admitted 25/5/1880; James S. GRS-14317/1/1, p294, admitted 20/9/1883; Eileen Daisy R. GRS-14310/1/2, p285, admitted 2/9/1908.
[126] Thomas, 'A Month in Kew Asylum,' *Argus* 1876.
[127] Conolly, *The Treatment of the Insane*, 95.
[128] PPSA, No 136, 1884, iii.

had appeared in the press concerned the treatment of an epileptic 'idiot' girl.[129] Nine-year-old Jane R was admitted 'in a dirty condition in 1883, but thirty three days later was 'removed by her mother who thought she was neglected in the asylum'. The charge of neglect was premised on the child being isolated and kept in what the matron described as, 'a nice single room by herself' for most of the day. Isolation was used because 'she pulled other patients about … [and they] had a number of old women in that ward and they became very much annoyed'.[130] According to Matron Morris, it required two nurses to look after Jane at all times (except when she was confined in her room), to feed, dress, clean, and walk her in the garden twice daily. Alongside other behavioural problems, Jane would smear herself with and eat her faeces, 'if not prevented'.[131] The matron claimed that Jane could not be in the day room without someone holding her and that it was 'impossible to keep her clean'.[132] The newspaper report, however, stated that Jane was kept 'almost half naked, half starved, dirty, and on one side of its head was a large untended sore'. The doctor responded that in fact she had gained weight in the asylum, and the wound was an old one, reopened, and one that he could not treat as the child continually pulled any dressings off. He thought the only alternative would have been to confine her movements using a strait jacket, but on balance thought this would have been worse for the girl.[133] Her mother claimed she had 'put the child in the asylum being told that *every care* would be taken of it there', and when she spoke to the nurses they seemed 'utterly indifferent as to whether it lived or died, [so] she took the little thing away with her'.[134] It is unlikely that the nurses were intentionally cruel to Jane. Rather, their actions suggest they calculated how best to deploy the available workforce. Indeed, their solution is reminiscent of Jeremy Bentham's utilitarian philosophy, that the 'greatest happiness of the greatest number should be the guiding principle of conduct'.[135] In this case, they were looking after the

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[129] 'Lunatic Asylum Cruelties,' *Adelaide Observer,* 1883, 12. Jane R. 40, GRS-14227/1/3, admitted 19/3/1883.

[130] PPSA, No 136, 1884. Q. 943.

[131] PPSA, No 136, 1884. Q. 962.

[132] PPSA, No 136, 1884. Qs. 4269-77.

[133] PPSA, No 136, 1884. Q. 9623.

[134] PPSA, No 136, 1884. Q. 956.

[135] 'Utilitarianism, n.'. OED Online. July 2018. Oxford University Press. http://www.oed.com.proxy.library.adelaide.edu.au/view/Entry/220768?redirectedFrom=utilitarianism (accessed September 13, 2018).

happiness of the old female patients, rather than providing respectful and humane care for Jane.

Not all accounts were critical about the provision of care, although some also alluded to the possibility of neglect. In 1894, George Ash, a politician and an official asylum visitor, published a series of newspaper articles in which he described twenty-four children at the Parkside Asylum. Ash was part of a reform movement whose aim was to provide education for 'weak-minded children', and his articles were written for this purpose.[136] Ash identified neglect as the absence of educational opportunities for the children at the asylum. One child he wrote about was Agnes J, who had been transferred to the asylum from the Magill Industrial School when she was five, three years previously. Her epilepsy was not considered particularly severe, but her notes state that she 'would not be amenable to the ordinary supervision required by other children'.[137] Between seizures she was thought to be 'in many things quick and intelligent'. Agnes provided Ash with rambling accounts of both asylums. She told him that she preferred the Adelaide Asylum and was 'always wishing she was back there', liking that Dr Paterson 'used to come round in the morning and talk to her'. At the Parkside Asylum she said that, 'Miss Lucy [the matron] and Miss Ganny [ward nurse] are kind to me here'. The matron had recently taken her into town to buy shoes and had let Agnes look in all the shop windows. However, although the 'people at the asylum' were kind to her, Agnes did not like that 'when she was naughty she was punished by being put into K ward [for violent women]'.[138] It is unsurprising that kindness was tempered with punishment, as attendants were required to enforce discipline. And the practice of moving patients between wards had historical precedent, having been used at the York Retreat by William Tuke as part of moral treatment.[139]

What the families of patients thought about the care provided is hard to ascertain as few letters remain. Some complaints were made, but no one besides Jane's mother removed their charges from the asylum as a consequence. Rather, several asked that their family members not be returned home as they could not themselves provide the care

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[136] 'Home for Weak-minded Children,' *Express and Telegraph*, 1898, 3.
[137] Agnes J. GRS-14227/1/4, p260, admitted 11/11/1891.
[138] 'The Treatment of Weak-Minded Children. No V,' *Advertiser*, 1894, 5.
[139] 'The Treatment of Weak-Minded Children. No V,' *Advertiser*, 1894, 5.

required.[140] Some letters were appreciative of the care provided, although these have to be interpreted cautiously. When George D wrote to the asylum following his discharge he stated that he was 'extremely obliged to you for your kindness'.[141] However, the purpose of his letter was to ascertain whether he had left some money behind, which may explain his good manners. Another problem with the care of epileptic patients relates to their many injuries. Thus, one father commented that although his son 'complained so much of ill-treatment', and had severe bruising on his legs, he was 'not blaming the attendants of ill-usage as they appear to be very kind'. This problem was discussed in the 1884 inquiry, when it was stated that epileptics 'would imagine a great many things' when they recovered from a seizure.[142] William Cleland commented that 'they have one very peculiar delusion, and that is that the attendants knock them down, and then jump on their neck'.[143] Nevertheless, when a mother wrote to the asylum following the death of her son, she said she was 'truly grateful to [Matron Lucy] and Mrs McCarthy and the other nurses that had the care of my child, has [*sic*] I can feel all kindness was shown him'.[144] The father of Ethel F wrote to William Cleland asking about the benefits of certain medications, and noted how a friend 'speaks very highly of your treatment … also of your kindness'.[145] Some families continued to hope that the patient might be cured, whilst others wrote to say they could not afford to look after the family member at home. Drawing conclusions from such a small volume of correspondence is problematic; however as documented here, there is some evidence that families appreciated the provision of kind care, perhaps believing that this offset the 'disadvantages' of using the institutions.

As noted in the introduction to this thesis there are many ways of describing and defining care.[146] When describing care as a practice, Joan Tronto, for instance, defines it in terms of attentiveness, responsibility, competence and responsiveness.[147] It can be argued that the asylum attendants in South Australia did provide care according to this

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[140] For instance: Henry H. GRS-14317/2/1, p103, admitted 21/10/1898; George T. GRS-14317/2/1, p369, admitted 4/3/1902; George F. GRS-13211/1/1, admitted 15/6/1887; Courtney F. GRS-14324/1/1, p91, admitted 9/2/12.

[141] George D. GRS-14322/1/1, p101, admitted 11/8/1903.

[142] PPSA, No 136, 1884. Q. 7367.

[143] PPSA, No 136, 1884. Q. 7956.

[144] Arthur W. GRS-14317/1/1, p445, admitted 21/12/1887.

[145] Ethel F. GRS-14310/1/2, p260, admitted 24/3/1908.

[146] See introductory chapter.

[147] Tronto, *Moral Boundaries*, 106-7.

framework. Their rules of employment required them to be kind, gentle, and attentive whilst maintaining discipline, and with few exceptions this appears to be how they behaved professionally. They were more vigilant in the care of people with epilepsy as they had to watch for imminent seizures. And they were also required to be responsible for taking a specific course of action during seizures. Hence, when asylums stopped relying on physical restraints, the treatment of epileptic patients can best be described as care-based. Families evidently expected that care would be provided and were willing to place their charges in the asylum in order to obtain it.

CONCLUSION

Up until the middle of the nineteenth century, gaol-like conditions prevailed in many asylums. This was particularly cruel for people with epilepsy whose management frequently involved them being tied to beds and chairs. This chapter has demonstrated that the removal of restraints from asylums inadvertently contributed to the provision of better care for people severely affected with epilepsy. The elimination of restraints also meant that the people responsible for their care had to provide them with more focussed attention, and the environment was modified to minimise inadvertent harm during seizures. Conolly's influential views regarding asylum management were particularly evident in South Australia where the Colonial Surgeon, Dr Moore asserted his authority by demonstrating a direct link to the famous doctor. However, there is little doubt that the principles underlying moral treatment had already been understood in the province prior to Moore's engagement. With only a few exceptions, the asylum attendants met the standards of care expected of them, and their role in the South Australian asylums was valued. In general terms, the combined effect of the management structure, audited environment and provision of codified nursing care all contributed to a system that favoured the poor and chronically sick epileptic patient, something that has not previously been described. The next chapter further explores this through a more detailed examination of the specific requirements of epileptic patients and their different care requirements.

CHAPTER 3

LEAVING THE ASYLUM

This chapter examines the pathways by which people with epilepsy left the South Australian lunatic asylums. Ironically, by showing how and why epileptic patients left the asylum, a more nuanced picture emerges to explain why they were there. Numerous studies have focussed on the uncontroversial fact that lunatic asylums were custodial, and some assert that this was their primary function.[1] Undoubtedly, custodialism was important, and there are robust studies showing that families actively sought to have their charges secured in lunatic asylums. However, by examining how periods of confinement ended for epileptic patients, this chapter highlights that custodialism alone is insufficient to explain why families used lunatic asylums. Rather, three additional patterns of usage emerge, based on varying requirements of families and patients. For some patients who were approaching death, the use of the lunatic asylum can best be described as providing access to an early form of palliative care. For epileptic patients who lacked mental capacity and support networks, the lunatic asylum provided a long-term refuge. Lastly, in some circumstances, the lunatic asylums provided temporary respite for patients and their families.

PALLIATING THE INCURABLE

In rare instances a series of fits occurs in which the patient does not recover consciousness in the intervals between the seizures, but, while in the post-epileptic sleep another attack occurs. This has been termed the status epilepticus. It is a very grave condition. In its most severe form … the intervals between the fits become shorter, the coma deepens, the pulse and respiration become very frequent, the temperature rises, it may be to 104°, 105° or even 107°. Sometimes hemiplegia comes on after the condition has existed for several days. The patient may die in a state of collapse, death being apparently due to the violent and almost continuous convulsions, or, the fits

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[1] Walton, 'The Treatment of Pauper Lunatics in Victorian England,' 166-98.

ceasing, he may become delirious and present symptoms of meningitis, with rapid formation of bedsores, and may die in stages. At any period the symptoms may lessen and the patient recover. A large proportion of cases, however, end fatally. Fortunately, this severe degree of the status epilepticus is very rare, at any rate out of asylums for the insane.[2]

When Eric Gowers wrote about the causes, symptoms and treatment of epilepsy in 1881, he stressed that for most, 'the danger to life in epilepsy' was not great.[3] Accidental death from asphyxiation or burns was a concern, but dying in status epilepticus was 'so rare, and the liability to it is so small, that it cannot be regarded as measurably increasing the risk of death in consequence of the disease'.[4] Yet for those epileptics who were admitted to the lunatic asylum, the risk of death was not insignificant. In South Australia, three quarters of people admitted with epilepsy died in the asylum, mainly from causes that were attributed to epilepsy, including 'status epilepticus'.[5] A fifth of the deaths occurred within one year of admission, and nearly a half within five years. Lunatic asylums, it would appear, attracted the most severely affected epileptics (Table 2).

TABLE 2: 'EPILEPTIC' DEATHS IN THE SOUTH AUSTRALIAN LUNATIC ASYLUMS[*]

	Number of epileptic patients	Percentage of patients affected
Death within 1 year	109	20%
Death within 5 years	248	47%
Death after 5 years	175	33%

* Deaths occurred between 1853 and 1964

Deaths that took place in lunatic asylums were interpreted as a sign of institutional failure and hence were a concern to medical superintendents.[6] When the statistically-

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[2] Gowers, *Epilepsy,* 193-4.
[3] Gowers, *Epilepsy,* 241.
[4] Gowers, *Epilepsy,* 242.
[5] Aggregated information from South Australian records.
[6] Leonard Smith, 'Welcome Release,' 117; Cathy Smith, 'Visitation by God,' 104.

inclined John Thurman examined insanity in British lunatic asylums, he noted that the presence of epileptics skewed the number of deaths due to their 'very high' mortality.[7] Lunatic asylums that did not admit people with epilepsy, such as Bethlem and St Luke's, consequently reported lower mortality rates. Thurman noted that many epileptics often arrived 'in so feeble and shattered a state of health as not to survive more than a few weeks or even a few days'.[8] Having been 'kept as long as possible at home' they were sent to the lunatic asylum 'in consequence of the increased difficulty in their management and of the amount of care and nursing which they require'.[9] This, according to Thurman, was a serious 'evil' for medical superintendents whose statistics would be much improved if they could exclude 'many hopeless cases, and such as are in a dying state'.[10] By describing the increased care and nursing required by epileptics as they approached death, Thurman alluded to its availability in lunatic asylums. Evidently, families were willing to take advantage of this when their relatives were approaching death. In this sense, therefore, the lunatic asylum was being used by families to obtain what would later be described as palliative care.

The idea that lunatic asylums provided higher standards of care than workhouses was noted by a number of commentators in the nineteenth century.[11] In 1875, J. Mortimer Granville compiled reports published in *The Lancet* into the state of English county lunatic asylums in what he hoped was a 'tolerably complete critical survey' of lunacy and asylums.[12] When reflecting on the dilemma of housing incurable patients, he contemplated whether separate 'medical care' for epileptics might be better, albeit within the framework of the older lunatic asylums.[13] In this he differed from the author of one report who stated that such separation would be detrimental to those for whom the 'hope of recovery usually exists to the last'.[14] Consignment to an 'incurable asylum' would extinguish any residual hope of recovery and 'their general management would most likely become less careful and less promotive of amelioration'.[15] Overall, 'any

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[7] Thurnam, *Statistics of Insanity,* 43.
[8] Thurman, *Statistics of Insanity,* 43.
[9] Thurman, *Statistics of Insanity,* 44.
[10] Thurman *Statistics of Insanity*, 44.
[11] Ellis, *Treatment of Insanity,* 246; Clouston, *An Asylum or an Hospital-Home*, 4; Conolly, *Lunatic Asylums and Hospitals for the Insane,* 2-5.
[12] Granville, *Care And Cure Of The Insane,* viii.
[13] Granville, *The Care And Cure Of The Insane,* 10.
[14] Granville, *The Care And Cure Of The Insane*, 164-5.
[15] Granville, *The Care And Cure Of The Insane*, 165.

difference of arrangements … would lead to serious neglect, and to the occurrence of lamentable accidents'.[16] The writer, John Conolly, evidently believed that lunatic asylums were able to provide a therapeutic environment for people who could not be cured. Conolly's ideas foreshadowed the change that took place over the next half century as institutions, rather than the home, became the accepted places to die.

During the second half of the nineteenth century, the locus of dying began to change, particularly for the poor. Statistics collated by Pat Jalland demonstrate a rapid shift towards people dying in institutions at this time, rising from eleven percent in 1860 to thirty-five percent in 1920.[17] Importantly, this shift occurred in Australia before Britain, reflecting the dislocation of people from former patterns of family and community support.[18] According to Jalland, most institutional deaths resulted from the admission of older and frailer patients to destitute asylums and hospitals.[19] Jalland also noted that lunatic asylums did not experience such a large increase, only rising from seven to nine percent of total institutional deaths between 1860 and 1920.[20] Nevertheless in South Australia, there was an increase in the number of epileptic deaths in the lunatic asylums, most occurring within five years of admission. In the two asylums, the number rose from a total of fifteen 'epileptic' deaths in the 1860s to over fifty during each of the subsequent three decades. This exceeded the increase in population during this period, rising from ten deaths per 100,000 in the 1860s, to 28 per 100,000 in the 1890s. Few of these deaths affected older patients, highlighting that decrepitude did not influence this increase. Indeed most (82%) were people under fifty, and half were aged under thirty. Whilst it is not possible to know with accuracy the 'real' cause of death, in most cases it was attributed to factors associated with epilepsy.[21] These figures corroborate the finding that lunatic asylums were used to accommodate people who were severely affected by epilepsy, and were increasingly accepted as the locus for dying for this group of patients, particularly by families.

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[16] Granville, *The Care And Cure Of The Insane*, 165.
[17] Jalland, *Australian Ways of Death,* 200.
[18] Jalland, *Australian Ways of Death,* 200.
[19] Jalland, *Australian Ways of Death*, 204-5.
[20] Jalland, *Australian Ways of Death,* 200.
[21] There were several types of cause of death which resulted from epilepsy such as: 'epilepsy', 'epileptic exhaustion', 'epileptic mania', 'status epilepticus', 'epileptic dementia', and variants of these.

One perspective regarding the upsurge in 'hopeless and incurable cases' was that lunatic asylums provided 'convenient places to get rid of inconvenient people'.[22] These words were articulated by Scull in his early work, where he suggested that the lunatic asylum provided a social solution for people who were unable to work in the new industries that arose during the industrial revolution.[23] Later he would attenuate his argument, describing the linkage of lunatic asylum with the 'capitalisation' of the whole economy.[24] Most likely his view changed as other scholars demonstrated that asylum populations increased equally in rural and urban/industrial communities.[25] Scull suggested that as the workforce moved towards waged labour, families struggled with the increased burden of keeping an unproductive member at home.[26] In his analysis of British lunatic asylums, Klaus Doerner also regarded the use of lunatic asylums in socio-economic terms, a means of controlling the 'smooth operation of the economy'.[27] More recent scholars have focussed on what Elaine Murphy described as the 'important role of kinship and family ties in the admission, discharge and negotiation of patients' care'.[28] In this view, admission to the asylum depended on negotiations between 'community and authority'.[29] Evidently, the placement of severely affected epileptics in lunatic asylums must also be carefully interpreted within the economic, medical and familial milieu of this period.

When the doctor Edward Sieveking attempted to enumerate the number of people with epilepsy in England, he assumed that it affected males and females similarly.[30] Nevertheless, in the South Australian lunatic asylums, more males than females were admitted each year with a diagnosis of epilepsy than might be expected from the population (Tables 3a & 3b).[31]

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[22] Scull, 'Convenient Place to Get Rid of Inconvenient People,' 37.
[23] Scull, 'Convenient Place to Get Rid of Inconvenient People,' 37.
[24] Scull, 'Convenient Place to Get Rid of Inconvenient People,' 364-5.
[25] Finnane, 'Asylums, Families and the State,' 137.
[26] Scull, 'Convenient Place to Get Rid of Inconvenient People,' 32-3.
[27] Dorner, *Madmen and the Bourgeoisie,* 85.
[28] Murphy, 'The administration of insanity in England,' 336.
[29] Murphy, 'The administration of insanity in England,' 336; see also Wright, 'Getting Out of the Asylum, 137; Clark, 'Lessons from the Past,' 320; Cathy Smith, 'Family, Community and the Victorian Asylum,' 109.
[30] Sieveking, *On Epilepsy and Epileptiform Seizures,* 80.
[31] Population data obtained from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3105.0.65.0012006

TABLE 3A: GENDER IN SOUTH AUSTRALIA

Year	Male	Female	Total population	Percent males
1865	84255	77222	161477	52.2
1875	108706	101370	210076	51.8
1885	162425	14688	309313	52.5
1895	180314	171654	351968	51.2
			Average	**51.9**

TABLE 3B: GENDER OF PEOPLE WITH EPILEPSY IN THE SOUTH
AUSTRALIAN LUNATIC ASYLUMS[*]

Year	Male	Female	Total population	Percent males
1860-9	35	17	52	67.3
1870-9	95	51	146	65.1
1880-9	128	81	209	61.2
1890-9	141	98	239	59.0
			Average	**63.2**

*includes readmissions

As the two tables show, fifty-two percent of the South Australian population was male compared with sixty-three percent of epileptics in the lunatic asylum. Overall, males accounted for sixty-one percent of admissions in the South Australian asylums, and, as will be shown for epileptic patients, there were some clear medical and social reasons for this.[32] Epileptic seizures sometimes affected people admitted with 'General Paralysis of the Insane' (GPI), the late (and terminal) phase of syphilis.[33] As noted by various scholars, this diagnosis primarily affected men.[34] Only three percent of the South Australian epileptic males had GPI clearly noted in their records. However,

[32] *SAGG*, 'Report for 1898; Lunatic Asylums,'22/6/1899, p137. Report covered the period 1854 to 1898.
[33] Metropolitan Commissioners in Lunacy, *Report to the Lord Chancellor,* 1844, 109-10; Savage, 'The Warnings of General Paralysis of the Insane,' 778-9; Jelly, 'General Paralysis of the Insane,' 217-20.
[34] Described by each of the authors in the previous citation. Recently by Coleborne, 'White Men and Weak Masculinity,' 472.

another three percent had symptoms suggesting they might have the disease (for instance a trembling tongue, and problems with speech and swallowing).[35] Inevitably these men died quickly, having been admitted in a decrepit state and in need of palliative care. For instance, when John G from Crystal Brook was admitted in 1889, his physical condition was described as 'very weak and frail'.[36] He had 'marked oedema of legs and also ulcerations, a mass of bruises, [and a] severe scalp wound'. Mentally he was suffering from 'dementia probably from severe epileptic seizures, has hardly any lucid intervals, wet and dirty and swallows with great difficulty'. He died six days after admission, and his cause of death was stated to be GPI. The gendered nature of GPI and its association with epilepsy thus served to skew the proportion of males in the asylum. The last section of this chapter also shows that the proportion of 'epileptic males' was increased by the preponderance of males acutely affected by alcoholic toxicity. Thus, although epilepsy was not in itself a gendered illness, its symptomatic appearance in diseases such as terminal syphilis and alcoholic toxicity did result in the admission to the asylum of more epileptic males than females.

As described previously, the South Australian process for lunacy was modelled on the British system, with a centralised bureaucracy and a similar legal framework and medical body.[37] It was, however, part of less complex health system than its British counterpart.[38] Thus when examining why the asylum became the main locus of care for ailing and decrepit epileptic patients, it is perhaps more evident that it was providing impoverished patients with access to medical and nursing support. In nineteenth-century South Australia, there were no alternatives. Reports and newspaper articles from the mid- to late nineteenth century also published information about the South Australian asylums which was readily available to people who had responsibility for looking after terminally sick relatives.[39] These contemporary accounts of the asylums highlighted their attributes and often strongly praised their virtues.[40] Some scholars

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[35] Mickle, *General Paralysis of the Insane*, 28-9.
[36] John G. GRS 14316/2/5, p379, (admitted 6/4/1889).
[37] See also, Coleborne, 'Psychiatry and its Institutions,' 372; Garton, *Medicine & Madness*, 17-19.
[38] An overview of British processes is included in: Borsay, *Disability and Social Policy in Britain*. In South Australia the absence of such processes is described in: Dickey, *Rations, Residence, Resources*, Introduction.
[39] The idea that asylums should be 'clean, cheerful, and comfortable' was reiterated throughout nineteenth-century reports. For instance, in a review of the world's lunatic asylums undertaken during the 1880s all asylums were evaluated on these criteria: Tucker, *Lunacy in Many Lands*, 4.
[40] Examples of newspaper reports include: 'The Lunatic Asylum,' *Adelaide Observer*, 30/12/1865, 6; 'A Visit To The Lunatic Asylum,' *South Australian Weekly Chronicle*, 12/5/1866, 1; 'Christmas Eve at the

have suggested that the South Australian asylums did provide more humane care than other states in Australia during this period.[41] Although the chronically unwell could be troublesome, embarrassing, and awkward, it is likely that families did not place them in lunatic asylums solely because they were 'inconvenient'. Rather, the provision of care in institutions was beginning to be regarded as an acceptable alternative to home care. Hence the use of lunatic asylums for dying family members suggests a developing acceptance of institutional care, something that can be observed more directly in South Australia where there were no alternative options for the poor.

If medical superintendents regarded asylum deaths as a mark of failure, families were more pragmatic. In a letter to the head attendant at the Parkside Asylum, the family of Clara H asked whether she was 'expected to live'.[42] Clara was forty-five and had been affected by epilepsy from the age of nine. She had been bed-bound for two years prior to her admission and could not answer questions or dress herself. She was violent when people attempted to change her clothing. The decision to place her in the asylum followed her mother's worsening health.[43] Clara died one month after her family wrote to the asylum, and less than a year after her admission. In the letter, they specifically asked whether Clara would die so 'as we would be more prepared, so that her death does not come sudden to us'. Whether the family was thinking of financial or emotional preparedness is not stated; however it is most likely that they were referring to the pragmatic arrangements required after her death, such as the return of her body, and her funeral and burial requirements. Asylum patients with no relations, or whose families could not afford traditional death rituals, were consigned to unmarked pauper graves at the West Terrace Cemetery in Adelaide. Following Clara's death, however, her body was transported sixty-five kilometres and buried close to her family home.[44] Her family had looked after her to the best of their abilities for over forty years. But when she

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Lunatic Asylum,' *Adelaide Observer*, 31/12/1870, 5; 'Parkside Lunatic Asylum,' *South Australian Chronicle and Weekly Mail*, 22/1/1876, 6; 'Annual Picnic Given the Inmates of Parkside and Adelaide Lunatic Asylum,' *Pictorial Australian*, 1/1/1885, 6; 'Among The Lunatics Visit To The Adelaide Asylum,' *South Australian Chronicle*, 10/1/1891, 7. A description of the Adelaide Asylums was included in book written for the Great Exhibition of 1862: Sinnett, *An Account of the Colony of South Australia*, 87-89.

[41] Jalland, *Australian Ways of Death,* 219.
[42] Clara H. GRS-14310/1/2, p375, admitted 6/4/1910.
[43] Clara's mother died 4 Oct 1911 'after 16 months of suffering,': 'Births, Marriages, and Deaths,' *Chronicle* (Adelaide, SA: 1895 - 1954), 7 October 1911, 36.
[44] Information obtained through SA genealogy records (genealogysa.org.au) and South Australian Cemeteries.

became bed-bound the family could no longer cope, particularly as this coincided with her mother becoming ill.[45] Admission to the lunatic asylum was provided because she occasionally exhibited 'dangerous' behaviours; thus her family gained access to desperately needed medical and nursing care. In death, her family reasserted control and re-admitted her back to the family and community through the public rituals of funeral and burial. In Clara's case, the asylum provided an acceptable alternative when her needs could not be met either by her family or any other institution in the colony. Figure 3 shows Clara's gravestone, and the translated inscription reveals her family's heartfelt hope that her suffering had finally ended.[46] The gravestone inscription reads, 'Finally, finally, the misery must come to an end, finally the hard yoke breaks, finally fear and grief disappear, finally the grief-stone must also be transformed into gold'.

FIGURE 3: GRAVESTONE OF CLARA H.

Not all patients who were approaching death had such close relationships with their families, and some were certainly an inconvenience. The widow, Mary G, spent her last two years at the Adelaide Asylum, having been transferred from the destitute asylum,

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[45] The death notice stated that: [the mother died] on the 23rd September, at her son's residence, Hope Vale, after 16 months' suffering, aged 68.

[46] The verse was taken from a seventeenth century book of spiritual verse.

where she 'could not be managed'.[47] She was described as having 'dementia during the epileptic state, and at other times appears more weak-minded'.[48] Mary was not without family. Her two daughters had both attempted to give their mother 'a happy, joyous home'.[49] According to Mary's son-in-law, his wife's health had been affected by attending to her mother 'day and night', and her conduct had made their home 'miserable'. The second daughter then looked after her for a while, but subsequently also had to 'send her away', explaining how their mother came to be resident at the destitute asylum. Such had been Mary's impact on the family that her son-in-law 'absolutely refuse[d] to have anything more to do with her'. As neither her family nor the destitute asylum could cope with Mary's erratic behaviour, she was transferred to the lunatic asylum where she was looked after during her final months. In death, however, her friendlessness was evident. Her body was subjected to a post-mortem examination after which she was buried in an unmarked grave.[50] Many post-mortems were performed, to help the doctors 'keep their hands in' but only on asylum 'patients who have no friends'.[51] Evidently there was a price to pay for obtaining palliative support, when families could not, or would not, take responsibility for burying their relatives.

In addition to epileptic patients sent from the destitute asylum, the Adelaide Asylum received a number of sick patients from the Adelaide Hospital. Accounts of their physical condition on arrival highlight their poor state of health, described as 'very frail', 'emaciated', 'confined to bed' and 'not weighed, too feeble'.[52] Another institution that surprisingly transferred a frail epileptic to the lunatic asylum was a nearby convent.[53] Sister Anne was fifty when she was admitted; her body was adequately nourished but not robust, and she had acne. This last fact likely indicates that some form of care had been attempted at the convent, as acne was a well-known side effect of bromide therapy.[54] According to her notes, she 'had been this way for

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[47] Mary G. GRS-14310/1/1, p538, admitted 25/5/1897, (includes letter), & GRS-14227/2/5, 215.
[48] Mary G. GRS-14310/1/1, p538.
[49] Mary G. p538, GRS-14310/1/1.
[50] Personal communication with archivist at West Terrace Cemetery, South Australia.
[51] PPSA, T*he Adelaide and Parkside Lunatic Asylums*, 1884, Q. 5712-20.
[52] Patients --Thomas H. GRS-14316/2/5, p103, admitted 25 /2/1886; Benjamin T. GRS-14316/2/6, p57, admitted 23/6/1891; John E. GRS-14316/2/5, p349, admitted 11/12/1888.
[53] Anne O. GRS14310/1/1, 516, admitted 12/12/1896.
[54] Bennett, *A Statistical Inquiry into the Nature and Treatment of Epilepsy,* 37; Williamson, *Observations on the Treatment of Epilepsy,* 14.

years', showing that the convent had provided for her care during this time.[55]
Something had changed, and the convent regarded the lunatic asylum as the better place
to locate Anne as she approached death. She had no known family in the colony, so the
convent had been her sole support. It is pertinent that both the hospital and the convent
sent very sick epileptic patients to the lunatic asylum. Evidently both institutions
preferred to use the lunatic asylum for longer-term care of the dying, when there was
nowhere else to send such patients.

The care that was provided for the dying was chiefly the responsibility of attendants and
nurses, under the supervision of the head attendant and matron. Some patients needed
help from the start and had to be 'carried to bed on admission' or 'helped to the ward'.[56]
The healthy patients remained in the general wards, but the sick and dying were
transferred to the asylum infirmary. Instructions for attendants were published in book-
form by the Medico-Psychological Association in 1885.[57] The book was widely
circulated throughout the world and became known as the Red Book, based on the
colour of its cover.[58] The Adelaide Asylum already had a copy in their library by
1886.[59] According to the Red Book, the physical environment of the infirmary, or sick-
room, was of particular importance. The air had to be pure, and bad (unhealthy) smells
eliminated using adequate ventilation. The temperature of the room was to be
controlled, neither too hot nor too cold, and patients were not to be exposed to
draughts.[60] It was also suggested that lighting be 'subdued but cheerful' and loud noises
avoided.[61] More so than in other parts of the lunatic asylum, the sick room had to be
especially clean, cheerful and orderly.[62] In addition to providing a healthy environment,
the Red Book issued instructions for nursing care. The dying were to be fed with great
care, especially epileptics, for whom soft food was to be given due to the risk of
choking.[63] Attendants had to be alert to the amount of food and sleep that patients were
getting, to lessen the risk of death from exhaustion, a common cause of death in the

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[55] Anne O. GRS14310/1/1, p516.
[56] Benjamin T., *GRS-14316/2/6*; Marker Nathaniel F., *GRS-14316/1/4*, 110; *GRG34-18/1*, (admitted 19/5/1885)
[57] Royal Medico-Psychological Association (RMPA), *Instruction of Attendants on the Insane*.
[58] Walk, 'The History of Mental Nursing,' 1.
[59] A copy bearing the stamp 'Adelaide Lunatic Asylum, South Australia, 15 April 1886' is retained in the University of Adelaide library.
[60] RMPA, *Instruction of Attendants on the Insane,* 21.
[61] RMPA, *Instruction of Attendants on the Insane,* 21.
[62] RMPA, *Instruction of Attendants on the Insane,* 22.
[63] RMPA*, Instruction of Attendants on the Insane,* 30 & 47.

nineteenth century.[64] 'Medical comforts' were administered at the doctor's request, which in South Australia included items such as arrowroot, tapioca, milk and eggs.[65] Beds were to be aired and changed frequently, particularly for patients who were soiling them.[66] It was also recommended that weak patients avoid the risk of draughts and chills, by being cleaned in bed, rather than being sent to bathe elsewhere.[67] In the event of death, the Red Book also provided detailed instructions for the 'laying out'. Despite the fact that lunatic asylums were ostensibly institutions of cure, considerable detail was provided in the Red Book regarding the care of the sick and dying. The provision of care was not heavily medicalized, being based largely on the provision of a suitable interior environment within which nurses and attendants administered care according to patients' needs. Death was not unexpected in lunatic asylums, particularly amongst epileptic patients, and provision of what we would now consider to be palliative care was part of the treatment.

The provision of patient care was not unappreciated. A number of letters from the South Australian archives show that families were grateful to doctors and nurses for the care provided for their relatives. One bereaved mother expressed her gratitude to the nurses, noting that 'all kindness was shown to him' [her son].[68] She also described her joy knowing that 'God has been merciful in taking mine to dwell with him forever', apparently satisfied that the lunatic asylum was no impediment to the life ever after.[69] For families with sufficient money, the dead could be publicly recognized through a funeral, headstone and memorial. However, no attempt was made to mark the deaths of patients who were destitute or had no family in the colony, other than by recording their names in the *Government Gazette*.[70] Destitute burials were derisory. Indeed, even as late as 1890, complaints were made about the 'disgraceful' way in which the destitute were buried in South Australia.[71] Whilst the lunatic asylum provided the poor with a

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[64] RMPA, *Instruction of Attendants on the Insane,* 10. Medical dictionaries from the mid-1850s describe exhaustion as a loss of strength and great fatigue. See: Dunglison, *A Dictionary of Medical Science;* Bucknill & Tuke. *Manual of Psychological Medicine*. 224, 768. Bucknill & Tuke attribute a cause of death to the 'gradual exhaustion of the vital powers'. In relation to epilepsy, they state that 'a patient died after a series of epileptic convulsions due to exhaustion resulting from 'chronic changes in the nutrition of the brain'.

[65] PPSA, *Report of the Commission,* 1884, Q.2394.

[66] Royal Medico-Psychological Association, *Handbook for the Instruction of Attendants*, 22-24.

[67] Royal Medico-Psychological Association, *Handbook for the Instruction of Attendants*, 24.

[68] Arthur W. GRS-14317/1/1, p445, admitted 21/12/1887

[69] Arthur W. GRS-14317/1/1, p445.

[70] Hall, *South Australian Index of the Deaths,* s2.

[71] Jalland, *Australian Ways of Death,* 216-7.

well-managed environment in which to die, the treatment of their bodies after death demonstrated an absence of care.

Clearly, dying in a lunatic asylum was not ideal; however it appears to have been actively chosen by some families of people with epilepsy as a viable alternative to home-based care. Likewise, the fact that institutions such as the hospital, destitute asylum and convent also turned to the lunatic asylum for support for the most severely affected epileptic patients suggests a similar ethos. The increase in deaths that took place amongst this group of patients during the nineteenth century also indicates that public attitudes regarding the locus of dying were shifting towards institutionalised care. Nevertheless, as the following sections demonstrate, not all patients with epilepsy were destined to die soon after arrival. Some were 'hopeless and incurable cases', but relatively long-lived.

A PLACE OF REFUGE

> The patient neither recovers nor dies, but remains an incurable lunatic, requiring little medical skill in respect of his mental disease and frequently living many years.[72]

Whilst the majority of epileptics died or were quickly discharged, around one third lived in the lunatic asylum for many years (Table 2). The likelihood of becoming a 'long stay' epileptic patient affected males and females equally.[73] These were the chronic and incurable patients who 'silted up' the asylums and were the *bête noire* of superintendents.[74] When the scholars Anne Shepherd and David Wright examined patterns of patients who were discharged or died at the Brookwood Asylum in Buckinghamshire, they found that most left within five years (and usually much earlier); however, around a third remained for considerably longer periods.[75] This mirrors the pattern of residency for epileptic patients in South Australian lunatic asylums. Patients who remained beyond five years were rarely discharged and typically

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[72] Metropolitan Commissioners in Lunacy, *Report to the Lord Chancellor*, 1844, 92.
[73] As described in this chapter, epilepsy associated with GPI was more prevalent in males, and skewed the number of 'early deaths', whereas epilepsy associated with alcoholism also affected more males and skewed the number of 'short stay' patients.
[74] Leonard Smith, 'Welcome Release,' 125.
[75] Shepherd, 'Madness, Suicide and the Victorian Asylum,' 183.

died in the asylum.[76] Due to the extended periods of their residency, their care needs are not described in this thesis as palliative, particularly as their social status and medical requirements were significantly different to other epileptic patients. As shown in Table 4, this group had a much greater degree of mental impairment overall. For these patients, the use of the lunatic asylum is best described in terms of a refuge, alluding to the meaning of a 'secure place, shelter, or retreat'.[77] In addition to greater levels of mental impairment, the patients who remained for long periods were more likely to be affected by poverty, abandonment, and the dislocation of migration. This was a group whose members could not care for themselves, and the lunatic asylum was the only resource in nineteenth-century South Australia where others would take responsibility for their care.

TABLE 4: MENTAL CAPACITY AND DEMOGRAPHIC STATUS OF EPILEPTIC PATIENTS

	SHORT STAY (less than 5 years)		LONG STAY (more than 5 years)
	Discharged 130 patients	Died in asylum 247 patients	Mainly died in asylum 180 patients
Male to female ratio	1.58 males per female	1.77 : 1	1.1 : 1
Average age at admission	33 years	33 years	29 years
Aged under 20	16%	24%	30%
Single (over 19)	56%	61%	71%
Dementia from epilepsy	17%	41%	49%
Amentia	7%	20%	23%
Dementia or amentia	23%	54%	63%
Destitute	7%	8%	10%

Table 4 reveals the extent of social and medical disadvantage experienced by the 'long-stay' epileptic patients, compared with the other two groups. Of particular relevance is the fact that more 'long-stay' patients had irreversible brain damage, based on

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[76] 95% of patients who remained in the lunatic asylum for longer than five years would die there.

[77] 'refuge, n.'. *OED Online*. June 2018. Oxford University Press. http://www.oed.com.proxy.library.adelaide.edu.au/view/Entry/161119?rskey=6uvbev&result=1 (accessed August 14, 2018).

descriptions that included the words 'amentia' and 'dementia', as is discussed in more detail below. As will be shown, these words reflected an inability of long-stay patients to look after themselves, a fact that was frequently recorded in their notes. Younger patients also comprised a larger percentage of long-stay patients, mainly because more had been affected from birth. Most of the adult patients were single, demonstrating their social isolation and more limited familial support. In addition, there was a higher ratio of female and destitute patients amongst the long-stay patients. Taking all these differences into consideration, it is evident that these patients were socially vulnerable and exhibited more severe mental disability than other epileptic patients. In the absence of other forms of care, the lunatic asylum provided an environment where the socially and mentally disenfranchised could obtain care and remain for life. In other words, it was a refuge.

The fact that so many long-stay epileptic patients also had mental conditions described as dementia and amentia requires explanation. Up until the early nineteenth century, the two words shared a common meaning. For instance, Hooper's Medical Dictionary of 1825 defined amentia as

> imbecility of intellect, by which the relations of things are either not perceived or not recollected … when it originates at birth, it is called amentia congenita, natural stupidity; when from the infirmities of age, amentia senilis, dotage or childishness.[78]

According to Hooper, amentia could arise at birth or in old age. However, by the mid-nineteenth century, the 'language of medicine' used by asylum doctors placed amentia more firmly at the time of birth.[79] Esquirol, in his 1845 treatise on insanity, suggested that amentia should be used to describe 'a condition in which the intellectual faculties are never manifested'.[80] From here on, the terms amentia and 'idiocy' could be used synonymously, because as Esquirol explained, idiocy (or amentia) 'commenced with life' and resulted in arrested intellectual development.[81] Idiots were born idiots, whereas dementia could arise later in life. Hence to say an epileptic had amentia was to describe a person who had been affected from birth. This was different to those epileptics who

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[78] Hooper, *Lexicon-medicum; Or, Medical Dictionary,* 1825. 72.
[79] Esquirol, *Mental Maladies*, 446.
[80] Esquirol, *Mental Maladies,* 446.
[81] Esquirol, *Mental Maladies,* 446.

developed 'chronic' epileptic dementia later in life. This form of dementia shared much in common with 'senile' dementia, or dotage in older people.[82] Esquirol eloquently distinguished between amentia and dementia when he stated that 'a man in a state of dementia is deprived of advantages which he formerly enjoyed; he is a rich man, who has become poor. The idiot, on the contrary, has always been in a state of want and misery'.[83] Esquirol noted that idiots rarely lived past the age of thirty, whereas 'a person, who has fallen into a state of dementia does not die immediately, he may live a long time, and reach a very advanced age'. Overall, any individual whose epilepsy was complicated with amentia or dementia was likely to be severely disabled. For these people, the lunatic asylum provided a therapeutic niche that was otherwise unavailable.

Around one-third of the South Australian 'long-stay' patients had entered the asylum as young patients. The words that were used to describe their condition included amentia, 'idiocy', 'congenital', and 'from birth'. Whilst some epileptic patients were described as 'weak-minded', this did not consistently mean a condition arising from birth, and usually referred to less severe mental impairment. However, when four-year old Alice S was transferred to the Parkside Asylum from the Magill Industrial School, her mental condition was described as 'epileptic amentia (congenital idiot)'.[84] This description clearly showed that Alice's unique blend of problems had arisen at the time of birth. Amentia patients or idiots, as they were otherwise known, did not necessarily suffer from epilepsy, but, as in Alice's case, there was a strong correlation between the two. At the Newcastle Asylum for Idiots and Weak-minded Children in New South Wales, over a quarter of the resident children had epileptic seizures.[85] Despite Esquirol's predictions that the life expectancy of idiots was severely curtailed, most of the South Australian 'amentia' patients survived beyond the age of thirty. In fact, Alice remained at the Parkside Asylum for sixty-eight years.[86] Her longevity was not exceptional; several young amentia patients survived into their sixties and seventies. Evidently the profound disabilities that could emerge at birth did not always render asylum residents physically or constitutionally weak. Nor was the asylum an environment that lowered people's life expectancies.

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[82] Esquirol, *Mental Maladies,* 447.
[83] Esquirol, *Mental Maladies,* 447.
[84] Alice Maud S., GRS-14310/1/2, p211, admitted 1/6/1907.
[85] Tucker, *Lunacy in Many Lands,* 645.
[86] Alice was discharged in 1975, possibly to an aged care facility.

Many of the amentia epileptic patients lacked familial support. Some, like Alice, had spent short periods of time in the Industrial Schools, institutions that were designed for orphaned, neglected or criminal children.[87] As the name suggests, the purpose of Industrial Schools was to prepare young people to become employable members of society. Those with intellectual disabilities and who were unable to follow instructions, or worse, were disruptive or considered dangerous, were transferred to the lunatic asylum. Some of the older epileptic 'children' in the lunatic asylum also lacked families that could support them[88] This was the case for Anna B and Frank F whose mothers were both resident at the Destitute Asylum.[89] In other cases, family members were in receipt of outdoor relief.[90] A few amentia patients had been charged with vagrancy and transferred to the lunatic asylum from gaol or directly from court, suggesting they had been living on the street and homeless. Not all amentia patients were without families; however it is clear from the records that many only had widowed mothers or siblings who were unable to provide the necessary support. For some, the whereabouts of family members was unknown. The parents of two 'long-stay' patients were themselves patients in the South Australian asylums and hence unable to provide support. The sentencing of her mother to gaol precipitated the admission of Mary F. Mary was fourteen when she was admitted, her mother having been convicted for running a brothel.[91] The majority (89%) of these 'long stay' amentia patients were, like Mary, classified as paupers. For this group in particular, there were no alternative places where they could obtain care.

Effectively, the lunatic asylum became a 'home' for the epileptic amentia and dementia patients whose families or other state organisations were unable or unwilling to support them. Whilst a few did live in the South Australian Destitute Asylum, this only continued whilst their behaviour was not considered threatening.[92] There were no

[87] *Destitute Persons Relief Act, 1866* (SA).

[88] *Destitute Persons Relief Act, 1866* (SA) s34: Definition of child: 'Every boy and girl under the age of sixteen years shall be so to be deemed to be a "child"'.

[89] Anna B. GRS-14310/1/1, p688, admitted 14/11/1899; Frank F. GRS-14317/1/1, p152, admitted 9/11/1878.

[90] Outdoor relief was provided to the poor in the form of money, food, clothing or goods, without the recipient having to enter an institution For a description of outdoor relief in South Australia see: Dickey, *Rations, Residence, Resources*, 85-9. In Britain, see: Peter Bartlett, *The Poor Law of Lunacy*, 14-15.

[91] Mary F. GRS-14310/1/1, p155, admitted 9/6/1882; 'This Day,' *Express and Telegraph* (Adelaide, SA : 1867 - 1922), 23 September 1880, 2.

[92] 'The Destitute Act Commission,' *South Australian Advertiser*, 20/12/1884, 1.

alternative places in South Australia that provided practical assistance for these patients during this period. Charitable organisations focussed their attention on orphans, 'fallen women', and the general poor and aged, most of whom were expected to work in return for their rations.[93] In his review of social welfare in South Australia, Brian Dickey highlights the limits of various nineteenth-century non-governmental organisations, noting they 'dealt in hundreds of pounds, the government agencies dealt in tens of thousands'.[94] Even when a home for 'weak-minded' children was opened in South Australia in 1898, it precluded children with epilepsy.[95] Indeed, at the formal opening, Mr. Josiah Symon, Q.C. explained to those who had gathered, 'what the institution [Minda] was and was not':

> Considerable misapprehension existed as to the objects of the home, he said. It was not a lunatic asylum or an asylum for those afflicted with mania, or oppressed with the cloud of idiocy. Neither was it for epileptics, but the Committee hoped that as they were able to segregate the pupils, part of the institution might be devoted to these unfortunate people.[96]

Eventually Minda did admit some young people with epilepsy; however only four patients moved between Minda and the lunatic asylum, two were transferred from Minda to the asylum, and two went from the asylum to Minda. It might also be imagined that when the Home for Incurables (renamed the Julia Farr centre in 1981) opened in 1879 it would have accepted epileptics affected by dementia. However it did not, 'nor would it accept cases of blindness, cancer, or consumption'.[97] The absence of alternative care was not unique to South Australia. As noted previously, whilst people with milder forms of epilepsy could be housed in English workhouses, transfer to the lunatic asylum only took place for those deemed to be dangerous.[98] Likewise, in Scotland where there was a greater focus on boarding-out chronic patients to the community, the Board of Lunacy considered this to be unsafe for those affected by epilepsy.[99] Indeed, long-term residency in lunatic asylums was the norm for epileptics

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[93] Dickey, 'Chapter 6: Charity and the Community,' in *Rations, Residence, Resources*, 98-121.
[94] Dickey, *Rations, Residence, Resources*, 120.
[95] Minda – during its early years, it only accepted children with epilepsy if they were capable of light employment. 'Our Imbecile Children,' *South Australian Register*, 27/2/1894, 5.
[96] 'Home for Weak-Minded Children,' *Express and Telegraph*, 19/9/1898, 3.
[97] 'Crying Need,' News, 10/11/1924, 8.
[98] Bartlett, *The Poor Law of Lunacy,* 62-64.
[99] Sturdy, 'Boarding-out the insane,' 127.

of low socio-economic status, limited ability to work, high care requirements, difficult behaviour, and in the absence of families willing or able to provide for their care.

As indicated by the Metropolitan Commissioners in Lunacy, when lunatic asylums were used for long-term incurable patients, the medical skills required for their care were negligible.[100] Indeed, epileptic patients who remained for extended periods had little to gain from medical treatment but did benefit from practical care and a well-provisioned and safe environment. They were an extremely disenfranchised group, isolated and poor, disabled from birth or from the onslaught of dementia. Whilst the lunatic asylum might well have been a 'dustbin for the useless and unwanted of industrial society', it can also be perceived as a place of refuge for this group of people.[101]

A TEMPORARY RESPITE

Whilst most epileptic patients died in the asylum, not everyone departed in a coffin. Nearly a quarter were discharged, mostly within one year of arrival. This proportion was substantially lower than for non-epileptic patients. For instance in South Australia, the overall rate of discharge from the lunatic asylums was between forty-eight and sixty-two percent.[102] In New South Wales and Victorian asylums, the percentage discharged hovered around fifty percent.[103] According to David Wright, discharge rates from British asylums were generally around fifty percent, mainly within twelve months of admission.[104] Based on the large percentage of patients who were quickly returned to the community, some scholars have asserted that lunatic asylums should not be simply regarded as repositories for undesirable people.[105] Oonagh Walsh, for instance, describes the use of an Irish asylum by patients, relatives and officials at other institutions not as 'a simple vehicle for the incarceration of the insane, but as a resource,

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[100] Metropolitan Commissioners in Lunacy, *Report to the Lord Chancellor*, 1844, 92.
[101] Quote by Roy Porter in Porter & Wright, *Confinement of the Insane*, 9.
[102] *SAGG*, No. 29, 22/6/1899, 1377.
[103] Garton states total rate of discharge between 1880-1889 in NSW was 47% for men and 52% for females: Garton, *Medicine & Madness,* 36. Rates of discharge for different Australian states are provided in: Tucker, *Lunacy in Many Lands*, 637-697.
[104] David Wright states that 49% of patients were discharged in: Wright, 'The Discharge of Pauper Lunatics,' 95; Cathy Smith states discharge figures for Wales were between a third and a half of patients: Smith, 'Family, Community and the Victorian Asylum,' 117.
[105] Wright, 'The Discharge of Pauper Lunatics,' 95; Smith, 'Family, Community and the Victorian Asylum,'111; Walsh, 'The Designs of Providence,' 238-40.

to be used for reasons other than the strictly medical'.[106] Whilst the overall number of epileptic patients who were discharged was substantially lower than amongst other patient groups, nevertheless a significant number were discharged. For this group of patients in particular, their time spent in the lunatic asylum does not fit well with the custodial model. Rather, the asylum provided a temporary respite, both for the patients and for their relatives.

The power to discharge patients from South Australian lunatic asylums lay with legal representatives until 1847.[107] Relatives and friends could apply to have family members released but the authority to approve a discharge resided with Justices of the Peace. Families had to demonstrate that they could care for, and protect the patients, and that there would be no risk posed to the community. After 1847, an amendment was introduced which increased the responsibility of asylum doctors in the process. Thereafter, medical superintendents could recommend discharge, as long as they had the support of two official asylum visitors.[108] This shift in power from the legal to the medical profession remained through all subsequent updates of the lunacy laws. In 1884 when the medical superintendent of the Adelaide Asylum, Alexander Paterson, described his duties, he stated that

> The medical charge of the patients belongs to me. I am responsible for the medical management, and for the general management of the staff of the asylum. I have to see that patients are properly admitted here according to the Act, and when the patient has recovered I have to discharge him, or rather recommend his discharge to two visitors of the asylum-there are various ones. I recommend the discharge. In fact, virtually, all the responsibility of discharging patients rests upon me.[109]

Paterson very clearly felt that authority for patient discharge resided with him. He notes the role of official visitors almost as an afterthought and does not mention that three visitors could order a discharge independently of the doctor. Paterson also overlooked

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[106] Walsh, 'The Designs of Providence,' 240.

[107] *An Ordinance to make provision for the safe custody of, and prevention of offences by, Persons dangerously Insane, and for the care and maintenance of Persons of Unsound Mind*, 1844, No. 10 (SA).

[108] *Further To Provide For The Care And Maintenance Of Persons Of Unsound Mind*, 1847, No. 2 (SA) s16.

[109] PPSA, R*eport upon the Adelaide and Parkside Lunatic Asylums,* 1884, Q6.

the importance of families and friends in initiating the movement of patients out of the lunatic asylum.

The law, however, recognized the right of relatives to request discharge, regardless of recovery.[110] Most patients were not directly discharged; the more usual practice was for them to be 'released on trial' for periods of one to three months, into the care of friends or family.[111] In an 1884 report to government, Patterson described that this was helpful for patients whose mental state had improved from the time of their admission, but who were 'not absolutely at the point of perfect health'.[112] He maintained that a probationary period at home could assist in their continued improvement. If patients subsequently recovered, their families were required to submit a medical certificate to the lunatic asylum so that their medical record could be adjusted to reflect this. Paterson noted, however, that as medical certificates cost one guinea, this document was rarely obtained in practice, so most patient records continued to show that they were 'discharged improved' (or not improved).[113] Patients who relapsed during their trial period at home could return to the asylum without the need to go through the formal readmission process. Around one in five of the South Australian epileptic patients had two or three home trials before their final discharge. As such, families were both instrumental in gaining access to the lunatic asylum for short periods of time and also in deciding when to discontinue its use.

In general, the 'short-stay' patients were less severely affected by their illness and more of them were married than for either of the previous two groups (see Table 4). They were also more likely to have been in work prior to admission, and notably, the group included more private patients.[114] The fact that there was also a gender imbalance is best explained by the number of alcoholic men in this group (17%).[115] Epileptic seizures were a well-documented side effect of alcohol toxicity, and this helps to explain why some were discharged 'recovered'.[116] Their seizures ameliorated once the acute (and dangerous) effects of alcohol toxicity had settled. The use of asylums for alcoholism

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[110] *Lunatics Act* 1864, No. 21 (SA) s.38.
[111] PPSA, R*eport upon the Adelaide and Parkside Lunatic Asylums,* 1884, 20, Q.582.
[112] PPSA, R*eport upon the Adelaide and Parkside Lunatic Asylums,* 1884, 20, Q.583.
[113] PPSA, R*eport upon the Adelaide and Parkside Lunatic Asylums,* 1884, 20, Q.583.
[114] Private admissions accounted for 17% of short stay, 12% of early deaths and 13% of long stay patients.
[115] 21 of the 22 people affected were male.
[116] Echeverria, 'Alcoholic Epilepsy,' 489.

was, according to the medical historian Nancy Tomes, approved of by General Practitioners in the nineteenth century, as there was 'compulsory privation of drink, therapeutic remedies, moral enlightenment and encouragement of mental recreation and physical employment'.[117] In her review of alcoholism in the Adelaide lunatic asylum, Evelyn Shlomowitz shows that during the years 1871 and 1884 between fifteen and twenty-six percent of all admissions were alcohol-related. They also accounted for nineteen percent of all discharges, mostly within three months of admission. Shlomowitz describes the early release as a failure on the part of the asylum to cure their underlying addiction problems. She notes however that when the medical superintendent attempted to detain alcoholics for longer periods during in the 1860s in order to deal with their addiction, this was quickly curtailed due to opposition from the official visitors.[118] Although legislation in the 1870s and 1880s facilitated the opening of a retreat for inebriates, many continued to be sent to the lunatic asylum, where Alexander Paterson's practice 'was to discharge them once their physical condition had improved and their mental condition stabilized'.[119] The asylum did not cure, but it did provide care.

Amongst the other 'short stay' patients, around one quarter of patients in this group exhibited similar levels of disability to those seen in the 'long stay' group. They needed care; however they also had families that could provide more support. Albert A was a sixteen year old, who required 'constant care and attention', yet was removed from the Adelaide Asylum after four weeks by his mother.[120] Likewise, Meta Ruth E needed 'much supervision … not attending to herself', yet, after two months she too was discharged into the care of relatives who 'thought they could manage her'.[121] Another, Frederick D, aged fifteen was 'unable to take care of himself and has been found unmanageable at home'.[122] Frederick was moved between home and the asylum several times before remaining 'unimproved' with his parents, a process that played out over three years. Each of these three patients were on the verge of adulthood and unable to care for themselves. Unlike those described in the previous section, their families could care for their profound disabilities most of the time. Whether they hoped for some

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[117] Tomes, *A Generous Confidence,* 106.
[118] Shlomowitz, 'The Treatment of Mental Illness in South Australia,' 252.
[119] Shlomowitz, 'The Treatment of Mental Illness in South Australia,' 254.
[120] Albert A. GRS-14323/1/4, p211, admitted 13/2/1892.
[121] Meta Ruth E. GRS-14324/1/1, p153, admitted 7/11/1912.
[122] Frederick D. GRS-14323/1/4, p125, admitted 1/8/1889.

improvement in their physical and mental state whilst in the asylum or conversely were in need of temporary respite is not stated. Other scholars have also questioned this use of lunatic asylums. Tomes, for instance, examines family correspondence sent to the medical superintendent at Pennsylvania Asylum in Philadelphia (USA), and concludes that 'the asylum promised both a respite and a remedy, a potent combination for the families of the insane'.[123] Cathy Smith, examining an English asylum in Northampton, also concluded that its use was flexible, providing the community with 'long-term care or short term respite', depending on their needs and local social and economic conditions.[124]

Not all patients were affected by amentia or dementia; rather, some deliberately chose to spend time in the lunatic asylum. For these, the lunatic asylum offered a range of advantages, including withdrawal from the world, treatment, and sustenance. For instance, it was noted in the case of Alice R that it was

> Difficult finding much the matter with her mind. Says that she cannot get on with people outside and that she is subject to epilepsy the result of a fall from a horse. Says she feels more comfortable in the asylum.[125]

Alice stayed for one month, and was then discharged as 'detention was no longer considered necessary'.[126] Another patient, Charles S, was described as 'quite rational' at the time of his admission.[127] His notes record that he was 'said to have fits and admits that he has had convulsive seizures of a cataleptiform nature, at which times he becomes extremely dangerous. *Treatment is the object of his coming to the asylum*'.[128] He left the asylum one month later 'feeling better'.[129] Florence P, a domestic servant, entered the asylum 'at her own wish', whilst Emma B said she was content to remain there 'for a time'.[130] There are even indications that some patients feigned illness. Thomas B, a 'bushman' from New South Wales, was described as epileptic and

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[123] Tomes, *A Generous Confidence*, 118.
[124] Smith, 'Family, Community and the Victorian Asylum,' 121.
[125] Alice R. GRS-14227/1/4, p78, admitted 6/8/1888.
[126] Alice R. GRS-14227/1/4, p78
[127] Charles S. GRS-14313/2/5, p133, admitted 16/6/1886.
[128] Charles S. GRS-14313/2/5, p133. We cannot be certain what was meant by 'cataleptiform', however the Mirriam-Webster Dictionary defines catalepsy as 'a trancelike state marked by loss of voluntary motion in which the limbs remain in whatever position they are placed'. My italics.
[129] Charles S. GRS-14313/2/5, p133.
[130] Florence P. GRS-14310/1/1,p 994, admitted 20/6/1903; Emma B, GRS-14324/1/1, p214, admitted 10/10/1913.

dangerous in his admission notes.[131] Shortly after admission, however, an entry in his notes reads, 'this man has never had a fit in the asylum and has much improved in bodily condition. He is quite rational'.[132] He was discharged a few days later. In general, improvements in 'bodily condition' referred to an increase in weight, recorded on entry and discharge. Patients invariably gained weight during their stay, highlighting the relatively straightforward relationship between food and health in the nineteenth century. For some, this was adequate; for others, a period of social withdrawal sufficed.

The agency of patients to use asylums on a temporary basis was noted by the historian Stephen Garton in his study of New South Wales. Garton states that for 'patients from poor circumstances [for whom] the prospect of regular meals and a bed where "everything ... is clean, light and airy" could be a welcome relief'.[133] Garton described a woman who found the asylum a respite from an abusive partner, and preferred 'Gladesville ten thousand fold before my home'.[134] The fact that some people chose to use the asylum alludes to its emerging acceptance during the nineteenth century, something that would have been unimaginable during the eighteenth century. Tomes suggests this arose from 'a popular appreciation of moral treatment as an innovative therapy'.[135] As described previously, moral treatment was premised on an idealised middle-class family home with elements of bourgeois morality. Evidently elements of this belief were still being promoted in 1899, when the South Australian Medical Superintendent, William Cleland was reported in the paper as saying:

> Home life is the ideal set before the officials as defining the kind of routine and treatment calculated to be most beneficial to the patients, and the matron receives hearty praise for the skill and ingenuity which she has shown in organizing the meals with this idea in view. In short, it is plain to demonstration that the unfortunate insane persons of the colony are in good hands, and that everything that high medical skill and careful attendance can do for them is being done.[136]

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[131] Thomas B. GRS-14316/1/2, p283, admitted 9/4/1878.
[132] Thomas B. GRS-14316/1/2, p283.
[133] Garton, *Medicine & Madness*, 176.
[134] Garton, *Medicine & Madness*, 176.
[135] Tomes, *A Generous Confidence,* 124-5
[136] William Cleland, 'The Lunatic Asylums,' *Adelaide Observer* (SA : 1843 - 1904), 1 July 1899, 13.

Information such as this undoubtedly influenced patients and families alike, reinforcing the notion that asylums provided home-like environments.

Nearly one-third of short-stay epileptic patients in South Australia were described as suicidal. By the end of the eighteenth century, suicide occupied an ambiguous position, and was variously defined as a felony or an act of temporary insanity. In the eighteenth century, the legal scholar William Blackstone had stated that suicide 'ranked amongst the highest crimes, making it a peculiar species of felony'.[137] It was 'peculiar', because it required the prosecution of the corpse in a coroner's court.[138] For people who were of sound mind and had reached their 'age of discretion', ecclesiastical penalties were applied in England until 1823 which deprived the suicide access to consecrated ground, their body could be buried at a crossroad, with a stake through the heart.[139] If this was not punishment enough, civil law also required the suicide's property be forfeited to the crown, something not repealed until 1882 in England.[140] To circumvent a guilty verdict, the coroner could declare that a person had been of unsound mind (*non compos mentis)* or temporarily insane when they killed themselves, thus ensuring that dependents would not be left destitute. This was almost universally adopted by coroners by the end of the eighteenth century.[141] In South Australia, it became unlawful to refuse a Christian burial for a suicide or forfeit their goods and chattels by an act of 1871.[142] Nevertheless, the act of suicide remained on the statute book as a criminal offence until 1935.[143] Attempted suicides could be tried in criminal courts where their 'crime' was treated as a misdemeanour, rather than a felony.[144] Under the 1844 lunacy legislation, those who were 'discovered and apprehended … under circumstances denoting … a purpose of committing suicide' could be treated as temporarily insane and committed to the lunatic asylum.[145] Alternatively if it was determined the attempted suicide was 'sane', they were ordered to 'keep the peace' for a period of time and to provide steep financial

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[137] Blackstone, *Commentaries,* V.1, 937.

[138] Laragy, 'A Peculiar Species of Felony,' 734.

[139] MacDonald, *Sleepless Souls: Suicide,* 15.

[140] Laragy, 'A Peculiar Species of Felony,' 733.

[141] Laragy, 'A Peculiar Species of Felony,' 733; Blackstone, *Commentaries*, 938; Justice of the Peace, 'Suicide,' 260.

[142] *An Act to amend the Law relating to Verdicts of "Felo-de-se"* 1871, No. 5 (SA).

[143] *Criminal Law Consolidation Act* 1935, No. 2252 (SA).

[144] Anderson, *Suicide in Victorian and Edwardian England,* 282-3. This was also true for South Australia: Clifford, *Suicide in South Australia*, 31.

[145] *An Ordinance to make provision for the safe custody of, and prevention of offences by, Persons dangerously Insane, and for the care and maintenance of Persons of Unsound Mind*, 1844, No. 10 (SA).

sureties.[146] A prison sentence was given to those who could not raise the surety.[147] The judgement of insanity for attempted suicides explains the relatively short amount of time some suicidal epileptics spent in the lunatic asylum. They were not highly disabled people, and the lunatic asylum provided a better alternative than gaol.

For some people with epilepsy, doctors attributed their suicidality to their unconscious mind, suggesting the action could therefore not have been premeditated or intentional. In South Australia for instance, the medical notes of one 'suicidal' epileptic patient (John C) recorded that he could not 'remember having done certain acts with a razor and oxalic acid, although such was the case … the explanation … probably that he suffers from states of epileptic unconsciousness'.[148] He was removed 'improved' by his wife, eleven days later. The idea that an act of harm involving poison and a razor could be performed unconsciously appears strange, but resonated with contemporary attitudes concerning epileptic responsibility.[149] John C's 'confinement' was brief, long enough for him to recover from this episode, but short enough to have little impact on his family life, or his work as a milk vendor. For epileptics like John C, a short stay in the lunatic asylum circumvented the need for gaol and meant they did not need to find the large sums of money required for sureties. Attributing actions to John's unconscious mind provided a conduit to short-term care in the asylum, rather than the gaol, whilst ensuring that family were not financially disadvantaged.

The route of admission for most suicidal epileptic patients did not result from legal proceedings. Rather, the description of 'suicidal' was based on an assessment of their emotional and physical states during admission; these patients were more likely to be male (62%). Such descriptions of suicidality increased towards the end of the nineteenth century. In the 1870s, only twelve percent of 'short stay' patients were thought to be suicidal, but this increased progressively so that in the 1900s it applied to over forty percent of the group. Typical of these descriptions were those of Elizabeth S (suffering from melancholia and taking 'no interest in her surroundings') and David E who had 'lost interest in life, desponding and will take interest in nothing'.[150] Other

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[146] According to Olive Anderson, this appeared in the Magistrates books from 1850 in Britain: Anderson, *Suicide in Victorian and Edwardian England,* footnote 69, 283.

[147] Justice of the Peace, 'Suicide,' 259.

[148] John C. GRS-14316/2/5, p367, admitted 25/2/1889.

[149] Eigen, 'The Case of the Missing Defendant,' 177.

[150] Elizabeth S. GRS-14310/1/1, p1016, admitted 8/10/1903; David E, GRS-14316/2/6, p300, admitted 15/1/1894.

apparently suicidal behaviours included nervousness and a lack of confidence. The fact that people with epilepsy were depressed, nervous and anxious is unsurprising given that their abilities to live independent, productive lives was gradually eroded. However, the increase in rates of suicides that occurred towards the end of the nineteenth century also suggests links to social stigmatisation and public discussions about hereditarian causes of epilepsy which erupted during the 1860s. In his study grounded in nineteenth-century France, Jason Szabo highlights many of the factors that contributed to the existential despair of people with chronic diseases.[151] Afflicted with uncertainty about the future coupled with the knowledge of suffering and loss to come, shame and censure 'loomed large in the setting of chronic disease'. Many with incurable diseases sought to end their lives, and according to Szabo, 'humiliated by their inability to work' these feelings affected men more than women.[152] Most suicidal epileptic patients in South Australia were still able to care for themselves. Hence, it is likely that they were admitted because they were affected by feelings of unhappiness and hopelessness.[153] Their quick discharge and 'improved' or 'recovered' status attests to this. For instance, Walter B, a twenty-seven year old farm labourer, was described as epileptic and suicidal.[154] He had used a knife to wound himself at the base of his penis. As epilepsy was considered by some doctors during this period to result from masturbation, it is possible that Walter's attempt at self-mutilation stemmed from this.[155] His notes describe him as 'depressed, does not seem to know why he tried to mutilate himself. Has probably been overtaxing his strength'.[156] Walter was eventually released on trial into the care of his father and described as 'improved'. This improvement does not imply that he had recovered from epilepsy, only that his suicidal state of mind had improved. Thus, the lunatic asylum was also a temporary locus of care for psycho-social problems arising as a consequence of epilepsy.

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[151] Szabo, *Incurable and Intolerable*, 81.

[152] Szabo, *Incurable and Intolerable*, 81.

[153] Note however, as discussed in Chapter 1, some suicidal behaviour was also likely linked to the effects of epilepsy.

[154] Walter B. GRS-14316/1/3, p221, admitted 20/12/1880.

[155] As noted by Stephen Garton, 'from the mid-nineteenth century, medical practitioners, social reformers, hygienists, pedagogues and philanthropists in Britain, Europe and North America became obsessed with the deleterious effects of masturbation': Garton, *Medicine and Madness*, 100. Roy Porter also noted that the Swiss physician, Samuel-Auguste Tissot, developed the notion that epilepsy could be the consequence of the solitary vice. As late as the 1880s, William Gowers was still suggesting epilepsy was linked masturbation. Porter, 'Epilepsy,' Ch. 6, 170.

[156] Walter B. GRS-14316/1/3, p221.

Describing lunatic asylums in terms of temporary respite is not new, although it has not previously been demonstrated for epileptic patients.[157] This type of use was principally mediated by families, and is more in evidence for this group of patients than amongst the long-stay patients. Whilst there were some in the 'short stay' group who could not look after themselves, their use of the asylum was temporary because they had families who could continue to provide care. Some people voluntarily elected to spend time in the lunatic asylum, although a few benefitted from being described as temporarily insane, in order to avoid prison or financial penalties. Overall it is hard to imagine how the use of the asylum for temporary respite could be described in terms of social control. Rather, it appears to have been actively used for therapeutic reasons. This was particularly evident amongst the people (mainly males) with alcoholic toxicity for whom epilepsy was a side-effect. Abstinence and a protein-rich diet did not cure their addiction but did improve their physical condition and for those affected, 'cured' their epileptic seizures.

CONCLUSION

The argument that lunatic asylums were primarily used for custodial purposes is not supported by the observed patterns of discharge by epileptic patients. The evidence shows at least three alternative explanations for their use, described here as palliative support, temporary respite care and long-term refuge. Custodialism undoubtedly figured in the use of lunatic asylums for some patients, but this was not evident for most patients with epilepsy. Indeed, the relatively short length of stay for many suicidal epileptic patients argues against custodialism as it helped patients avoid longer gaol sentences. There appears to have been widespread acceptance for the services available in the lunatic asylum, not least because care of the demented, depressed, or dying was not available elsewhere. Admission was sought by the families of epileptic patients, although some were admitted via the destitute asylum, industrial school, hospital, convent, police court and goal. Some voluntarily sought admission. The provision of care for people with epilepsy was rigorous and eventually standardized through training and text books. In juxtaposition to their eighteenth-century counterparts, the 'clean,

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[157] Noted for example in: Garton, *Medicine and Madness*, 176; Smith, 'Family, Community and the Victorian Asylum,' 109, 121; Tomes, *A Generous Confidence*, 118; Wright, 'Mental Disability in Victorian England,' 94.

cheerful and comfortable' spaces of nineteenth-century lunatic asylums offered a new environmental approach to care. Evidently the availability of this government-funded environment was quickly and widely accepted, especially amongst the poor. Their use increased at the same time as attitudes to the locus of dying were changing. Rather than viewing institutions as 'dustbins of the useless', a better way of understanding them might be in terms of a more general acceptance of institutionalized care.[158] As Cathy Smith suggested when describing the Northampton Lunatic Asylum in England, 'the Victorian asylum evolved into a flexible institution that could be used by its local community as a place of long-term care or short-term respite, as keeper of the dangerous and suicidal and as a hospice for the chronically ill'.[159]

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[158] Quote by Roy Porter in Porter, *The Confinement of the Insane*, 9.
[159] Cathy Smith, 'Family, Community and the Victorian Asylum,' 124.

CONCLUSION

A 2012 book review entitled 'How mental health was dealt with in the 19th century', began with a reverie:

> You're strolling along the street, wondering whether to visit a friend or go to the smart new emporium for some dress material, and – shock! – you suddenly hear the drumming of hooves, a carriage door banging open, and hurried footsteps. Rough hands seize hold of you, and drag you away.[1]

The book reviewed is Sarah Wise's *Inconvenient People*, which focusses on how people could be incarcerated in lunatic asylums for spurious reasons.[2] Wise's book speaks to a popular belief in wrongful imprisonment, brought about by unscrupulous family members. Once inside the lunatic asylum, the keys were metaphorically thrown away. Another review of Wise's book evoked the gothic horror of institutionalisation, describing how people were carted off 'to a villa on the edge of town that looked pleasant enough from the outside, but contained a kind of living hell within'.[3] The author of *Inconvenient People* acknowledges that her title references Andrew Scull's 1980 essay, 'A Convenient Place to Get Rid of Inconvenient People'. Consequently, Wise's book and this thesis share something in common in that both draw upon the work of scholars like Scull to question the purpose of lunatic asylums. Nevertheless, this thesis reaches a different conclusion, arguing that nineteenth-century lunatic asylums provided care and a safe environment for people with severe and incurable epilepsy. Accordingly, care rather than custody better explains the use of lunatic asylums by people with epilepsy in South Australia.

In general, the scholarship that seeks to explain the purpose of lunatic asylums does not engage with narratives of care. Rather, scholars interpret their use in terms of power relationships, variously ascribed to medical, legal, social, administrative and familial authorities. However, by closely examining the records of nearly six hundred epileptic patients in the South Australian lunatic asylums, this thesis has shown that most power

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[1] Mooney, 'How mental health was dealt with in the 19th century'.
[2] Wise, *Inconvenient People*.
[3] Hughes, 'Inconvenient People'.

narratives do not sufficiently explain the admission of people with epilepsy. Michel Foucault, for instance, asserts that power lay with the asylum doctors who used moral treatment to exert their authority over patients by making them internalise bourgeois family values. Nevertheless, Foucault does not adequately represent the role of asylum doctors, nor does he provide an accurate description of moral treatment in the mid- to late nineteenth-century asylum. Furthermore, Foucault never attempts to explain the wide-scale use of lunatic asylums by people with chronic conditions such as epilepsy. As my thesis has demonstrated, the role of asylum doctors was largely managerial, and their asylums were subject to regular external scrutiny to ensure that specific standards (broadly described under the rubric of moral treatment) were being met. These standards related to physical aspects of the buildings and grounds, the provision of resources and activities for the patients, the absence of restraints as a form of treatment, and the delivery of care by trained female nurses and male attendants. Reports of these audits provide evidence that these aspects of lunatic asylums were generally met and thus, they were not places of 'living hell'.[4] In South Australia the auditing process was less formal than in Britain, but it is evident from examining newspaper articles, asylum reports and Royal Commission reports that expectations were similar in both places. Hence, I argue that the adoption of the environmental principles of moral treatment benefitted incurable and highly dependent epileptic patients, something that has not previously been demonstrated.

In Britain scholars, such as Peter Bartlett, argue that the lunatic asylum was inextricably connected with the English Poor Law of 1834. According to this view, power resided with the legal and administrative regimes, rather than with asylum superintendents. The value of situating this study in South Australia, is that, despite there being no Poor Law, there were similar rates of admission for people with epilepsy in both places. This raises the question as to why so many patients were described as dangerous in England and South Australia. Scholars of English asylums explain its use as a function of the Poor Law, yet this was evidently not true, as shown by the situation in South Australia. The South Australian admission records also show that it was not used to describe homicidal maniacs, despite the widely repeated view, held in the nineteenth century, that this could affect people with epilepsy. The idea that dangerousness referred to seizures or to

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[4] Quote from Hughes, 'Inconvenient People'.

people's responses to them is also discounted.[5] For instance, Szasz stated that epileptics were institutionalised because 'people found it intolerable to witness a person having a seizure' and wanted to be 'spared this spectacle'.[6] By examining South Australian demographic information this thesis demonstrates that most people with epilepsy remained in the community. Hence, seizures and responses to them cannot explain the use of dangerousness in the admission records. In fact, a close examination of the language used revealed that although some epileptic patients were occasionally violent or exhibited suicidal behaviours, dangerousness typically referred to disruptive and difficult behaviours. Many patients were admitted after developing dementia or as a consequence of profound physical, intellectual or neurological problems arising from birth. Word analysis makes it clear that many were incapable of attending to their own needs. Hence, the use of the word 'dangerous' was not linguistically accurate. Rather, its use appears to reference former legal requirements that stipulated dangerous lunatics should be detained in lunatic asylums. Families, doctors and magistrates were evidently complicit in describing epileptics as dangerous, helping people whose care requirements could not be met elsewhere, gain access to the asylum.

Andrew Scull argues that lunatic asylums were used as a form of social control, forced upon families by the requirements of the nineteenth-century commercial market economy. According to Scull, it was convenient for society to get rid of inconvenient people in this way. Many of the people admitted with epilepsy were impoverished, and sometimes became destitute when their condition worsened and they were unable to work. This would have undoubtedly increased their social 'inconvenience'. Nevertheless, analysis of South Australian sources has demonstrated that despite the extra expense of maintaining people in lunatic asylums, it was widely understood that people with severe epilepsy would receive better care than in the destitute asylum. For those who had support, the South Australian records also show that families did not relinquished their charges quickly. Many people with epilepsy were looked after at home for many years prior to being admitted. Families mainly turned to the lunatic asylum when their ability to provide safe home care was diminished. People with epilepsy were not pushed into lunatic asylums because there was a social imperative to

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[5] Cathy Smith, 'Insanity and the civilising process,' 257
[6] Szasz, *Cruel Compassion,* 61.

control them. Rather, families actively chose to use asylums, knowing that their charges would be cared for within a well-resourced environment.

The argument that people with epilepsy were forced out of the community and into lunatic asylums as a form of social control also ignores the diverse ways in which asylums were used. By closely examining the admission and discharge records of epileptic patients this thesis has shown that there were three patterns to asylum use; admission shortly preceding death (described as palliative care), relatively short periods spent in the asylum (described as respite care), and long-term care, mainly for people who lacked family support (described as refuge). The fact that a proportion of epileptic patients returned home contradicts the idea that social control was the main driver of asylum use, as does their use for late-stage palliative care. Rather than social control, this thesis argues that a new therapeutic environment arose due to the codified and audited prerequisites of moral treatment. This encouraged use of the lunatic asylum, particularly by poor families with no other options. Lunatic asylums were the only places in South Australia where incontinent patients could be toileted and cleaned, where those who could not feed or dress themselves could have this done for them, where the demented could be prevented from wandering, where there was constant oversight to prevent or minimise physical harm arising from seizures, and where the dying and infirm could be cared for in an infirmary. If this was social control, it was value-added social control.

Whilst the findings outlined in this thesis are robust for the South Australian lunatic asylums, nevertheless, further research is warranted before these conclusions can be conclusively demonstrated to represent asylum admissions of all epileptic patients. Further research would also help to answer one question that was beyond the scope of this thesis; the extent to which doctors contributed to the stigmatisation of people with epilepsy. Although the role of asylum superintendents was largely managerial, these doctors actively engaged in broader debates about lunacy through books, medical journals and medical conferences. Throughout the latter part of the nineteenth century they discussed their concerns about degeneracy of the human 'race', and their narratives often included epileptics. Their medical opinions were widely disseminated in newspapers and through popular fiction. Using Scull's social-control theory it can be hypothesized that these 'medically sanctioned' beliefs would have caused more people

with epilepsy to be institutionalised. However, in South Australia there was no evidence of this in terms of admissions during the period under consideration. Further research could examine whether the proportion of people with epilepsy increased elsewhere, and whether over time, less severe cases were admitted to lunatic asylums. This would be especially significant if differences could be discerned between countries that sterilised people with epilepsy in the twentieth century and those that did not. It is worth noting that these changes may also have occurred in South Australian lunatic asylums during the early decades of the twentieth century, however, this cannot be determined yet as access to these records is restricted.

Much scholarly research that has been undertaken to date into the history of epilepsy has focussed on; changes in treatment, how it came to be understood as a neurological condition, and the lives of the doctors, such as John Hughlings Jackson, who worked on epilepsy. The value of this thesis is that it engages with the social history of epilepsy, albeit from the perspective of the most disadvantaged. If the purpose of a social history of medicine is to provide a 'bottom-up' approach to patient experiences, it would be hard to find patients closer to the bottom than the epileptics in lunatic asylums. In the absence of personal diaries, their lives have been reconstructed from a range of sources, including the official but sparse documentation of the lunatic asylums. By engaging with these records, this thesis provides an alternative explanation behind the reasons for epileptic admissions, arguing that it was most likely premised on their care requirements. This offers a different way of understanding how communities used lunatic asylums and suggests they were not merely a means of getting rid of the inconvenient.

APPENDIX

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I.   STATE RECORDS FOR ADELAIDE AND PARKSIDE LUNATIC ASYLUMS

Date Range	Series Id	Series Title
1837 - 1963	GRG24/90/38	Miscellaneous records of historical interest, artificial series - Colonial Secretary's Office, Governor's Office and others.
1864 - 1902	GRG34/16	Medical journals - Adelaide Lunatic Asylum
1869 - 1901	GRG34/17	Record of seclusions - Adelaide Lunatic Asylum
1879 - 1884	GRG34/18	Record of admissions - Adelaide Lunatic Asylum
1867 - 1902	GRG34/20	Head Attendant`s journal - Adelaide Lunatic Asylum
1866 - 1902	GRG34/21	Daily state books - Adelaide Lunatic Asylum
1867 - 1905	GRG34/22	Night Attendant`s report books, male patients - Adelaide Lunatic Asylum
1867 - 1876	GRG34/23	Night Attendant`s report book, female patients - Adelaide Lunatic Asylum
1852 - 1902	GRG34/24	Statement of allowances, receipt and issues of food and medical comforts - Adelaide Lunatic Asylum
1911 - 1947	GRG34/38	Annual reports - Director-General of Medical Services, Parkside and Northfield Mental Hospitals and Enfield Receiving House
1884 - 1925	GRG34/54	Night Attendant`s report books (male patients) - Parkside Lunatic Asylum, later Parkside Mental Hospital
1880 - 1935	GRG34/55	Night Attendant`s report books (female patients) - Parkside Lunatic Asylum, later Parkside Mental Hospital
1893 - 1936	GRG34/72	Correspondence files - Lunatic Asylums Office, later Parkside Lunatic Asylum, later Parkside Mental Hospital
1854 - 1882	GRG34/85	Copies of letters sent and miscellaneous information - Adelaide Lunatic Asylum
1898 - 1909	GRG34/86	Patients removed on trial - Lunatic Asylums Department
1868 - 1893	GRG34/87	Roll of applicants for position of attendant etc - Parkside Lunatic Asylum

1868 - 1877	GRG34/88	Patients` property book - Adelaide Lunatic Asylum
1862 - 1865	GRG34/91	Superintendent`s instructions and memoranda - Adelaide Lunatic Asylum
1855 - 1866	GRG34/93	Annual statistics relating to patients - Adelaide Lunatic Asylum
1881 - 1883	GRG34/95	Register of letters received and despatched - Lunatic Asylums and Colonial Surgeon
1847 - 1902	GRG34/97	Official visitors` books - Colonial and Adelaide Lunatic Asylums
c 1870 - c 1930	GRG34/99	Indexes of regulations, dates of installations, appointments etc - Parkside Lunatic Asylum, later Parkside Mental Hospital
1914 - 1916	GRG34/103	Guard books of invoices for medicines and other goods bought - Parkside Mental Hospital
1897 - 1898	GRG34/107	Letters to Dr W.L. Cleland, Superintendent - Parkside Lunatic Asylum
1885 - 1901	GRG34/118	Register of male patients - Adelaide Lunatic Asylum
1891 - 1909	GRG34/119	Record of patient deaths at Adelaide and Parkside Asylums - Lunatic Asylums Department
1846 - 1880	GRG34/140	Register of patients - Colonial and Adelaide Lunatic Asylums
1846 - 1883	GRG78/8	Colonial Surgeon`s medical journal - Adelaide Lunatic Asylum
1839 - 1840	GRG78/11	Dispensary record - Colonial Surgeon (?)
1865 - 1925	GRG78/108	Legislation and regulations on public health in South Australia
1845 - c 1981	GRS/13461	Admission papers, annual single number series - Colonial Lunatic Asylum, Adelaide and Parkside Lunatic Asylums, Parkside Mental Hospital and Glenside Hospital
1852 - 1900	GRS/14227	Female case books - Adelaide Lunatic Asylum
1856 - c 1921	GRS/14310	Female patients` case books - Parkside Lunatic Asylum, later Parkside Mental Hospital
1846 - 1902	GRS/14311	Admission books - Colonial, later Adelaide Lunatic Asylum
1857 - 1902	GRS/14312	Register of criminal and dangerous patients - Adelaide Lunatic Asylum
1850 - 1901	GRS/14316	Male patients` case books - Adelaide Lunatic Asylum
1853 - 1922	GRS/14317	Male patients` case books - Parkside Lunatic Asylum, later Parkside Mental Hospital
1866 - 1901	GRS/14319	Criminal patients` case book - Adelaide Lunatic Asylum

1866 - 1896	GRS/14320	Dangerous patients` case book - Adelaide Lunatic Asylum
1863 - 1914	GRS/14322	Dangerous patients` case book - Parkside Lunatic Asylum, later Parkside Mental Hospital
1862 - 1901	GRS/14323	Private patient case books - Adelaide Lunatic Asylum
1862 - 1915	GRS/14324	Private patient case books - Parkside Lunatic Asylum, later Parkside Mental Hospital
1845 - 1860	GRS/15230	Miscellaneous papers relating to administrative matters – Colonial Lunatic Asylum and successor
c 1908 - c 1930	GRS/16121	Index to male patients - Parkside Lunatic Asylum, later Parkside Mental Hospital

II. PATIENT IINFORMATION INCLUDED IN TEXT

Case ID and Patient ID refer to reference numbers used in the spreadsheet

Name	State record ID	Folio page	Date of admission	Age at admission.	Patient ID	Case ID	Alternative folios
Albert A	GRS-14323/1/4	211	13/2/1892	16	393	413	
Thomas B	GRS-14316/1/2	283	9/4/1878	37	306	294	
Walter B	GRS-14316/1/3	221	20/12/1880	27	310	302	
Michael B	GRG34-118/0/1		20/7/1894	21	113	84	GRS-14317/1/1; GRS-14316/2/6
Anna B	GRS-14310/1/1	688	14/11/1899	14	460	492	
Lily B	GRS-14310/1/2		7/11/1905	55	481	514	
Elizabeth B	GRS-14310/1	210	16/3/1885	19	27	25, 26, 27	GRS-14319; GRG34-119; GRS-14312; GRG-34/17/2
Emma B	GRS-14324/1/1	214	10/10/1913	53	568	606	
John B	GRS-14317/1/1		28/7/1881	43	83	58	
Margaret B	GRS-14310/1/1	468	11/7/1895	59	444	475	GRS-14227/1/5, p141
Edward C	GRG34-85/1/1		25/8/1854	42	334	350	
John C	GRS-14316/2/5	367	25/2/1889	24	524	559	GRS-14312/1/1
Susan Rebecca C	GRS-14310/1/2	402	8/8/1910	30	501	536	
Alexander C	GRS-14320/1/2	26	19/10/1875	26	168	134	GRS-14322/1/1
Alexander C	GRS-14317/1/2	429	23/9/1902	50	168	624	GRS-14322/1/1
George D	GRS-14322/1/1	101	11/8/1903	56			
Frederick D	GRS-14323/1/4	125	1/8/1889	15	379	396	
Charles D	GRS 14319/0/1	23	19/10/1871	47	21	19	
David E	GRS-14316/2/6	300	15/1/1894	49	351	367	
Meta Ruth E	GRS-14324/1/1	153	7/11/1912	24	562	600	

Name	State record ID	Folio page	Date of admission	Age at admission.	Patient ID	Case ID	Alternative folios
William E	GRS 14317/1/2	93	21/1/1899	24	571	609, 617	
John E	GRS-14316/2/5	349	11/12/1888	43	376	393	
Ethel Mary F	GRS-14310/1/2	260	24/3/1908	22	489	522	
Marker Nathaniel F	GRS-14316/1/4	110	19/5/1885	72	49	310	GRG34-18/1
Mary F	GRS-14310/1/1	155	9/6/1882	14	64	48	
Frank F	GRS-14317/1/1	152	9/12/1878	42	93	67	GRS-14316/1/3 p46
Courtney F	GRS-14324/1/1	91	9/2/1912	27	558	596	
George F	GRS-13211/1/1		15/6/1887	17	171	136	
Sarah F	GRS 14310/1/1	321	4/10/1890	49	110	249	
John G	GRS 14316/2/5	379	6/4/1889	45	378	395	
Henry G	GRG34-85/1/1		24/10/1854	42	335	351	
Mary G	GRS-14310/1/1	538	25/5/1897	79	450	482	GRS-14227/2/5 p215
Henry H	GRS-14317/2/1	103	21/10/1898	64	576	612	
William H	GRS-14316/1/3	106	30/7/1879	25	29	29	GRS-14317/1/1, p209
Clara H	GRS-14310/1/ 2	375	6/4/1910	45	500	535	
Catherine H	GRG34-16		9/10/1854	19	336	353	
Eugene H	GRG34-85/1/1		11/3/1855	32	337	253	
Thomas H	GRS-14316/2/5	103	25/2/1886	53	362	379	GRS-14317/1/1
Alexander H	GRS-1424/1/1	42	22/6/1911	37	554	593	
William H	GRS-14311/1	3	12/3/1853	42	1	1	GRG78-8
Gertrude J	GRS-14324/1/1	251	1/5/1914	28	570	608	
William J	GRS 143241/2	32	11/5/1911	26	552	591	
Agnes J	GRS-14227/1/4	260	11/11/1891	5	275	253	
Joseph J	GRS-14316/2/5	324	12/10/1888	29	360	377	
Mary Ann K	GRS-14310/1/1	119	20/2/1885	27	235	158, 206	
William L	GRS-14311/1/1	3	12/3/1853	30	101	74	GRG34-119/1, GRG34-140/1, GRS-14317/1/1
Mary L	GRS-14227/1/1	323	24/10/1875	36	218	199	
Samuel M	GRS-14316/2/5	521	14/8/1890	29	82	57	GRS-14317
Arthur M	GRS-14317/1/1	180	25/5/1880	18	36	435	
Margaret M	GRS-14310/1/1	131	1/3/1881	49	256	217	GRS-14227/1/2, p215
Rose M	GRS-14227/1/3	128	28/11/1884	NK	74	228	
Flora M	GRS-14323/1/4	218	18/8/1892	25	518	556	GRS-14323/1/4, p233.
Sophia M	GRS-14324/1/1	31	2/5/1911	29	551	590	
Agnes N	GRS-14310/1/1	38	9/3/1883	34	70	226	GRS 14227/1/1/V3 4/3/1890, p307
Anne O	GRS14310/1/1	516	12/12/1896	50	122	91	
David O	GRS-14316/2/6	114	25/2/1892	14	529	566	GRS-14317/1/2, p360
Michael O	GRS 14317/1/2	546	1/1/1904	28	588	630	
Florence P	GRS-14310/1/1	994	20/6/1903	24	471	504	
Alice R	GRS-14227/1/4	78	6/8/1888	28	268	242	
William, R	GRS-14324/1/1	230	5/1/1914	39	569	607	
Eileen Daisy R	GRS-14310/1/2	285	2/9/1885	20	492	527	

Name	State record ID	Folio page	Date of admission	Age at admission.	Patient ID	Case ID	Alternative folios
Elizabeth R	GRS-14227/1/2	48	5/10/1879	NK	253	208	
Jane R	GRS-14227/1/3	40	19/3/1883	9	71	227	
Joseph S	GRS-14317/1/1	694	5/8/1893	32	112	83	GRS-14316/2/6, p243
Charles S	GRS-14313/2/5	133	16/6/1886	38	366	383	
Sarah S	GRS-14310/1/2	362	23/10/1909	26	497	532	
Alice Maud S	GRS-14310/1/2	211	1/6/1907	4	486	519	
Elizabeth S	GRS-14310/1/1	1016	8/10/1903	64	473	506	
James S	GRS-14317/1/1	294	20/9/1883	NK	315	311	
George T	GRS-14317/2/1	369	4/3/1902	24	159	125, 623	
Benjamin T	GRS-14316/2/6	57	23/6/1891	55	390	409	GRG34-118/1
Elizabeth T	GRS 14310/1/1	621	27/10/1898	46	455	487	4
Arthur W	GRS-14317/1/1	445	21/12/1887	10	418	442	

Full information at FigShare:

https://figshare.com/articles/EPILEPSY_IN_THE_LUNATIC_ASYLUMS_OF_SOUTH_AUS
TRALIA_1852_1913_/7263476

III.   ADMISSION FORMS, SOUTH AUSTRALIA AND ENGLAND

| 1864 Lunatics Act (South Australia) | 1845 Lunacy Act (England) |

Admission statements required paupers under South Australian and English law[1]

Admission statements required for dangerous (left) and criminals (right) under South Australia's Lunacy Act 1864

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[1] The Lunatics Act, 1864, No 21 (SA, Australia); Lumley, William G. *The New Lunacy Acts*, 108.

IV.   COLONIAL SURGEONS AND LUNATIC ASYLUMS IN SOUTH AUSTRALIA

Facility	Year
Adelaide Gaol	1841
Colonial Lunatic Asylum	1846 - 1852
Adelaide Lunatic Asylum	1852 – 1902
Parkside Lunatic Asylum	1870 – 1913
Parkside Mental Hospital	1913 – 1967
Glenside Psychiatric Hospital	1967 →

Colonial Surgeon	Year
James Nash	1839 - 1855
William Gosse	1855 – 1858
Robert W Moore	1858 – 1869
William Harrison	1865 – 1867
Alexander Peterson	1867 - 1896
William Cleland	1878 - 1913

The duties of the Colonial Surgeons were described on the appointment of Dr Moore:

> You will have to advise the Government in all matters affecting the public health and the sanitary conditions of the colony; to exercise the entire charge and, control over the Public Hospital; to act as Superintendent of the Lunatic Asylum, and Medical Superintendent of the Convict Stockade; to take medical charge of the Gaol; of sick and destitute persons, receiving Government aid, within the city boundaries of North and South Adelaide; of the Sappers and Miners, with their wives and families; of the Mounted and Foot Police ; to give evidence at the Supreme and Local Courts; and to attend Inquests, whenever called upon by the Coroner; to examine and give certificates to all candidates for admission into, the Police Force; also to be President of the Medical Board and Central Vaccine Board. and Member of the Destitute Board.

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