Freud in the Antipodes

A cultural history of psychoanalysis in Australia

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UNSW PRESS

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Introduction

These are relatively new theories, of course, and to what degree they will prove worthy of acceptance must be decided as time goes on.[1]

'Psychoanalysis', noted the Melbourne analyst Frank Graham in 1967, 'no matter where, always arouses interest, friendly or hostile … rarely is it ignored altogether'. [2] In Australia, as in many Western countries throughout the twentieth century, Freudian ideas have been alternately hailed as holding the key to understanding modern civilisation, and dismissed as fraudulent nonsense. Yet, despite ongoing controversies regarding their veracity, many of the concepts Freud developed relating to trauma, repression, defences, the unconscious, the Oedipus complex, projection and displacement have not only endured but have provided the very framework through which Australians have come to understand their own version of the Western 'self' at the juncture of the late twentieth and early twenty-first centuries. Psychoanalysis – the body of thought which brings Freudian ideas into a coherent theory – differs from other theories of the self because it takes the unconscious as its key organising principle. Unlike psychology, which is concerned with the conscious world and aspects of socialisation, psychoanalysis privileges the life of the unconscious as the way to understanding psychic life.[3]

This book is a history of Freudian ideas in Australia and, as such, it is an attempt to fill the gap in the history of the practice and ideas of psychoanalytical thought. It is also a way of adding a further dimension to our understanding of the complexity of cultural life and the history of ideas in Australian society. While some aspects of this book

have been the subject of several short studies by both historians[4] and psychoanalysts[5], this is the first time a cultural history of psychoanalysis in Australia has been written in its own right. Although Freud has never been a dominant force here as he has been in many other countries, his theories have permeated aspects of cultural life and to some extent clinical practice. I argue that there is a little known, yet important, story to tell about the influence of psychoanalysis in this country, especially in intellectual circles and within sections of the medical profession.

So why is this a significant story? A key underlying aim of this history is to challenge assumptions that Australian intellectuals and Australian culture in general have not embraced questions of inner life through psychoanalytic understandings. Australia is often constructed as a land of pleasure and opportunity: symbolised by the 'beach' – synonymous with unreflective hedonism[6] – and populated by Australian males who value independence and individualism, negate emotion and self-expression and have no care other than for immediate, material concerns. But, despite the stereotypes, this does not mean there have not been efforts to explore interiority through psychoanalytic frameworks.

While historians have interrogated the mythical images of the national 'type' to illuminate the class, gendered and racialised assumptions which inform the image of the larrikin, the noble bushman, and bohemian intellectual, they have not taken into account material which suggests that 'Australianness' embodies a psychological as well as a cultural dimension. This study will consider how Australians have reflected on the diversity, complexity and depth of their emotional lives through the insights and methods that psychoanalysis has to offer.

This book also opens up a discussion about the influence of Freud both inside and outside the medical field. Despite a great deal of resistance from many practitioners of psychiatry and psychology, these two disciplines have been influenced, at least to some extent, by aspects of Freudian thought. However, the general trend in the use of Freud's theories in medical practice has been to help identify modes of 'normal' behaviour and reinforce current ideals, rather than to offer a radical treatment alternative. In the main, it has been in intellectual circles where Freud's ideas have been most enthusiastically, albeit selectively, embraced.

Any exploration of the reception of psychoanalysis in Australia in the popular and cultural realm can be by no means comprehensive or exhaustive. For all the examples I give, there remain many untold stories. While I look at advice columns in magazines, popular radio, the

academic arena, political movements and the artistic realm, there are many more fields that warrant close, detailed examination such as literature and cinema. I hope others will take up the challenge of examining the role psychoanalysis has played in shaping these cultural forms.

When I began looking at the influence of psychoanalysis in Australia over the last century, a number of themes became apparent, and I have used them to underpin this book. The first of these themes was a gradual move through the twentieth century in both medical and general terms to concentrated listening. The second has been the way in which Freudian thought has been taken up during different periods for different temporal and cultural reasons. And, the third and final theme has been the way in which Freudian theories have been used to shape the idea of the 'self' in modern society.

The listening cure

The psychoanalyst is paid not to talk too much, because talking is a good way of not listening. Being listened to - making one's presence felt through one's words, and through one's body which is making the words - at its best, restores one's appetite to talk.[7]

Some analysts have observed that psychoanalysis is not only a 'talking cure' but also a 'listening cure'. Renowned English psychoanalyst Adam Phillips says:

> Calling psychoanalysis a talking cure has obscured the sense in which it is a listening cure … Being listened to can enable one to bear – and even enjoy – listening to oneself and others; which democracy itself depends upon. Whether or not the whole notion of equality was invented to make it possible for people to listen to each other, or vice versa, listening is privileged in democratic societies.[8]

In focusing on listening I do not want to suggest that a dichotomy exists between talking and listening, or to imply that talking is not a significant aspect of the dialogue that takes place within analysis. In psychoanalytic practice, the two are intimately connected and are a part of a dynamic psychoanalytic exchange. But when considering its history over the past century, the power of psychoanalysis was often understood to be in its contribution as a listening device. Certainly this was the case in its early years when untrained doctors and enthusiastic intellectuals adopted Freudian ideas and practices in ways which were eclectic, improvised and informal. For them, it was one technique to

be applied amongst many and had not yet been perceived as a broader philosophy of the mind.

The adoption of psychoanalysis signalled a transition from the nineteenth century practice, used by the French neurologist Jean Charcot, of looking for symptoms in patients in the treatment of mental health, to the practice of listening to them and searching for meaning in their narratives, in the late nineteenth and early twentieth centuries.[9] With the advent of the 'talking cure' and the analytical hour – where Freud and his colleague Joseph Breuer encouraged their patients to speak to them and perhaps even more importantly, listened to and heard what they had to say – the doctor–patient relationship was redefined. This is not to say there was equity in this exchange or that what the patient said was heard. One can hear but not listen. But the point to make here is that listening became a part of medical examination in new ways.

This shift in dynamics in the medical context was also reflected in society in general. There was a move, more broadly, from learning about the world by looking, and observing in institutions such as museums, exhibitions and galleries in the Victorian period[10] to interpreting one's surrounding by listening to the radio, conversing on the telephone and going to the cinema, from the 1920s onwards. While historians and other social theorists have focused primarily on the visual and its influence in the construction of identity, little attention has been given to the auditory in understanding the 'modern' notion of the self. By connecting technology and new modes of communication with the emergence of psychoanalysis, this book addresses Steven Connor's injunction that we consider the 'compelling importance of the auditory in the cultural, clinical and technological constitution of the modern self'.[11]

This study begins with the Victorian era, at a time when the body rather than the mind was believed to hold the answer to psychological problems. For example, the bodies of the 'insane' were scrutinised for signs of 'madness' and were believed to hold the key to understanding mental illness. A move to listening occurred during World War I when the narratives of shell-shocked soldiers were analysed in an attempt to find the cause of neuroses. In the process psychoanalytic terms were often used and psychoanalytic techniques applied.

By the inter-war years, the modern self was becoming increasingly defined and understood through psychoanalytic categories that had been both influenced and mediated by the technologies of the day such as cinema, radio and telephone. What Walter Benjamin has famously described as the search for the 'ideal listener' took place in the period from the mid-twentieth century onwards, and it was a search that was

abetted by psychoanalysis. In the 1940s, the 'therapeutic conversation' was used to treat soldiers during the Second World War and reflected the growing influence of these ideas in the medical arena; while, during the 1950s, psychological and psychoanalytic categories were used to help understand and allay the anxieties and fears of a wider listening radio public.

In the early 1960s, the introduction of telephone counselling further illustrates the continuing nexus between technology, the auditory and psychotherapeutic confession. This spilled over to later social movements, such as the women's movement, which gained a great deal of their impetus through talking and listening in consciousness raising groups. Thus it can be seen that in using the psychoanalytic technique of 'skilled listening', it has been the auditory, and not just the visual, that shaped identity in the twentieth century.

Freud revivals

Every so often there is a Freud revival.[12]

A second theme of this book is the way certain Freudian ideas gained currency at particular historical moments. I want to examine how, throughout the twentieth century, each generation adopted the aspects of Freud which spoke to specific historical moments and conditions in Australia.

In the late nineteenth century the focus was on bodily expression of insanity through hysteria as it was understood in that period that the physical, not the psychological, was the source of madness. On the other hand, at times of social and cultural change such as the 1920s and 1960s, the emphasis shifted to theories of personal liberation and repression. During the upheaval of the two world wars the focus fell on trauma, early childhood, neurosis and familial dislocation. While in artistic representation, Freudian ideas were adopted by avant-garde movements to make social and political commentary on the war through movements such as surrealism. Through the Cold War, with its climate of suspicion, disloyalty and deviance, the drama associated with the Oedipal triangle was identified as the cause of homosexuality.

In grounding the reception of Freudian ideas historically, my aim is to explore the historical contingency of concepts of inner life such as the self, emotions, and personality.[13] How has cultural and social change facilitated the adoption or rejection of ideas about repression, transference, sexuality and the unconscious? What events have led to

cultural commentators, political activists, academics and artists favouring certain ideas over others in any given period of history?

Not all of Freud's ideas were simply a moving feast, a menu from which to choose the most alluring concept. Some of them resonate throughout the decades. Psychoanalytic theories have had a consistent presence in the areas of family, motherhood and child guidance, and two concepts in particular – childhood sexuality and the Oedipus complex – have had an enduring impact on ideas about how psychic life is shaped and formed.

During the inter-war years, the obsession with scientific motherhood and child psychology was often couched in Freudian terms. This use of Freud translated into a scrutiny of mothering, and led to the development of elaborate methods of how children should be raised. Mothers commonly discussed an anxiety associated with children's 'nerves'. The rise of the psychological expert produced a new way of describing the self through terms such as neurosis, repression and the unconscious which cast doubt on whether some women were equipped to rear their children. It was women themselves who often promoted such discourses in psychiatry and psychology as well as in psychoanalysis itself. It was not until the rise of the women's movement in the 1960s that feminists began to fiercely criticise these theories because they believed that they bound women to domesticity and maternity.

Refashioning the individual self

Freud's main contribution to our liberation must be in … the development of methods of consciousness raising which will bring us to terms with the irrational.[14]

Psychoanalysis rose in tandem with modernity. It provided a map of the psyche, explanations for the hitherto inexplicable workings of the unconscious and a framework for the scientific analysis of the individual self: its concern was overtly with the examination of the *individual subject*.

In the overcrowded and congested asylums of the nineteenth century, the individual treatment of the neurotic and psychotic patients was impossible. But this changed significantly with the dramatic influx of soldiers with male psychosis – or 'shell shock' – during World War I. Most doctors were completely overwhelmed by the numbers and severity of the cases and many came to believe that the only real

solution to the long-term effects of shell shock was a scientific exploration of the individual subjectivity of these soldiers using basic psychoanalytic principles.

Throughout the inter-war years, this trend continued outside of the medical field. Intellectuals with diverse interests – such as the Anglican clergyman Ernest Burgmann, the sex educationist Marion Piddington, the psychologist H Tasman Lovell and the Hungarian anthropologist Geza Roheim – represented different responses to the unconscious at this time. What united them was a focus on individual analyses of the self.

After World War II, however, other practices emerged which drew on wider values and beliefs. The discourse of the self in relation to the state, the community, the collective good and society emerged during the 1950s and became part of public policy, culminating in the emergence of the welfare state. This evolving discourse of self and community was also reflected in the development of a new method of psychoanalytic practice to emerge after the war: that of group therapy. In this practice, which was introduced in Australia in 1949, the individual explored his or her unconscious by being a part of a group dynamic. Individual analysis continued to be central to psychoanalysis, but supporters of this method argued that much could be learnt about one's anxieties and behaviour through an interaction with others. The analyst would play a central role in highlighting transference in the group, reliving the past through the present and helping the patient to a greater awareness of his unconscious mental processes, through the group.

The place of a changing self in relation to a wider society became the theme that found its most emphatic expression in the social movements of the 1960s. Activists did not stand united about Freud. Although many of them were dismissive about his ideas, some in the gay and women's movements found in his theories new ways of understanding personal oppression and liberation. Amongst those who perceived a radicalism in Freud's analysis were some feminists who – through the slogan the 'personal is political' – embraced his method as a way of understanding how sexuality, subjectivity and self-discovery were acquired and understood. Aspects of psychotherapy were merged with categories and understandings of psychoanalysis to offer possibilities of new self-expression.

Despite many bitter and angry criticisms being levelled at psychoanalysis by feminists throughout the twentieth century – by leading figures such as Melanie Klein, Karen Horney, Helene Deutsch – psychoanalysis has continued to attract women both as analysts and as analysands. A significant aspect of the psychoanalytic profession is

what we might today refer to its gender balance. Women have played a significant and influential role in Australia's history of psychoanalysis. This has included Clara Lazar-Geroe, Vera Roboz, Janet Nield and Rose Rothfield. More recently, Judy Kinnane, Helen Martin, Esther Faye, Silvia Rodriguez and Marîa-Inés Rotmiler de Zentner were among the women who have trained and practised as analysts. In Australia, as elsewhere, women have been leading practitioners and consumers of psychoanalysis, as well as vociferous critics of psychoanalytic ideas and techniques.

The psychoanalytic profession

I would stress that there are no miracles in this work. It takes time and concentration.[15]

Psychoanalysis became a profession in Australia with the establishment of the Melbourne Institute of Psychoanalysis in 1940, and the Sydney Institute in 1951. Prior to this, Freudian ideas were learnt from guidebooks and applied in an ad hoc manner mainly by medical practitioners. The institutionalisation of Freud's techniques through training institutes phased this out.

During this early phase the institutes were by no means insular. Evidence suggests that during the 1940s and 1950s there was a great deal of effort made to broaden the activities of the institutes, opening up talks and seminars to a wide range of health and education professions. But with professionalisation came rigorous training, and a degree of cloistering. Eclecticism was left to the untrained – invariably those within the universities who saw in Freudian theory exciting ways of analysing and dissecting the cultural, social and political world around them.

Another striking theme of the post-war period is the way in which the history of psychoanalysis in Australia is also the history of migration. The first analysts from Europe to Australia were Jewish and came from Hungary during World War II. Most notable among them was Clara Lazar-Geroe, who was instrumental in setting up the Melbourne Institute of Psychoanalysis. The second wave consisted of a group of analysts who returned from training in London where they had been immersed in the theories of Melanie Klein, Donald Winnicott, William Bion and WH Fairbairn. The final wave was made up of those who came from Argentina in the 1970s and formed a substantial presence, mainly in Melbourne, of analysts influenced by the work of French psychoanalyst, Jacques Lacan.

In recent years, the increasing use of drugs to treat mental health has tested the relevance and strength of psychoanalytic ideas and methods. The time commitment involved – of many hours and sometimes years – spent talking, listening and analysing could not compete with the instant cures often promised by the pharmaceutical revolution. Although the use of drugs has been the most significant development in the treatment of mental illness in the last century, psychoanalysis remains strangely resilient – perhaps because, unlike drugs, psychoanalysis provides human contact and an essential space for listening.

Whatever the verdict on the veracity of Freud's ideas, the historical shifts that are documented in this book – the need to be listened to analytically, the place of the auditory in defining the modern self, the evolving focus on the individual subject and the emergence of the twentieth century phenomena of individual analysis, and the appropriation of Freudian ideas to make sense of the times – continue to have an enduring influence well into the twenty-first century.

These developments did not emerge uniformly around the world: Freud's influence has been different in each country. The Australian case offers a compelling story of how the self-exploration of conscious and unconscious impulses has unfolded and evolved in a specific time and place. The personal challenges this has opened up for Australians seeking to make sense of themselves, their world, and how they live, lies at the heart of what follows.

Chapter 1

Seeing is believing: Victorians and insanity

The importance of the psychical factor is becoming increasingly recognised even in unsuspected directions.[1]

Drinking and masturbation are the two great causes of insanity in Victoria.[2]

On a blustery, wet September evening in 1884, John Springthorpe, a young up-and-coming Melbourne physician, delivered an intriguingly titled talk, 'On the Psychological Aspect of the Sexual Appetite' to the Victorian branch of the British Medical Association. In front of him, dozens of men, sporting the customary starched collars and dark top-coats and trousers of the day, sat listening to what Springthorpe had to say about the 'enormous influence that the sexual instinct has exerted upon our race'.[3]

While some of the men present – for indeed there were no women members of the Victorian branch – praised Springthorpe's talk for its scientific and philosophical treatment of a 'delicate subject', many others of the staid Melbourne medical fraternity were somewhat unsettled. What John Springthorpe was proposing in his speech was not just a re-evaluation of Victorian attitudes to sex – contentious enough in itself – but the beginnings of a whole new way of looking at the psyche and treating mental illness; for Springthorpe believed in, among other things, the importance of 'psychic' factors in mental health, and the role of the 'sex instinct' in psychic life.

The paper Springthorpe gave that evening was only the beginning: this doctor, who went on to become one of the leading physicians of the day, continued to raise the implications of these theories at any

opportunity with those of his medical colleagues who were prepared to listen. Over the years, as Freudian ideas came to the fore, he developed an abiding interest in the practice of psychoanalysis. Although at times critical of Freud, and certainly not a devotee, he became one of the first in the Antipodes to take Freud's work seriously. In fact, in his pursuit of such ideas, Springthorpe was often considered to be as peculiar as Freud himself.

Many adjectives have been used to describe John Springthorpe: outspoken, controversial, energetic, practical, indefatigable. He was born in 1855 (just one year before Freud) in Staffordshire, England, and came to Australia as a child. Something of a polymath, before the age of thirty he had accumulated a Master of Arts, Bachelor of Medicine and Doctor of Medicine. He took up his first position as a medical officer at the Beechworth Lunatic Asylum, before travelling to Britain in 1881 where he became the first Australian graduate to be admitted to the membership of the Royal College of Physicians. He returned to Australia in 1883 and completed his final degree a year later. He worked as a pathologist at the Alfred Hospital, a lecturer at Melbourne University, established his own private practice in exclusive Collins Street and, over the ensuing years, went on to hold a number of key roles in the Victorian medical community.[4]

Springthorpe was also a prolific writer for local and overseas journals, writing extensively on questions relating to typhoid and pneumonia, and on the relationship between psychological factors in disease, especially the relation of suggestion to the causation and treatment of hysteria.[5] He was briefly the editor of the influential *Australian Medical Gazette*.

But arguably Springthorpe's greatest legacy was his challenge of the 'abuse and misuse of authority' in his crusade for reform of the treatment for the insane.[6] His attempts to introduce reforms to the decaying asylums in Victoria became the hallmark of his professional career. *Table Talk*, the celebrity magazine of the day, described him in 1904 as one of the 'most enterprising and public spirited of the medical profession'.[7] Energetic and lively, Springthorpe (or 'Springy' as he was affectionately known)[8] was independent in mind and spirit, and his tenacity made him a formidable opponent.

Despite being unusual among his medical peers in Australia, Springthorpe was, nevertheless, typical of those likely to read Freud anywhere in the world in the first few years of the twentieth century. He was part of a readership drawn mainly from the medical fraternity: one that was middle or upper class, educated, white and male. These men were reading Freudian theory in its nascent stage; at a time when it was arousing interest and debate but not yet creating the controver-

sies which were to shadow Freud and his ideas throughout the twentieth century.

The late nineteenth to early twentieth century was a period when the subjectivity of patients was yet to be of concern to doctors; when the insane were housed in large, overcrowded psychiatric hospitals, and classification of mental illness and attention to individual psychosis was not yet the norm. The focus during this period in the diagnosis of the mentally ill was on the body rather than on the mind. Significantly, this was a time when treatment of the 'insane' involved looking at and attending to the physical aspects of the patient's well-being, rather than listening to individual testimony – a method that would later become the defining practice of psychoanalysis.

In this climate, the conservative Australian medical profession – with its roots in the British tradition of pragmatism and empiricism – had practically ignored what it perceived to be Freud's unscientific and fanciful assertions. The time was not yet right for Freud's ideas to gain acceptance. However, there were changes afoot; and Springthorpe would be one of those at the forefront of psychiatric health care reform who would ultimately radically challenge the practices of the medical profession around him.

Doctors in asylums

In Australia, as in the English-speaking world and western Europe during the late eighteenth and early nineteenth centuries, insanity was generally conflated with criminality – the usual 'treatment' for 'lunatics' was incarceration in prison. It was not until 1811 that patients began to be admitted into asylums specifically for the mentally ill. Initially these were controlled by lay superintendents. But in the mid-nineteenth century, the colonial state took over the role. Asylums were supported, supervised and inspected by the state, but run by medical personnel.[9] Despite these changes, asylums were understaffed, badly equipped, and the attendants who worked there were poorly trained. The asylums provided little opportunity for scientific research, and the methods of treatment employed by the staff – such as the nineteenth century practices of restraint and seclusion – were, to say the least, crude.[10]

Certainly, there had been some improvements following an inquiry into the Kew Lunatic Asylum in Melbourne in 1876. This inquiry found that the asylum was 'not so much as a hospital for the curative treatment of the insane as a convenient prison-house for incarcerating idiots, imbeciles, and drunkards temporarily mad'.[11] Writing thirty

years later in 1906, Robert Jones, a leading English doctor and lecturer on mental diseases at Westminster Hospital in London, observed that the asylum system had made many advances from when it consisted of gaols, prisons, 'tortures and exorcism'. For example, there was an increasing recognition that 'mental diseases [were] an integral part of disorders of the nervous system, and not a fragment detached ... from the domain of general medicine'.[12]

The treatment of mental illness had certainly improved but there remained severe problems. Among the most outstanding and enduring of these were the lack of medical training for diagnosing the mentally ill, and the attitude of doctors towards mental illness. The medical profession as a whole remained not only indifferent to, but also perplexed by, any need for the treatment of the insane. In 1888, Frederick Norton Manning argued that 'the medical profession as a body takes but little interest in insanity, and … medical practitioners as a rule consider their duty with regard to it to consist in the somewhat perfunctory signature of medical certificates'.[13]

Manning, who was medical superintendent of Gladesville Hospital – as well as inspector-general of the insane in NSW (1879–1899), and a lecturer on psychological medicine at the University of Sydney[14] – was not sure of what could be 'done' with madness, the extent to which it could be cured, or whether it would in the future arouse any interest within the medical fraternity. All that could be asked of the profession, he believed, was to perform 'what is expedient or possible, instead of what is right and best, and to be content, or as content as we can, with an attainable good instead of an unattainable better'.[15]

Speaking over twenty years later, William Beattie-Smith, a key figure in mental health reform in Victoria, reiterated Manning's reflections. Like his New South Wales counterpart, Beattie-Smith had extensive experience within the asylum system. Throughout the 1880s he worked at the Ararat and Yarra Bend asylums and lastly at Kew Asylum where, in 1889, he became superintendent. During this period, he attempted to lift the standard of care in the asylums by improving the conditions and treatment for patients, insisting on training of nursing staff, and extending the knowledge of mental disease among general practitioners. Described as 'forthright and an autocratic disciplinarian', he resigned from his asylum position in 1902 after disagreement with the chief secretary. In 1903, he began practising as Victoria's first independent psychiatrist.[16]

While Beattie-Smith thought it was a fantasy to think that insanity could be eradicated, he did believe efforts at prevention were worth pursuing:

> It would be to deceive ourselves and deceive the public if we spoke of insanity ever being entirely prevented ... But the recognition of preventable and curable cases of insanity is a work which carries not merely the saving of public funds but the alleviation of a vast amount of human misery.[17]

Unfortunately, the general 'unscientific' approach to mental health clouded such efforts. The diagnosis of patients suffering mental illnesses was ad hoc and arbitrary. Most medical officers working in asylums lacked specialist qualifications. And, qualified or not, they rarely had the time to devote to their patients, keep proper case notes or to become acquainted with the medical literature of the day.

The Zox Royal Commission, chaired by businessman Ephraim Zox, investigated lunacy reform for two years in Victoria from 1884 to 1886, and agreed that there was a lack of knowledge in the profession regarding the so-called diseases of the brain. The Commission interviewed about a hundred witnesses, all of whom were associated with the administration of asylums, including politicians, medical practitioners and warders.[18] It found that gross errors had been committed, including the fact that 'between 1880 and 1885 no less than 54 people [had] been incorrectly committed to asylums'.[19]

In 1893, when William Beattie-Smith began teaching at Kew, attendance at the asylums for a term of lectures and demonstrations was made a compulsory part of the training of all medical postgraduates. 'Other than this', he observed, 'there was little provision of opportunity for medical men to gain a knowledge of insanity, except incidentally in practice, or by the kindness of their seniors.'[20] As Stephen Garton notes in his essay, 'Freud and the Psychiatrists: The Australian Debate 1900–1940', there were increasing efforts to professionalise psychiatry, in an attempt to establish its status as a legitimate medical occupation. By the early twentieth century, doctors working in state institutions had begun a campaign for better training and recognition of the psychiatric profession. They organised a psychiatric section at the 1908 Australasian Medical Congress, and called for increased undergraduate and postgraduate training in psychiatry at university. They argued for changes in the system that would encompass the need for voluntary admissions, prevention programs and specialisation.[21]

At this point, there were few psychiatrists in private practice, but those who were included leading practitioners such as William Beattie-Smith, JW Fishbourne and John Springthorpe in Melbourne; while in Sydney, Frederick Norton Manning began practising independently in 1898.[22]

Physical treatments of 'insanity'

During the eighteenth century the treatment of the mentally ill took the form of crude physical methods such as coercion, restraint, seclusion and isolation. Humane 'moral' treatments, involving the doctor appealing to the patient's moral sense, conscience and reason, became more prevalent during the latter part of that century.[23] These treatments, initiated by the French physician Philippe Pinel, appealed to the psychology of the patients with the aim of encouraging them to acquire the 'self-control' to contain their lunacy.[24]

Following the publication of Charles Darwin's *The Origin of the Species* in 1859, with its emphasis on evolutionary biology, the attitude towards treating the mentally ill shifted in emphasis once again. As the belief gained hold in the latter part of the nineteenth century that insanity was a hereditary disease, the treatment of the insane focused on physical solutions. The insane were considered to be an inferior species of the white race and it was thought that treatment was unlikely to assist in their rehabilitation.[25] This belief in hereditary causes and the physical basis of insanity dominated Victorian views.

In 1871 the leading British physician, Henry Maudsley, summarised many of the views that were to endure in Britain and Australia during the late nineteenth and early twentieth centuries. He believed that insanity was a 'disease which, having existed in the parent, may entail in the child a predisposition more or less strong like a disease'. The signs were physical and there to see: 'I am tempted sometimes to think that no person goes mad, save from palpable physical causes, who does not show more or less plainly by his gait, manner, gestures, habits of thought, feeling, and action, that he is predestined to go mad'.[26]

The hereditary nature of insanity was discussed at a collective as well as an individual level. Colonial culture, it was believed, created certain types of 'mental' states of being. John Springthorpe argued that the history of the Victorian colony meant that certain traits were inherited:

> One very important cause I consider to be the past history of the whole colony. You may call it our fevered past – the time of the gold fields – the distinct nervous tendency inherited from those times, the excited natures that came out, and which have been transmitted to their descendants.[27]

Thus, generally, the diagnosis of mental patients focused on observing their physical traits and not entering into any dialogue with them. Rowden White, who graduated in medicine from the University of

Melbourne in 1906, noted in his undergraduate lectures of 1898 that, according to his lecturer John Williams, there were '3 principle methods of examining patients'. The first and third points involved physical examination and composure. The second was most telling, as Williams advised his charges assiduously to avoid psychological examination:

> Method of interrogation – study of subjective symptoms. Do not put leading questions ie – questions that suggest an answer – espec. [with] neurotics. Best to ask p[atient] what he complains of.[28]

Indeed, many of the cases from the Kew Asylum during this period attest to there being a 'look' of insanity. The demented nature of one George Oldfield, a widower, was ascertained through physical traits. Admitted in October 1894, Oldfield's mental state was characterised by 'exhaltation, excitement, depression, and enfeeblement', and his speech was incoherent. His physical 'symptoms were well marked' his 'right pupil' was 'dilated'. Although quiet and clean, he was 'very dirty in his habits', and 'very demented'. Another sure sign of 'mental enfeeblement' was masturbation. George Lawson, a single man of 'good habits' was admitted into Kew in 1895. He looked 'emaciated, dull and stupid', and 'apparently masturbates as he stood look [sic] at picture in the male waiting room at the same time having his hands which were in his trouser pockets in constant motion'.[29]

In terms of listening, it was the coherence – or lack thereof – of a patient's speech that was taken into account rather than its content. On 12 August 1906, Mrs Mabel Reitman was admitted into the Kew Asylum. She was diagnosed with acute melancholia. Although she spoke, what she enunciated was not taken seriously; her dialogue was seen as a result of her condition, not a symptom. She was:

> Quiet and subdued in manner. Answers rationally but with a little hesitancy – Is somewhat inattentive, being self-absorbed … The starting point of her troubles she says, was owing to her quarrelling with her neighbours and they set people to say things about her. Has distinct auditory hallucinations … thinks she has committed a great sin and is to be hanged by her feet … Says she is unworthy to live. Memory is affected.[30]

Her physical condition was noted on admission: 'Pupils rather dilated – light reflex normal: Lungs normal: Heart normal: Right breast distended with milk (says her baby is eleven months old). Movements rather sluggish … very anaemic.' Although the prognosis was 'acute melancholia', 'probably lactational' (or what we might call now post-natal depression), her words were dismissed as nonsensical.

Silence was also deemed to be a sign of a disturbed mind.

Reitman's medical reports noted the times when she was mute, when she was responsive, or not responsive. In a similar case, Mrs Sarah Jane Fry, who was admitted on 13 August 1906, was described as suffering from 'mania – delusional'. Despite speaking, she was not heard. Her testimony was dismissed and considered to be part of the problem; the principal interest was on her physical appearance, and in her actions and behaviour as a mother and home keeper.

Many of these reports focus on women and their behaviour, although there were more men than women who were inmates.[31] In her classic text, *Good and Mad Women*, Jill Matthews has argued that there is a historical link between the pressures imposed on women to conform to the feminine ideal and madness. The dishevelled and untidy looks of women, their subversive gestures and their indifference to conventional expectations of femininity shocked the authorities. These asylums held individuals who were society's outcasts and those on the margins.[32] As English psychoanalyst Adam Phillips so poignantly observes, 'the history of madness is also the history of fear'.[33]

Women's bodies and their reproductive capacities were identified as holding the key to insanity. Menstruation was perceived to be the link between their reproductive organs and their state of mind. In an examination of this issue at the time, Kate Hogg, who was a junior medical officer at Callan Park Asylum in New South Wales, captured many of the assumptions about the relationship between the physical and the mental. She noted: 'The necessity of the regular functioning of the generative organs for the well-being and mental stability of the individual is established'. She could not observe the insane 'without becoming profoundly impressed with the connexion between menstrual irregularities and insanity'. She also observed how irregularity of a period 'would suggest itself as a cause'; the 'highest success from the psychical point of view has resulted from operations on the ovaries and tubes'.[34] Pregnant women also came under scrutiny. Overall, the causes of insanity were identified as the 'direct effect of the uterine nervous activity', and the 'undue accumulation in the system of material that should properly have been eliminated, causing a species of septic poisoning'.[35]

If diagnosis was inclined to be physical and understandings of mental illness were prone to be hereditary, then the discourse surrounding racial groups such as Aborigines fed into the most appalling stereotypes. Writing in 1889, Manning reflected the attitudes of the day in observing that:

> So far as can be gathered from the accounts published by explorers and early colonists, insanity was a very rare affection among the Australian aborigines whilst in their primitive and uncivilised condition.[36]

Commonly it was believed at the time that because of their 'simple' existence, Aborigines did not have the depth of feeling or complex adult emotions. For this reason they were deemed to be unlikely to suffer from 'insanity'. The impact of colonialisation was identified as the 'cause' of insanity. It was 'beyond doubt' that the main reason for this, Manning observed, was 'due to civilisation and its accompanying views, and to the changes of life and habits incident to this'.

Just as diagnosis was reached through physical observation, treatment of the insane looked for physical solutions. In 1901 JT Murphy, the medical officer at the Kew Asylum, related how one patient – 'H.A.B, male, 24, single labourer' – suffered from depression. The solution was hydrotherapathy.

> Each morning the patient was stood in a tub of warm water, temperature 100°F, and a cold douche of some force applied to the spine for about a minute; then he was taken out and well rubbed down till he was warm; this was followed by a short walk, and afterwards rest.[37]

Fredrick Manning's solution to 'curing' insanity was through a range of physical treatments. 'Is the Turkish bath employed either as frequently or as fully as it might and should be, and is our use of simple or medicated baths carried out even to the full scope of the means at our command?', he asked. Massage seemed another option.

> The physical inaction of a number of the insane ... points to massage as a curative agent as yet too little used and understood in our specialty.[38]

In his presidential address to the Ballarat branch of the British Medical Association in January 1903, Beattie-Smith, the retiring president, advocated a combination of cures that drew on the physical state and the mind. In his view, one needed to:

> approach your patient as a medical man called to see him. There must be no subterfuges or deceptions; approach him from a physical point of view – tongue, food digestion, and so on – with other systems, and you will thus engage his attention, and you will remember that the mind is fed by special subjective symptoms, and then you will test the symptoms which may be true. As to Acts, the conduct generally, during conversation, will help you in testing alike the mind and the facts.

Even when speech was scrutinised it was to instruct rather than to listen to patients. 'Broadly speaking', continued Beattie Smith:

> the treatment of melancholics is by speaking fully and openly before them, as by doing so they find their notions anticipated, and wonder how we know so much of them. Let them hear all you think of them, let them hear all you want them to do and to avoid. Take them into

> your confidence in order to gain theirs, and give them infusion of hope.

'Give sunshine, exercise, out-of-door occupation, and baths', he advised. 'Avoid drugs, alcohol infrequently – don't recommend sea voyages and travel – travel, per se, is not a health restorer. Order change of air, scene and occupation, within easy access of home.'[39]

Even by 1911, the treatments were still not sophisticated. 'A mode of treatment', noted MH Downey, the medical officer for the insane in South Australia, 'which is becoming very fashionable in cases of early insanity is complete rest in bed'. Systematic regularity, diet, 'warm baths and warm drinks at bedtime are exceedingly useful, and should always be tried'.[40] But some physicians were beginning to signal a change. Unlike most of his colleagues, Dr Soloman Iffla suggested, in 1885, means other than physical ones:

> You enter into a conversation with them generally, and touch them on various points. You have previously some information from the friends as to the particular bias of this individual's mind, and then you enter into conversation, and take the general connexion of his ideas and coherence, speak to him upon those subjects, and see how far he is reasonable upon them, at the same time examining his physical condition, the state of his pulse, the heart's condition, his eyes, and the temperature of his body; you get as much as you can of the family history, and the personal history of the individual; you encourage him to converse freely on the particular subjects where he appears to be astray, and you compare his ideas with what should be the ideas of a sane man; test him in every way you can mentally.[41]

John Springthorpe would have agreed with Iffla. He too believed that while the psychic realm held the key to understanding the mentally ill, it was but one aspect of understanding the whole mystery of insanity. For Springthorpe, the most pressing question was: How could doctors better access the mind, and hence provide better treatment? Springthorpe, ever tenacious, made this pursuit his professional challenge.

In his writings and lectures, Springthorpe identified two issues that signified a major departure from the ideas and practices of his Australian contemporaries. The first was to acknowledge the central importance of sexuality to emotional life. The second, which was perhaps more immediately significant, was to emphasise the importance of what he termed the 'psychic', or the psychological, in the treatment of mental health – and this demanded listening to patients. In both respects it was for Springthorpe, and others in Australia – indeed around the world – Freud's work that eventually exploded conventional practices and opened up these areas for examination and exploration.

Sexuality

The talk Springthorpe gave 'On the Psychological Aspect of the Sexual Appetite' on that September night in 1884 outlined to his colleagues his belief that the 'sexual appetite' played 'a part scarcely second to any other in originating and directing our ideas, emotions and volitions'. In his talk he connected the physiology of sexual organs to individual psychology, sex drives, and then to culture. In a young colony such as Australia, he believed, there developed a need for 'some discussion into the means best fitted to improve the sexual atmosphere of our rising population'.

Springthorpe was a firm believer in the role of sex education to promote the 'chastity of mind', and to prevent 'the access of sexual phenomena into the brain cells, and their registration there to originate fresh sexual ideas or facilitate old sexual actions'. He observed that masturbation – which was, according to Victorian thought, a sure sign of mental instability – predominated 'in our midst to a saddening extent'. It was an 'indulgence that speedily exceeds the bounds of moderation'.[42] Hysteria, he believed, was also closely aligned to sexuality. The 'nervously unstable', he wrote reflecting the view of the times, become 'specially troubled sexually'.[43] When Springthorpe thus considered issues of crime, hysteria and insanity he did so with reference to the 'sexual instinct', and discussion of the importance of the sexual education of children.[44]

In writing on hysteria, Springthorpe echoed the interests of many of his contemporaries. The nineteenth century fascination with hysteria, especially as manifested by women, had become almost an obsession. The desire to understand apparent 'disturbances' of the central nervous system – those of pain, paralysis, loss of sensation, seizures, headaches, depression – defined Victorian psychiatry. Historically, hysteria was commonly understood to be a 'woman's disease', as these symptoms were first believed to have originated in a woman's uterus, then in the nervous system. By 1900, it was considered to be – like many other real or supposed mental illnesses – a hereditary phenomenon. However varied the interpretation of the causes of hysteria, and despite several male cases having been diagnosed, it was usually identified with women.[45] Feminist scholars have observed 'hysterical' women were invariably intelligent women, and have noted that a strong connection was made between the emerging New Woman – independent, assertive, articulate and engaged with politics and intellectual ideas – and the nervy or 'hysterical' woman.[46]

In his ideas about hysteria and sexuality, Springthorpe was greatly influenced by leading neurologists of the day, such as the celebrated

Frenchman Jean-Martin Charcot. Charcot's ideas were revolutionising medical science and influencing physicians, neurologists and psychiatrists around the world – including Freud himself. Charcot's belief was that hysteria was a physical illness, created by a hereditary condition which caused damage to the nervous system. In his clinic at La Salpêtrière in Paris he earned his international reputation not only for his claim to have cured those inflicted with hysteria, but perhaps more famously, for his theatrical and dramatic performances with hysterics. His patients were, overwhelmingly, poor women on whom he used hypnotism to 'cure' them of their hysteria.[47]

When Freud and his confidante and friend, Josef Breuer, published *Studies in Hysteria* in 1895, they situated sexuality at the centre of their work. In what became a seminal text in the history of psychoanalytic thought, they drew a connection between sexuality and the unconscious through their treatment of female patients who reported 'hysterical' symptoms. Unlike Charcot, they believed hysteria originated from sexual trauma that had been repressed into the unconscious, and was then channelled through bodily expressions. Thus Freud and Breuer concluded, for their patients 'anything sexual is something incompatible with their ethical standards, something dirtying and smirching. They repress sexuality from their consciousness, and the affective ideas with a content of this kind which have caused the somatic phenomena are fended off and thus become unconscious'.[48] Ten years later, in 1905, Freud published another major text on sexuality entitled 'Three Essays on the Theory of Sexuality'. In this work, he posited the radical concept of infantile sexuality, where he argued that children were sexual from birth. He referred to sexuality not only as the familiar genital sexuality, but also to the pleasure and sensuality of infant bodily sensations.[49]

Springthorpe would later refer to Freud's obsession with sexuality, and was often dismissive of it; but his own interest in masturbation, sex education amongst children and sexual practice, points to an ongoing fascination with the topic himself. Foucault's observation that the Victorians did not suppress sexuality, but rather could not stop talking about it, is certainly exemplified in Springthorpe's own publications and preoccupations.[50]

Psychic suggestion

The physician who 'fails to bring suggestion to bear upon treatment', is like a 'fighter who enters upon a severe contest with one arm bound',[51] said John Springthorpe in typical unequivocal style. A strong

proponent of suggestion, he believed its techniques were under-utilised and that the medical profession was 'generally unduly unconcerned and even ignorant as to its true position and therapeutic application'.[52]

Springthorpe believed suggestion was important because it worked on the connection between the mental and the physical. He insisted that the mind and the body be viewed in relation to each other, where 'psychical changes are the occasion of the physical, neither alone being explicable from the other'.

The radical proposal of examining the 'psychical' factor at a time when physical solutions were posited as the 'cure' for mental illness, cannot be underestimated. Springthorpe argued it was necessary to seize 'the psychological moment, to select the most appropriate suggestion, and to apply it in the aptest manner'. 'Securing the patient's confidence' was crucial for this method to work, and it also enhanced the power of the physician. This method 'really consists in grafting onto the patient's cortex the idea and belief that you thoroughly understand his case, are thoroughly interested in it, will do your best, and that it is thoroughly safe in your hands'.[53] If, in this exchange, Springthorpe told a gathering of nurses in 1905, the physician 'can create the certainty of cure, so much the better all around'.

Like Freud's views at this time, these crucial ideas signified a shift away from physical treatments to psychological ones. Communicating with patients on an individual level, where there was 'suggestion' made by the physician that would reach the level of 'auto-suggestion', signalled a major shift of existing practices in two ways.

First, in arguing for the need to seize the 'psychological moment', and in opening up the analysis of patients to something more than a *physical* analysis, Springthorpe was offering a radically different approach to the treatment of so-called lunatics. Springthorpe was not privileging the 'psychical means alone', but arguing that the psychical factor 'in the diagnosis and treatment of everyday disease' had been ignored.[54]

Second, in stressing the *individualised* treatment of patients, through the use of *suggestion*, Springthorpe was indicating a radical shift in how patients were to be cured. He observed the difference that was made to patients who had been 'silent and motionless, the embodiment of inertia, in the depressing airing courts of Kew and Yarra Bend'. In these courts there was only 'one attendant to some 40 patients'. He was pleasantly surprised with the 'marked difference when similar cases were taken into private establishments with individual supervision, improved environment … and the daily carrying out of an individualised physical prescription of exercise, work, baths, massage etc'.[55]

Today, the buildings of what was once the Kew Asylum still stand, beacon-like and formidable, atop a hill overlooking Melbourne's Yarra River. After being sold by the Victorian state government in the 1990s, the institution was 'developed' and converted into apartments and townhouses. Those who live there now couldn't be more different from those who were housed there a century or more ago. In the mid-1880s, the Kew Asylum was one of the largest in Australia, the superintendent and one assistant doctor supervised 900 – mainly poor, disadvantaged and female – patients. By 1898 the figure had risen to 1000, but there remained only two medical staff.[56] In most cases, it was the ill-trained attendants who actually had most contact with patients.[57]

In 1905, there were six asylums in Victoria – Yarra Bend, Kew, Ararat, Beechworth, Sunbury and Ballarat servicing a population of just over one million people. The total number of patients was 4768, supervised by six superintendents and eight medical officers – a ratio of one medical officer to 350 patients.[58] But, despite these conditions, the ever-optimistic Springthorpe urged his colleagues to be 'up-to-date in our diagnosis, and in our psychology', as the 'problem becomes complex and individual'.[59] However, as he was all too aware, the Australian asylum system was hopelessly understaffed, making systematic individual treatment on a large scale virtually impossible.

Yet it was this individual treatment that was at the heart of psychoanalysis. It had been taken up as a method by Freud and Breuer in the 1880s, following Breuer's successful treatment of the German feminist and social worker Bertha Pappenheim ('Anna O') who came to him suffering from paralysis and hallucinations. By encouraging Pappenheim to talk to him about her symptoms, and perhaps even more importantly, listening to and hearing what she had to say, Breuer has been credited with redefining the doctor–patient relationship. However, as feminists have shown, Pappenheim was a key player in this dynamic. It was she who initiated the 'talking cure' with Breuer, and she who forced the issue of transference love in the doctor–patient relation.[60]

The next stage – that of interpretation – was a technique Freud developed later within this relationship between doctor and patient.[61] The need to listen rather than to dictate the conversation was an important part of encouraging the patient's 'free association', where patients would talk with limited intervention.[62] In this procedure, Freud and Breuer challenged the medical relationship of the nineteenth century, which was based more commonly on silence, and the passivity of the patient.[63] The theory of transference, where patients unconsciously transfer onto the therapist the relationship they had as

children with their parents, allowed the therapist to explore the 'unconscious re-run of the patient's earliest relationships'.[64]

As Daphne de Marneffe has argued in 'Looking and Listening: The Construction of Clinical Knowledge in Charcot and Freud', the emergence of psychoanalysis signalled the transition from the nineteenth century practice of looking at patients in the treatment of mental health, to listening to them.[65] Freud's use of the material he was given, and what he heard, especially in relation to incest and sexual abuse, has been a matter of much controversy.[66] Feminist critic and thinker Elaine Showalter has described Freud as a 'stubborn, bullying interrogator of hysterical women'.[67] It is true that Freud adopted a selective method of listening, but the advent of the 'talking cure' transformed the doctor–patient relationship. As Rob Gordon has noted, Freud's achievement was to not 'see' the psychical apparatus, 'but to establish a discourse in which the experience could be transmitted and scientific work done with it'.[68]

John Springthorpe did not embrace Freudian thought unconditionally. He described Freud's psychoanalysis as a 'scientific detailed attempt to discover all the significant experiences and psychologically important motives and impulses from the earliest childhood, and to utilise these factors therapeutically – even dreams … are thus analysed'. He believed that Freudian analysis, 'in the hands of experts, no doubt … will be exceedingly valuable'. But he argued that a less elaborate method would achieve equally effective results.[69] In the context of the Victorian 'lunatic' asylums, such methods were impossible even to begin to contemplate, given the crowded conditions and the emphasis on physical treatment.

Listening to patients: hypnosis and the individual

Another form of treatment that also began to attract attention in the late nineteenth century was hypnosis, which was deemed to be important because, significantly, it signalled the presence of the unconscious. However, hypnosis had not gained lasting favour with Freud. He had used it in the treatment of his patients between 1887 and 1896, but had abandoned it because he found its effects were not lasting: resistance to a particular memory would re-emerge following the trance, and the patient would forget. Freud believed it was the *patient* who needed to be exposed to his or her unconscious thoughts – not the *hypnotist*.[70]

Because of the uneven results he obtained through hypnosis, Freud adopted the new method of free association. This required the radical step of asking the patient to discuss his or her thoughts, openly and freely, and thereby provided the 'path leading to what had been forgotten or fended off'[71] – that is, more lasting access to the unconscious. With this method, Freud placed emphasis on interpreting patients by listening to them. As prominent American psychoanalyst Harold Blum argues, for Freud, 'listening to the patient became not only an art but a science. He listened for the content of his patients' conflicts but also for their criticism of his technique'.[72]

The use of hypnosis also occupies a place of importance in this history because of the way in which the rational and the scientific was increasingly associated with studies of *the individual*. In attempting to move towards rationality and science in the theory and practice of mental health, the individual subject became central.[73] Among the middle classes during the latter part of the nineteenth century, stress was placed on the self, rather than just on the doctor, as a source of knowledge and meaning. With the shift to the individual, self-reflection and the rise of the autobiographical text, the language and speech of the ill began to be recognised and legitimated as part of the patient's subjectivity.

Before the advent of the 'talking cure' it was the autobiography that expressed the inner life of the Victorians both in Australia and Britain.[74] Freud biographer Peter Gay states that the Victorian period was marked by the 'ascent of inwardness'. Autobiography, he claims, served as the means of confession during that period, expressing emotions and passions, as 'a kind of therapy'. The nineteenth century spawned far more autobiography than before, and it was characterised by a heightened form of memory and nostalgia.

The novel, of course, was the other cultural form that became the way in which 'the story of private people expressed the general experiences of society'.[75] Through reminiscences and confessions, the private self of Victorians was on public view. While these texts employed clichés and plagiarisms – 'usually disappointing guides to the inner dimension' – Gay argues, their confessions were 'enshrined [in] an authentic feeling'.[76]

Another popular form of enunciating one's private self which predated these methods was the Catholic confession.[77] Freud modified these confessional techniques in order to introduce a method of interpretation which recognised the need to analyse the confessional scientifically and analytically.

However, hypnosis was a far cry from the method eventually developed by Freud. In hypnosis the patient remained passive and was

dependent on instruction by the hypnotist. Hypnosis had no notion of transference, or the unconscious. But hypnosis was an important step in breaking with accepted methods by focusing on the individual, as well as shifting the emphasis onto the *discourse* of the patient.

In Australia, Richard Arthur was the staunchest advocate of hypnosis. He completed his doctorate of medicine on 'Hypnotism and its Therapeutic Uses' at the University of Edinburgh. Then, in 1890, after suffering from cholera and then contracting influenza, he was convinced of the need to settle in Australia 'for the sake of his health'. A year later he began practising in Mosman, Sydney. In many of his writings on hypnosis Arthur was at pains to challenge critics who believed the method was 'unscientific'. Writing in 1892 in the *Sydney Quarterly Magazine*, he attempted to impress upon his audience that it was not quackery, and did not rob patients of control. People 'do not lose consciousness, and retain their will-power so far that they will do nothing that is contrary to their wishes or feelings'.[78] In its emphasis on listening and suggestion, we can discern the precursor of psychoanalysis.

JM Creed was another leading hypnotist of this period. Like Arthur, he strongly believed in the power of hypnosis in curing illnesses. These included alcoholism, insomnia, asthma, bronchitis, epilepsy, and headaches. He especially recorded an impressive cure in the case of asthma: after hypnosis, he suggested to his patient that 'his spasm would be less, his breathing easier, and that this cough and expectoration would improve'. This was repeated for ten days, when the patient 'was free from respiratory distress, having hardly any cough, walking upstairs without difficulty and with very considerable speed in the streets'. When challenged, Creed replied that he simply aimed to show that 'hypnotism is a valuable adjunct to medicine'.[79]

Historian Michael Roe is right to suggest that Arthur's ideas 'might have presaged' him as a pioneer in Australia, perhaps to be the country's first psycho-analyst'. But his crusade for hypnosis did not translate into an enthusiasm for psychoanalysis.[80] Rather than see similarities with psychoanalysis, Arthur was suspicious of what it could do and why it needed to take so much time:

> And of late years the psycho-analysts have come forward to claim the whole field of nervous disorders for themselves and to dismiss hypnotic suggestion as a futile tinkering with symptoms and effects. I find myself too old and indolent to embark on this new therapy which seemingly demands a day of ninety-six hours and inexhaustible patience to carry out effectively, and am content with the results got from the method which has given satisfaction in so many cases.[81]

Arthur himself did not make the intellectual shift from the methods of hypnosis to psychoanalysis, and he echoed the views of many of his colleagues in querying its use.

Freud in the Antipodes

The first reference to Freud in Australia is made in Ernest Jones' biography of Freud. Jones mentions that a Presbyterian minister, Dr Donald Fraser, wrote to Freud in 1909 indicating that a group of his followers were studying his ideas. Apparently, Fraser was forced to resign from the church because of his views, but there is little evidence to illuminate this incident.[82] And there is no evidence of Freud's response to Fraser's letter, if he did respond at all.

This was an auspicious year for the reception of Freud's ideas abroad, for it was in 1909 that he was invited to Clark University, Massachusetts, in the United States, as part of its twentieth anniversary celebrations. Following Freud's trip – the only one he was to make to the US – there was a flurry of activity as the media and psychological journals took up his ideas with relish. Although Freud himself referred to America as a 'gigantic mistake', it is beyond doubt that the US 'proved remarkably fertile for the growth of psychoanalysis'.[83]

There were no such trips to, nor fanfare in Australia. Throughout the twentieth century Freud would be received with an ambivalent response in the Antipodes. Prior to 1914, Freud's ideas were not in common currency in Australasia and were known little outside of medical circles. American psychologist Nathan Hale has argued, in his study of psychoanalysis in the United States, that the positive reception Freud received in the US was related to the 'openness of American medicine' from 1910, and the 'fluid state of American medical institutions'.[84] The conservative and staid British traditions that Australia inherited did not allow for a favourable response to the Freudian ideas that had challenged so many of their assumptions. Rob Gordon argues that British philosophy never 'threw reason into question as Kant had for the German world'.

An emphasis on British pragmatism and empiricism prioritised coherent and logical facts. The result, argues Gordon, was that in Britain 'the emphasis was put on utilitarian ethics and political economy, epitomised by Bentham [and] Mill'. Even in James Strachey's translation of Freud's texts 'we find embarrassment with metapsychology', where even some ordinary words are rejected as too

scientific and 'generally tidied up to be more presentable in polite English intellectual society'.[85] Around the same time, David Eder and Ernest Jones – two British doctors who applied psychoanalytic techniques – were greeted with a walkout when they presented papers to the neurological sections of the British Medical Association. 'Their audiences rose and left the room en masse before discussions of their papers were due to commence.'[86]

Australians, on the other hand, did not respond with such hostility. In 1911, Freud, Carl Jung and Havelock Ellis were invited to read papers in the Psychological Medicine and Neurology section of the Australasian Medical Congress. While they did not attend, they sent papers.[87] Freud's Australian paper, which was published in October 1911 in the *Australian Medical Journal*, was simply entitled, 'On Psycho-Analysis'. It was an exposition of the key concepts which formed the basis of his theories, and like 'every new product of science', he wrote, it remained an unfinished project. Writing about his findings on hysteria, hypnosis, infantile sexuality, the interpretation of dreams, the unconscious, repression and the methods and techniques of psychoanalysis, Freud argued that 'the purely medical and non-psychological teachings have up to now done very little towards the understanding of the psychic life'.[88]

Readers of the *Australian Medical Journal* would have also noticed the publication of Havelock Ellis' paper in 1911, on 'The Doctrines of the Freud School'. In this article, Ellis introduced a range of Freudian concepts and arguments which, he argued, transformed scientific thinking. He provided a brief history of Freud; of the unconscious, free association, infantile sexuality and dream analysis. For Ellis, 'whatever conclusions we may finally reach in regard to Freud's work, there can be no doubt that that work demands careful study, and that we can no longer afford to pass it by with contemptuous indifference'. Although he expressed the reservation that Freud 'generalises too rapidly, and that he too rigidly excluded any explanation of the facts that fails to fall within his own theory', it was beyond doubt that 'Freud has certainly enlarged our horizon and dug deeper into certain psychic fields than any of his predecessors'.[89] For those who wished to pursue Freudian ideas, Ellis noted that there was an English version of the 'Selected Papers on Hysteria and Other Psycho-neuroses', and there was soon to be an English translation of 'the new third edition of the book on dreaming'.[90]

The leading medical journal, the *Australasian Medical Gazette*, remained unconvinced, and continued to stress the importance of physical factors in treating the mind. In reviewing 'Papers on Psycho-Analysis' by Ernest Jones, the *Gazette* suggested that Freud 'lay undue

stress on the strictly psychical aspects of the neurosis to the neglect of the physical'. In offering such an analysis, the journal isolated one of the key criticisms that would be levelled against Freud's work in Australia. It was thought that an 'attempt to treat the neurosis by purely psychoanalytical methods [was] like attempting to treat pain in the head without any attempt to ascertain its cause'. The verdict was that Jones 'fails in these essays to recognise the closer association of physical states with mental disturbances'.[91]

In 1907, Abraham Brill, a well-known American Freudian and loyal friend of Freud, became his first official translator into English, as well as writing his own work in psychoanalysis.[92] In a discussion of Brill's work, the *Australasian Medical Gazette* was critical.

> This becomes very obvious when we read the interviews with patients recorded in this book, and we are not convinced that more can be accomplished by this method in the way of successful treatment than by the ordinary methods of careful investigation of every patient and his history, and the adoption of physical methods of treatment combined with suggestion.[93]

Another piece by Freud was published in the *Australasian Medical Gazette* in 1912, outlining the progress of some of his key theories. Psychoanalysis was placed in the context of a rejection of the view that hysteria was hereditary, relating it instead to the process of repression. Freud also explained free association. The predisposition of 'neurotic afflictions' was traced to 'infantile sexuality'. It was infantilism, sexuality and repression that formed the 'principal characteristic of the psycho-analytic theory and marks its difference from other conceptions of morbid psychic life'. There was a need to incorporate these considerations, he argued, for 'purely medical and non-psychological teachings have up to now done very little towards the understanding of the psychic life'.[94]

Despite the controversial nature of his statements, his Australian audience remained largely indifferent.

Conclusion

Freud's first biographer, the British analyst Ernest Jones, recalled (in his own memoirs) Freud's revolutionary contribution to the process of listening to patients.

> [The] most casual remarks of his patients were really facts, data to be seriously examined ... What a revolutionary difference from the attitude of previous physicians who would hear, without listening,

> their patients' remarks, discounting, forgetting, or even pooh-poohing them while their own thoughts were elsewhere, concerned perhaps with the patient's welfare but from a totally different angle.[95]

Physicians on the eve of World War I had not begun to listen to the mentally ill in this manner. In 1914 the *Australasian Medical Gazette* lamented the 'discernible increase in "registered" insanity' – that is, of those certified as insane. It was 'a matter of regret that in spite of all the researches which have been carried on during the past few years on the pathology of insanity, we have not yet been able to devise any method for the arrest of this increasing amount of mental disorder, nor any system of treatment which has so far improved the recovery rate'. The editorial stressed 'open air' solutions for the 'feeble minded':

> Many cases of insanity are really cases of physical disease which can be well treated in the wards of a public hospital, but other cases, especially the feeble-minded, the subjects of various neuroses, and the neuropathic, are better treated by open air methods in institutions on the cottage system.[96]

The onset of World War I challenged many of these assumptions, and forced the profession to look elsewhere for explanations. To many in the conservative medical profession, the thought of listening to patients and applying a method of analysis to the unconscious seemed too far removed from their training and understanding of treatment of mental health to be credible. But when confronted with the challenge and the mysteries of shell shock, the conventional physical treatments were found wanting. Although Springthorpe himself was at times critical of aspects of Freud's method, he could see the need to listen to the afflicted soldiers, and begin a psychotherapeutic approach to treating them. Psychoanalysis it might not be, but the methods of the talking cure were about to be listened to in a way unprecedented in the history of psychoanalysis.