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**GENDER AND LUNACY**  
**A study of women patients at the**  
**Auckland Lunatic Asylum**  
**1870-1910**

A thesis presented in partial fulfillment of the  
requirements for the degree of Master of Arts in  
History at Massey University.

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1990

**ABSTRACT**

This is a study of the experience of the insane in nineteenth century New Zealand and it examines in detail a sample of 45 women and 15 men who were admitted to the Auckland Lunatic Asylum between 1870 and 1910. Based on patient casenotes, reports by asylum officials, newspaper accounts, and drawing on recent overseas historical literature about insanity, the thesis analyses why these patients were labelled insane, what that process involved, and the techniques adopted to treat the mentally ill. Throughout it emphasises the socially-constructed nature of mental illness and aims to determine the extent to which gender was a factor in the processes of detection and incarceration. Although the focus is primarily on women, men are included as it is argued that gender is a comparative tool of analysis. The study concludes that committal and treatment were all heavily influenced by gender in varying degrees. However it also argues that examining gender does not tell the whole story. Complex pressures all played their role. These included notions of propriety, social and familial conflict, economic distress, material conditions and race.

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## ABBREVIATIONS

AP	Auckland Provincial Records
<u>AJHR</u>	<u>Appendices to the Journals of the House of Representatives</u>
<u>APCVP</u>	<u>Auckland Provincial Council Votes and Proceedings</u>
<u>APGG</u>	<u>Auckland Provincial Government Gazette</u>
<u>DSC</u>	<u>Daily Southern Cross</u>
GP	General Practitioner
H-MHD	Health Department Files, Mental Health Division
<u>NZH</u>	<u>New Zealand Herald</u>
<u>NZJH</u>	<u>New Zealand Journal of History</u>
<u>NZMJ</u>	<u>New Zealand Medical Journal</u>
<u>NZPD</u>	<u>New Zealand Parliamentary Debates</u>
<u>WN</u>	<u>Weekly News</u>
YCAA	Carrington Hospital Files

## Introduction

This is a study of the experience of the insane in late nineteenth century New Zealand. It will emphasise certain issues and questions, including the socially-constructed nature of mental illness, the reasons why people were labelled insane and what that process involved, the techniques adopted to treat the mentally ill, and the extent to which these practices were affected by gender. The vehicle through which these themes are examined is the Auckland Lunatic Asylum and the thesis is based on a discussion of the experience of selected patients admitted there between 1870 and 1910.

The literature on the insane is now extensive, in Britain and North America as well as Australia, but for all that it is only recently that writers have turned their attention to the experience of committal and incarceration. Instead, previous studies have tended to focus on the differentiation of the insane as a distinct problem group in the community and the changing place held by the mad in popular and learned culture; the development of state policies towards the insane and the rise of a state asylum system; and the emergence of the psychiatric profession which came to control these new institutions.<sup>1</sup>

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<sup>1</sup> Among the more important are: Michel Foucault, Madness and Civilisation: A History of Madness in the Age of Reason (New York, 1965); Gerald N. Grob, Mental Institutions in America: Social Policy to 1875 (New York, 1973); Gerald Grob, The State and The Mentally Ill: A History of Worcester State Hospital in Massachusetts 1830-1920 (Chapel

These studies have been influential in fostering a more critical history of mental health care. They revealed that official and cultural perceptions of "madness" have a different meaning in each time and place. Their findings undercut the idea that mental illness is a "natural" event, by emphasising that to a large extent it is socially caused or socially constructed.<sup>2</sup> Such writers also attempted to utilise the concept of "social control" to explain the function of asylums, from an institutional perspective. However these studies are of limited value in attempting to understand the definition, significance and consequences of madness in everyday life.

Like the histories of the colonial wars, these accounts tell us more about the relations between the imperial powers than about the "third world" of the mentally ill themselves. Yet however important a part psychiatry played in structuring the career of mental patients and the perception of their disorders, the fact remains that they existed: who they were and what was up with them, makes a crucial difference to our interpretation of psychiatry's handling of them.<sup>3</sup>

Through a concentration upon casenotes, a perspective adopted by a growing number of writers, it is possible to

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Hill, 1966); D. Rothman, Conscience and Convenience: The Asylum and its Alternatives in Progressive America (Boston, 1980); D. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston, 1971); Andrew T. Scull, Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England (London, 1979); Andrew T. Scull ed. Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era (London, 1981).

<sup>2</sup> L. J. Jordanova, "Mental Illness, Mental Health: changing norms and expectations", in Women in Society: Interdisciplinary Essays, The Cambridge Women's Studies Group (London, 1981), p.101.

<sup>3</sup> David Ingleby, "Mental Health and Social Order", in Social Control and the State, eds. Stanley Cohen and Andrew Scull (New York, 1983), p.144.

explore these theoretical issues in a concrete context. In particular, these historians have emphasised the social functions of commitment, the variety of people who sought to have individuals committed and the importance of the institutional experience of the patients. This patient-based perspective argues that the mad represented threats to persons, property, law and order and "articulated moral norms".<sup>4</sup> As a result community officials and policing agents figure in these accounts more frequently than do medical men. These and other writers place a new importance on the role of the family in the committal process and on domestic and social crisis as catalysts for admission.<sup>5</sup> More recently studies of individual asylums have reconstructed daily life for the patients and shown that inmates were not just passive recipients of state and medical policy and that a changing clientele forced adjustments in therapeutic regimens. Moreover, the goal of treatment is shown to be the maintenance of specific types of social order.<sup>6</sup>

<sup>4</sup> J.K. Walton, "Casting out and bringing back in Victorian England: pauper lunatics, 1840-70", in The Anatomy of Madness: Essays in the History of Psychiatry 2 Institutions and Society, eds. W.F. Bynum, Roy Porter and Michael Shepherd (London, 1985), p.132; Richard W. Fox, So Far Disordered in Mind: Insanity in California 1870-1930 (Berkeley, 1978), p.152.

<sup>5</sup> Michael Ignatieff, "Total Institutions and Working Classes; A Review Essay", History Workshop Journal, 15 (Spring, 1983), pp.167-172; Mark Finnane, "Asylums, Families and the State", History Workshop Journal, 20 (Autumn, 1985), pp.134-148. See also Finnane's book, Insanity and the Insane in Post-Famine Ireland (London, 1981).

<sup>6</sup> Anne Digby, Madness, Morality and Medicine: A Study of the York Retreat 1796-1914 (New York, 1985); Nancy Tomes, A

Some of these recent writers give a limited recognition of gender as an element in the experience of commitment and incarceration, but for the most part historians of psychiatry and madness have taken little notice of sexual difference. In such accounts class has been seen as a more primary division than gender. Those that do comment raise the possibility that women were identified as mad and treated in gender-specific ways, but seldom go on to account for these variations in any sustained way. Jill Matthews and Elaine Showalter are two exceptions whose studies of madness use gender as a primary tool of analysis. Their analyses, like those outlined above, provide a number of important ideas which can be tested in the Auckland context.

Matthews examined the experience of women committed to a psychiatric hospital, and their treatment there, to explore the construction of femininity in twentieth century Australia. She claims that the process of becoming a woman "is the pursuit of femininity, the attempt to live up to the various standards of her society, the struggle to behave like and to be a good woman according to her own and her society's standards". Women who were defined as mad had failed in the pursuit of femininity.<sup>1</sup> Psychiatric treatment therefore, was not just concerned with restoring "normal"

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Generous Confidence: Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883 (New York, 1984).

<sup>1</sup> Jill Julius Matthews, Good and Mad Women: The Historical Construction of Femininity in Twentieth Century Australia (Sydney, 1984), pp.3-8.

individuals, but with producing "normal" women and "normal" men. By definition, she argues, normal women attempted to become good and feminine women.<sup>8</sup> As well as the multiplicity of prescriptions that besiege each woman, Matthews believes that the substance of what it means to be a good woman is constantly changing. Thus, although "[t]he ideals are static, representing a state of being", it requires continued efforts to achieve them "throughout the various and changing circumstances of her life". According to Matthews, the changing basis of femininity means that it is, by definition, ultimately unobtainable.<sup>9</sup>

Elaine Showalter makes similar observations about nineteenth century England, although her material does not draw on casenotes because she believes they silence women's voices. Instead she analyses developments within the psychiatric profession and contends that in this century a "feminization" of madness took place; women not only became the primary recipients of psychiatric treatment but also served as the cultural exemplars of madness. Female madness was associated with the sexuality and essential nature of women.<sup>10</sup>

A third writer has incorporated an analysis of gender into one of the most comprehensive studies yet made. In his study of insanity in New South Wales between 1880 and 1940, Stephen Garton starts from the belief that "[p]atient

<sup>8</sup> *ibid.*, p.24.

<sup>9</sup> *ibid.*, pp.6-7.

<sup>10</sup> Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London, 1987), pp.7,52.

populations are constructed by particular social contexts and specific social policies". His account embraces both traditional and modern historiographical concerns: the development of mental health policy and the growth of the psychiatric profession, but also the mental hospital patients, the social context of their committal and treatment, and the institution itself. More particularly he looks at the different consequences of gender on the construction of the patient population, analysing men as well as women. Garton breaks new ground by arguing that "problems and contradictions in the construction of masculinity" and femininity were at the heart of detection and incarceration.<sup>11</sup>

Much of the New Zealand historical literature on the insane remains faithful to the traditional historiography. Studies have been made of specific institutions,<sup>12</sup> more

<sup>11</sup> Stephen Garton, Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940 (Sydney, 1988), pp.5,131,140.

<sup>12</sup> R.M. Hunter, "Historical Notes on the Auckland Psychiatric Hospital", The New Zealand Nursing Journal, (February, 1957), pp.15-21; Betty Bradwell, "And So It Began, Oakley Hospital 1867-1964", The Oakley News, 5:6 (1964), pp.8-13; W.A. Brunton, "Hospital or Prison? - Some Attitudes at the Nelson Lunatic Asylum 1858-1872", Comment, 31 June 1967, pp.19-23; M.S. Primrose, "Society and the Insane: A Study of Mental Illness in New Zealand 1867-1926 with special reference to the Auckland Mental Hospital", MA Thesis (University of Auckland, 1968); W.A. Brunton, One Hundred Years 1872-1972. To Commemorate the Centennial Celebrations of the Seaview Hospital (Hokitika, 1972); Caroline Hubbard, "Lunatic Asylums in Otago 1882-1911", BA Hons Essay (University of Otago, 1977); J.H. Bloomfield, "Dunedin Lunatic Asylums 1863-1878", BA Hons Essay (University of Otago, 1979); Wendy Hunter Williams, Out of Mind Out of Sight: The Story of Porirua Hospital (Porirua, 1987).

general institutional developments,<sup>13</sup> state policy towards the insane,<sup>14</sup> and the psychiatric profession.<sup>15</sup> Even if patient data is used however, administration, bureaucratic developments and a psychiatric perspective still dominate these accounts. This is true, too, of the first attempt to incorporate gender into an analysis of early mental health care. Hilary Haines' study of the causes of insanity among New Zealand women between 1878 and 1902 is an examination of psychiatrists' views on women and madness.<sup>16</sup> The social significance and explanations behind the resort to asylums by people in the community remains obscure.

<sup>13</sup> R.L. Jermyn, "The Treatment of the Mentally Ill in New Zealand 1840-1880", MA Thesis (University of Victoria, 1951); W.A. Brunton, "Citadels - some factors in the survival of psychiatric hospitals", New Zealand Health Review, 5:2 (Autumn, 1985), pp.3-7; W.A. Brunton, "Insitutionalisation: A Romance For All Seasons", in The Future of Mental Health Services in New Zealand: deinstitutionalisation: volume two of the edited proceedings of the Mental Health Foundation of New Zealand's 1985 Conference, eds. Hilary Haines and Max Abbott (Auckland, 1986), pp.44-63; W.A. Brunton, "The New Zealand Asylum - Conception and Misconception", in Proceedings of the First New Zealand Conference on the History of New Zealand and Australian Medicine, ed. R.E. Wright-St Clair (Hamilton, 1987), pp.155-171.

<sup>14</sup> W.A. Brunton, "Mental Health Law in New Zealand: Some Sources and Traditions", Community Mental Health in New Zealand, 2:1 (July, 1985), pp.70-83; W.A. Brunton, "Hostages to History", New Zealand Health Review, 3:2 (Autumn, 1983), pp.3-6.

<sup>15</sup> W.A. Brunton, "If Cows Could Fly", Australian and New Zealand Journal of Psychiatry, 6 (March, 1972), pp.46-51; C. Caldwell, "Truby King and the Seacliff Asylum, 1889-1907", BA Hons Essay (University of Otago, 1985); Madeleine Seager, Edward William Seager: Pioneer of Mental Health (Waikanae, 1987).

<sup>16</sup> Hilary Haines, "'The Peculiarities of their Sex': An Analysis of the 'Causes of Insanity' among New Zealand Women from 1878-1902", in Women's Studies Conference Papers '81 (Auckland, 1982), pp.175-190.

Two exploratory papers raise questions that will be considered in this thesis. Ann Magee's examination of the place of asylums in New Zealand's social order explicitly shifts away from the administrative focus through its consideration of the family's active role in the committal process.<sup>17</sup> Barbara Brookes' paper, a very preliminary discussion of the admission and treatment of patients to Seacliff asylum in Dunedin, raises the issue of the importance of gender in any analysis.<sup>18</sup>

This thesis, then, is different from most previous New Zealand studies of madness because of its focus on gender and its concentration on casenotes as a primary source. In pursuing some of the considerations outlined above, it will attempt to explain how insane women were detected and treated and to what extent that experience was affected by gender. As well as being a study of madness it also sheds some light on the role of women in colonial New Zealand and other social and economic changes of the time.

Although it is based on an institution the study focuses on the experience of patients in the process of admission and treatment. It proceeds on the premise that institutions can yield information about the kinds of people who usually left no other record of their life

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<sup>17</sup> Ann Magee, "Asylums and the Social Order in Colonial New Zealand: An Exploratory Study", Unpublished paper presented to the 1981 Geography Conference, Wellington.

<sup>18</sup> Barbara Brookes, "The early days of Seacliff Asylum: the admission and treatment of patients", in Proceedings of the First New Zealand Conference on the History of New Zealand and Australian Medicine, ed. R.E. Wright-St Clair (Hamilton, 1987), pp.172-176.

experience. Their passage through an institution such as a state asylum generates a wealth of information in the form of casenotes and other records. This approach also goes some way towards solving a problem that sometimes besets historians of women - lack of written sources (although as shall be seen, there are still problems with case records as they relate to both male and female inmates).

This thesis follows Matthew's methodological model. I have taken a random sample of twenty patient case records from the years 1870, 1890, and 1910, sixty in total. Five male cases are included in each year, because I believe gender is a comparative tool of analysis. Although the focus is primarily on women's experience, sex-role stereotypes occur in relation to each other, and socially-approved models of behaviour are constructed for each sex - points which Garton considers but Matthews and Showalter do not. Cataloguing women's oppression is not enough, for historians must consider how and why oppression operates.<sup>19</sup> As Natalie Zemon Davis argues of the European past, "we should not be working only on the subjected sex any more than an historian of class can focus exclusively on peasants."<sup>20</sup> The study spans from the early years after the opening of the Auckland Lunatic Asylum, when records become readily available, until the year before the 1911 Mental

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<sup>19</sup> The London Feminist History Group, The Sexual Dynamics of History: Men's power, Women's resistance (London, 1983), pp.2-3.

<sup>20</sup> Natalie Zemon Davis, "'Women's History in Transition: The European Case", Feminist Studies, 3 (1976), p.90.

Defectives Act: that Act changed official mental health terminology and provision for patient care, heralding what can properly be considered a new era.

The records on which this study is based are not without their difficulties and limitations.\* Casenotes, the primary source of evidence, are problematical, as well as vital because they provide an individual focus to general trends, and information about people who left no other records. As Matthews notes, such records are neither autobiographical nor biographical. A patient has no say in their recording and the notes do not seek to present a person's life in any terms other than those which further the interests of the institution.<sup>21</sup> They, and other types of institutional records, are necessarily selective and place a case-history construction on the patient's past life.<sup>22</sup> All historical records however, including diaries, are filtered through the writer's particular perspective and written with the perceived need of a reader in mind, and the historian has always to deal with these issues. The Auckland Asylum records in particular vary in quantity and quality, and this, in itself reveals much about perceptions of patients and methods of treatment.

Heightened awareness of bias in historical records is another consequence of using gender as a tool of analysis. Feminist historians realise that "positivist conceptions

<sup>21</sup> Matthews, pp.24-25.

<sup>22</sup> Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (Chicago, 1962/1968), p.145.

\* I was only granted access to them on the condition that I changed identifying details. Fictitious names have been used throughout, except where names were already a matter of public record.

leave little room for deduction, inference, symptomatic reading or accounting for absences and silence in extant evidence".<sup>23</sup> Underlying this thesis then, is the question of what can be known from surviving records about women's experience in a lunatic asylum, and, by extension, of women's lives generally at that time.

My other main sources are the annual reports of the lunatic asylums of the colony, published in the Appendices to the Journals of the House of Representatives. These contain often quite detailed reports and statistics on each asylum, from both the government inspector and the medical superintendent. Most of the time they concentrate on the male patients. A lack of a central government archives relating to the asylum was partly remedied by the extensive Auckland Provincial Government files covering the period 1872-1876.<sup>24</sup> They reveal much of the administrative detail which structured the experience of the women inside the asylum. Newspaper accounts of the asylum, coroner's reports on individual patients, and inspector's and official visitor's reports on the institution's conditions filled out the picture. Often a wide range of materials had to be

<sup>23</sup> Judith Allen, "Evidence and Silence: feminism and the limits of history", in Feminist Challenges: Social and Political Theory, eds. Carol Pateman and Elizabeth Gross (Sydney, 1986), p.176.

<sup>24</sup> "Administrative action" was responsible for the destruction of most Health Department registered files prior to the 1920s. Fire destroyed the Auckland provincial archives prior to 1872. See S.R. Strachan, "Archives for New Zealand Social History", NZJH, 13:1 (April, 1979), pp.89-90 and IAl 1933/182/7 Records - Mental Hospitals Department - transfer of files to Mental Hospitals Department.

brought together in order to reconstruct the experiences which are examined.

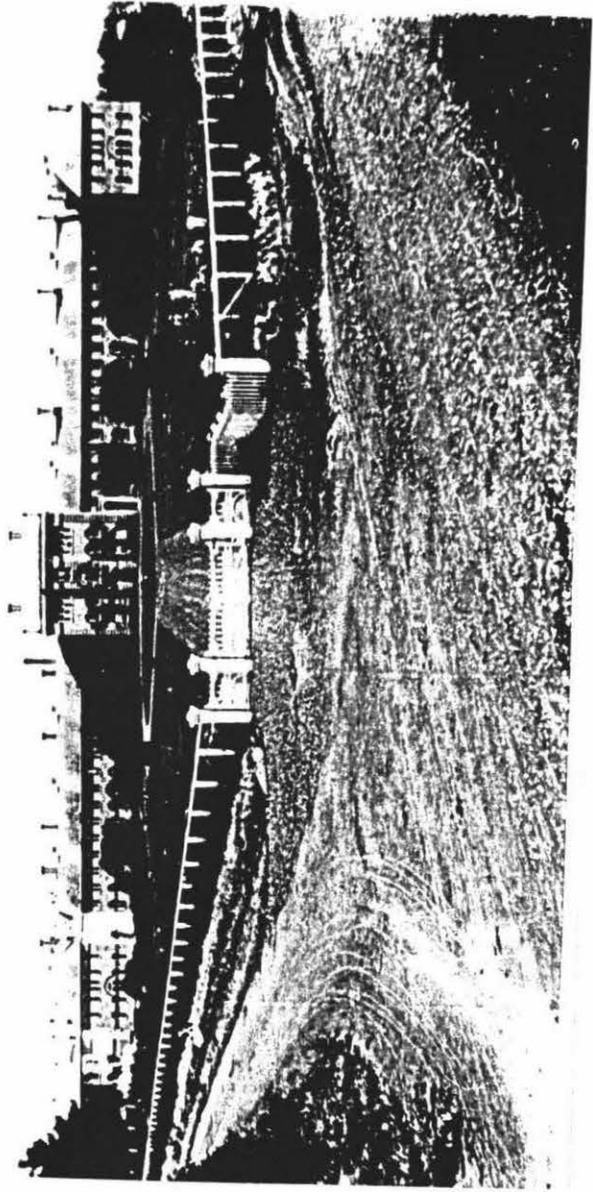
The thesis covers both committal and treatment, reflecting my belief that the process of admission is just as important as the experience of being a patient. As Michael Ignatieff and Mark Finnane have argued, the significance of the asylum in a community, and the reasons why various people were committed to it (and why others were not) can only be partially grasped by studying what happens inside its four walls. What drove families to commit their female members? What did the patients do first to be labelled mad, and second to be committed? Guidelines were laid down by the state and by medical men, but how they were interpreted by the community could be another matter altogether. Detection is as significant as treatment because definitions of insanity and thus the kind of women being admitted affected methods of treatment. The asylum experience, I would suggest, is not self-contained but as much a reaction to the structure and functioning of society outside its walls.

The chapters trace the journey a patient would have taken. Following preliminary chapters on the background to asylum care in New Zealand and the Auckland Lunatic Asylum, chapter three looks at the reason why individuals were committed. It reveals that families put up with deranged women for quite some time until they felt they could no longer cope, and that social and economic factors played a

determining role. All parties to committal placed heavy emphasis on whether women were performing their household duties and living up to the expected women's role. Chapter four examines the second part of the committal process when doctors assigned official causes of insanity. Gender becomes an even more dominant influence there. The examination of treatment begins with a social profile of the asylum patients, while chapter six focuses on the therapy provided and daily life in the institution which, it was found, was conceived according to strict sex-role stereotyping.

The Auckland Lunatic Asylum in the 1890s, photographed by  
Margaret Matilda White

**Source:** Auckland Institute and Museum



## Chapter One

### The Institutional and Legal Context

One of the frameworks within which public views of insanity were formed was provided by the principles underlying both the building of state asylums, and the enactment of statutes concerning both their management and the confinement of lunatic individuals within them. This chapter will first consider how and why public care for the insane developed, outlining the confusion of responsibilities and institutions from the 1840s to 1860s and the consequent construction of specialised asylums up until the late 1880s. It will then examine the legal developments which accompanied the provision of these new institutions and finally, the characteristic features of New Zealand's asylums will be considered.

New Zealand followed overseas developments in seeing institutionalisation as the proper response in treatment of the insane in the nineteenth century, this in turn being part of the wider trend in the western world of the sequestration of particular problem groups and the creation of special institutions in which to cure or rehabilitate them.<sup>1</sup> The differentiation of the insane was accompanied in

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<sup>1</sup> George Rosen, Madness in Society: Chapters in the Historical Sociology of Mental Illness (Chicago, 1968), pp.159-164; M.A. Crowther, The Workhouse System 1834-1929 the History of an English social institution (London, 1981), p.268.

Britain by the rise of the state asylum. Madhouses (which were mostly run for profit), charitable institutions and places in gaols, houses of correction and workhouses were replaced by a national system of public and county borough asylums, in a move predicated on new assumptions about madness. From the late eighteenth century in Britain, Europe and North America, a group of lay reformers argued that madness was a moral problem and that lunatics were not unfeeling brutes but capable of reform. In England these new "humanist" attitudes were the catalyst for the struggle for improved conditions within institutions, the creation from the 1830s of new asylums geared to the moral reform of inmates, and the development of laws governing the committal of lunatics to institutions.<sup>2</sup>

Institutionalisation, medicalisation and more formal admission procedures characterised the treatment of the insane in England from the mid-nineteenth century and these changes were reflected in New Zealand legislation which was derived from the English. The Lunatics Act of 1845 required all counties and principal boroughs of England and Wales to make provision for the care of lunatics.<sup>3</sup> It provided for government licensing and inspection of both the existing private and new public asylums, and funding organised through central, rather than local government nominees. (Bodies elected by local ratepayers, such as boards of

<sup>2</sup> Garton, Medicine and Madness, pp.2-3; Showalter, The Female Malady, p.25; Brunton, "Mental Health Law", p.71.

<sup>3</sup> Showalter, The Female Malady, p.17

guardians and local boards of health, consistently held back public health and other improvements.<sup>4)</sup>

The 1845 Act reflected doctors' arguments that madness was a physical problem requiring medical intervention. It enabled doctors to establish a monopoly in this previously lay field, by requiring asylums to keep records of medical visits and treatments. Yet this development should not hide the fact that insanity was visibly a threat to life and property, and therefore a law and order problem. Indeed, the asylum's acceptability to taxpayers, ratepayers and county elites was greatly assisted by its associations with public order and the security of life and order.<sup>5</sup>

More formal admission procedures were also established in amending legislation of 1853 and 1862 as a result of what might be called the "save the sane campaign"<sup>6</sup> and fears of wrongful confinement. Patient rights received a higher profile because of the unsavoury reputation for exploitation and illegal detention attached to private care of the mentally ill. Newspapers printed stories of asylum scandals, cases of abuse of admission procedures and incidents which linked mental illness with violent behaviour.<sup>7</sup>

<sup>4</sup> *ibid.*, p.26; J.K. Walton, "Casting Out", p.133.

<sup>5</sup> J.K. Walton, "Casting Out", p.134; Brunton, "Mental Health Law", pp.73-74.

<sup>6</sup> An expression used by Brunton in "Mental Health Law", p.74.

<sup>7</sup> *ibid.*, pp.74-75; Scull, Museums of Madness, pp.50-54; Brunton, "Citadels", p.4; For more detail on this phenomenon see Clive Unsworth, "The Balance of Medicine, Law and Social Work in mental health legislation 1889-1959", in Social Work, Welfare and the State, eds. Noel

The provision of care for the mentally ill in early colonial New Zealand followed English precedent although it developed in a more ad hoc and piecemeal fashion. Viewed primarily as disruptive of law and order, most lunatics in the first pakeha settlements were housed in the local gaol. There the insane joined a motley collection of first offenders, hardened criminals, children and debtors, in the overcrowded, insanitary and unsecured lockups.<sup>8</sup> If it was feasible, female lunatics were sometimes placed in separate wards in the more respectable environment of the local hospital, showing that differentiation by gender, which was to be a feature of asylum care, was a consideration in some areas from the beginning of settlement.<sup>9</sup>

The centrality of the link between insanity and law and order was reinforced by the legalistic mode of committal, for police acted as "go-betweens". Information frequently passed from relatives to officials via the police, and even if a friend or relative initiated proceedings the police carried out the formal requirements and conveyed alleged lunatics to asylums or courts pending examination.<sup>10</sup> The symbolism of such words as "arrest" and

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Parry, Michael Rustin and Carole Satyamuri (London, 1979), pp.104-124.

<sup>8</sup> Jermyn, pp.23-32; Brunton, "The New Zealand Asylum", p.157.

<sup>9</sup> Brunton, "Citadels", p.3.

<sup>10</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, s 5, 10-11; The Lunatics Act, 1882, ibid., 1882, s 5, 12-16; W.E.Collins, On Suggestions for the Reform of the Lunacy Laws, with special reference to the nomenclature used and the present methods of procedure under the Act (Wellington, 1898), p.5; Reports on the Lunatic Asylums of the Colony, AJHR, 1882, H.9, p.3.

"detention", used by people in and outside the asylum system, cemented the connection between insanity and law and order.<sup>11</sup> Newspapers published the proceedings of the daily court sittings, including cases of lunacy.<sup>12</sup> Lunatic asylums and gaols were frequently discussed in the same breath,<sup>13</sup> and residents were referred to as "inmates" and their rooms as "cells".<sup>14</sup> Moreover, the Lunatic Acts gave the police power to detain people who had not committed a crime by holding them in custody pending examination. As Mark Finnane notes of the Irish and Australian situations, an asylum constructed on this basis was not simply a refinement of the workhouse or gaol. Neither was it an effect of the medicalisation of the treatment of the mad, as reformers and doctors claimed. Rather than more positive benefits accruing for the mad, their institutionalisation carried a renewed element of punishment.<sup>15</sup>

Emphasis on the criminal and legalistic flavour of New Zealand's response to insanity alerts us to the more complex nature of New Zealand society which has given itself a reputation for being a "welfare laboratory", based on the relatively early provision of old age pensions and the introduction of the "welfare state" by the first Labour government. In an important article, W.H. Oliver argues that there was as much evidence of paternalism,

<sup>11</sup> NZPD, 129 (1904), p.410.

<sup>12</sup> For example, NZH, 13 September 1870, p.3, 26 May 1876, p.3.

<sup>13</sup> NZPD, 111 (1900), p.261.

<sup>14</sup> NZH, 26 October 1871, p.2.

<sup>15</sup> Finnane, "Asylums, Families and the State", p.138.

characterised by control, discipline and efficiency, as progress and reform; "one should look beyond old age pensions and votes for women to the prisons and lunatic asylums".<sup>16</sup> Control, discipline, efficiency and order were regarded with particular importance in the period that asylums were established in New Zealand. The colony underwent a "phase of consolidation" from the 1860s and 1870s and as a dependent economy, imported the institutions required for economic growth, along with migrants, capital and technology.<sup>17</sup> At the same time, the state had to fund schools to train citizens, hospitals to care for the physically and mentally incapacitated, and institutions to correct, retrain and punish the criminal. Ann Magee places the detection and incarceration of the insane against this background of economic and social development, and sees it as part of the geographical separation of groups who threatened the basis of production (that is, land and labour power), and thus the social order of New Zealand. The Maori, she contends, withdrew to reserves and the remote interior, the Pakeha poor were set apart in prisons,

<sup>16</sup> W.H. Oliver, "Social Welfare: Social Justice or Social Efficiency? Social Policy in the Liberal Period", NZJH, 13:1 (April, 1979), pp.25-26. Oliver enlarged upon this view in his essay "Social Policy in New Zealand: an historical overview", in New Zealand Today: report of the Royal Commission on Social Policy, April 1988, Vol.1, AJHR, 1988, H.2, pp.3-45. This idea receives extended treatment in Margaret Tennant, Paupers and Providers: Charitable Aid in New Zealand (Wellington, 1989).

<sup>17</sup> W.J. Gardiner, "A Colonial Economy", in The Oxford History of New Zealand, ed. W.H.Oliver with B.R. Williams (Wellington, 1981), pp.261-262.

asylums and slums, and women relegated to the kitchen.<sup>18</sup> The committal and treatment of patients at the Auckland asylum and the laws on which they were based add weight to her assertions.

Yet at the same time more benevolent impulses operated. Many were unhappy with this emphasis and throughout the nineteenth century argued against the "lunatic=criminal" view. Reformists who held to the medical model of madness, which gained increasing support by the end of the century, denied any connection between crime and insanity. They criticised the legalistic mode of committal for a variety of reasons. Some sought further clarification of the law and more effective legal procedures. In 1873, when the Legislative Council debated a motion to appoint an Inspector-General of Lunatic Asylums for the colony, one member voiced his lack of confidence in the five year old Lunatic Act. "Its machinery was capable of being put into motion so as to endanger the liberty of the subject", he argued.<sup>19</sup> The issue of wrongful committal dominated debate on mental health care during the 1880s and 1890s, and a member of the House claimed in 1889 that "everyone knew the ease with which persons could now be put into lunatic asylums".<sup>20</sup> Others questioned the whole basis of the laws. Thus by 1900, concerned individuals urged voluntary admission, believing it would facilitate treatment by

<sup>18</sup> Magee, p.13.

<sup>19</sup> NZPD, 14 (1873), p.361.

<sup>20</sup> *ibid.*, 64 (1889), p.358.

catching the illness in its early stages. It would also avoid the stigma of committal through the police and the courts: when two medical men certified a person insane, the case went before a magistrate and he had no alternative but to commit the person to an asylum.<sup>21</sup> According to the "mental science point of view" of Mr Wilford, the Member of Parliament for the Hutt, mental hospitals were for deranged men, not criminals.<sup>22</sup>

At a practical level, problems abounded from the beginning in the attempt to regard insanity in the same light as criminality. Treatment for the mentally ill in the gaols was non-existent, and the more violent interrupted gaol discipline. Both humanitarian reformers and gaolers condemned the lack of classification, mixing of the sexes and terrible overcrowding that resulted.<sup>23</sup> The subsequent more frequent use of hospital wards or annexes in the 1850s and 1860s was regarded as an equally temporary solution, because of similar management problems and the fact that the insane, in the words of W.A. Brunton, "hardly fitted the sickness model either".<sup>24</sup> Even after an asylum annexe was constructed in the hospital grounds at Auckland in 1853, the occasional lack of space forced the authorities to revert to the use of the prison.<sup>25</sup> A third alternative,

<sup>21</sup> *ibid.*, 113 (1900), p.71.

<sup>22</sup> *ibid.*, 138 (1906), p.251.

<sup>23</sup> Jermyn, pp.42-45.

<sup>24</sup> Brunton, "The New Zealand Asylum", p.157.

<sup>25</sup> Robyn Anderson, "'The Hardened Frail Ones': Women and Crime in Auckland, 1845-1870", MA Thesis (University of Auckland, 1981), p.172.

community care in the form of boarding out of lunatics to private families for payment, had proved "defective and inadequate".<sup>26</sup> Voices from the more influential section of major towns, aided by their local newspapers, public meetings and the occasional scandal through the 1850s and '60s, called for the establishment of separate institutions for the insane.<sup>27</sup>

The concept of specialised asylums had been embodied in the first piece of legislation dealing with insanity, the 1846 Lunatics Ordinance, although the first lunatics' building at Karori was not established until 1854. During the provincial period a network of lunatic asylums was founded. Dunedin and Christchurch opened their asylums in 1863, Nelson in 1864 and the Whau Lunatic Asylum was proclaimed in Auckland in 1867. Westland's Seaview asylum at Hokitika was the final asylum built in this period in 1872.<sup>28</sup> The tiny licensed asylums at Napier and New Plymouth which were established in 1870 and 1874 remained located in a wing of the gaol and hospital respectively.<sup>29</sup> After the provinces were abolished in 1876, two further asylums were built, principally because of overcrowding. The transfer of patients from Dunedin asylum to a new institution at

<sup>26</sup> Brunton, "The New Zealand Asylum", pp.157-158.

<sup>27</sup> *ibid.*

<sup>28</sup> *ibid.*, p.159.

<sup>29</sup> Reports on the Lunatic Asylums in New Zealand, *AJHR*, 1870, D.29, p.8. The Napier asylum closed in 1886 and the New Plymouth asylum had released its last patient in 1880. Patients were then transferred to other provincial amenities.

Seacliff began in 1878 and was completed in 1884,<sup>30</sup> and in 1887 a new asylum was opened out at Porirua near Wellington. The Mt View asylum which had replaced the Karori institution in 1873, continued to operate in tandem with the new one at Porirua until 1910.<sup>31</sup> These asylums were just one kind of institutional response to social problems in nineteenth century New Zealand and were part of a wide-ranging and growing system of reformatories, industrial schools, rescue homes, old people's homes and prisons.<sup>32</sup>

Unlike England with its mixed public and private asylum provision in the same period, asylums here were primarily a state responsibility. Both practically and philosophically, private asylums were not a viable alternative on a wide spread basis. Their scandalous history of profiteering in England made the colonists suspicious of their efficacy,<sup>33</sup> and a precedent had already been set for public provision of lunatic care in Britain. More importantly, New Zealand lacked the large reserves of private wealth which spurred philanthropic endeavours

<sup>30</sup> See Hubbard, pp.7-8.

<sup>31</sup> See Williams, chapter three, for more information.

<sup>32</sup> For studies of the latter institutions see Bronwyn Dalley, "From Demi-mondes to Slaveys: A Study of the Te Oranga Reformatory for Delinquent Women, 1900-1918", MA Thesis (Massey University, 1987); Margaret Tennant, "Elderly Indigents and Old Men's Homes, 1880-1920", NZJH, 17:1 (1983), pp.3-20; Margaret Tennant, "Maternity and Morality: Homes for Single Mothers 1890-1930", Women's Studies Journal, 2:1 (August, 1985), pp.28-50.

<sup>33</sup> Scull, Museums of Madness, pp.50-54.

elsewhere towards the insane and others.<sup>34</sup> Government commitment here reflected a pragmatic recognition that "neither private benevolence nor local rate revenues could be attracted to the needs of the mentally ill - a meaningful contrast with hospitals and charitable aid".<sup>35</sup> The earliest asylums attached to hospitals and gaols were financed largely by public subscription, in a similar manner to hospitals.<sup>36</sup> But the marked lack of public interest and enthusiasm, along with the stigmatisation of the insane, and the fact that New Zealand's population was not big enough to sustain a dual system, forced provincial governments to administer and fund the new asylums. For example, the inspector at the Auckland asylum noted in 1870, three years after it had opened, that no large donations or bequests had been made in that interval.<sup>37</sup> Not too surprisingly, the Department of Lunatic Asylums was the first state social service established after the abolition of the provinces.<sup>38</sup>

<sup>34</sup> Primrose, p.41; Margaret Tennant, "Magdalens and Moral Imbeciles: Women's Homes in Nineteenth Century New Zealand", Women's Studies International Forum, 9:5 (October, 1986), p.494.

<sup>35</sup> W.H. Oliver, "The Origins and Growth of the Welfare State", in Social Welfare and New Zealand Society, ed. A.Triln (Wellington, 1977), pp.3-4; Max Abbott and Hilary Haines, "Deinstitutionalisation and Social Policy in New Zealand 1: Historical Trends", Community Mental Health in New Zealand, 1:2 (February, 1985), p.51; A Health Service for New Zealand, AJHR, 1975, H.23, p.13.

<sup>36</sup> Abbott and Haines, p.45.

<sup>37</sup> H.H. Turton to Provincial Superintendent, 27 February 1874, AP2 1874/683, p.4.

<sup>38</sup> For the Department of Lunatic Asylums' administrative history see Brunton, "Hostages to History".

Institutionalisation of the insane was accompanied by an elaborate set of mental health laws. Four major statutes were enacted before 1910: the Lunatics Ordinance of 1846 (amended in 1858 and 1866), the Lunatics Acts of 1868 and 1882 (amended in 1891, 1894 and 1900), and the Lunatics Act of 1908, which did not add anything new but consolidated existing legislation as part of a general review of New Zealand law.<sup>39</sup> In addition, there were two acts, passed in 1873 and 1879 during a period of government-organised immigration, that aimed to prevent the importation of "imbecile" passengers into New Zealand.

In general terms the 1846 Lunatics Ordinance aimed to prevent the commitment of criminal acts by the insane, and provided for the apprehension and safekeeping of such "dangerous lunatics" in gaols or hospitals, and their subsequent transferal to a public lunatic asylum until recovered. The Ordinance also provided for the removal to an asylum of insane prisoners, persons on trial who were acquitted on the grounds of insanity, and "persons who are insane but not dangerously so" on the application of their family or friends. Lunatics could only be taken under the care and protection of relatives and friends if the latter placed a bond for the lunatic's peaceable behaviour and safe custody with the court. The cost of their maintenance was to be met by the colony, except where relatives might agree to meet the cost of maintenance out of the lunatic's

<sup>39</sup> Brunton, "Mental Health Law", p.71.

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estate. The Ordinance also stipulated that visitors be appointed to the lunatic asylums.<sup>40</sup>

The 1858 Lunatics Ordinance Amendment made more explicit the rather vague definitions of insanity in the 1846 ordinance. It was concerned with "mental derangement" as well as the "dangerously insane". A person could now be apprehended if "suffering from mental derangement, either permanently or temporarily as aforesaid, which is likely to endanger the safety of any person whomsoever or to result to any injury to property..."<sup>41</sup> The Lunatics Act of 1866 redefined the arrangements for persons on arraignment and found to be insane, and for insane prisoners.<sup>42</sup>

By the time mental health legislation was next revised a national network of asylums was being built and more comprehensive legislation was required. The 1868 Lunatics Act was divided into five parts. The first part rehearsed the proceedings for "restraint" (the legal term for detention), although official forms to be used for committal were appended to the Act for the first time. Two new criteria for committal were introduced: lunatics wandering at large, not being properly taken care of or being cruelly treated, and drunkards who volunteered for treatment, or who in the view of a relative or friend were squandering their income or neglecting or abusing their

<sup>40</sup> Lunatics Ordinance 1846, Statutes of New Zealand, 1846, No. 21.

<sup>41</sup> The Lunatics' Ordinance Amendment Act, 1858, *ibid.*, 1858, No. 61, p.337.

<sup>42</sup> The Lunatics Act, 1866, *ibid.*, 1866, No. 74.

family. The other four parts of the Act were new. They made provision for officials to be appointed to the new asylums and licensed houses, and for registers, medical journals and case books to be kept within them. Procedures for inspectors and official visitors were laid out in precise detail, as was the policy and practice of discharge. The powers and duties of the registrars and the Supreme Court in respect to lunatics' estates were also set out.<sup>13</sup>

Subsequent changes to mental health law did not change any of the basic principles, but made provisions more detailed and specific, suited to changing economic and social factors. The Lunatics Act of 1882 added clauses on the recovery of maintenance monies and boarding out of lunatics. It also devoted an entire new part to the regulation of the work of "habitual drunkards" and the prevention of their escape.<sup>14</sup> The 1891 Lunatics Act Amendment Act recognised that the country was in the midst of an economic depression and that its asylums were becoming overcrowded and underfunded. A standard cubic space for dormitories and sleeping rooms was stipulated. Provision was made to commit the estates of alleged lunatics and not the individuals, if they were capable of managing themselves but not their affairs. Similarly, upon each committal officials now had to inquire into the lunatic's means and make an order for maintenance. Recovery of monies could be made after death or discharge. Husbands

<sup>13</sup> The Lunatics Act, 1868, *ibid.*, 1868, No. 16.

<sup>14</sup> The Lunatics Act, 1882, *ibid.*, 1882, No. 34.

were now liable for the maintenance of wives and vice versa. The Act also gave the Public Trustee more powers to deal with estate monies.<sup>45</sup> The effects of the "save the sane" campaign are evident in the act too. New clauses gave protection to persons signing and carrying out orders, reports and certificates. Further amendments in 1895 and 1900 extended the Public Trustee's jurisdiction.<sup>46</sup>

Overseas efforts in this area were monitored closely, and much of New Zealand law was either wholesale adoption or reformulation of English and Australian statutes to suit local conditions. Many saw here the beginnings of problems that had developed fully elsewhere and therefore could, they assumed, be controlled or eradicated before they had taken hold.<sup>47</sup> The Imbecile Passengers Acts of 1873 and 1879 illustrate this belief in the scourge of the old world, and the fear that such persons might become a charge on the public purse.<sup>48</sup>

The development of separate asylums and the accompanying laws which isolated care of the insane from other health

<sup>45</sup> The Lunatics Act Amendment Act, 1891, *ibid.*, 1891, No.22.

<sup>46</sup> The Lunatics Act Amendment Act, 1895, *ibid.*, No.56; The Lunatics Act Amendment Act, 1900, *ibid.*, 1900, No.4.

<sup>47</sup> Oliver, "Social Welfare", p.26.

<sup>48</sup> The Acts required the owner, charterer or master of a ship to secure a bond of 100 pounds on every passenger who, in the opinion of the provincial superintendent, was either lunatic, idiotic, deaf, dumb, blind or infirm and therefore likely to need public or institutional relief. The Imbecile Passengers Act, 1873, Statutes of New Zealand, 1873, No. 70, ss 3-4; The Imbecile Passengers Act Extension Act, 1879, *ibid.*, 1879, No. 39.

measures was assisted by the attitudes of hospital authorities, who actively disassociated themselves from mental health care. Because asylums were state-funded and could not refuse patients who were committed by court order, locally-funded hospitals sent them their worst and most expensive cases, while passing regulations denying admission of the insane.<sup>49</sup> In addition, those in charge of old people's homes and refuges and Charitable Aid Boards increasingly attempted to get troublesome individuals suffering from senile decay committed to the public asylums.<sup>50</sup> The fracas at Auckland's Costley Home for the Aged is a case in point. Duncan MacGregor, Inspector-General of Asylums, wrote to the Auckland Hospital and Charitable Aid Board in 1890 suggesting that about thirty elderly lunatics could be transferred to the new home. Six were taken there immediately before the Board could consider the proposal, whereupon the secretary refused to admit them and the Asylum superintendent refused to have them back. The police had to take charge of them. The Board claimed that it could not be expected to support the men from the local rates, when they had been admitted from all over the country, and said there was no room. Other boards watched developments, fearing an influx of harmless, but

<sup>49</sup> Brunton, "Citadels", p.4.

<sup>50</sup> These moves were controversial. A continuing discussion was conducted in the New Zealand Herald over this issue and it was brought up in parliament and in the annual reports on the lunatic asylums: NZH, 18 January 1888, p.4, 28 January 1888, p.3, 21 February 1888, p.4; NZPD, 67 (1890), pp.157-158; AJHR, 1898, H.7, p.3, 1903, H.7, p.3.

troublesome and poor, senile old people into their homes. The Auckland Board won, for the Salvation Army offered to take the men in.<sup>51</sup>

As a result of these processes the New Zealand asylum developed particular characteristics. It was originally conceived of as a "largely self-supporting small community with something of a family atmosphere",<sup>52</sup> and initially some of them were of this nature. Yet by 1876 capacities ranged from 57 to 238 beds at the eight facilities, with an average size of 133. A mixture of social, economic and political factors accelerated this trend to large and complex institutions. Mental health services were increasingly associated solely with psychiatric hospitals under the founding head of the state Lunacy Department, Inspector Skae, who resisted the unpopular alternative of community care.<sup>53</sup> Since those in charge of asylums could not turn anyone away, the senile, mentally handicapped, epileptic, alcoholic and individuals suffering from general paralysis of the insane<sup>54</sup> continued to be admitted. Because of the ageing bachelor population in this period, many of these patients had no relatives in the colony and therefore could not be cared for at home. Finally, as the families of

<sup>51</sup> Tennant, Paupers and Providers, pp.47-48.

<sup>52</sup> Brunton, "Citadels", p.4.

<sup>53</sup> For a discussion of these factors and Skae's career see Brunton, "If Cows Could Fly".

<sup>54</sup> General paralysis of the insane manifests itself with the involvement of the central nervous system in the later stages of untreated syphilis.

those who had previously been cared for at home became casualties of the economic downturn in the 1880s and early 1890s, they were forced to give up their members to state care.<sup>55</sup> Thus by 1900 the average bed capacity had risen to 600, and the asylums had indeed become "citadels".<sup>56</sup>

These huge asylums required expanding numbers of staff to run them. At Auckland only twenty staff were employed in the early 1870s, whereas by 1910 the number was close to one hundred. While the Inspector-General of the Lunatic Asylums (later Mental Hospitals) Department had overall responsibility, on-site staff were involved in the day-to-day management. At the outset lay superintendents and visiting medical officers stood at the pinnacle of the hierarchy within the institution, but by the 1880s, as had happened in England, resident medical superintendents assumed the controlling position, a move coinciding with the assertion of medical dominance in the new field of mental science.<sup>57</sup> By the 1890s growing patient populations encouraged the appointment of assistant medical superintendents at the larger institutions. Below the superintendent came the matron and head male attendant (or keeper as he was formerly called) who oversaw the female and male staff respectively. Asylums also employed night staff, domestic servants, clerks to keep the patient

<sup>55</sup> Brunton, "Citadels", p.4.

<sup>56</sup> *ibid.*, p.7.

<sup>57</sup> Brunton, "If Cows Could Fly", pp.49-50. For the earlier example of this trend in England, see Scull, Museums of Madness, pp.162-163.

records, and farm managers and gardeners since many of the institutions were located on farms in order to keep costs down and provide a means of patient employment. A system of district inspectors and official visitors complemented the residential staff and acted as public watchdogs.

From the point of view of the patients there were three issues of special interest. The first covered the vexed issue of defining exactly what was meant by the term "lunatic". The second theme involved the question of finance - who would pay for the required certification and the maintenance of individuals once they were inside. Lastly, parliamentarians were very concerned to provide adequate and comprehensive inspection of conditions within each asylum. Definition and maintenance were grounded in apparently gender-neutral law, but the provisions covering inspection demonstrate a clear example of the widespread perception that female and male lunatics had different needs.

From the beginning the definition of insanity was couched in law and order terms, as we have seen. Suspected lunatics were detained under legislation which designated them "dangerous lunatics" or suffering from "mental derangement, either permanently or temporarily as aforesaid, which is likely to endanger the safety of any one person whomsoever or to result in any injury to property", or any person detained in custody who "is at that time or is likely shortly to become dangerous to

himself or others, or is in any way disposed to violence."<sup>58</sup> The equation of lunacy with criminality was continued by the Lunatics Act of 1866 which was concerned solely with the charged and convicted insane and with lunatic prisoners.

Subsequent acts defined "lunatic" more benignly as "any insane person, idiot, lunatic, or person of unsound mind or incapable of managing himself or his affairs, whether found lunatic by inquisition or not...."<sup>59</sup> Nevertheless the law continued to associate insanity principally with criminal acts, including suicide. Of the four categories under which lunacy was dealt with in law, three dealt with dangerous lunatics, lunatic prisoners and lunatic charged with indictable offences.

Yet many were not "dangerous lunatics". An early inspector at Auckland, reiterating a point that was apparently often overlooked, wrote that patients "are not the subjects of crime and are not sent here to undergo punishment".<sup>60</sup> Later in the period, an official visitor declared that "it is evident that there are in our asylums persons who are no more dangerous than many persons in our streets...."<sup>61</sup>

<sup>58</sup> Lunatics Ordinance 1846, New Zealand Statutes, 1846, preamble; The Lunatics' Ordinance Amendment Act, 1858, *ibid.*, s 1-2.

<sup>59</sup> The Lunatics Act, 1882, *ibid.*, 1882, preamble, p.288.

<sup>60</sup> H.H. Turton to Provincial Superintendent, 27 February 1874, AP2 1874/683, p.8.

<sup>61</sup> NZH, 12 April 1888, p.6.

Moreover, many remarked on the nebulous and extremely wide ranging definition of lunacy, whether "dangerous" or not. In a debate over the 1895 Lunatics Estates Bill, members of the Legislative Council felt the criteria for insanity ought to be more limited, claiming people would be "less anxious to get rid of their relatives because they happened to be troublesome or eccentric".<sup>62</sup> No one could, with certainty, find an incontestable line between sanity and insanity: "the difficulty was to decide as to who was a lunatic and who was not".<sup>63</sup> Chapter three shows, as other studies of madness have demonstrated, that "the range of behaviour it [insanity] could be stretched to encompass was almost infinite".<sup>64</sup>

Despite the difficulties of detection and definition, there were changes in terminology during the period as increasing concern was expressed over the use of "lunacy", "lunatic" and "asylum". These words were judged by some to have "no scientific significance", but were "merely the relics of the ignorance of the 'dark ages'".<sup>65</sup> By 1910 lunatic asylums were re-titled mental hospitals and during the period "attendants" came to care for "patients", rather than "keepers" looking after "lunatics".

<sup>62</sup> NZPD, 91 (1895), p.689.

<sup>63</sup> *ibid.*

<sup>64</sup> Scull, Museums of Madness, p.238; See also Matthews, pp.21-22; Showalter, The Female Malady, pp.105-107; Joseph Robins, Fools and Mad: A History of the Insane in Ireland (Dublin, 1986), p.109.

<sup>65</sup> NZPD, 123(1900), p.162.

A second thrust of the mental health legislation in this period, namely, the question of who should pay for the maintenance of these new "beneficiaries of institutionalisation", provoked as much discussion as who should be the beneficiaries. As will be shown in chapter three, economic considerations were a significant determinant in the choice of committal for friends and relatives, not least because the cost of certification and asylum care could be carried by the state. With increasing numbers of lunatics and rising costs however, the Lunatics Act was amended in 1891 and certification costs were transferred to relatives or to the alleged lunatic's estate. The consolidated fund was viewed as a last resort.<sup>66</sup>

The considerable costs involved in treatment meant that relatives and friends had always been encouraged to care for the insane themselves if it was possible.<sup>67</sup> However, because of the necessity of institutional care in so many indigent cases, strict conditions of maintenance were applied. In the provincial period, the beleaguered Auckland Provincial Council passed an act compelling relatives who lived in the province and had sufficient money, to pay up to 30 shillings a week in support.<sup>68</sup> After the abolition of the provinces, relatives were held

<sup>66</sup> The Lunatics Amendment Act, 1891, New Zealand Statutes, 1891, s 2(1).

<sup>67</sup> Lunatics Ordinance 1846, *ibid.*, s 2; The Lunatics Ordinance Amendment Act, 1858, *ibid.*, 1858, s 4; The Lunatics Act, 1868, *ibid.*, 1868, s 12 and 1882, s 5.

<sup>68</sup> APCVP, 19 (1868), p.118.

responsible under The Destitute Persons Act of 1877, which set a rate of up to 20 shillings a week. In non-pauper cases, attempts were made to recoup money out of the lunatic's estate.<sup>69</sup> Yet because even these strategies did not work,<sup>70</sup> the 1891 act contained further amendments, which made it mandatory for officials to inquire into the lunatic's means and from the day of committal to make an order for maintenance. Orders could also be made retrospectively upon discharge or death. The onus for proving that a relative did not have sufficient money to comply with the Destitute Persons Act now lay with the defendant. Even if a wife or husband was detained without either spouse's consent, they were liable for the other's maintenance. Furthermore, in a radical departure, a new provision enabled a Magistrate to commit the estate but not the person, based on the premise that lunatics may be incapable of managing their affairs, but able to manage themselves without fear of danger.<sup>71</sup> Principles gave way to practicalities; before the two incapacities were regarded as synonymous.

Only with the issue of inspection, the third theme of this section, is there any sign of gender as a consideration in the definition and care of lunatics. The

<sup>69</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, ss 3-5; The Lunatics Act, 1882, *ibid.*, ss 286-287.

<sup>70</sup> At Auckland for example, in 1881 maintenance payments were only made on behalf of 27 of the 235 patients, and in only two cases did the money cover the entire cost of the care.

<sup>71</sup> The Lunatics Act Amendment Act, 1891, New Zealand Statutes, 1891, ss 8, 9, 12-13, 5.

Lunatics Acts of 1868 and 1882 provided for district inspectors and official visitors for individual asylums, all of whom would be Justices of the Peace. These officials were expected to inquire into the treatment and mental and physical health of the inmates; their living conditions; the provisions made for religious services, occupations and amusements; the classification and diet of inmates; and whether any system of coercion was used.<sup>12</sup> During the second reading of the 1891 amendment bill, a plea was made to alter the method of selecting official visitors to the asylums, in order to include more "ordinary" types of people. One member claimed "the whole country would be satisfied if what I may term the masses of the people were recognised in this way, and there would be more confidence in these institutions than there has been hitherto".<sup>13</sup> Three years later, the distinction of Justices of the Peace was dropped, not to allow the "masses" to inspect the institutions, but to pave the way for women visitors, who it was felt would be in a better position to see and make known the requirements of female patients.

The appointment of female visitors was part of a general movement seeking greater participation of women in more senior positions of all social services at the end of the century, which had been initiated by various women's groups and supported by local newspapers, the government

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<sup>12</sup> The Lunatics Act, 1868, *ibid.*, s 56; The Lunatics Act, 1882, *ibid.*, 1882, s 136.

<sup>13</sup> NZPD, 72 (1891), p.338.

and members of the Legislative Council.<sup>74</sup> Notions of gender roles were paramount. The Hon. W.P. Reeves, Minister of Education and Labour and also in charge of lunatic asylums, "took the stand on principle that for every institution where females were there should be female visitors".<sup>75</sup> A member of the Legislative Council agreed that "there was no doubt that the ordinary [official visitors] were not able to devote the attention to the requirements of women in the same way as women visitors might be able to do".<sup>76</sup> Female visitors were firmly identified with accepted feminine activity, confined as they were to the inspection of the female departments of the asylum only.

In the nineteenth century the insane were separated from the public and incarcerated within purpose-built asylums, cared for by increasingly "psychologically" trained staff. These institutions, particularly in the last quarter of the century, became overcrowded, grew larger and remained under resourced. In terms of the laws governing this social service, most of the innovations occurred in the areas of finance and inspection, as a response to pragmatic considerations. The mechanisms for committing individuals remained largely unaltered, although the terminology used

<sup>74</sup> Margaret Tennant, "Mrs Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions", *NZJH*, 12:1 (April, 1978), p.3.

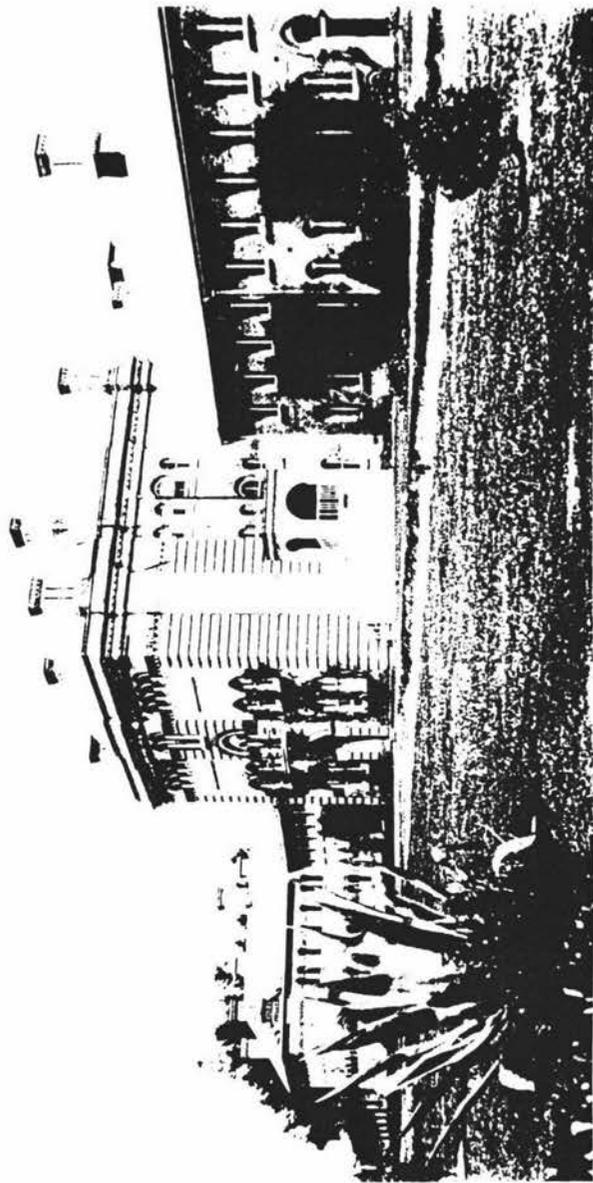
<sup>75</sup> *NZPD*, 83 (1894), pp.137-138.

<sup>76</sup> *ibid.*, p.612.

to describe these processes came under increasing attack and gradually changed.

The Auckland Lunatic Asylum in the 1890s, photographed by  
Margaret Matilda White

**Source:** Auckland Institute and Museum



## Chapter Two

### The Asylum

Having traced the development of mental health law and institutions in New Zealand, the discussion turns here to the physical and social environment of the asylums they entered, focussing particularly on the Auckland Asylum. The environment had a very important influence on what was and was not done to restore individuals to normality. It also set up expectations as to the kind of patients that would be committed, and was altered in turn to meet the demands of the patients that entered its confines. Three features in particular - the site, the buildings and its administration - demonstrate the contours of this habitat, which was based upon distinct theories of what female and male patients would want and need.

Ideas about the proper asylum environment were heavily influenced by foreign developments, particularly those in Britain. The environment in which Auckland lunatics were confined was established when the "moral management" school of insanity predominated in medical circles. This outlook, which had its heyday from the late eighteenth to the mid nineteenth centuries, had become the dominant conceptual paradigm in the care of the insane. It was stimulated by an ideological shift in the way madness was viewed and treated. By the end of the eighteenth century, lunatics

were viewed increasingly as sick humans rather than brute unfeeling animals, as was the case previously. The insane became objects of pity whose reason might be restored by kindly care. In existing asylums, "paternal surveillance and religious ideals replaced physical coercion, fear and force".<sup>1</sup>

Andrew Scull also argues for the materialist basis of these largely ideological changes. He places importance on the changes wrought by industrial capitalism. "In a society still dominated by subsistence forms of agriculture, nature rather than man is the source of the activity... But under the rationalization forced by competition, man's [sic] active role in the process presents itself ever more insistently to people's consciousness". Capitalism demanded a reform of character, consisting of the internalisation of new attitudes and responses and the practice of self discipline. The transformation in the conception of the lunatic was part of this wider shift.<sup>2</sup> The consideration of gender must be added to this account, for women had a specific role to play in the emerging capitalist society - that of reproducer of labour and keeper of the private sphere of the home.

The distinguishing characteristic of moral treatment was the emphasis on moral force and inner effort as a means of cure, based within the segregated, carefully ordered

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<sup>1</sup> Showalter, The Female Malady, p.8. See Digby, Madness, Morality and Medicine, chapter one, for an extended discussion of these developments.

<sup>2</sup> Scull, Museums of Madness, p.70-73.

environment of the new asylum. As Roy Porter has described it:

Madness was thus essentially a delusion, and delusion sprang from intellectual error. Mad people were trapped in fantasy worlds, all too frequently the outgrowth of unbridled imagination. They... required a stiff dose of rigorous mental discipline, rectification and retraining in thinking and feeling.<sup>3</sup>

Doctors believed that behaving as if the lunatic was a rational person would be the best way to cultivate the sense of self-esteem that led to self control. The lunatic's living conditions were critical to this process, as the proponents of this school of management believed that the lunatic's mind was still capable of responding favourably to an ordered and gentle environment.<sup>4</sup> In England this process entailed a "domestication" of the asylum, organised on a family model, with the resident medical superintendent and his wife serving as father and mother, the attendants as elder brothers and sisters and the patients as children.<sup>5</sup> Indeed the staff would play an indispensable role in the re-education process, providing dedicated and unremitting care, attention to the needs of individual cases, and also a personal example of an upright moral character.<sup>6</sup> The buildings were envisioned as

<sup>3</sup> Roy Porter, A Social History of Madness: Stories of the Insane (London, 1987), p.19.

<sup>4</sup> Digby, Madness, Morality and Medicine, pp.33-42; Scull, Museums of Madness, pp.68-69; Showalter, The Female Malady, pp.29-31.

<sup>5</sup> Showalter, The Female Malady, p.28. See Andrew Scull, "The Domestication of Madness", Medical History, 27 (1983), pp.233-248, for a fuller discussion.

<sup>6</sup> Digby, Madness, Morality and Medicine, p.140; Scull, Museums of Madness, pp.69,102.

instruments as well as places of therapy. Inside inmates were to be classified and separated according to the nature of their disorders, their social class and their sex, in a building that was meant to be reminiscent of a home rather than a prison. Finally, according to influential romantic notions, the new institutions were situated in rural locations away from the city and the factory of the spreading industrial landscape, which were thought to have increased the rates of insanity.<sup>7</sup>

By the 1870s in Europe and North America however, more and more patients filled the asylums, conditions deteriorated and many proved incurable.<sup>8</sup> Somatic or physiological pessimism was replacing the more optimistic theories of social causation. Neo-Darwinian theory brought more "scientific" rigour to the study of madness. "Alienists", as this new generation of doctors called themselves, insisted that insanity had a physical cause that could be discovered by "sophisticated medical practice".<sup>9</sup> Thus "Darwinian psychiatry" emphasised the organic nature of all mental illness and stressed the hereditary origins of mental weakness and defect, operating on the basis of what has been called the degeneration hypothesis. This theory focussed on the laws of selection

<sup>7</sup> Chris Philo, "'Fit localities for an asylum': the historical geography of the nineteenth-century 'mad-business' in England as viewed through the pages of the Asylum Journal", Journal of Historical Geography, 13:4 (1987), p.407.

<sup>8</sup> Digby, Madness, Morality and Medicine, p.115; Showalter, The Female Malady, p.102.

<sup>9</sup> Showalter, The Female Malady, p.104.

and survival believed to operate in the mental and social worlds. Thus it was argued that there is a degeneration from the normal human type, progressively transmitted through the generations. Moreover the apparent success of medicine in controlling infectious diseases in physical health contributed to the reduction of the importance of environmental approaches to mental as well as physical wellbeing.<sup>10</sup> The emergence of physiological explanations also helped raise the professional status of "mad doctors" who were the cinderellas of medicine and fighting to establish the credibility of the psychiatric profession.<sup>11</sup>

The rise of neo-Darwinism in mental health care did not lead to many innovations in environment design and administration, compared to the changes in treatment that were instituted. Rather, there was an effort to hold onto what was already there. Personalised care became impossible however, and more overt disciplinary techniques were used in an effort to cope. The asylum superintendents could not find the satisfaction in their work that their predecessors had, because of its low medical content and the ever-growing administration caused by larger patient numbers. They were not family-oriented; it was felt that too close a relationship with the insane, who were now often thought to

<sup>10</sup> This outline is taken from Digby, Madness, Morality and Medicine, p.115; Showalter, The Female Malady, pp.102-104; Peter Conrad and Joseph W.Schneider, Deviance and Medicalisation: From Badness to Sickness (Missouri, 1980), p.51-52.

<sup>11</sup> M.A. Shepherd, "Lunacy and Labour", Bulletin for the Study of Labour History, 34 (1977), p.64.

be incurable degenerates, was defiling and in particular it was not appropriate for wives to be matrons. The sheer size of the place inhibited interaction with patients. Faults in design and the consequences of age led many of the asylums to fall into disrepair, but economic and pragmatic considerations were uppermost. Plain materials, frugality and cost-cutting were features of the many additions to existing buildings in this period.

Larger social and economic developments contributed to this change of outlook. Severe economic depression, industrial unemployment and socialist organising undermined the hope that housing reform, moralising philanthropies, and the forces of social and industrial progress would reduce the problem of poverty as moral management was reducing the problem of lunacy.<sup>12</sup>

These British neo-Darwinian ideas were very evident amongst New Zealand's asylum doctors, whose background, training and Departmental leadership led them to revere foreign ideas.<sup>13</sup> Concerns particular to New Zealand (although manifesting themselves in different ways in other countries) bolstered this tendency. The changing outlook of alienists here in this period supported and was influenced

<sup>12</sup> Showalter, *The Female Malady*, p.109.

<sup>13</sup> Superintendents at the Auckland Asylum were born overseas and trained there. Even Dr Robert Beattie, superintendent at the end of the period from 1897, was born in Melbourne, studied at Otago University, and trained in medicine at the universities of Edinburgh and Aberdeen. *Cyclopedia of New Zealand*, vol.2 (Auckland, 1902), pp.190-191. Duncan MacGregor and Frank Hay, Inspector-Generals of the Department of Lunatic Asylums from 1886-1906 and 1907-1924, were strongly evolutionary.

by a wider concern with racial fitness and purity prompted by the perceived menace of the physical and moral decline of the Anglo-Saxon race, the falling birth rate and fears of an Asiatic influx.<sup>14</sup>

The hegemony of moral management was also undermined here by several other factors, some of which England experienced. The reorganisation of social services and local government, an extended economic depression, and the change in public attitudes effected by the "save the sane" campaign, led to overcrowding, underfunding, an influx of poor and chronic cases and a growing institutionalisation within the asylum.<sup>15</sup> The establishment and development of the Auckland asylum acts in many ways as a microcosm of these wider trends.

Opened in 1867, the Auckland Lunatic Asylum was situated on a government reserve of twenty five acres on the banks of the Whau creek at Point Chevalier, five miles from the centre of Auckland. In its early years it was known as the Whau Asylum, and later as the Auckland or Avondale Mental Hospital. The choice of site conformed to several of the moral management school's beliefs about the importance of medical, hygienic and moral environmental factors in an asylum's location. The Provincial Council committee in charge of its establishment recommended the Point Chevalier

<sup>14</sup> Phillip J. Fleming, "Eugenics in New Zealand 1900-1940", MA Thesis (Massey University, 1981), pp.76-77.

<sup>15</sup> Brunton, "The New Zealand Asylum", pp.158-159.

location because of its "cheerful aspect, nature of the soil, supply of water, and easy distance from town".<sup>16</sup> The Daily Southern Cross confirmed the situation as "healthy and retired, and abundance of scope is given for recreation grounds, as well as for gardening and farming, to which pursuits the more docile patients are profitably kept in similar institutions in the mother country".<sup>17</sup>

The motives behind the choice however were not as benevolent as these public statements might indicate. The asylum was situated on government land which would have decreased the initial costs of establishing the institution. Cheaper land prices in the countryside played some role in the establishment of other rurally-based institutions.<sup>18</sup> While industry and recreation in the "fine tonic air" was meant to aid recovery,<sup>19</sup> self-sufficiency based upon patient labour was a guiding principle in the establishment and successful operation of this and other public asylums in New Zealand.<sup>20</sup> In 1872, a Commission of Inquiry which had been appointed with the intention of improving the effectiveness of the mental and physical therapy offered at the asylum,<sup>21</sup> noted that "the economical management of such an institution is however most successful when the labour of the inmates is turned towards

<sup>16</sup> APCVP, Session 15, p.87.

<sup>17</sup> DSC, 25 January 1864, p.3.

<sup>18</sup> Margaret Tennant, "Elderly Indigents", pp.7-9.

<sup>19</sup> Annual Report of the Auckland Provincial Lunatic Asylum, APGG, 1868, p.131.

<sup>20</sup> Williams, p.125.

<sup>21</sup> NZH, 5 July 1872, p.2.

producing supplies for their own use."<sup>22</sup> Although the health of the patients was always advanced as the higher consideration, economic calculations were just as important. As the annual report for 1876 noted in regard to the smallness of the vegetable garden and the small amount of land under cultivation, "it is more important for the patients to have employment than eat peaches".<sup>23</sup> The purchase of 139 acres of adjoining land for a farm in 1879 was announced as promoting economy, outdoor employment and exercise.<sup>24</sup>

In addition, the potential of the site had to be realised by the patients. No improvements were made before occupation and the grounds were described as "sour and barren" and as a "cheerless heathy moor".<sup>25</sup> The site needed to be drained and cultivated, which, the 1872 commissioners noted, "with such an amount of labour at the disposal of the management [as] afforded by the numerous male inmates, ...could be done at a very trifling cost, tools and materials being all that is necessary".<sup>26</sup> By 1880, inmate labour was producing potatoes, fresh butter, milk, fruit

<sup>22</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.1.

<sup>23</sup> Reports on the Lunatic Asylums of New Zealand, AJHR, 1877, H.8, p.23.

<sup>24</sup> *ibid.*, AJHR, 1880, H.6, p.11.

<sup>25</sup> H.H. Turton to Provincial Superintendent, 27 February 1870, AP2 1874/683, p.2; The New Zealander, 11 July 1865, p.2.

<sup>26</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.1.

and vegetables as well as fattening pigs.<sup>27</sup> The head gardener was an attendant, assisted by a "thoroughly recovered patient", who was "exceedingly useful", and had nowhere to go if discharged. The patient was not paid until the inspector recommended compensation.<sup>28</sup> Once the farm was established, a large part of the medical superintendent's time was also taken up with the daily tasks of a gentleman farmer: inspecting stock, checking accounts and discussions with the farm manager.<sup>29</sup>

As well as financial considerations, it must be remembered that the only other choices facing staff at this time would have been restraint or a limited range of drugs. Outdoor work for male patients was healthy and attempted to direct them to regularity in work habits. There are strong signs here however (which are elaborated in chapter six) of a more general attempt to inculcate the internal compulsions of a protestant-capitalist work ethic, as Scull has argued. Moreover, as Chris Philo has so aptly expressed it, "this 'management of mad people by chaining them to plough handles' provides a striking example of how questions of asylum site and situation could be

<sup>27</sup> WN, 27 November 1880, p.10; A farm balance sheet is attached to the annual report for 1880, AJHR, 1881, H.13, p.19.

<sup>28</sup> Reports on the Lunatics Asylums in New Zealand, AJHR, 1876, H.4, p.2; B. McLean to Provincial Superintendent, 11 August 1876, AP2 1876/2093.

<sup>29</sup> Wendy Hunter Williams describes this process at the Wellington asylum in her book, Out of Mind Out of Sight, p.125.

inextricably intertwined with questions of both asylum functioning and the plight of asylum inmates".<sup>30</sup>

An ambivalent attitude in relationships with the outside community is another characteristic of the Auckland asylum. As part of the first generation of New Zealand asylums, it was located on the outskirts of town for close interaction with it,<sup>31</sup> and visitors were supposed to be encouraged by the fact that the Auckland Asylum was situated a walkable distance from town. Initially they were. Instances of public-patient mingling, such as entertainment given by visitors, were held nearly every month. However, they were stopped abruptly and without explanation by the Provincial Secretary in mid 1872, and only resumed towards the end of the period.<sup>32</sup> A growing desire for a degree of separation is also suggested by the report of the 1872 Commissioners. They wanted to utilise all the available space for patients, and to prevent easy escape they recommended that the grounds "should be enclosed by a wall, in order to add to the security of the patients". They also argued that this move would "prevent too curious passengers from overlooking their actions".<sup>33</sup> Some sections of the public agreed that patients and community should be separated. "A strongly worded protest" from adjacent residents was made

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<sup>30</sup> Philo, p.407.

<sup>31</sup> Brunton, "The New Zealand Asylum", p.8.

<sup>32</sup> NZH, 10 July 1872, p.3.

<sup>33</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.1.

when, after a fire in 1877, female patients were temporarily quartered in the immigration barracks in the middle of town.<sup>34</sup> The New Zealand Herald reported on the "morbid curiosity" of the "crowds" gathered round the Albert Barracks, "eagerly watching the antics and movements of the unfortunates". The police drove them away but they came back, standing in the "pouring rain" to catch a glimpse.<sup>35</sup> The residents stated that properties had been purchased there on condition that the barracks were to be turned into public parks.<sup>36</sup> Visitors were admitted to the asylum at fixed hours on specified days, and although these rules were later changed, few came.<sup>37</sup> Similar factors operated in the location of other kinds of institutions such as industrial schools, or homes for the elderly and indigent.<sup>38</sup>

Moral considerations were also active in the architecture of an asylum. In a Legislative Council debate on the merits of appointing medical superintendents for New Zealand asylums, a "proper building" was deemed the first requirement in the correct care of lunatics, and the treatise of the pioneering English asylum superintendent, Dr John Connolly, entitled The Construction and Government of Lunatic Asylums (1847) was referred to as the

<sup>34</sup> NZH, 28 September 1877, p.2.

<sup>35</sup> *ibid.*, 24 September 1877, p.2.

<sup>36</sup> *ibid.*, 28 September 1877, p.2.

<sup>37</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1876, H.4, p.3; NZH, 3 May 1886, p.6; Hubbard, p.64.

<sup>38</sup> Tennant, "Elderly Indigents", pp.7-9.

authoritative guide.<sup>39</sup> Connolly's text described the dimensions and materials of the model asylum, including suitable windows, carpets, privies, baths, furniture, linens and pianos, in the most minute detail.<sup>40</sup> In all asylums built at this time the emphasis lay on a physical structure that would facilitate the creation of a new environment.<sup>41</sup>

The architecture at Auckland was based on the principle of classification. Patients were to be segregated according to sex, social class and the behavioural nature of their disorder. The proposed ward layout and the range of accommodation reflected these tenets, so that men were segregated from women to prevent sexual misdemeanours, and the "quiet and convalescent" from the "noisy and violent".<sup>42</sup> Separation by class was also thought to improve the chances of cure, since the sensibilities of the respectable would not be offended and the need for privacy observed.<sup>43</sup> In theory at least, the superintendent as head of the house presided over a largely self-supporting small community which had something of a family atmosphere.<sup>44</sup>

<sup>39</sup> NZPD, 16 (1874), p.474.

<sup>40</sup> Showalter, *The Female Malady*, 33-34.

<sup>41</sup> Grob, *The State and the Mentally Ill*, p.171.

<sup>42</sup> Brunton, "The New Zealand Asylum", pp.158-159; Magee, p.7; Brookes, p.175.

<sup>43</sup> The Seventh Annual Report of the State of the Auckland Provincial Lunatic Asylum, APGG, 1874, p.51; *The New Zealander*, 1 December 1865, p.3; Report of the Joint Committee on Lunatic Asylums, AJHR, 1871, H.10, Appendix, pp.16,19.

<sup>44</sup> Leonore Davidoff, Jean L'Esperance and Howard Newby, "Landscape with Figures: Home and Community in English Society", in *The Rights and Wrongs of Women*, eds. Juliet Mitchell and Ann Oakley (Harmondsworth, 1976), pp.153-154;

Floor plan for the Auckland Lunatic Asylum, 1867

**Source:** Reports on the Lunatic Asylums of New Zealand,  
AJHR, 1877, H.8.



Indeed the attendants were directed to act as if their charges were children: "...uncleanly habits will generally be corrected by those repeated attentions, which are used with success in the case of children."<sup>45</sup>

The Auckland Lunatic Asylum was a "large and imposing building" of red brick. Built in the same style as the asylums at Nelson and Christchurch, it was planned in an 'E' shape consisting of a central services block connected by long corridors to male and female wings at either end of the building. Because of a lack of necessary funds, only the eastern wing was completed initially, so that until 1881 when the other side was built, women and men occupied the same side, although on different floors.<sup>46</sup>

The plan of the ground floor in 1877 is shown opposite. Although it consists of only one wing, it gives some idea of contemporary concepts of lunatic care. The emphasis on classification is immediately evident in the provision of associated dormitories and single rooms intended "for those of the lunatics who are not so far gone as some of their more unfortunate comrades, and who prefer privacy to mixing with the rest"<sup>47</sup>. So, too, is the importance of occupations for the patients with the carpenters, tailors and shoe shop. This portion of the

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Brunton, "Citadels", p.4; Grob, The State and the Mentally Ill, p.171.

<sup>45</sup> Auckland Asylum: revised rules and regulations for the attendants, servants etc (Auckland, 1866), p.6.

<sup>46</sup> H.H. Turton to Provincial Superintendent, 27 February 1870, AP2 1874/683, p.1; WN, 11 February 1865, p.7.

<sup>47</sup> The New Zealander, 1 December 1865, p.3.

asylum was intended for the males, who dominated numerically: in 1870 they formed seventy-two percent, and by 1910 still sixty-one percent of the total population. The principle of segregation of the sexes is emphasised by the concentration of patients towards the outer extremity of the building, buffered from the other wing by the kitchen facilities, dining room, official's and staff rooms. Female lunatics were to be accommodated in a matching wing opposite.

Extreme measures were sometimes taken to keep the segregation of the sexes intact. In the female division in 1872, for example, the greater part of each window in the single rooms was walled up because they looked out onto the male airing-court.<sup>48</sup> In line with prevailing concepts of women as more passive, submissive and demure than men, the management did not expect the female patients to require a padded cell and provided none, whereas the male floor also had two padded cells for dangerous patients.<sup>49</sup> The supposedly weaker and more tender nature of women is also evident in the provision of the forty by twenty yard exercise or "airing" courts. Enclosed on all sides by high walls, the male court was covered in scoria, while the female yard was sown with grass.<sup>50</sup> No provision was intended for female workshops. As the final chapter will

<sup>48</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.2.

<sup>49</sup> The New Zealander, 11 July 1865, p.2.

<sup>50</sup> The Eighth Annual Report of the State of the Auckland Provincial Lunatic Asylum, APGG, 1875, p.207.

show, women were very directed to acceptable "feminine" pursuits in the dayrooms, wards and kitchen. The third significant element of this plan is the central position given to the management's committee, drawing and dining rooms, both as a practical measure and as a symbolic statement of who was in control.

However, as with the intentions of the chosen location of the Auckland asylum, the aim of an instrumental role of the asylum building was overtaken by more practical considerations. Defects were noted in the building plans from the start. A lack of space and money contributed to the on-going tension between the ideal and reality. The New Zealander remarked in 1865 that the original building was intended to accommodate fifty four people, although up to 100 could be placed in it.<sup>51</sup> The stated objective of an upper limit of 300 was exceeded in the early 1880s and by 1910 there were 947 in the institution.<sup>52</sup>

A year after the asylum opened, one workshop had been converted into a sleeping compartment. The single rooms intended for privacy quickly became the preserve of the noisy and intractable. None of the dormitories had lighting, nor did an attendant sleep in them at night.<sup>53</sup> The 1872 commissioners noted that "no proper separation of quiet from noisy, clean from dirty patients, or

<sup>51</sup> The New Zealander, 1 December 1865, p.3.

<sup>52</sup> This limit was defined in E.W. Alexander, "Insanity in New Zealand with suggestions for the Disposal of the chronic insane", NZMJ, 1 (March, 1888), p.160.

<sup>53</sup> Annual Report on the Provincial Lunatic Asylum, APGG, 1868, p.132.

classification of any kind can be carried out".<sup>54</sup> By 1877

things had become even worse:

The only day room in the male department has long since been converted into dormitory space, as has the tailors' and shoemakers' shop. The carpenters' shop is now the only available dayroom. At night it is used as a dormitory. The corridor, passages, stairhead, two former female dormitories and the doctor's office are all used as male sleeping quarters. Women have appropriated the chapel and the Medical Officer's dining room as sleeping quarters. A row of five wooden "cells" has been erected in the airing court for men and another ten in the female airing court. Some of the single rooms on the female's side are occupied by two, a dangerous arrangement... There is only one bath in each department and no hot water.<sup>55</sup>

The institution also had its fair share of accidents. In 1877 the women were shifted to the old hospital because a fire destroyed part of the building, and were only shifted back to the asylum on completion of the new men's wing in 1881. In 1882 a wooden auxiliary was built for male patients on probation prior to discharge, only to be burnt down in 1894.<sup>56</sup>

Appalling conditions therefore subverted the "moral" nature of the institution, as had happened overseas. Some of the dormitories had only 270 cubic feet of space per inmate, which was well below the regulation 500 cubic feet. According to one annual report, "an attendant stated that by about 9pm the stink in the dormitories was quite

<sup>54</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.2.

<sup>55</sup> ibid., AJHR, 1877, H.8, p.22.

<sup>56</sup> ibid., AJHR, 1878, H.10, p.7 and 1882, H.9, p.3; A.H. Walker, Papers 1861-1961, NZ MSS 567, p.31.

overpowering".<sup>57</sup> A review of over 400 asylums in Europe, North America and Australasia, published in 1887, contained the following description of Auckland's institution:

The bedrooms contain nothing but large wooden bedsteads; buckets supplied the place of chamber utensils. Only one room had pictures on the walls, the rooms for the most part being cold and naked.... The windows were mostly guarded with iron wire guards, which, while they effectively prevent the escape of patients, give a prison-like appearance to the place. There was nowhere an attempt at ornamentation, or at softening the real character of the place, and no furniture beyond tables and forms without backs.<sup>58</sup>

The Auckland asylum was, in the words of one Inspector-General, "the opprobrium of the department".<sup>59</sup> There had been four public inquiries into the asylum in the 1870s: in July 1872, May 1876, February 1877 and October 1877. As the New Zealand Herald stated with some justification, "[t]he thought never seems to have occurred to them, when appointing one Commission, that they had not paid any attention to the recommendations of the last."<sup>60</sup>

Nevertheless, while conditions were bad, they were not quite so inadequate for most of the women. In many respects their surroundings approximated more closely to the moral ideas upon which they were founded. Much of this advantage

<sup>57</sup> Reports on the Lunatic Asylums of New Zealand, AJHR, 1877, H.8, p.22.

<sup>58</sup> G.A. Tucker, Lunacy in Many Lands (Sydney, 1887), p.672.

<sup>59</sup> Reports on the Lunatic Asylums of the Colony, AJHR, 1887, H.9, Vol.1, S2, p.5. The state of the asylum provoked discussion in parliament, with one member stating that he had received letters and telegrams describing its condition as "one of the greatest scandals of modern times, it being hardly fit for the accommodation of sheep and cattle, not to speak of human beings". NZPD, 55 (1886), p.156.

<sup>60</sup> NZH, 21 September 1877, p.2.

was the result of their smaller numbers. The allotment of sleeping space, for example, was nearly always better for women. In 1867 they had 791 cubic feet, whereas the men only had 535 cubic feet each. As conditions worsened before rebuilding, the women still had 380 cubic feet, while the men had just 218.<sup>61</sup>

Other factors were pertinent in this advantage. Even when conditions were particularly bad in 1877 and the male wards were bare and almost devoid of furniture, the female side, in keeping with ideas of appropriate femininity, had a mirror and a number of prints from fashion books pasted on the walls. As things improved, official visitors noted that the quiet female patient rooms were "bright with pot plants in full bloom, while cut flowers abound everywhere".<sup>62</sup>

In 1886 the central government had sufficient funds to authorise a building programme. Both the male and female divisions got new blocks or wings. The enlargement of the kitchen enabled the sexes to have separate dining rooms. A new auxiliary was built in 1896 and later a laundry, exercise park, butcher's shop, bakehouse, store, morgue and separate Medical Superintendent's residence. By 1910 a new female airing court, female wing and new laundry had been constructed. Official visitors reported the changes in

<sup>61</sup> Annual Report of the Provincial Lunatic Asylum, APGG, 1868, p.132; Report on the Lunatic Asylums of the Colony, AJHR, 1887, H.9, Vol.1, S2, p.5.

<sup>62</sup> Official Visitors Book - Women 1895-1910, YCAA 1049/1, 30 September 1901, p.138.

glowing terms, noting the "carefully tended beds of flowers" and "trim appearance of the shrubs, not to mention the asphalted exercise yards and metalled roads".<sup>63</sup> Inside the asylum could now boast of "long lace curtains, pictures on the walls, flowers, and little nick nacks to please and entertain"; "fresh paint in cheerful colours and tasteful stencil patterns", resulting in "an air of homeliness and comfort about the place".<sup>64</sup>

Once again women had the advantage. Improvements were made earlier in the female division. When the building programme was begun in 1886, women occupied a new 100 patient block first, while the male side remained extremely overcrowded. In 1893 the Inspector-General wrote that there was "ample" room on the female side and that the state of things there was very satisfactory. The men did not get their new wing until 1897.<sup>65</sup> In 1907, Inspector-General Hay wrote that "the institution was clean and tidy, and looked cheerful. Particularly homely are those parts of the women's side where the patients are capable of appreciating their environment".<sup>66</sup>

The management framework is the third element of the environment which had critical implications for patient

<sup>63</sup> NZH, 9 November 1889, Supplement, p.1; Auckland Star, 3 May 1892, p.3.

<sup>64</sup> Auckland Star, 3 May 1892, p.3; YCAA 1049/1, 23 February 1898, p.64.

<sup>65</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1893, H.4, p.3 and 1898, H.7, p.5.

<sup>66</sup> *ibid.*, AJHR, 1877, H.8, p.22; YCAA, 1049/1, 30 September 1901, p.138.

treatment. The administration of the asylum differed in one important respect in its early years from that of others in New Zealand. Where they had lay superintendents and visiting medical officers, the Auckland asylum had a resident medical officer from the beginning. He shared the task of management with a lay keeper, but had ultimate jurisdiction within the institution. By 1879 when the other New Zealand asylums had all gained resident medical men, Auckland's head keeper had been dispensed with.<sup>67</sup>

Below the superintendent in the hierarchy were the head attendant and the matron, who directly oversaw the male and female staff respectively. Through the nineteenth century the English matron had suffered a drop in status. During the first half of the century when male superintendents were usually lay people, she had been held in equal esteem, according to Anne Digby. That all changed with the rise of the "medical expert". A matron's lack of training meant that she was reduced to a subordinate role, and all her management decisions were subject to the superintendent's approval.<sup>68</sup> The matron equalled housekeeper in the asylum context.

This ancillary status was firmly established by the time New Zealand asylums were built and institutions here followed that lead. Even when matrons were eventually

<sup>67</sup> Reports on the Lunatic Asylums in the Colony, *AJHR*, 1872, G.27, p.3 and 1879, H.4, p.5.

<sup>68</sup> Digby, *Madness, Morality and Medicine*, p.121; Showalter, *The Female Malady*, p.54.

trained, it was only as "professional nurses".<sup>69</sup> In England, qualifying as doctors helped women regain authority towards the end of the century. The possibility of employing female doctors in asylums was raised in the New Zealand parliament in 1903, but there is no evidence that changes were made in this respect at the Auckland asylum in this period.<sup>70</sup> A possible reason for this is offered by Beryl Hughes. In her article on professional women, she suggests that early women doctors had difficulty getting employment and that working in the asylums was only done for want of something better.<sup>71</sup>

Matrons' wages were accordingly very low. In 1874 the Auckland matron earned less than the senior male attendant, and by 1899 her pay was less than that of many of the ordinary attendants. The allocation of wages reflected contemporary assumptions about women's financial needs. Men received more money because they were expected to provide for a wife and children. In 1876, for example, the Provincial Superintendent authorised an increase of ten pounds in the cook's pay because of his need to support a wife and four children, as well as the increasing numbers

<sup>69</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1892, H.4, p.2.

<sup>70</sup> Digby, *Madness, Morality and Medicine*, p.121; Charlotte Mackenzie, "Women and psychiatric professionalisation, 1780-1914", in *The Sexual Dynamics of History Men's Power, Women's Resistance*, pp.112-113; *NZPD*, 125 (1903), p.605.

<sup>71</sup> Beryl Hughes, "Women and the Professions in New Zealand", in *Women in New Zealand Society*, eds. Beryl Hughes and Phillida Bunkle (Auckland, 1980), p.130.

for whom he had to cook.<sup>72</sup> In England the low pay was seen as an encouragement for matrons to view themselves in relation to other female employees, rather than administrative staff.<sup>73</sup> Auckland evidence supports Showalter's assertion that in the patients' eyes, the low status of the matron would have reinforced contemporary models of femininity, with women being accustomed to submit to the authority of fathers, brothers and husbands. Case records show that women patients thanked the female staff, but reserved special praise for the superintendent.

As the asylum expanded it employed a sizeable number of staff to care for the patients and maintain the institution. As well as attendants and nurses, there was a clerk, laundresses and cooks, farm and grounds staff and workshop employees. Initially a musical instructor was engaged, but his job subsequently became an unpaid extra duty for one of the nurses.<sup>74</sup> In 1867 a staff of nine cared for 86 patients. Ten years later the institution held 216 patients and was run by 24 employees. By the end of the period there were nearly 100 attendants and nurses for 817 patients.<sup>75</sup>

<sup>72</sup> Dr Aickin to Provincial Superintendent, 17 November 1876, AP2 1876/2709.

<sup>73</sup> Mackenzie, p.113.

<sup>74</sup> Inspector's Outwards Letterbook no.6, 24 December 1896, p.637, H-MHD.

<sup>75</sup> Annual Report on the Provincial Lunatic Asylum, APGG, 1868, p.134; Reports on the Lunatic Asylums of New Zealand, AJHR, 1877, H.8, p.23; Report on the Mental Hospitals of the Dominion, AJHR, 1908, H.7, p.10.

In keeping with the aims of moral management, male staff were called attendants rather than the earlier names of warders and keepers. Female staff were generally called nurses (although earlier there are references to female attendants), reflecting both the trend to the creation of a hospital environment in asylums in this period, and the different qualities female staff were expected to demonstrate. At the beginning of the period no special skills were necessary, apart from suitability of temperament and practical abilities. An English handbook of directions for attendants used in New Zealand asylums stated that "attendants should combine in their character and disposition firmness and gentleness; they should be able, by their education and habits, to superintend, direct, and promote the employment and recreation of the patients".<sup>76</sup>

Each staff member attended to his or her own sex, for it was widely believed that women were the most suitable individuals to work with females, being supposedly more understanding and sympathetic to women's needs. In terms of treatment and rehabilitation under the school of moral management, female staff would be better placed to encourage woman patients to sew and knit, and resume other womanly ways.<sup>77</sup> Female attendants were expected to be

<sup>76</sup> Quoted in NZPD, 45 (1883), p.230.

<sup>77</sup> An inspection of New Zealand's asylums in 1872 recommended that some of the female staff consist of dressmakers, machinists, tailoresses and the like. General Report on the Lunatic Asylums in New Zealand by Dr Paley,

maternal and caring, as well as good at their job: Annie Caldwell, a domestic servant, was "kind hearted [and] sensible besides [being an] efficient nurse".<sup>78</sup> Male attendants, on the other hand, often had military or penal experience. In four instances, one prospective candidate was from the armed constabulary,<sup>79</sup> one was previously a warder at the Mount Eden Gaol,<sup>80</sup> another was a non-commissioned officer in a branch of the British Army,<sup>81</sup> while the last man had been in charge of the Military Lunatic Asylum in Barbados, West Indies.<sup>82</sup> Later, agricultural experience was considered necessary for male staff, because of the requirements of directing patient labour for the asylum farm.<sup>83</sup>

Even with professional training these ideas about the appropriate qualities of female and male staff remained. By 1891 systematic courses of instruction had begun at Auckland, Wellington and Seacliff asylums.<sup>84</sup> Yet as late as 1903, the female official visitor at Auckland wrote:

I have long since come to the conclusion that our female patients fare better than the male, because of more humane treatment; in other words, our nurses

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[Inspector of Lunatic Asylums for Victoria] *AJHR*, 1874, H.1, p.5; see also *AJHR*, 1877, H.8, p.24.

<sup>78</sup> Dr Aickin to Provincial Superintendent, 15 April 1876, AP2 1876/1053.

<sup>79</sup> Dr Aickin to Provincial Superintendent, 22 May 1873, AP2 1873/1854.

<sup>80</sup> *ibid.*

<sup>81</sup> Dr Aickin to Provincial Superintendent, 6 March 1876, AP2 1876/535.

<sup>82</sup> Dr Aickin to Provincial Superintendent, 3 June 1875, AP2 1875/2560.

<sup>83</sup> *Cyclopedia of New Zealand*, p.190.

<sup>84</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1892, H.4, p.2.

seem to realise, that they are actually nursing patients, and that kindness and forbearance, are essentially a part of their business; while on the other hand, attendants seem quite unable to view their charges, in the light of actual patients.<sup>85</sup>

Nationwide state training began in 1903. Attendants and nurses were required to undergo three years instruction under the medical superintendent and matron. Lessons included anatomy, physiology, dietetics, rules and regulations for the protection of patients, nursing care of epileptics and first aid treatment for cases of choking, haemorrhage and fractures.<sup>86</sup> A register of mental nurses was also established.<sup>87</sup> Anne Digby makes the interesting observation that professionalisation of asylum staff in England helped reinforce the authority of the medical superintendent, "since if the attendant was converted into a trained nurse she was more likely to defer to the expertise of the doctor".<sup>88</sup> Something similar seemed to happen here.

Authority became an important issue as patient numbers grew. Uniforms for staff became compulsory at the same time as training was initiated, motivated by disciplinary

<sup>85</sup> YCAA 1049/1, 3 June 1903, p.182; In 1900 the Medical Superintendent wrote that the "average man is an impossible nurse", urging the introduction of elderly married women. Report on the Lunatic Asylums of the Colony, AJHR, 1900, H.7, p.4.

<sup>86</sup> R.M. Hunter, "Historical Notes on the Auckland Psychiatric Hospital", pp.20-21.

<sup>87</sup> Williams, p.57.

<sup>88</sup> Digby, Madness, Morality and Medicine, p.168.

concerns as much as professional matters.<sup>89</sup> The 'perceived need for stricter management in the interests of efficiency and the smooth operation of the institution further reduced the desirable goal of an informal family environment. In 1887, for example, Inspector-General Duncan MacGregor wrote that defective buildings, overcrowding and the initiation of the rebuilding programme induced Dr Cremonini, the superintendent, to make "stringent regulations" in order to minimise the "inevitable dangers".<sup>90</sup>

Lack of discipline among attendants was remarked upon in several annual reports and the junior staff learnt that they defied the asylum hierarchy at their peril. When the new rules promulgated by Dr Cremonini caused a management crisis, Duncan MacGregor found it unremarkable that, during his investigation, the staff complained of Cremonini's overbearing manner and his insistence on being saluted. Three years later a Member of Parliament complained about the desire of the heads of department to run every lunatic asylum, so far as its officials were concerned, "upon something like martial discipline".<sup>91</sup> This was an obvious reference to MacGregor, who was "a forceful and intimidating character in the extreme",<sup>92</sup> although the goal

<sup>89</sup> Tucker, p.675; Report on the Lunatic Asylums of the Colony, *AJHR*, 1897, H.7, S2, p.2.

<sup>90</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1887 (S.1), v.2, H.9, p.5.

<sup>91</sup> *NZPD*, 111 (1900), p.260.

<sup>92</sup> Margaret Tennant, "Brazen-faced Beggars of the Female Sex: Women and the Charitable Aid System, 1880-1920" in *Women in History: Essays on European Women in New Zealand*, eds. Barbara Brookes, Charlotte Macdonald and Margaret Tennant (Wellington, 1986), p.49.

of strict subordination to rules and regulations is evident throughout the period.

The nurses gave cause for special comment a number of times. The 1877 annual report noted that

the female attendants have very lax notions of discipline. They consider themselves entitled to receive visitors, and even retain them in their house for a few days at a time without as much informing the matron. They also work at their own sewing during the day, when they should be devoting their whole attention to the patients.<sup>93</sup>

As a result extra regulations were posted specifically for the female staff. It was decreed that "no female attendants [were allowed] to leave the Asylum on any pretence without the leave of the matron. All female attendants [were] to be under the orders of the matron and to obey her directions in all respects". Furthermore, the matron was given powers of suspension for "disobedience of orders or other dereliction of duty", pending, of course, the agreement of the superintendent.<sup>94</sup> The patients would thus have seen that as the matron was dependent on the superintendent, so the nurses were on her. The nurses provided an exemplary role model of what the female patients should be striving for: kind and caring yet dependent and subordinate.

Reading accounts of the arduous duties involved and the long hours that attendants were expected to work, it is

<sup>93</sup> Reports on the Lunatic Asylums of New Zealand, *AJHR*, 1877, H.8, p.24.

<sup>94</sup> Miss Hamilton to Provincial Superintendent, 22 May 1876, AP2 1876/118.

easy to understand why discipline was often a problem and the standard of care patients received was frequently less than adequate. The female official visitor remarked in 1903 that with overcrowding, the management "find it impossible to retain the services of really first class nurses".<sup>95</sup> The rules and regulations drawn up in 1872 set out the basic pattern of asylum life.<sup>96</sup> Attendants received patients into the asylum, bathed them, cut their hair and inspected them for marks of bodily violence. After rising at six a.m. to wash and dress patients, the staff spent a twelve hour day with them, supervising their activities and encouraging them to work. After supper they put them to bed. Attendance was also required at patient entertainments and chapel service. In the early period time off was rare. In 1873, the inspector complained to the superintendent that nurses should be granted "an occasional absence from such wearing and worrying toil". The eldest nurse, he said, had just been granted some leave, having not been away from the asylum for more than a few hours in the past five years. The matron had not been to town more than once or twice during the same period.<sup>97</sup> By 1894, attendants had one day off every fortnight and 28 days leave annually.<sup>98</sup> In 1906 the hours were still very long: "half past six to half past five, and from half past six to eight on alternate days,

<sup>95</sup> YCAA 1049/1, 8 July 1903, p.184.

<sup>96</sup> Dr Aickin to Provincial Superintendent, 22 May 1876, AP2 1876/1188.

<sup>97</sup> H.H. Turton to Provincial Superintendent, 9 December 1873, AP2 1873/3593, p.2.

<sup>98</sup> NZPD, 94 (1896), p.229.

with only half an hour for meals, which often consisted of bread and butter only".<sup>99</sup>

The pay was barely compensatory. In 1883 a Member of Parliament reminded the house that attendants received 70 pounds to 80 pounds a year while a gaol warder earned 150 pounds a year. Similarly, a head attendant received 5s. 4d. for a twelve hour day while a day labourer got 6s. 6d. for an eight hour day.<sup>100</sup> The discrepancies remained throughout this period, causing an extended discussion about pay and conditions during the debate over supply in 1903.<sup>101</sup> To add insult to injury staff had no appeal against dismissal. Despite numerous attempts to establish some kind of mechanism to deal with the matter, a bill to establish a board of inquiry for each asylum was thrown out in 1899.<sup>102</sup>

Finally, the regime at the Auckland asylum shows us that as in other nineteenth century institutions, the life of the staff as well as the patients was conditioned by the "total" nature of the institution. Both the senior and junior staff resided at the institution, working, eating and sleeping in the same buildings. In his 1874 annual report, Dr Aickin recorded staff complaints at having to live apart from their families and forgo the "privileges of married life".<sup>103</sup>

<sup>99</sup> *ibid.*, 138 (1906), p.250.

<sup>100</sup> *ibid.*, 45 (1883), p.229.

<sup>101</sup> *ibid.*, 125 (1903), pp.602ff.

<sup>102</sup> *Bills Thrown Out*, 1899.

<sup>103</sup> *The Seventh Annual Report of the State of the Auckland Provincial Lunatic Asylum*, APGG, 1874, p.52.

There was however, another set of people who were also supposed to act in the patients' interests. A system of district inspectors and official visitors, appointed by head office, acted as independent judges of the asylum's administration and treatment. They reported regularly in some detail upon every aspect of the "comfort, safety, and general wellbeing" of the patients and had free access to listen to residents' individual complaints.<sup>104</sup> These officials were to be citizens of some standing in the community, trustworthy and of impeccable character. From the point of view of the Inspector-General, the inspectors and official visitors were employed to assure the public that the asylum was a valuable institution, as much as to act as impartial critics of its operations: "the visits", he wrote in 1897, "...have helped in a great degree to remove the feelings of suspicion with which this, like other institutions of the kind, is always regarded."<sup>105</sup> The officials concurred with this role. Annie Armitage, an official visitor from 1896, longed for the public to "disabuse their minds of the idea that harsh treatment is employed" and commended the "air of homeliness and comfort about the whole place which dispels at a glance the old idea of padded cells and harsh treatment".<sup>106</sup> To this end,

<sup>104</sup> YCAA 1049/1, 6 November 1899, p.100; The Lunatics Act, 1868, New Zealand Statutes, 1868, s 52-58.

<sup>105</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1897 (S.2), H.7, p.8.

<sup>106</sup> YCAA 1049/1, 24 August 1909 and 24 June 1910, p.240 and 252.

many of F.G. Ewington's reports of visits in the 1880s and 1890s were reprinted in the daily newspapers.<sup>107</sup>

At the same time, such visits were also thought to be "a valuable link" between patients, the attendants and the public.<sup>108</sup> Thus they were, as Goffman asserts, meant to be a reminder to patients that they were not cut off from the wider world and had some measure of status in it.<sup>109</sup> As a result these men and women had to be seen to play an adjudicatory role, arbitrating in the matter of complaints and charges of assault. Yet in common with other institutions here and overseas, surviving reports indicate that they most often sided with the staff against the patient, believing that it was common for asylum patients to complain without reason.<sup>110</sup> For example, a charge of ill treatment led to the following superficial assessment by Ewington: "it is very doubtful whether any assault took place at all, if it did, it was not unprovoked, and was very slight, being only necessary force used for the patient's own good. I did not think it expedient to examine other persons".<sup>111</sup>

Conscious of their lay status, the visitors and inspectors rarely questioned medical decisions. Referring to a particularly perplexing case, F.G. Ewington wrote "I

<sup>107</sup> For example, *NZH*, 4 January 1888, p.6 and the *Auckland Star*, 3 May 1892, p.3.

<sup>108</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1901, H.7, p.4.

<sup>109</sup> Goffman, p.104.

<sup>110</sup> Crowther, p.270; Scull, *Museums of Madness*, p.204.

<sup>111</sup> YCAA 1099/1, 27 March 1909, p.43.

cannot see signs of insanity in him, but I do not doubt Dr Beattie's opinion that the patient is properly detained here".<sup>112</sup> On only two occasions was any evidence of disagreement about management found.<sup>113</sup> In one case details are available and the complaints were ignored. Inspector Morpeth wanted the practice stopped of allowing "foul body linen and worn-out garments of the dead and diseased" to be collected together until the end of the year with other irreparable clothing. Dr Aickin replied that these items were stored in a cellar one hundred feet from the patients. The Provincial Superintendent also wrote to Morpeth intimating that as he had also been difficult over the subject of his pay, a new person might be found for the job of inspector. Morpeth requested the withdrawal of the report that contained these and other complaints about the asylum management, but it had already been laid before parliament. He was then sacked.<sup>114</sup>

Nevertheless in other less controversial respects they did try to ameliorate conditions within the system, by raising funds for picnics and encouraging the public to donate illustrated papers, magazines and books, although their efforts did not always meet with success, because of the lack of response from the wider community.

<sup>112</sup> YCAA 1099/1, n.d., p.55.

<sup>113</sup> NZH, 3 February 1876, p.2; NZPD, 62 (1880), p.542.

<sup>114</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1876, H.4, p.3; Dr Aickin to Provincial Superintendent, 15 February 1876, AP2 1876/712; NZH, 3 February 1876, p.3.

The asylum environment was a product of the tension between the original ideal of the philosophy of moral treatment and the reality of cramped, rudimentary and basic conditions. Gender was highly influential in both the theory and the practice. The segregation of the sexes was maintained and women had different facilities from men on a number of counts. The defective buildings and congested environment were however a more severe factor for the men. Women had more space, better decorated wards and rooms and when improvements began to be made, they obtained theirs earlier. Moreover asylum care in terms of the qualities and concerns of the staff appeared to favour women too, for their nurses were described as more caring and concerned.

Much of the discussion thus far has however been one-sided, relating the concerns of officials and medical men or those with positions of power in the community rather than of the patients, and dealing with the external features of the "lunacy" service, specifically those at Auckland. In order to gauge perceptions of insanity in practice, and to determine, amongst others, what impact gender had in the interpretation of the law, the experience of the individual women who became patients at Auckland will be examined.

Some of the entries in the 1910 casebook have photos attached to them. A selection of these appear at the beginning of the next three chapters, with some patient details.

Age: 40  
Status: Married  
Admission date: 6 March 1910  
Condition/previous occupation: Household duties  
Previous abode: Gisborne  
Supposed cause of insanity: Climacteric  
Bodily condition: Indifferent health & condition  
Duration of existing attack: 5 months  
Date of discharge: 27 July 1910 recovered

Source: Text: Register of Committed Patient Admissions, YCAA  
1021/5

Photo: Casebook, YCAA 1048/11, p.273.



Age: 40  
Status: Married  
Admission date: 6 July 1910  
Condition/previous occupation: (aboriginal native)  
Previous abode: Waiuku  
Supposed cause of insanity: Unknown  
Bodily condition: Indifferent health & condition  
Duration of existing attack: 3 weeks  
Date of discharge: 30 September 1910 recovered

**Source:** Text: Register of Committed Patient Admissions, YCAA  
1021/5  
Photo: Casebook, YCAA 1048/11, p.334.



### Chapter Three

#### Pathways into the Asylum:

##### The Process and Nature of Committal

Patients were committed to the Auckland Lunatic Asylum through formalised legal processes. This chapter will provide a more specific analysis of committal procedures, examining first where the authority for committal came from, how the procedure was administered and by whom. The second part of the chapter will focus on the experience of individual woman patients, and seek to outline who initiated their committal and the reason why these steps were taken.

The sources and nature of the authority for committal were laid down explicitly in successive Lunatic Acts and changed only slightly over the forty years of this study. Under the first Lunatics Act of 1868 authority for committal rested with two Justices of the Peace, assisted by two doctors. The only exception to this rule was made in the case of prisoners or persons guilty of indictable offences, in which cases the Colonial Secretary had ultimate jurisdiction. However he also relied upon the Justices' and doctors' testimony.

After the second Lunatics Act was passed in 1882 authority was given to the Resident Magistrate, assisted by two Justices and two doctors. The Justices could now exercise authority independent of a magistrate only if they

were more than ten miles from the courthouse where the magistrate usually sat, or if he was absent. The Colonial Secretary continued to provide warrants in prison or court cases.

These procedures remained the same under the consolidating Lunatics Act of 1908, except in that the titles had changed. Resident Magistrates gave way to Stipendary Magistrates and the Colonial Secretary was replaced by the Minister in Charge of Lunatic Asylums. On paper at least, the process of committal was first of all a legal one: its medical aspect came second.

A variety of committal procedures were followed, requiring a number of different forms, but in all cases both legal and medical figures were involved and the information recorded on each type of form was broadly similar. The choice of form to be used depended on how the individual was committed: no distinction was made between procedures involving women and men. As we saw in chapter one, there were six ways in which individuals were declared to be insane. For those detected and committed under the first category of "dangerous lunatic", it was necessary to have an "Order for Reception of a Lunatic into an Asylum" signed by two Justices of the Peace (until 1882) or a Resident Magistrate (after 1882), and two "Certificate[s] that a Person is a Lunatic and a proper Person to be

detained under Care and Treatment" completed by two doctors.<sup>1</sup>

The committal of insane prisoners involved three forms: a "Certificate that a Prisoner or Person detained is Insane" signed by two Justices or a Magistrate, two medical certificates and a handwritten warrant signed by the Colonial Secretary (until 1882) or Minister in Charge of Lunatic Asylums.

Forms were not provided in the 1868 and 1882 Acts for lunatics charged with indictable offences because proceedings were authorised by the Colonial Secretary. This category was deleted from the 1908 Lunatics Act and its provisions were governed by the committal of insane prisoners.

Lunatics deemed to be at large or insufficiently cared for were required to be apprehended by a constable and taken before a Magistrate or two Justices. A single Justice of the Peace could receive a lunatic wandering at large from 1882. The usual two medical certificates were then completed and two Justices or a Magistrate signed an "Order for Conveyance to an Asylum etc of a Lunatic not under proper Care and Control etc".

Proceedings initiated by friends and relatives, which were recognised in the 1882 Lunatics Act, were subject to the same certification procedure as for "dangerous lunatics". Thus whatever the mode of committal, legal

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<sup>1</sup> See Appendix A for copies of the 1882 committal forms.

evidence of insanity consisted of, at the very least, an order for committal (often called a warrant by contemporaries) and two medical certificates attesting to the individual's insanity.

These procedures for incarcerating the insane were established at a time of growing fears of wrongful confinement and increasing support for "save the sane" campaigns. As a result, there was a greater emphasis on more formal committal procedures and more attention paid to patient rights. Such safeguards as having two doctors complete medical certificates instead of just one, penalty clauses and provision for amending certificates were built into New Zealand legislation. Receiving alleged lunatics into an asylum without the necessary forms was considered a misdemeanour in the 1868 and 1882 Acts.<sup>2</sup> From 1908, when fears had reached a peak, lack of proper certification was regarded as a crime.<sup>3</sup> Some exceptions were granted. After 1882, friends and relatives who initiated proceedings were given some leeway. In special cases, the certificate of one doctor was sufficient provided that the Magistrate explained why in his order and two further medical certificates were supplied to the asylum superintendent within three days.<sup>4</sup>

<sup>2</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, s 15; The Lunatics Act, 1882; *ibid.*, 1882, s 27.

<sup>3</sup> The Lunatics Act, 1908, *ibid.*, 1908, s 22.

<sup>4</sup> The Lunatics Act, 1882, *ibid.*, 1882, s 25(9); The Lunatics Act, 1908, *ibid.*, 1908, s 20(8).

In addition, the Lunatics Acts allowed orders and certificates which were "incorrect" or "defective" to be amended within twenty-one days, subject to the Colonial Secretary's or Minister's sanction. The asylum inspector could also direct the keeper or superintendent to amend orders and certificates, and if necessary discharge inmates.<sup>5</sup>

These were the rules but were they kept? Administrative conformity to or deviation from official directives can be measured in the records which are extant for the patient sample. Most of the committal forms survive and are located in the patient case files, which also contain any correspondence concerning the patient and discharge or death forms. These committal forms, which exist in incomplete runs, constitute the basis for this part of the study. Fortunately, the committal process was administered from inside the asylum and further records were made there: these survive in large numbers and serve to complement and corroborate patient detail in the committal forms.

Of the original committal documents for the total patient sample of sixty cases, there are warrants and medical certificates for just eighteen women and seven men committed in 1870 and 1910. There are no clear reasons why there are such gaps in the original documents, but two

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<sup>5</sup> The Lunatics Act, 1868, *ibid.*, 1868, s 19; The Lunatics Act, 1882, *ibid.*, 1882, ss 35-36; The Lunatics Act, 1908, *ibid.*, 1908, ss 30-31.

factors may have influenced their retention. The first concerns the deficiencies of the clerical system. Once a patient arrived at the asylum, the Clerk entered her or his particulars in a patient register and sent a notice of the patient's admission, together with the order and medical certificate, to the Colonial Secretary (until 1882) or the inspector.<sup>6</sup> However it appears that the clerk did not always keep track of these forms.<sup>7</sup>

Second, over time these records did not always receive the best of care. They languished at the asylum, which later became Oakley then Carrington Hospital, until they were deposited at the National Archives Records Centre in Auckland in 1985. While at the asylum, some of these paper casefiles were badly damaged by damp.<sup>8</sup>

However the task of analysis is made easier by the existence of the admission registers and patient casebooks. These other two types of records provide an alternative source of information to the warrants and medical certificates contained in the patient casefiles. Through them we can more fully trace what happened.

<sup>6</sup> The Lunatics Act, 1868, *ibid.*, 1868, s 24; The Lunatics Act, 1882, *ibid.*, 1882, ss 52-53; The Lunatics Act, 1908, *ibid.*, 1908, ss 50-51.

<sup>7</sup> A number of annual reports of the asylum refer to the fact that registers and books were not well kept. Several clerks were sacked and duties taken over temporarily by attendants, presumably untrained. See Reports on the Lunatic Asylums of New Zealand, *AJHR*, 1877, H.8, p.24 and [Hospital Chronology], Historical Records Collection, YCAA 1083/5f.

<sup>8</sup> Agency documentation and descriptive list of YCAA records.

The admission registers give the name and office of the committal authority. In addition, because the committal records were quickly sent on to the Colonial Secretary or inspector for his approval and therefore went out of the asylum record-keeping system, the details of the medical certificates were copied by the Medical Superintendent into the casebooks. These contained the mental and bodily condition of each patient and the history of their treatment. A comparison of the medical certificate and the version copied into the casebook from the available examples in the 1870 and 1910 samples, shows that the transcription was almost verbatim. Certainly all important details were transferred.

This discussion of the survival of records makes it clear that there was a conflict between the demands of the law and the needs of the asylum. Because the committal procedure was administered on site, the needs of the asylum usually won out. Thus only the documents pertinent to the task at hand, that is the medical certificates and the later statements of mental and bodily condition, were monitored closely. By the end of the period record-keeping was much more rigorous, although gaps remain.

There were no substantial changes to either the documents or the way they were administered in this period. The procedure appears to have been satisfactory in administrative terms, as there is no evidence of any desire on the part of Justices, Magistrates or doctors to exceed

the limits of the forms or alter the procedure in any significant manner. This lack of change justifies the choice of three sample years within a forty year period as the evidential base remains consistent.

All three sources - admission registers, committed patient casefiles containing the Justices' warrants and doctors' certificates, and casebooks recording the medical superintendent's prognoses - show that legal procedures were observed in the widest sense. That is, every patient was committed on the order of a Justice or Magistrate, accompanied by two medical certificates. An example from 1870 suggests that the procedures were observed closely. The casebook entry for Alexander S. states that:

There are four medical statements viz. two from practitioners in Whangarei which were furnished at the asylum yesterday but unaccompanied by a Magistrate's warrant. The patient was therefore not received, on his return to Auckland he was seen by Drs Stockwell & Lee & by two Justices of the Peace on whose warrant he was this day admitted.<sup>9</sup>

These records give what appear to be a full and accurate picture of admissions, even though the set procedures were deviated from in various minor respects. The sample records indicate that there was some carelessness or sloppiness with regard to bureaucratic detail. In the twenty-five cases where full documentation exists, the committal of ten women and seven men was technically incorrect according to the detailed guidelines outlined above. The agents of committal either used the

<sup>9</sup> Case 164, Casebooks 1853-1911, YCAA 1048/1, p.221.

wrong forms and then amended them,<sup>10</sup> or they did not fill out the full number of required documents.<sup>11</sup>

The three reasons why practice may have deviated from legislative directive were first, the fact that the procedure was fairly complicated and involved an extensive amount of paperwork. Second, because most of the extant records are concentrated in the first sample year, only two years after the introduction of the first comprehensive Lunatics Act in New Zealand, it appears that those involved in its implementation went through a necessary learning period. Third, the statutes themselves had to be tested in a practical context and deviations stemmed from the needs of individual situations. Of all the cases consulted only one had any variation in procedure that seems to be of a more serious nature. The file of Susannah E., committed in 1870, contains a conveyance order but only one medical certificate. However two doctor's names are recorded on the order and the committal was legally correct.<sup>12</sup>

<sup>10</sup> In five instances the wrong conveyance order was used. The alleged lunatics were declared insane under the section for those "not under proper care and control" but on the form intended for "dangerous lunatics". The word "dangerous" was crossed out and the words "not under proper care and control" substituted. In one case the Justices did not even bother to delete the word "dangerous". Case 170, Committed Patient Case Files 1869-1910, YCAA 1026/3. Handwritten and out-of-date forms were also used.

<sup>11</sup> The majority of patients in the sample were committed under the section concerning "lunatics not under proper care and control" which necessitated the signing of an order for the apprehension of those so defined, before any examination took place. Yet not one of the casefiles contains this order. Doctors also failed to always include testimonies of previous treatment as required by law.

<sup>12</sup> Case 119, YCAA 1026/2.

The preceding emphasis on statutes and administrative procedure disguises a key feature of the committal process - the centrality of medical men. Doctors were the true agents of committal because the Justices and Magistrates were required to commit an individual on the basis of medical evidence of insanity: the Lunatics Acts of 1868, 1882 and 1908 all stipulated that committal could not take place solely on the evidence of lay people.<sup>13</sup> Doctors were, in fact, the record-makers. They recorded both their own opinions and those of others on the medical certificate. They controlled what was or was not written down.

It is, however, difficult to determine anything about the majority of the doctors and their background. The Auckland edition of the Cyclopedia of New Zealand noted in its section on Auckland physicians that "medical men, as an organised body, take the view that members of the profession should not be parties to the publication of particulars concerning themselves, personally or professionally".<sup>14</sup>

The legal position of doctors in making committals is clearer. The statutes governing asylum committal gave quite specific guidelines as to who could perform the medical examination of alleged lunatics. Each of the two physicians was required to be legally qualified and currently in practise. No doctor could sign a certificate to commit his

<sup>13</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, s 16; The Lunatics Act, 1882, *ibid.*, 1882, s 29; The Lunatics Act, 1908, *ibid.*, 1908, s 24.

<sup>14</sup> Cyclopedia of New Zealand, p.283.

relative, partner or assistant to an asylum, and no medical certificate could be completed by the relative of any officer of a public or private asylum. Furthermore, the two medical practitioners who declared the individual insane could not be in partnership together or related to each other.<sup>15</sup>

All the certificating doctors who committed patients in the sample were men. Although New Zealand women gained entry to medical courses earlier than their counterparts overseas, the first woman did not enter Otago until 1891. Furthermore, female graduates faced great difficulty in finding employment before World War One because of the lack of state appointments considered suitable for women, and the time and money needed to set up private practices.<sup>16</sup> As will be seen in the discussion of attitudes, the gender of the examiner was very important.

A variety of doctors examined the patients; there is no evidence of any one doctor monopolising the committal procedure. Obviously there was a smaller pool of physicians to draw upon in 1870 than there was in 1910. In the first sample year four doctors were involved in the committal of five or more individuals, but most of the eighteen physicians who appear in the sample cases examined one or two women and men only. In 1890 the patients were spread

<sup>15</sup> The Lunatics Act, 1868, *New Zealand Statutes*, 1868, ss 15-17; The Lunatics Act, 1882, *ibid.*, 1882, ss 31-33; The Lunatics Act, 1908, *ibid.*, 1908, ss 26-28.

<sup>16</sup> Michael Belgrave, "A Subtle Containment: Women in New Zealand Medicine, 1893-1914", *NZJH*, 22:1 (April, 1988), pp.45, 48-49.

more evenly among twenty-one doctors. Only three men examined more than four individuals. By 1910 twenty-seven physicians were involved in twenty cases and none had examined more than three individuals. Most of the doctors who examined the male patients also saw the female patients; their involvement was not gender-differentiated. Only five general practitioners examined individuals in more than one sample year, and no doctors were involved over the entire forty year period. The sixty case samples, then, do not reflect the opinions of one or two key men, but of a large number of doctors from throughout the Auckland Province.

The certificating doctors had no special expertise in psychiatric medicine. This was true of both the early men who were largely British-born and trained, and their later colleagues who were generally born here. They were usually general practitioners who, in common with their counterparts in Europe and Australia "were no better educated in the complex world of 'mental disease' than anybody else".<sup>17</sup> Education in psychological medicine for general practitioners was only begun in the latter part of the period under study. A start was made overseas in the 1870s, but it was not until the early twentieth century that such courses were taught in Australia.<sup>18</sup> Thus, as Mark

<sup>17</sup> Finnane, Insanity and the Insane, p.107.

<sup>18</sup> ibid., p.109. Stephen Garton, "Bad or Mad? Developments in Incarceration in NSW 1880-1920", in What Rough Beast? The State and Social Order in Australian History, Sydney Labour History Group (Sydney, 1982), p.107.

Finnane has pointed out in his study of Irish Insanity, most doctors who signed lunacy certificates "were not doing so on their possession of specialised knowledge of insanity but rather on the basis of their rising professional status and the successful assumption by a fraction of the profession of the care of the insane."<sup>19</sup>

There was little interaction between the asylum medical staff and the medical profession in general. This separation of the record makers and the treaters caused frustration on the latter's part. For example, Dr Herbert Barraclough, at one time assistant medical superintendent at the Auckland asylum, complained in 1904 about the "loose" and "inaccurate" compilation of particulars on the committal certificates. "Sometimes one medical man gives a very reasonable cause, whilst the other gives the cause as unknown though he has the same sources of information...."<sup>20</sup>

The lack of any pretension to specialist knowledge is evident in the medical certificates of the sample patients, where the diagnoses were phrased in very general, mostly non-medical terms. This was due to the manner of the examination as well as lack of specific training. The doctor made his decision on the basis of a single examination, and the patient was usually unknown to him. Most doctors conformed to a pattern of describing

<sup>19</sup> Finnane, Insanity and the Insane, p.109.

<sup>20</sup> Herbert Barraclough, "The Causation of Insanity", NZMJ (April, 1904), p.335.

appearance, conduct and behaviour and transcribing "delusions".

There is evidence of the adoption over time of a more self-consciously clinical approach by some of the doctors, although there are a few instances in the 1870 cases. Dr Goldsbro, a coroner and military surgeon who was perhaps more accustomed to acting in an official capacity for the state and is one of the few doctors about whom something is known, used such terms as "cerebral disease" and "puerperal mania". From 1890 onwards the use of medical jargon is more frequent. The terms "dementia", "idiotic", "maniacal" and "imbecility" are to be found, as are such phrases as "the left pupil is more dilated than the right, gait unsteady, speech thick, slow and irregular..." in the case of a congenital imbecile.<sup>21</sup> In the sample from 1910 the descriptions became even more identifiably psychological. Paulina W., for example, was described as "exhibiting evidence of profound mental shock".<sup>22</sup> These developments should not be overemphasised however. Most doctors continued with the original descriptive tendency such as was normal or average for the time.

Although these documents are primarily bureaucratic in intention and character, many of the biases and attitudes of the doctors are clear. Because the initial examination contributed much to the ultimate pronouncement and subsequent treatment, it is worthwhile to explore these in

<sup>21</sup> Case 1616, YCAA 1048/5, p.438.

<sup>22</sup> Case 3967, YCAA 1048/11, p.273.

more detail. The women and men who were believed to be lunatics were scrutinised in an equivalent manner, and in some respects male and female were treated similarly. For example, unfavourable judgements were made of both sexes if the alleged lunatic revealed "incoherency as to dates and places",<sup>23</sup> an "inability to give an account of themselves",<sup>24</sup> or simply refused to answer questions.<sup>25</sup> But in many others additional factors operated in the case of women.

The discussion of grounds for committal below shows that if women gave the expected answers in an attempt to avoid certification, they had to be careful to keep within the boundaries of acceptable female behaviour, and not talk too freely, laugh immoderately, use bad language, make public accusations, or even resist the conclusions made by the doctor.

In making their judgements on people who were often not their patients and who they only saw once, these general practitioners were largely confirming, and giving legitimacy to, decisions already made by others. It was, in fact, principally family, friends and neighbours who instigated proceedings or allowed them to continue. The doctors may have been the final arbiters in legal terms, but it was a range of other people who set the ball rolling. The latter's decisions can be found in two of the

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<sup>23</sup> Case 165, YCAA 1026/3.

<sup>24</sup> Case 1650, YCAA 1048/5, p.491.

<sup>25</sup> Case 4123, YCAA 1048/12, p.28.

available sources. In the second section of the committal medical certificate doctors recorded facts indicating lunacy reported by others. Such statements, in contrast to the medical pronouncements were completely non-technical, and focused almost exclusively on perceived behavioural aberrations.

A number of different people contributed to this part of the committal certificate. In the sample cases, family members were always consulted if they were available, as were friends and neighbours if they were involved in the situation that led to committal. If a patient was hospitalised or under medical care at home, nurses contributed their testimony. Their comments tended to echo many of the medical statements, with their references to appearance and responses. If the patient had been arrested or conveyed to the place of examination by the police, then police evidence was given priority because of its authoritative nature. Deviant conduct was the focus of the constable's evidence, as it was the target also of the statements of family and friends.

The second place where evidence of the centrality of lay action can be found is in the casebook entries of patients committed in 1910, when more extensive records were kept. By that time, each new entry contained not only a transcript of the committal medical certificates, but also any family medical history and the patient's own medical and personal history. This was usually given by a

spouse or relative. Thus a thorough reading of all available legal and medical sources, not just the law or the reports of doctors, reveals this crucial nonprofessional role. The sources also reveal that even though the patient's voices were largely absent in the records, it was not just those of the women, as Showalter argues - male voices were silenced too.

Given the nature of the documentation, what can be said about initiation and committal and the influence of gender upon these processes? It must be borne in mind that the issue of initiation of proceedings is not a question the committal forms were designed to answer. They were used with bureaucratic and legal needs in mind and attempted simply to establish evidence of insanity. In overseas studies there have been discussions about the range of people who were thought to have initiated committal proceedings, and a number of individual examples in which these different initiators acted have been presented.<sup>26</sup> Yet as far as I know no one has attempted to analyse this process in any systematic fashion. Historians cite the often inadequate nature of the evidential base as a principle reason for this gap in analysis.<sup>27</sup> Because of the limited and specific nature of this study, and the good

<sup>26</sup> Walton, "Casting out", pp.137-140; Finnane, "Asylums, Families and the State", pp.134-148; Ignatieff, pp.167-172; Finnane, Insanity and the State, p.106, 161-169; Tomes, pp.103-121, Garton, Medicine and Madness, chapters 6 and 7.

<sup>27</sup> Walton, "Casting out", p.136; Finnane, Insanity and the Insane, p.162.

range of records available, a clearer picture of this part of the process emerges.

Some preliminary and cautionary words need to be said about the source material, however. The limited nature of some of the evidence makes it difficult in several of the cases to decide exactly where the initiative came from. In this particular sample there is a lack of direct information in at least five 1890 cases, because the warrants and medical certificates have not survived, and unlike the rest of the cases in that year, were not copied into the casebooks. Moreover in the cases where there is more information, a number of other difficulties present themselves. For example, if constables were involved in conveying the individual to the gaol or asylum for examination, then they were also called upon to supply information as authoritative witnesses, which often gives a distorted impression of their importance in the process. Similarly, because it appears that family members were always consulted for evidence, it is not easy in some cases to distinguish between a member as initiator or merely as an informant. In addition, a discussion of both the initiators of and the reasons for committal reveals that, as other historians of madness have discovered, there was a range of influences and possibilities.<sup>28</sup> Many cases at Auckland reveal that more than one person was involved in

<sup>28</sup> Walton, "Casting out", p.137. See also Finnane, Insanity and the Insane, chapter 4 and Garton, Medicine and Madness, chapter 6 and 7.

the decision to commit an individual, and that there was more than one reason for the decision taken. Thus the following conclusions are based on a composite quantification. Because of the smaller number of male cases compared with female cases, the men are used as a reference sample only, rather than as a control group. The concern here is with the effect of gender on women: another study would be required to explore more fully these issues as they affect men.

**TABLE 3.1**  
**Agencies of committal among sample female patients,**  
**1870-1910**

Agency of committal	1870		1890		1910	
	%	No.	%	No.	%	No.
Family	57	(13)	56	(9)	42	(10)
Friends	4	(1)			4	(1)
Neighbours	4	(1)			8	(2)
Medical	22	(5)	13	(2)	25	(6)
Penal	13	(3)	13	(2)	21	(5)
Uncertain			20	(3)		

**Note:** These are the minimum figures: in three 1890 cases the agency of committal was uncertain and could not be determined.

**Source:** Committed Patient Case Files, YCAA 1026/1-12; Casebooks, YCAA 1048/1-12.

Table 3.1 shows that the family was the main agency of committal, and confirms the suggestion of others that the family was the principle site of power and influence in the course of incarceration.<sup>29</sup> As we have seen, family (and friends to a lesser extent) had a large say in whether a person would be confined both at a formal and informal

<sup>29</sup> Walton, "Casting out", p.139; Ignatieff, p.172; Finnane, "Asylums, Families and the State", p.145; Finnane, *Insanity and the Insane*, p.162; Tomes, p.2.

level because they provided a substantial portion of the evidence on the medical certificate.

Asylum officials recognised the importance of the family in the committal process, and in their view relatives were sometimes using the institution for their own convenience. In 1876 the Inspector claimed the non-pauper insane were "too often placed in the asylum by friends for the purpose of relieving themselves of their plain duties and responsibilities".<sup>30</sup> Relatives' desire to avoid "trouble and expense" again drew comment in the annual report in 1884.<sup>31</sup> Overcrowding (caused by a decrease in the relative proportion of discharges rather than an increase in the committal rate in this period<sup>32</sup>) led to the erroneous belief that "[t]he relatives of these patients have either a growing faith in the advantages and conveniences of our asylums, or they are becoming more intolerant of the mentally afflicted in their own homes".<sup>33</sup> The evidence examined here, however, supports the opposite view: procrastination and a reluctance to use the asylum were a marked feature of the admission process, for women at least. The percentage of family-initiated committals among the women in the sample dropped over time, from around 57 to 42 percent, although figures remained substantial.

<sup>30</sup> NZH, 16 June 1876, p.2.

<sup>31</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1884, H.9, Vol.2, S.2, p.2.

<sup>32</sup> *ibid.*, 1881, H.13, p.5.

<sup>33</sup> *ibid.*, 1901, H.7, p.6.

The importance of the role of the family in the committal of women is complicated by the issue of whether the domestic situation was a factor in provoking a woman's insanity, or simply that a woman's disturbed behaviour was most likely to be manifest in a domestic setting. Some evidence in support of the former proposition will be examined in the discussion of causes below.

A number of different family members initiated the committal of the forty-five sample women. Husbands made up the largest single group, taking action in fifteen cases. This is not surprising given that most women committed to the Auckland asylum in this period were within the marriageable age-group.<sup>34</sup> The distribution over time is uneven: seven husbands initiated committal in 1870, three in 1890 and six in 1910. There are two possible reasons for this low number in 1890. First, the process of committal is uncertain in three 1890 cases, due to lack of information: if they had been able to be quantified, might have confirmed the domination of the husbands. Alternatively, in 1890 Auckland was in the middle of a severe economic depression and husbands may not have been able to afford to give up a wife's unpaid labour in the domestic economy and her skills to "make ends meet".<sup>35</sup>

<sup>34</sup> See chapter five.

<sup>35</sup> The depression had its worst effects from 1887-1895 and was part of a nationwide "long depression" from 1878-1895. Margaret Mutch, "Aspects of the Economic and Social History of Auckland 1890-96" MA Thesis (University of Auckland, 1968), p.14; R.C.J. Stone, Makers of Fortune: A Colonial Business Community and its Fall (Auckland, 1973), pp.69-71. For its effect on women see Sandra Coney, Every Girl: A

The ages of the wives committed increased slightly over time. In the 1870 cases, two of the women were in their twenties, two in their thirties, one in her forties and one in her fifties. By 1910 two were in their thirties, two in their forties and two in their sixties. This trend appears to be related at least partly to two developments. On the one hand the rate of insanity attributed to childbirth complications fell (which was a corollary of the falling birth rate and smaller family size) and at the same time there was a higher rate of diagnosis of menopausal insanity as the population aged and ideas about "difficult" middle-aged women strengthened.<sup>36</sup>

In contrast to this female pattern, the committal of men by their spouses was much less frequent. It occurred in only two of the fifteen male sample cases, in 1870 and 1890, making spouses the smallest individual agency of committal for men.

Sisters were the only other family involved in female cases spread right across the sample years; of four such cases there was one in 1870, two in 1890 and one in 1910. In two of these instances the sister's role was an active one because her sibling was widowed or living with her. In the two instances from 1890 however, the sister's evidence was very much additional information which confirmed the decision already made by the husband. For example, Mrs

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Social History of Women and the YWCA in Auckland 1885-1895,  
(Auckland, 1986), pp.31-33.

<sup>36</sup> See chapter four.

Amelia Kelly told the certificating doctor that she had also seen Jessie N. "in the greatest state of excitement and that y'day she was especially violent".<sup>37</sup>

In a similar pattern to the female cases, brothers were the only other family initiators in the male sample spread across the forty year period. Such cases constituted four out of the total of fifteen. In three out of these four cases, a much higher rate than with the sisters in the female cases, these siblings acted alone as organisers of the proceedings rather than as corroborators of evidence.

The distribution of the involvement of the remaining family members in the female cases is uneven. None occurred in more than two cases in any one year and there is no trend over the period. Almost every other kind of family relationship is represented, including parents in five cases, a brother in one case and a brother-in-law in two cases, a daughter in another case and even an uncle. These family members acted as both initiators and informants. For example, a brother gave evidence in the committal of his forty-five year old widowed sister who was living with him.<sup>38</sup> Similarly, a twenty-six year old domestic servant was examined at the prompting of her uncle, with whom she was staying.<sup>39</sup> A more restricted range of family initiators is evident in the male sample. Besides wives and brothers

<sup>37</sup> Case 1656, YCAA 1048/5, p.503.

<sup>38</sup> Case 138, YCAA 1026/2.

<sup>39</sup> Case 1666, YCAA 1048/5, p.523.

already mentioned, only one sister and a sister-in-law were involved in the remaining family instigated male cases.

As well as differences in which family members initiated involvement in the female and male cases, the role of the informants themselves was determined by gender. Women were mostly the secondary suppliers of information, while men took the predominant role. In the sixty sample cases males were almost always consulted ahead of females. In the case of married women and even of widows, the female testimony was usually corroborated by authoritative statements from men. For example, the daughter of forty-five year old Mary H. informed the doctor that her mother had been "mentally afflicted for some time", yet a male near neighbour was also asked for evidence.<sup>40</sup>

Women were sole testifiers in only six of the forty-five female cases. In four of these six instances, the female informants held positions of power and authority as nurses or employers. In two further instances a mother gave evidence, and two women described their sister's delusions to the certifying doctor. The mother was the only informant because she was living with a man who was not her husband,<sup>41</sup> and therefore he could not take part in proceedings. The sisters gave evidence because the patient was a widow.

<sup>40</sup> Case 138, YCAA 1026/2.

<sup>41</sup> Case 1616, Record Book of Investigations into Relatives' Ability to Pay Maintenance 1890-1899, YCAA 1044/1, p.9.

Men on the other hand took unilateral action more frequently in the female sample cases, and they did so whether or not there were other people available to confirm the story. For example, a father had his twenty-eight year old daughter committed because of the severe animosity she showed towards other members of the family. Yet no other family members were consulted by the certificating doctor.<sup>42</sup>

This pattern occurred in the male cases as well. Brothers acting alone appear frequently as family initiators. In only one of four such cases did a sister-in-law also provide evidence of the man's insanity. In another such case the brother took charge even though the man was married, implying that as a man he had the greater authority. A wife was the sole informant in only one of the male cases, compared to many more cases where men were the sole informants in their wives cases. Here the man was fifty-seven and recently unemployed. His animosity was directed outside the family to the man who financed the mortgage on his house. In the other two examples of the committal of married men where corroboration was given by other witnesses, the two men were much younger (in their thirties) and they vented their fury on their wives directly, by verbally and physically threatening them. In two other cases no evidence was gathered from the wives, but instead a brother and near neighbour contributed

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<sup>42</sup> Case 165, YCAA 1026/3.

respectively. In the former case the reason is more obvious; the two brothers were out walking and the patient attempted to jump off Grafton Bridge.<sup>13</sup> However the wife in the other case was more directly involved. Her husband neglected his business and wandered off into the bush, leaving her to battle on alone.<sup>14</sup>

There are a number of reasons for this trend. The predominant role of men in informing reflects their position both in the family and in wider society. As will be discussed later, although changes did occur in the position of women in both private and public life in this period, these changes served to reinforce women's role as helpmeet and guardian of the family, rather than as an equal as of natural right. Men still had ultimate power and authority. Thus as Stephen Garton notes in relation to the reluctance of women to report their husband's domestic violence as evidence of insanity, it was not just that the authorities ignored all other possible witnesses.<sup>15</sup> From the point of view of the women, the problem of economic dependency, fears of reprisal, and notions of their husband's conjugal rights were important factors. Support of family, neighbours and friends were crucial in successfully proving lunacy.<sup>15</sup> In similar cases at Auckland, customary practice and material and social

<sup>13</sup> Case 3982, YCAA 1048/11, p.288.

<sup>14</sup> Case 164, YCAA 1026/3.

<sup>15</sup> Garton, Medicine and Madness, pp.129-130, 145.

factors worked in favour of men as informants, and therefore as arbiters of sanity at this lay level.

Friends and neighbours, in an extension of the domestic arena, also played a part as initiators of committal, although it was a relatively small one. Only one case of a neighbour starting proceedings is evident in the female cases, and that was because the woman involved was a widow and outside the more normal family context. Among the male cases there were two cases of neighbourly involvement. The former concerned the near neighbour of Alexander S., who took him into town to be seen by the certificating doctors. Because Alexander's wife did not accompany him, the neighbour was the sole informant.<sup>46</sup> In the second instance, John V.'s landlady provided testimony supporting his wife's evidence.<sup>47</sup> A slightly higher rate of neighbourly involvement in the male cases could well be a result of both the greater need to corroborate female evidence and bolster its authority, the greater ease with which men could participate in this public process, and the lack of family for many men in colonial New Zealand.

However, although family members were the chief instigators in the female cases, it is important to realise that neighbours and landladies played a crucial role as informants, as in the case of Blanche A., who annoyed fellow boarders but whose husband was reluctant to label

<sup>46</sup> Case 164, YCAA 1026/3.

<sup>47</sup> Case 130, YCAA 1026/2.

her insane.<sup>48</sup> P.N. Luke's study of suicide in Auckland at this time draws attention to the cramped living conditions of its residents. These included "small and thinly partitioned houses and the ubiquity of lodgers and neighbours...." Luke also comments on the large number of neighbours who overheard arguments, or were familiar with the details of the victim's marital relations.<sup>49</sup> This phenomenon was recognised by asylum staff, as had been the involvement of families. In 1889, for example, the Auckland superintendent drew attention to the case of an old woman brought to the asylum as the result of a neighbourly quarrel.<sup>50</sup>

Members of the medical profession were the second largest group participating in the committal decision in the female cases after family, friends and neighbours. Doctors and nurses were involved in thirteen of the forty-five cases. Yet this role was very much a secondary one, consigned largely to giving authoritative evidence, as they were acting in a medical capacity before any signs of lunacy were perceived. Six of the cases were transferred from hospital and the other women had already been a general practitioner's care for intervals ranging from "some weeks past"<sup>51</sup> to twelve months.<sup>52</sup>

<sup>48</sup> Case 3970, YCAA 1048/11, p.276.

<sup>49</sup> P.N. Luke, "Suicide in Auckland 1848-1939", MA Thesis (University of Auckland, 1982), p.119 & fn 3.

<sup>50</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1899, H.7, p.5.

<sup>51</sup> Case 157, YCAA 1026/3.

<sup>52</sup> Case 160, YCAA 1026/3.

None of the men in the sample were transferred from hospital. One man had been seen periodically by a doctor before he was committed. The doctor supplied an unusually detailed account of the case and his four visits, principally it seems because he had known the patient from childhood. He makes it clear, however, that the man's sister and brother took the initial steps by consulting him. Six days after the final visit, the doctor "issued a certificate directed to the Magistrates at Tauranga to the effect that [the patient] was suffering from a disordered mind and unable or incapacitated [sic] attending their summons".<sup>53</sup>

Constables were the third group involved in the committal process, operating in nine female cases. In one instance the police official was providing extra evidence in support of a husband's testimony. The constable stated that Sarah J. wandered about at night and frightened people by her "excited manner".<sup>54</sup> Proceedings in the other cases were initiated by constables alone. These women were almost all single or widowed, that is, those most isolated and least likely to have recourse to family and community support. Only one woman in the 1870 sample was found to be insane when she was in gaol and was transferred to the asylum on the testimony of the warder and matron.

In contrast to the female cases, a higher percentage of men were committed by the police. Constables were

<sup>53</sup> Case 176, YCAA 1026/3.

<sup>54</sup> Case 4117, YCAA 1026/12.

involved in the committal of at least four of the fifteen male patients. The distribution of these cases cannot be determined with accuracy because the circumstances of committal are unknown in two 1890 cases. However they formed the majority of cases in 1910 and references in the asylum's annual reports suggest that this was a prominent mode of committal for men generally. A higher proportion of men were single and admitted from non-domestic situations - they lived alone and were often tramps and semi-vagrants. A number of annual reports refer to patients arrested under the provisions of the Vagrancy Acts of 1866 and 1869, committed to gaol and sent to the asylum on being found insane.<sup>55</sup>

Besides family members, friends, doctors and the police, there is a fifth possibility in locating the initiative for committal. Although voluntary committal was not made legal until 1911, a handful of the cases in my sample indicate that certain individual actions were an "indirect" mode of voluntary committal. For example, Olive B., a forty-eight year old married housewife admitted in 1890, was "conscious that her mind is affected and that she cannot control herself, is sleepless and despondent..."<sup>56</sup> A similar case is evident in the male sample. Joseph T., a forty-six year old married foreman, informed one of his certificating doctors that "for six months he has had a

<sup>55</sup> Annual Report on the Lunatic Asylums of New Zealand, *AJHR*, 1881, H.13, p.6; *ibid.*, 1897, S.2, H.7, p.2.

<sup>56</sup> Case 1607, YCAA, 1048/5, p.428.

severe pain at top of head, and that he has been suffering from profound melancholy, he has also been unable to keep still or to occupy himself with any mental work as his mind gets so confused that he feels like a man lost in the bush."<sup>57</sup> This is obviously an area of greater speculation, which would be useful to carry further. However here the nature of the source material precludes any sustained examination.

An analysis of the grounds for committal in individual case histories helps to explain further the role of initiators and informants and why they took the committal decision. Yet the patterns in the reasons why these people were committed are, at times, more ambiguous. Again, incomplete evidence is obviously a factor. By comparison with the records used for Jill Matthew's survey of admissions to a twentieth century psychiatric institution, for example, the medical certificates of patients at the Auckland asylum were often filled out perfunctorily, to conform with bureaucratic standards rather than clinical needs. More generally, there was not the comprehensive examination of a patient's personal and social history that a post-Freudian psychiatry would consider necessary.<sup>58</sup>

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<sup>57</sup> Case 3982, YCAA 1048/11.

<sup>58</sup> More evidence of life histories is recorded in the later casenotes under the influence of social Darwinism, but from a genetic/hereditarian perspective, rather than a psychological viewpoint. See Matthews, p.24.

Just as there were difficulties with focussing on a single initiator in the process, there are also problems with assigning a single reason for committal. The case materials suggest the futility of such efforts and the arbitrary labelling and artificial simplicity in given reasons that must have resulted. There were often multiple pressures involved.

A range of committal grounds emerge, some of which were obvious, involving such things as threats to persons, threats to property, threats to articulated social norms and varying manifestations of "paranoia". Alleged lunatics' threats to persons included family members, friends, strangers and themselves. It is not surprising, given the domestic location of most women, that threats to family members were the most commonly cited single reason for committal among the female cases, occurring in six cases in 1870 and four cases each in 1890 and 1910, as Table 3.2 shows.

Some of the recorded reasons were brief. Jane B., a twenty-two year old carpenter's wife, was committed because she "threatened to kill persons around her"; exactly who was not specified.<sup>59</sup> In other cases there was more detail of the circumstances leading to committal. Twenty-eight year old Ellen L. attempted to bite her father and threatened her sister with a knife.<sup>60</sup> Elizabeth H., a thirty-three year old settler's wife, stripped herself

<sup>59</sup> Case 160, YCAA 126/3.

<sup>60</sup> Case 165, YCAA 1048/1, p.221a.

naked in front of the children and tried to injure them, taking them by the throat

**TABLE 3.2**  
**Causes of committal among sample female patients, 1870-1910**

Cause of committal	1870		1890		1910	
	%	No.	%	No.	%	No.
Threats to Persons						
-- family	13	(6)	9	(4)	9	(4)
-- friends					2	(1)
-- strangers	2	(1)	4	(2)	9	(4)
-- self	4	(2)	11	(5)	9	(4)
-- general	4	(2)	4	(2)		
Threats to property	11	(5)	9	(4)	4	(2)
Threats to social norms						
-- general	7	(13)	9	(4)	9	(4)
-- self expression	18	(8)	7	(3)	7	(3)
-- housework	2	(1)	7	(3)	2	(1)
-- marital	9	(4)	9	(4)	11	(5)
-- maternal	9	(4)	9	(4)	13	(6)
Paranoia	9	(4)	11	(5)	13	(6)

Source: Committed Patient Case Files, YCAA 1026/1-12; Casebooks, YCAA 1048/1-12.

and attempting to strike them with a large stick.<sup>61</sup>

Thirty-five year old Ellen M. "wished she had the killing" of her husband.<sup>62</sup> Only one woman in the sample expressed animosity towards friends: Paulina W. tried to kill a neighbour.<sup>63</sup>

Seven women threatened strangers. Table 3.2 demonstrates that the incidence of this reason increased in the period from one in 1870 to four in 1910. Many of these women were elderly. For example, Margaret L., who was married, in her sixties and wandered at night, threatened

<sup>61</sup> Case 128, YCAA 1026/2.

<sup>62</sup> Case 1605, YCAA 1048/5, p.426.

<sup>63</sup> Case 3967, YCAA 1048/11, p.273.

"to do for people".<sup>64</sup> A constable described Mary A., a seventy-year old widow, as being a lunatic for the last six months and dangerous to children.<sup>65</sup>

Any tendency to suicide by these women was especially worrying to their families. Suicide attempts caused practical difficulties in terms of the preventive vigilance required by family members. Yet they were also clear indications in most people's minds of temporary, if not long-term insanity.<sup>66</sup> Sane people did not threaten to take their own lives. By 1910 when case books had become standardised, entries always stated whether the patient was suicidal as well as dangerous or epileptic.

Threats to self were, after threats to family members, the second most common single reason for committal and they had also increased in frequency by 1910. Forty-five year old Olive B. tried to drown herself.<sup>67</sup> Jane E. "tried to choke herself with a handkerchief, and has said that she would cut her throat and throw herself off the balcony. At night she is maniacal and violent if restrained and prevented from carrying out her desire to destroy her life".<sup>68</sup> Not only did Paulina W. try to kill her neighbour, but she also attempted suicide by eating matches and hiding knives under her pillow.<sup>69</sup>

<sup>64</sup> Case 4116, YCAA 1026/12.

<sup>65</sup> Case 1631, YCAA 1048/5, p.453.

<sup>66</sup> Luke, pp.26-27.

<sup>67</sup> Case 3982, YCAA 1048/11, p.288.

<sup>68</sup> Case 3997, YCAA 1048/11, p.303.

<sup>69</sup> Case 3967, YCAA 1048/11, p.273.

Not all of these women went as far as attempting suicide. Francis F., for example, a forty-five year old settler's wife, required personal restraint to prevent injury to herself because she repeatedly struck her knuckles against the wall.<sup>70</sup>

Finally, in four of the forty five sample cases the violence was generalised and the women did not direct their behaviour at anyone in particular until attempts were made to apprehend or restrain them.

In many cases the women did not carry out their threats or preventive measures were taken in time. However in nineteen out of thirty-five cited instances of threats to people the violence was real, not just implicit. In a rather extreme example, seventeen year old Taruke W. "smashed" a girl's face in a coach journeying to Waiuku.<sup>71</sup> The proportion of threats which contained varying degrees of violence remained fairly constant over time, as Table 3.2 shows.

The issue of the degree of violence is crucial to an understanding of the reasons for committal. The women whose threats were violent appear to be in a different category from those deemed deranged or absurd. Why then were they not sent to prison? An examination of the one woman in the sample who was transferred from the prison to the asylum provides some clues. Bridget H., a twenty-five year old soldier's wife, was imprisoned twice in 1870 for being an

<sup>70</sup> Case 145, YCAA 1026/2.

<sup>71</sup> Case 4075, YCAA 1048/11, p.381.

"habitual drunkard". Her behaviour at the gaol was similar to the other women described above. She was "very violent towards the Matron and would have done her some bodily harm...", used "violent language, and threatened the inmates with personal abuse...."<sup>72</sup> What put her in the category of insane rather than criminal was not this behaviour alone, although it certainly contributed to the process. Indeed the attempted assault on the matron was made a month before Bridget was examined for signs of lunacy. Rather it was her "delusions" - voices at night, spirits annoying her - that decided her fate.

A similar pattern is found in the other cases. Many women threatened (and some carried out) acts of violence towards others, but at the same time they heard, saw or believed things that their family and friends did not accept to be valid.

In contrast to the women, the largest single threat in the male group was threats to self, which constituted three cases, one in 1870 and two in 1890. For example, John V., carried a scar on the right side of his neck as evidence of a previous suicide attempt.<sup>73</sup> County Foreman Joseph T. attempted suicide at least three times according to his brother, by cutting his throat with a razor and jumping off Grafton Bridge among others.<sup>74</sup>

<sup>72</sup> Case 125, YCAA 1026/2.

<sup>73</sup> Case 130, YCAA 1026/2.

<sup>74</sup> Case 3982, YCAA 1048/11, p.288.

Family members were threatened in a smaller number of male cases, a reflection of the high number of single men in the sample. Both cases involved threats against a wife. John V., a thirty year old doctor "repeatedly threatened to kill her".<sup>75</sup> Denis C., a thirty year old farmer went further than any of the women involved in domestic disputes when he struck his wife "with a bill hook".<sup>76</sup>

In parallel with the women in the sample, only one man threatened a friend. Two men out of the fifteen threatened strangers. Of the latter, one was threatening in a more specific way that had no correlation among the women. Herbert R., a fifty-nine year old single gumdigger was arrested because he was wandering about frightening women. The certificating doctor commented that "[t]he women are leaving their houses when he goes wandering near them".<sup>77</sup>

Although the sample of males is much smaller, the case records suggest that the degree of actual violence was greater in the male cases, and the women were more often restrained before carrying out their threats. Alternatively, the characterisation of the women's behaviour as less violent may reflect the greater sensitivity with which society regarded violent actions by women. Because nineteenth-century women were meant to be pious, demure and submissive, their deviations were all the more noticeable and challenged earlier. Male violence may

<sup>75</sup> Case 130, YCAA 1026/2.

<sup>76</sup> Case 176, YCAA 1048/1, p.229.

<sup>77</sup> Case 4105, YCAA 1026/12.

have been more likely to be seen as "normal" and expected. This is another area that would repay further study.

After threats to people, threats to property were the second group of reasons for committal of women and they constituted the smallest group of the four. The number of women manifesting this type of behaviour declined slightly over the period as Table 3.2 shows. Such women most commonly attempted to destroy things around them: their clothes, bedding and books,<sup>78</sup> or if in hospital institutional bedding and crockery.<sup>79</sup> One woman attempted to burn down the house.<sup>80</sup> Agnes E., a twenty-six year old servant, "put her hand thro' one or two panes of glass" in her employer's house.<sup>81</sup> A smaller number of women abused things that were not theirs or in their immediate environment. For example, Mary H. believed her next door neighbour had "illegally taken possession of her late husband's property." She was constantly giving her neighbour "notice to quit... and using violent means at night to gain admission into his house".<sup>82</sup> Only one woman in the sample did not use violence, instead she removed objects intact. Blanche A., a thirty-one year old housewife was "a great source of annoyance to boarders in the house taking possession of letters, telegrams etc...."<sup>83</sup>

<sup>78</sup> For example, case 165, YCAA 1026/3.

<sup>79</sup> As in case 1650, YCAA 1048/5, p.491.

<sup>80</sup> Case 138, YCAA 1026/2.

<sup>81</sup> Case 1629, YCAA 1048/5, p.451.

<sup>82</sup> Case 138, YCAA 1026/2.

<sup>83</sup> Case 3970, YCAA 1048/11, p.276.

Given the often nomadic and survival-based lifestyle of many of the male patients in this period, it is surprising that there was only one man who interfered with property in any way and his actions were not violent either. The man was William N., a fifty-nine year old unmarried clerk, who lived with his brother and sister-in-law. She told the certificating doctor in 1910 that he had "a habit of carrying away articles and not knowing where he has put them. Invariably answers, when asked, that they are in the closet."<sup>84</sup>

Few of these threats to property were regarded as criminal, although the actions of the property trespasser and the arsonist came closest to the mark. Even the actions of Blanche were put in context by the initiators and informants. Her letter-snatching was recorded as additional evidence, rather than a motivating factor. Constables initially became involved because she went to them making "extraordinary charges of persecution against certain people", not because she took the letters and telegrams.<sup>85</sup> For the most part, actions against property by women were carried out within a domestic situation and were seen as a nuisance rather than as illegal or punishable by law.

The third group of reasons for committal were threats to articulated social norms. A total of twelve women out of the forty-five exhibited such behaviour, with numbers rising slightly by 1910. These actions included five women

<sup>84</sup> Case 4047, YCAA 1048/11, p.353.

<sup>85</sup> Case 3970, YCAA 1048/11, p.276.

who persisted in going naked around the house and in front of the children. One of these women was a domestic servant who had also "been observed to pick up rubbish and even dirt and eat it".<sup>86</sup>

Another five women made public nuisances of themselves. Martha L., a forty-year old pensioner's wife, bothered the police when they were on duty, repeatedly interrupted business at the bank and wandered about the roads "talking aloud and gesticulating".<sup>87</sup> Arrest for "behaving in an extraordinary manner in Queen St" at five o'clock in the morning led to fifty-six year old Hannah W.'s committal in 1890.<sup>88</sup> Two women were committed in 1910 for, among other things, wandering at night and travelling in passing wagons.

The perception of threats to articulated social norms also contained racial overtones. Seventeen year old Taruke W. was found by the police wandering at large, insufficiently clothed and "caressing strangers on the street". As well as being very dirty and not speaking any English, "she catches hold of any person who approaches her and appears to be erotic". Maori women were among the first to be condemned as naturally promiscuous, a judgement later extended to "female defectives".<sup>89</sup> Forty year old Matua W.,

<sup>86</sup> Case 1627, YCAA 1048/5, p.449.

<sup>87</sup> Case 155, YCAA 1026/3.

<sup>88</sup> Case 1624, YCAA 1048/5, p.446.

<sup>89</sup> D. Ian Pool, The Maori Population of New Zealand 1769-1971 (Auckland, 1977), p.93. See also Tennant, "Magdalens and Moral Imbeciles", p.493 and Anderson, pp.91-95. Elizabeth Lunbeck has documented this belief in early twentieth century North America. She found that "[i]f white

who had attempted to burn down the whare at her settlement, also offended settler notions of propriety by believing she was Queen Victoria. This delusion was stated first in all witness accounts, indicating that it was regarded as seriously as the arson.<sup>90</sup>

This sort of threat was a greater factor in the male sample, accounting for eleven of the fifteen cases: two in 1870, three in 1890 and four in 1910. Some features similar to the women's behaviour are evident. These men stripped themselves naked and wandered off. Two men's insanity was characterised in part by their being alone in the bush. Alexander S. neglected his family and farm and roamed in the bush for two days. He was found six miles from home. A constable testified that Ray P., a twenty-five year old gumdigger "had been living alone in the Bush for some 2 or 3 years gumdigging. Refuses to answer questions & is very peculiar in his manner". The police had been trying to catch him for some months.<sup>91</sup> These last two cases suggest that solitude in the bush may have been an archetypal malady for men. Jock Phillips reports that the lone man in the frontier situation was often regarded as "more or less cranky" or a "hatter" from the phrase "as mad as a

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immorality was a symptom of disease, black immorality, on the other hand, was entirely normal...." Elizabeth Lunbeck, "'A New Generation of Women': Progressive Psychiatrists and the Hypersexual Female", *Feminist Studies*, 13:3 (Fall, 1987), p.535.

<sup>90</sup> Case 4028, YCAA 1048/11, p.334.

<sup>91</sup> Case 4129, YCAA 1026/12.

hatter".<sup>92</sup> In New South Wales in this period it was a theme of many cases and even entered the popular literature of the period.<sup>93</sup>

The committal of men for public threats to articulated social norms increased over the period. Jock Phillips has argued that "[w]ith the population increasing and larger cities appearing, respectable Pakehas became more intolerant of social disorder... Cities brought new expectations of order, routine and public decorum."<sup>94</sup> The case files of men committed to the Auckland Asylum add weight to this interpretation. For example, a fifty-seven year old gumdigger was certified because he talked a lot of nonsense. He believed he was the engineer of the world who would soon control the world, and that the British government owed him 32 200 000 pounds for use of his machinery. More importantly, he was also "curious in his behaviour".

Race was a factor for men too, except that among the smaller number of male cases, it was Pakeha who were manifesting the inappropriate behaviour by believing in or supporting Maori systems of belief. Dennis C., who beat his wife, did so because he thought that his wife had "makatued him". "He was told that blood was necessary to remove the witchcraft so he beat his wife to produce the blood".<sup>95</sup>

<sup>92</sup> Jock Phillips, A Man's Country? The Image of the Pakeha Male - A History (Auckland, 1987), p.27.

<sup>93</sup> Stephen Garton, Medicine and Madness, pp.118-119.

<sup>94</sup> Jock Phillips, p.49. See also Tennant, "Magdalens and Moral Imbeciles", p.493.

<sup>95</sup> Case 176, YCAA 1026/3.

The case of Charles J. is even more interesting for the light it casts on Pakeha views of the Maori. Charles called himself "White Chief Tiger Snake" of the Ngati Porou and wrote circulars championing Maori rights. After his admission he defended himself by saying "his mere feeling of fairness induced him to say that he would throw in his lot with the Maoris were any attempt made to exterminate them."<sup>96</sup>

While perceptions of insanity were influenced by notions of propriety and impropriety that were common to women and men, running through many of the cases involving women was something else, specifically linked to their having crossed the boundaries of acceptable feminine behaviour.

Their deviance in this second respect was an integral aspect of their perceived abnormality, as important as other more obvious reasons. Sometimes it was the only ground for committal. The codes of conduct that these women transgressed were situated in four areas: self expression, housework, marital relations, and maternal behaviour. In each area these women did not behave in what was believed to be a feminine manner.

Elaine Showalter has suggested that English women's "talkativeness, violations of conventions of feminine speech, and insistence on self-expression was the kind of behaviour that had led to their being labeled 'mad' to

<sup>96</sup> Case 1637, YCAA 1048/5, p.465.

begin with."<sup>97</sup> Many of the casefiles at Auckland bear this out. Committal certificates frequently comment on the violent and obscene nature of the women's language. Notions of piety and purity are explicit in the case of Agnes E., who "used horrible language, having been up to that time a decent & even religious young woman, fully self-respecting".<sup>98</sup> Other examples were "very talkative",<sup>99</sup> or "abusive threatening obscene".<sup>100</sup> In the case of one woman who passed the test of rationality and was coherent with a good memory for recent and past events, it was noted that she was "very argumentative".<sup>101</sup> "Immoderate" or inexplicable laughter was also emphasised as evidence of abnormality.<sup>102</sup> Good women were supposed to be quiescent, decorous and meek, qualities which many women at the Auckland asylum clearly did not possess. Good women were also ready to comply with other's wishes, but the female lunatics here were "rather obstinate and inclined to be more so",<sup>103</sup> or repeatedly replied "don't know" to questions at the medical examination.<sup>104</sup>

Femininity was thus associated with a lack of ego. Two cases in particular support this contention. Rebecca J., whose immoderate laughter has been noted, was described censoriously as talking "as if she were acting tragedy upon

<sup>97</sup> Showalter, *The Female Malady*, p.81.

<sup>98</sup> Case 1629, YCAA 1048/5, p.451.

<sup>99</sup> Case 138, YCAA 1026/2.

<sup>100</sup> Case 1611, YCAA 1048/5, p.432.

<sup>101</sup> Case 3947, YCAA 1048/11, p.253.

<sup>102</sup> Case 153, YCAA 1026/2.

<sup>103</sup> Case 3974, YCAA 1048/11, p.280.

<sup>104</sup> Case 145, YCAA 1026/2.

a stage".<sup>105</sup> Similarly, Amy G. was described upon release as "[m]entally with the exception of exaggerated egotism, shows no sign of insanity".<sup>106</sup> Linked to this, as Robyn Anderson has pointed out, was the fact that not all these women shared the sense of shame and repentance expected of them. Bridget H. had fifty different convictions for drunkenness in a total of six and a half years. She was transferred from the gaol to the asylum several times. Although she was always quiet and rational upon admission she stated defiantly when brought up before the court on a vagrancy charge that "she had been drunk for four years and would be drunk for four years more".<sup>107</sup>

Such prohibitions did not surround the men's behaviour. Although "raving", "volubility", "rambling" and "muttering" were noted as signs of abnormality, the informants did not view these deviations with the same degree of censure. Men were expected to be assertive and vocal; some were regarded as strange because they were "silent and retiring",<sup>108</sup> "dull, morose and silent"<sup>109</sup> or "very reticent".<sup>110</sup>

The second area of contention centred on women's role as homemakers. Many women were specifically noted as being "unable to attend to [their] household duties". The fact that this was a constant refrain throughout the casenotes,

<sup>105</sup> Case 153, YCAA 1026/3.

<sup>106</sup> Case 57, YCAA 1048/3, p.47.

<sup>107</sup> NZH, 20 January 1868, p.4. Cited in Anderson, p.77.

<sup>108</sup> Case 135, YCAA 1048/1, p.199.

<sup>109</sup> Case 176, YCAA 1048/1, p.229.

<sup>110</sup> Case 4129, YCAA 1048/12, p.34.

suggests that it was a standard test of female 'normality'. The women themselves, their families or husbands were acting upon the assumption that "[t]ruly feminine work, acknowledged only as a labour of love, was housework".<sup>111</sup> Because of its status as non-work, a housewife's standards were considered as an aspect of her personality. That is, women who stopped cooking, cleaning and sewing, were not just poor workers, but manifested personality defects that must be cured.<sup>112</sup> Elizabeth M. wrote a telling letter to the asylum superintendent after returning home. In a shaky hand, the note reads: "I have improved very much in my health since I came Home and am quite able to attend to my Household Duties... my Dear Husband was glad and happy to have back his cook and housekeeper...."<sup>113</sup> Judgement as to what constituted ability to perform household tasks could be quite exacting. Albina C. was witnessed sewing on a patch of calico with cotton used for stockings, instead of ordinary thread.<sup>114</sup>

Boundaries were also overstepped in the marital arena. Feminist historians have observed that marriage is the "cornerstone of femininity". Good women were expected to see marriage as "an essential part of every truly feminine woman's life plan", as natural and necessary.<sup>115</sup> Indeed in colonial New Zealand, the imbalance of the sex ratio in

<sup>111</sup> Matthews, p.49.

<sup>112</sup> *ibid.*, pp.156-157.

<sup>113</sup> Case 128, YCAA 1048/1, p.191.

<sup>114</sup> Case 157, YCAA 1026/2.

<sup>115</sup> Matthews, p.112.

favour of women gave greater opportunities for them to marry and "put a premium on women as wives".<sup>116</sup> Even domestic service, the largest category of paid work for women, was regarded as a preparation for marriage.<sup>117</sup> The laws surrounding marriage changed markedly in this period. In the 1870s marriage was regarded as a "union for life, in which the wife merged with the husband to form one financial, legal and social entity, of which the husband was the complete master". Any equality between partners, which obviously did occur in some marriages, was a "generous concession" on the husband's part, but was not guaranteed under law.<sup>118</sup> By 1910 there were improvements in women's legal position, in regard to rights, property and participation in public life, including the Married Women's Property Act of 1884. However these changes took place because they were seen as compatible with women's traditional role of wife, mother and home maker and were campaigned for on that basis.<sup>119</sup>

It has been argued that despite the legal and ideological constraints upon women in nineteenth century New Zealand, migrant women experienced a greater sense of purpose, a feeling of usefulness and a greater degree of

<sup>116</sup> Raewyn Dalziel, "The Colonial Helpmeet: Women's Role and the Vote in nineteenth-century New Zealand", in Women in History, p.58.

<sup>117</sup> Judith Elphick Malone, "What's Wrong with Emma? The Feminist Debate in Colonial Auckland", in Women in History, pp.71-73.

<sup>118</sup> *ibid.*, pp.76-77, 79.

<sup>119</sup> Dalziel, p.66. Bronwyn Labrum, "'For the better discharge of our duties': the Women's Movement in Wanganui 1893-1903", BA Hons Essay (Massey University, 1986), p.55.

independence than they would have in Britain.<sup>120</sup> Marriage became in practice much more of a partnership because husband and wife had to work together as an economic unit.<sup>121</sup> When the pioneering phase ending, women responded enthusiastically to the new cults of domesticity and true womanhood apparent in the early twentieth century which gave them a similar sense of importance, dignity and purpose.<sup>122</sup> As Margot Roth has pointed out, however true these assertions may be, they are based on the assumption "that women's lives are assessed by themselves and others in terms of acquiring a husband as a necessary prelude to housework and increasing the population".<sup>123</sup>

The experience of the women committed to the Auckland asylum offers a different kind of testimony to that of the strong colonial helpmeet ideal. Many women were not behaving as a respectful or satisfied wife should have been. For example, Susannah E. attempted to escape her husband by ship in 1870 and was subsequently admitted by him. This was not the first time. She was admitted twice in 1869. On her second admission, she was "still labouring under the impression that she requires another partner in order to be happy - states she did not live happily with

<sup>120</sup> Dalziel, p.59.

<sup>121</sup> Erik Olssen and Andree Levesque, "Towards a History of the New Zealand Family", in Families in New Zealand Society, ed. Peggy G. Koopman-Boyden (Wellington, 1978), p.3; Roderick Phillips, Divorce in New Zealand: a social history (Auckland, 1981), p.78.

<sup>122</sup> Olssen and Levesque, p.7.

<sup>123</sup> Margot Roth, "The New Zealand Family: Cornerstone of Colonisation", MA Thesis (University of Auckland, 1980), p.88.

her husband." Unsurprisingly, when committed by him a third time "she was rather depressed and bewails her fate most piteously".<sup>124</sup> Helen C. had, in the words of one of her certificating doctors, "taken an ill will against her husband, and accuses him of ill treatment". She had also been admitted three times, after either a birth or miscarriage. "She talks incessantly about her home life, complaining of her husband. She states that he ordered her out of the house as a 'bloody whore', after she had asked him for a drink of water. She states that her husband would kill her if he could. When she sees her husband she goes off at once in a violent attack of rage and raging".<sup>125</sup> Even if outright hostility was not a factor, other transgressions of behaviour were noted. Elizabeth M. for example, "parted from her husband with seeming indifference".<sup>126</sup>

Many women accused their husbands of ill treatment or infidelity and there is no evidence of any acceptance of the truth of their statements. Jessie N. believed her husband tried to poison her, would not let her husband near her and charged him with unfaithfulness, an allegation that the doctor believed to be "not unfounded". Yet she would not recant, carried her action through to the extent of suing her husband for maintenance upon discharge, and requested the asylum superintendent for a statement of her

<sup>124</sup> Case 101, YCAA 1049/1, p.172.

<sup>125</sup> Case 4066, YCAA 1048/11, p.372.

<sup>126</sup> Case 128, YCAA 1048/1, p.191.

condition and conduct, and whether her condition was the effect of her husband's ill treatment.<sup>127</sup>

As with cases of men charged with wife-beating in court, it seems that a woman's testimony was given a favourable hearing only if she was clearly an innocent or "genuine" victim. Women who did not live with their husbands, women in de facto relationships, and women who fought back were less likely to win their cases;<sup>128</sup> in the case of alleged lunacy it was women who fought back or who acted indifferently towards their husbands who lost.

Husbands did not seem eager to reclaim these truculent wives, in contrast to the area of contention discussed next, where the problems related to a woman's performance in her maternal role. It is my impression that confinement in these examples was a kind of de facto divorce. In other words, it was a way of getting rid of troublesome women. Divorce in nineteenth and early twentieth century New Zealand carried a very high degree of social stigma; there were a limited number of grounds under which it could be obtained; and up until 1881 all petitions had to be heard in Wellington.<sup>129</sup> A 1907 amendment to divorce legislation relates specifically to lunacy, and appears to have legitimated what was happening in practice, at least on the husband's part. Divorce was granted if one of the spouses had been confined to an asylum for a total of ten of the

<sup>127</sup> Case 1656, YCAA 1048/5, p.503.

<sup>128</sup> Anderson, chapter 10 passim.

<sup>129</sup> Roderick Phillips, pp.18, 110-111.

twelve years preceding the act of petition, and where there was little likelihood of recovery from lunacy. Objections during the reading of the bill reveal a recognition of the potential to use the asylum in this way. Dr Grey Hassell, superintendent of the Auckland and Porirua asylums, argued that some men and women would conspire to keep their spouses in an asylum in order to qualify for divorce. Significantly, he believed men would do this more frequently than women.<sup>130</sup>

The third area of deviance involved women's behaviour towards their children. From the beginning of colonisation in New Zealand the family had been promoted as a source of social stability and a means of reproducing labour. However, in a self-sufficient household, where women and men could both work in the family economy, there was a relatively flexible division of labour between the sexes.<sup>131</sup> By the end of the period of this study, the links between women and the family were being articulated in a more comprehensive and rigid fashion. As had already happened in England and North America, the cults of domesticity and true womanhood increasingly held sway. These cults emphasised almost exclusively the nurturant and maternal capacities of women, whose lives became even more dependent and privatised.

The new wife-mother and her attractive home was promulgated as the fitting solution to problems apparently

<sup>130</sup> *ibid.*, p.38.

<sup>131</sup> Dalziel, pp.60-61.

associated with urban growth: prostitution, destitution, illegitimacy, larrikinism and more general immorality and crime. Motherhood and housekeeping were increasingly professionalised, at a time when racial fitness and the supremacy of the British Empire were believed by some to be under threat.<sup>132</sup> Belief in social Darwinism and eugenics, championed by the emerging medical profession and the state, compounded the pressures on women, for it was argued that women were biologically suited for the roles of having children and keeping house.

A number of the women committed to the Auckland asylum were neglectful of or violent towards their children and this complaint became slightly more frequent in the later case files. Mary O. was admitted from hospital some weeks after giving birth. It was stated that "she refused to see her children in the room and told him to take them away from her".<sup>133</sup> Women were expected to want to be with their children at all times and have the predominant interest in their welfare. Jessie N. was censured for the "ready way she is satisfied with regard to her children... Says she would like to be with her children but expresses the wish in a vague way and seems far more satisfied to be absent from them than a sane mother would be".<sup>134</sup> Similarly, Dora T.'s husband wished her "to be under restraint as she

<sup>132</sup> Erik Olssen, "Truby King and the Plunket Society. An analysis of a prescriptive ideology", *NZJH*, 15:1 (April, 1981), pp.8-10, 21-22; Fleming, pp.9-10, 21-22.

<sup>133</sup> Case 132, YCAA 1026/2.

<sup>134</sup> Case 1656, YCAA 1048/5, p.503.

neglects her family so much".<sup>135</sup> Mothers in particular were supposed to be selfless and giving, servers not takers, not "self absorbed" as another "neglectful" mother was described.<sup>136</sup>

In contrast to the difficult wives, husbands were more eager to claim these women back, sometimes before the medical superintendent thought they were ready. This degree of willingness to reclaim discloses women's function as an economic adjunct, a purpose which is revealed in other ways. Roderick Phillips has shown how advertisements at the turn of the century demonstrate the pervasiveness of economic criteria in a marriage, and employment agencies which catered especially for domestic servants also offered matrimonial introductions; a blatant indication of the similar functions and legal status of servant and wife.<sup>137</sup> The following case indicates that their labour potential may have saved other women from confinement. Maria C. was a fifteen year old epileptic pupil at St Mary's Industrial School. The school's medical officer made much of the terror these fits produced in the other children and wanted her committed to the asylum. The provincial surgeon initially refused to declare her insane, finding Maria an intelligent girl, "and the constant work in which she is engaged... the best thing for her". In his reply, the medical officer advised him that he wanted to send her to

<sup>135</sup> Case 2800, YCAA 1048/9, p.304.

<sup>136</sup> Case 3997, YCAA 1048/11, p.303.

<sup>137</sup> Roderick Phillips, p.79.

the hospital or Old Women's Institute instead, and emphasised the availability of Maria's domestic services.<sup>138</sup>

The changing importance attached to women as mothers and indeed the many roles they had to live up to demonstrate how ideals of femininity varied. Women could never reach the ideal because it shifted on them. In this sense the ideal of the good woman, wife and mother was internally contradictory as Matthews has argued.<sup>139</sup> Yet these roles, particularly that of wife and mother towards the end of the period, were extremely important because there were few alternatives. The casefiles show that women continued to strive for this ideal. Mary P. was admitted in 1870 after "following men with the idea they were going to marry her".<sup>140</sup> Lydia Y., who was later diagnosed as mentally retarded, had "delusions as to marriage, says she is able to cook and perform all household duties...."<sup>141</sup> It therefore comes as no surprise to find, as the next chapter shows, that "disappointment in love" was a female dominated diagnosis.

A fourth reason why many of these women were committed was because they were regarded as "paranoid". Their case records suggest that instead of making a nuisance of themselves, they were unacceptable victims because of

<sup>138</sup> W. Lee to Provincial Superintendent, 30 July 1874, AP2 1874/2538.

<sup>139</sup> Matthews, pp.7-8.

<sup>140</sup> Case 134, YCAA 1026/2.

<sup>141</sup> Case 1616, YCAA 1048/5, p.438.

outlandish or unwelcome behaviour or they dwelt on real or imagined misfortune. Fifteen of the forty-five women fall into this category, making it the second largest. The distribution of these cases increased slightly by 1910, as did the incidence of threats to articulated social norms.

The unacceptable victims included Rebecca J., a thirty-four year old widow who went to live with her sister and brother-in-law after her husband's death. According to one of her medical certificates:

She has been a long time in a very excited state of mind in fact that it commenced about the time of late husband's illness... I heard this morning that she will not get up out of bed, but is expecting her husband (who has been dead some months) to return every minute.

Rebecca also believed that her sister had poisoned her husband and child, drank heavily and threatened her sister's children.<sup>142</sup>

Four women had delusions regarding their children. For example, Margaret L., a sixty year old housewife, believed that she had four children at home and that rats were threatening them. Forty year old Paulina W. could not get over the death of her baby five months previously and continually heard it's voice, saying "that if she had not lost her memory, her child would not have died".<sup>143</sup>

The reason why other women were victims is less apparent. Four of the fifteen were paranoid about being persecuted. Mostly it was just "everyone" or "others" who

<sup>142</sup> Case 154, YCAA 1026/3.

<sup>143</sup> Case 3967, YCAA 1048/11, p.273.

were believed to be the bullies. But in the case of Catherine D., a fifty-five year old single dressmaker, the perpetrators were specifically named. Catherine believed

that she is persecuted by detectives sent by Mr Kettle and Inspector Cullen to prevent her being allowed to stay in any lodging house. She also stated that several people - Mr Brown of Onehunga and her late landladies - Mrs Webb and Mrs Mckenna repeatedly tried to poison her food.<sup>144</sup>

The belief in poisoned food occurs repeatedly, and two women admitted because they stopped eating. Agnes F. told her certificating doctors that voices told her not to eat as people were poisoning her. Fifteen year old Margaret Y. was in Auckland Hospital for some months resisting attempts to feed her, before being committed to the Auckland Asylum. Margaret said that she had orders not to take food.

Half of the men in the sample displayed paranoid behaviour. Only one man in the sample was suspicious of food. He believed that he had lost part of his body and feared eating and drinking.<sup>145</sup> The other six believed that they were persecuted or had "unreasonable suspicions", the content of which were never divulged.<sup>146</sup>

As well as these four reasons for committal - threats to persons, property, articulated social norms and paranoid attitudes - there are two further issues which demand consideration. Again these matters were factors in many of these cases and were part of the multiple pressures

<sup>144</sup> Case 3974, YCAA 1048/11, p.253.

<sup>145</sup> Case 135, YCAA 1048/1, p.199.

<sup>146</sup> Case 1637, YCAA 1048/5, p.465.

operating in the process of committal. They are stresses that ran through all the cases but were not usually triggers in themselves. These two issues operated in the background; the patients had to offend in a further way to be committed.

Firstly, the case records show, as we have seen, that domestic crisis was an important feature of committal. Even if the cause of distress lay elsewhere, the abnormal behaviour and delusions associated with insanity played havoc with family life. For example, Ethel R., a thirty-three year old schoolteacher living at home

persistently [stood] and [would] not sit down even for food - which [had] to be spooned into her mouth - makes no effort at conversation... stands whining in the middle of the room with an appearance of abject depression and had an antipathy to anyone approaching her...<sup>147</sup>

This was less the case with the male patients because they most often came from non-domestic situations, but is apparent for those living with others. Robert T., a nineteen year old married settler, "got no sleep at night... kept muttering to himself the whole time" and was "occasionally very violent".<sup>148</sup>

Contrary to what might be expected, the family's response was ambivalent. An all too human picture emerges which shows that families were both resistant to and the trigger for committal. Families resisted institutionalisation, despite the fact that superintendents

<sup>147</sup> Case 4123, YCAA 1048/12, p.28.

<sup>148</sup> Case 169, YCAA 1026/3.

frequently urged earlier admission.<sup>149</sup> Although the asylum had established its legitimacy in the eyes of both patients and families, as grateful letters to the staff testify,<sup>150</sup> its standing was fragile and ambiguous. Despite what the authorities professed, the institution was clearly a last resort, not helped by the stigma attached to recipients of treatment, the therapeutic limitations of asylums and other negative features of their development.<sup>151</sup>

Family members were admitted months and even years after the first signs of abnormal behaviour were perceived, often because events had taken a sudden turn for the worse. Inspector-General MacGregor noted in his annual report for 1904 that 91 out of 580 admissions to all asylums had been cared for privately for the previous year. Only half were admitted within three months of their "first attack" and some were only admitted after their "second attack".<sup>152</sup>

Alicia H. had "been strange for twelve months past".<sup>153</sup>

<sup>149</sup> See, for example, Report on the Lunatic Asylums of the Colony, *AJHR*, 1887, H.9, pp.1-2, and 1898, H.7, pp.3,7-8, also 1908, H.7, p.3.

<sup>150</sup> The status that medicine in general and psychiatry in particular had reached by 1910 is shown in Ethel R.'s case. Her parents wrote that they "have been especially advised to put her under your care... we took the advice of medical men who perhaps knew better than we did.... we will be guided entirely by your skilled advice". The parents were very worried about their daughter and wrote frequently, continually apologising for, as one letter phrased it, "encroaching on your busy professional engagements". Case 4123, YCAA 1048/12, p.28.

<sup>151</sup> W.A. Brunton, "Institutionalisation", pp.49-50. Public suspicion of the asylum and its potential abuses has also been documented in England and Australia, see Finnane, "Asylums, Families and the State", pp.142-143.

<sup>152</sup> Report on the Mental Hospitals of the Colony, *AJHR*, 1905, H.7, p.2.

<sup>153</sup> Case 1611, YCAA 1048/5, p.432.

Ethel R. was under the care of a private nurse for seven months, and had been suffering for two years before her parents reluctantly committed her in 1910, when she became too much for the nurse to handle. Her sister wrote that "[m]y mother is very old and quite heart-broken about sending her little girl away".<sup>154</sup> Alexander S. had neglected his business and domestic affairs for two or three months while his wife took charge, and was finally committed when he left home and wandered in the bush.<sup>155</sup> Jane B.'s husband informed the doctor that her attack occurred some eighteen months ago, but that now "she cannot be kept quiet at home".<sup>156</sup> Similarly, Ellen L. had "suffered from mental for upwards of six years", but "it has only been recently that she became so violent as to require seclusion...."<sup>157</sup>

Indeed the decision often depended on how easy it was to care for the patient at home. Many of the individuals required constant watching. Emma G., a thirty year old housewife, had been under treatment before in Te Aroha, Wairoa and also at Hamilton Hospital. Her husband told the doctor that she "required watching night and day that she would lie on the floor rather than in bed, goes without food for days together and has a tendency to incendiarism".<sup>158</sup> It is easy therefore to see why many imbecilic, idiotic and congenital cases found their way

<sup>154</sup> Case 4123, YCAA 1048/12, p.28.

<sup>155</sup> Case 164, YCAA 1048/1.

<sup>156</sup> Case 160, YCAA 1048/1, p.218, 1026/3.

<sup>157</sup> Case 165, YCAA 1048/1, p.221a.

<sup>158</sup> Case 1649, YCAA 1048/5, p.489.

into the asylums even though these institutions were not meant for incurable cases. Nancy O., admitted in 1870, was idiotic from birth, "never troublesome or dangerous, but thoroughly helpless, requiring constant supervision and attention". The reason Nancy was committed at thirty-three may have been because her parents were too old to continue the round-the-clock care. Their resistance gave way. Families also procrastinated because they needed women as housekeepers and their men as breadwinners.

Despite the avoidance of institutional care by families, it is also true, especially for the women in the sample, that in many of these cases of domestic crisis, the family also acted as a trigger. We have already seen how Rebecca J. became antagonistic towards her sister's family after her husband died and accused them of poisoning him and her children, at the same time as she began to drink and be violent. The combined effects of frequent childbirth, onerous household duties and making ends meet exacted their toll too, although families and doctors were reluctant to acknowledge this. In the only case where this was formally recognised as the "exciting cause" of insanity, it was clear from the "impaired and thin" bodily condition.<sup>159</sup> Eight of the women admitted were suffering from puerperal mania and ignored or tried to hurt a new baby or other children. For one woman, the chance to escape to the asylum was a welcome relief. Amy G., a twenty-six year

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<sup>159</sup> Case 1611, YCAA 1048/5, p.432.

old settler's wife, admitted for the third time after the birth of her fourth child, was "perfectly cool and collected and rather pleased at being here where she says she will have better food than she has had lately".<sup>160</sup> Other women used the condition of pregnancy as a lever to get out of the home, if not to go to the asylum. Elizabeth H., a thirty year-old settler's wife insisted that she was "in the family way" and should be sent away.<sup>161</sup>

Amy's attitude raises the question of whether some women used the rebellious, wilful role of the madwoman to advantage. Although the Auckland evidence is circumstantial, feminist historians such as Carroll Smith Rosenberg and Charlotte MacKenzie have demonstrated that the sick role legitimated a withdrawal from domestic and conjugal duties.<sup>162</sup> "Complex personal needs could be met through the assumption of a sick role, and... once that role was adopted other aspects of behaviour which the family found embarrassing could be attributed to the patient's ill-health".<sup>163</sup>

The role of economic distress is the second theme that recurs throughout the case records. This issue was irrelevant in the documentation in the sense that it was not consciously addressed by many of the people involved in the process. Rather, the evidence consists of generalised

<sup>160</sup> Case 57, YCAA 1048/1, p.101.

<sup>161</sup> Case 128, YCAA 1026/2.

<sup>162</sup> Carol Smith Rosenberg, Disorderly Conduct: Visions of Gender in Victorian America (New York, 1986), p.98.

<sup>163</sup> MacKenzie, p.156.

statements rather than hard facts or income figures. Nevertheless, the very frequency with which economic trouble of many kinds presents itself in the patient case histories, and the primacy it holds in some cases, indicates that individuals in nineteenth century New Zealand were not allowed to be poor and drop out of society. A strong social norm or ethos appeared to operate. It held that you should pull yourself together, persevere and courageously fight through. For example, George K., a labourer recently laid off, was admitted in the winter of 1890, manifesting delusions of grandeur, wealth and "complete control over the world" coupled with a desire to "make the streets of Auckland flow in blood and Mr J B Russell's blood should flow in it". Russell was a prominent local businessman and holder of the mortgage on George's house.<sup>164</sup>

Stephen Garton notes with respect to committal in New South Wales, that it was the itinerant, casual and unskilled workers who constituted the bulk of the asylums populations. The same appears true here: these were the people who had the least resources to help them cope with illness, injury let alone the more common problems of relative poverty and hardship. Garton claims that "[c]ontinued hard work [was required] in order to balance a tight domestic budget". Case records such as those of Amy G. also confirm his assertion that "it was often the wife

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<sup>164</sup> Case 1648, YCAA 1044/1, p.4; 1048/5, p.489.

and mother who made the sacrifices of food to ensure that the breadwinner and the children were fed and clothed".<sup>165</sup> Chapter six shows that often women needed only adequate rest and a good diet to restore their physical and mental health.

The tendency of those involved on the committal process to ignore this kind of stress, particularly in the female cases, is illustrated in the fact that, unlike some men, women were not committed directly because of economic hardship. Instead, chapter four shows that "domestic troubles" tended to be assigned as a cause. Studies of other types of delinquent women note that the actions of such women were not seen to be prompted by economic motives but by psychological sickness, whereas delinquent men were perceived to be acting out of economic motives rather than immorality.<sup>166</sup>

A number of conclusions can be drawn. In previous research a significant relationship has been noted between committal and gender, the family, middle class respectability, evidence of medicalisation or criminalisation, and an apparent legitimisation of the asylum. This case study shows that in the experience of patients at Auckland these are also important, but to varying degrees.

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<sup>165</sup> Stephen Garton, *Medicine and Madness*, pp.107-108.

<sup>166</sup> Jan Robinson, "Of Diverse Persons, Men, Women and Whores: Women and Crime in Nineteenth Century Canterbury", MA Thesis (University of Canterbury, 1983), p.59; Anderson, p.47; Dalley, p.84.

The Auckland case study demonstrates that gender was an influential factor in several ways. Differences occurred between women and men in the mode of, and reasons for, committal. For women the family, members of the medical profession, constables, and "voluntary" committal in that order were important initiators of committal. For men constables came first and family second, while medical figures, and "voluntary" committal were less important. Spouses figured frequently for women as initiators, but not for men, and there was a wider range of family initiators in the female cases. When informants are examined, women acted more often as corroborators of evidence, while men were the "organisers" and dominated this part of the proceedings.

A similar pattern of gender differentiation is apparent in the reasons for committal. Although threats to property were reasons in a small number of both female and male cases, for women threats to family members and threats to self were the most important grounds for committal. In many cases the women did not carry out the threats or preventative measures were taken in time. For the men however, the order was again reversed and the degree of actual violence was greater. General threats to articulated social norms were greater too for men and increased over the period. Although general female threats to social norms were smaller, women became particularly troublesome if they overstepped the bounds of conventional feminine behaviour

in regard to demeanour, housework, maternal and marital duties. Men were not held to such roles.

Overseas studies have also argued that gender was influential in committal, although none of the authors have used exactly the same categories of analysis as I have. In his study of Californian patients (which concentrates on social patterns rather than interpersonal dynamics) Richard Fox contends that the commitment of women differed significantly from the commitment of men and that "examiners, witnesses and perhaps the women themselves believed that women had a predisposition to fall victim to - and need treatment for - mental or nervous disturbances".<sup>167</sup> Elaine Showalter shares this view, at least from the point of view of the psychiatric profession. She argues that in nineteenth century England a "feminization" of madness occurred; women came to be seen as the cultural exemplars of madness. Although she does not look at the process of committal, Showalter surmises that the female lunatics' talkativeness and violations of conventional feminine speech were a factor in their committal.<sup>168</sup> An emphasis on the breaking of feminine proprieties is also found in the work of Anne Digby and Jill Julius Matthews. Digby's study of the private York Asylum shows that, among other things, "the rigid limitations imposed on the Victorian's woman's role" may have produced either depression or rebellion. Moreover

<sup>167</sup> Fox, pp.124, 129.

<sup>168</sup> Showalter, *The Female Malady*, pp.7, 81.

women were particularly liable to be defined as 'mad because of mildly deviant and independent behaviour, or failure to be a "paragon of domestic virtue". None of the men in this analysis were pulled up by such strict behavioural codes.<sup>169</sup> Matthews argues that women who were defined as mad had failed in the pursuit of femininity, specifically in the fundamental areas of sexuality (heterosexual, monogamous legal marriage), work (centred on the family and home) and mothering.<sup>170</sup>

In the study that is perhaps closest to the aims of this one, that is in attempting to look in some detail at the contexts as well as reasons for committal, Stephen Garton finds that in New South Wales "tensions in the construction of femininity" were apparent in the delusions of female patients, although they had to develop in a specific material and social context for committal to be warranted. For single women committal was linked with police detection of prostitution and vagrancy. In the family, single women were committed because of tensions within it or their threats to it, and because they refused to help with the chores. He also discerns a growing intolerance of the unmarried daughter by the twentieth century as the structure of the family and the position of women within it changed. For deserted wives and widows economic problems loomed large. For married women domestic violence, tensions in the family, their own violence,

<sup>169</sup> Digby, *Madness, Morality and Medicine*, pp.96,190.

<sup>170</sup> Matthews, pp.147,172,185.

suicide and public displays of unwanted behaviour were factors in committal. The refusal to fulfill familial "duties" also looms large. Garton suggests further that men were reluctant to commit their wives while there was still an opportunity for them to continue their domestic duties.<sup>171</sup>

In a new direction for studies of madness, he begins to look at the genesis of male lunacy. Garton argues that police played the dominant role in the committal of men, the majority of whom were single, itinerant labourers. Isolation in the bush, poverty, drink and the desire of the community to rid itself of "unwanted elements" were key factors. These men had no family to hide in. For young men at home, threats and acts of violence were important. For married men domestic conflict, jealousy and fear of their wives' infidelity were characteristics of their breakdown. In a similar fashion, but more tentatively, Garton relates men's madness to problems and contradictions in the construction of masculinity.<sup>172</sup>

This study then affirms many of the emphases of overseas literature, such as the importance of the pursuit of femininity in its various definitions and the tensions within the social construction of it; the rigidity of women's roles in this period; and the clearly defined behavioural code for women. At a more specific level, the Auckland case study shares the conclusions of Australian

<sup>171</sup> Garton, Medicine and Madness, pp.140-147.

<sup>172</sup> ibid., pp.118-122,125-131.

work as to the importance of domestic violence, threats to family, suicide and economic problems. In regard to men, this study supports much of Garton's analysis. The committal of Auckland men was concerned with bush isolation, and the poverty and alcohol problems of many single, itinerant labourers. Their experience also reveals the growing concern with social order and propriety and the importance of domestic conflict as committal factors.

While this study substantiates the findings of previous investigations of gender and madness, it also modifies them. In particular it does not conclude that women were labelled mad principally because of their failure in the pursuit of femininity. While contemporary definitions of madness were influenced by expectations of appropriate womanly behaviour, the analysis presented here argues that gender roles appear to have been less circumscribed in nineteenth century New Zealand than they were to be in the early twentieth century, or in the period which Matthews surveys.<sup>173</sup> Related to this is the fact that in the nineteenth century there were fewer agencies of surveillance: the new professionals and experts who managed relations between women and men as "overseers of the gender order".<sup>174</sup> Neither does there seem to be evidence of the

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<sup>173</sup> Judith Allen makes an interesting supporting point, arguing that "historical inquiry into such subjects as housework, marriage, childcare, shopping, courtship, prostitution, pornography, local politics, religion, paid work and cultural production provide many instances of deterioration in women's situation by the late twentieth century". Allen, p.175.

<sup>174</sup> Matthews, p.92.

"feminization" of madness, or of the overwhelming existence of a prevailing perception of "a fundamental alliance between 'woman' and 'madness' at this lay level as Showalter claims for England.<sup>175</sup> The material conditions of individuals and their families emerged as crucial factors.

The role of the family and others is a second feature of committal. At Auckland we have seen that the initiative for committal was taken at various points; it was not imposed solely from above by state, either in the form of the police or the medical profession. Overseas writers are now drawing attention to the role of the family as a principal site of power and influence in the course of committal. It will be recalled that Michael Ignatieff, in an attempt to question the centrality of the state in the making of the social order, suggested that attempts to label people as insane began with the working class family, from which most patients came.<sup>176</sup> Elaborating on this thesis, Mark Finnane defined the asylum as an arbiter of social and familial conflict, including conflict between the sexes, used by both working and middle classes. Although he placed more emphasis on official policy and its implementation, he agreed that the asylum was "subject to processes of social change and alterations in popular mentality which lay outside the state's immediate control".<sup>177</sup> Other historians have affirmed and extended

<sup>175</sup> Showalter, *The Female Malady*, p.3.

<sup>176</sup> Ignatieff, p.172.

<sup>177</sup> Finnane, "Asylums, Families and the State", p.145, *Insanity and the Insane*, p.162.

this perspective.<sup>178</sup> The experience of patients at Auckland shows that the family was central to the process and that families were using the asylum for different reasons from those envisaged by asylum officials. Relatives often acted as a site of resistance to institutionalisation. However it also depicts the family's role as a gendered phenomenon; the pattern was different for men who were identified and detected by a wider range of "outsiders". For women especially, the family and their role in it, acted as a trigger of committal.

As well as the importance of committal initiative "from below", consideration has been given to the increasing importance of middle class notions of respectability, stimulated by urbanisation and subsequent overcrowding. These developments, it is argued, reduced tolerance for "unproductive", "inefficient" behaviour, such as public drunkenness and public loitering and led to the establishment of institutions and professions devoted to the control of such behaviour.<sup>179</sup> The Auckland sample shows that this model best fits the male experience and was of increasing importance by the end of the period. In New Zealand perceptions of respectability were also highly influenced by race, whether it was female Maori who were "un-English" or who appeared to treat English institutions lightly and without due respect, or Pakeha men who sought to side with the Maori. This model also needs to be

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<sup>178</sup> For example, Walton, "Casting Out", p.139; Tomes, p.2.

<sup>179</sup> Fox, p.7.

adjusted to take account of the specifically feminine notions of respectability evident in this case study. For women such assumptions were directly related to their performance in the roles of wife, mother, and housewife, and in their behaviour as women.

A fourth and final line of thought emphasises the process of the legitimisation of the asylum. This incorporated first its separation from criminality and law, then its refurbishment as a hospital of healing, and second, the "diffusion of medicine as a way of thinking about and acting on body and mind" among the general public.<sup>180</sup> Such a change in thinking about the asylum or medical matters was not apparent and would have been difficult to discern in such highly idiosyncratic sources as the case files. Nevertheless the sample shows that the Auckland asylum did achieve some validity and authority in the minds of lay people, although it was frequently viewed as a last resort and its use depended on how easy it was to care for individuals at home.

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<sup>180</sup> Finnane, "Asylums, Families and the State", p.143.

Age: 46  
Status: Married  
Admission date: 7 April 1910  
Condition/previous occupation: County Foreman  
Previous abode: Tapu Thames  
Supposed cause of insanity: Alcohol  
Bodily condition: Indifferent health & condition  
Duration of existing attack: 6 Months  
Number of previous attacks: 2  
Age on first attack: 39  
Date of discharge: 6 September 1910

**Source:** Text: Register of Committed Patient Admissions, YCAA  
1021/5

Photo: Casebook, YCAA 1048/11, p.288.



## Chapter Four

### The Medical Diagnoses

Once a woman had been defined as insane by family, neighbours or the police, the medical profession entered in upon the process. There were, however, two different kinds of medical intervention. The previous chapter looked at certification by general practitioners: this chapter focuses on the second medical examination, this is the more specific diagnosis by the asylum doctor. It is therefore an account of the medical perspective upon insanity, especially as it developed within the newly constituted psychiatric profession.

Because this part of the committal experience took place inside the institution, full records survive for each patient. These take the form of medical diagnoses entered into the patient casebooks. The "cause of insanity" was also written in the admission registers. However the comprehensiveness of each entry varies. The diagnoses are generally briefer in the 1890 sample, at a time when the asylum became particularly overcrowded and the medical superintendent was less able to give time and attention to each case. This situation had eased again by the end of the period, by which time an assistant medical officer had been employed and the asylum enlarged.

There is also a change over time in the depth of information presented in the records and the importance of the asylum doctor's role and the institutional examination. This development has implications for our reading of the asylum diagnoses and the significance we ascribe to this part of the committal process. Generally, the diagnoses from the 1870 sample rely more heavily on GP's and family opinions as recorded on the medical certificate, supplemented by a general account of the patient's bodily health. By 1890 examination at the asylum had gained in importance, becoming more comprehensive and standardised. A "supposed cause of insanity" and "duration of attack" headed up the entry. Eugenic and hereditarian suppositions drawn from family details, and inferences drawn from the patient's behaviour subsequent to committal, appeared more frequently. In the 1910 diagnoses, the layout and style of entries resembled something much closer to today's technical and scientific mode of inquiry. A definite "cause of insanity", "percentage of insanity" (if curable - under or over 40%), and "number of previous attacks" were to be recorded after a thorough physical examination, which included cranial measurements. The patient's statement, previous family history and in the case of women, their menstrual and childbearing histories were also recorded. By this time, the GP's initial verdict had taken a back seat and the balance had swung in favour of the increasingly professionalised asylum doctor.

The asylum doctors diagnosed a single, clear cause of insanity and began treatment on that basis. The analysis given here follows that practice. It should be remembered however, that there may have been several overlapping contributing causes, as there were a number of reasons why the initial decision was taken to commit an individual. Medical requirements did not allow for that kind of ambiguity and multiplicity, although by the end of the period annual reports listed "principal assigned causes of insanity". To disregard that complexity would be ahistorical.

The circumstances of this diagnosis were different from those conducted by the certificating GPs. First, the examination took place at the asylum, whereas most certification examinations were performed at home or at the local police station. Second, the medical superintendent's opinion did not need corroboration. Normally, the session took place in the presence of the medical superintendent only, with maybe one or two attendants present. The family were spoken to separately upon the patient's arrival, or the superintendent relied upon the certification testimony. A cause was assigned after one examination, which occurred as soon as possible after committal, either the same day or the morning after arrival. In the early cases gaps of two or three days were more common. In a handful of more difficult cases, concentrated in the earlier years when more reliance was placed on outside opinion, the diagnosis

was delayed longer. For example, Jane B. was committed on the 15 September 1870, but the first casebook entry was dated 23 September and no physical details were noted until 2 October. The superintendent noted in the first entry that "I have not yet obtained information sufficient to enable me to fathom an opinion as to the origin and precise character of her malady".<sup>1</sup>

There were two parts to the diagnostic session. The first consisted of questions and answers, with an appraisal of the patient's delusions and behaviour. For most of the period this was little different from the examinations conducted by GPs for certification. "Idiots" were treated more perfunctorily than others. All patients were judged unfavourably if they revealed incoherency, an inability to talk about themselves, or simply refused to answer questions. Yet this was a profoundly disturbing time for them. Refusal to answer questions might stem from reasons other than a defective intellect, mental illness and the intransigence associated with it. Non-cooperation or false answers could stem from efforts to salvage personal reputation, embarrassing questions or the stressful situation.<sup>2</sup> The examination process at Auckland confirms this. For example, one GP gave a woman's violence as evidence of insanity, despite his admission that he "persisted in questioning her".<sup>3</sup> The asylum doctor took

<sup>1</sup> Case 161, YCAA 1048/1, p.218.

<sup>2</sup> Goffman, p.145.

<sup>3</sup> Case 165, YCAA 1026/3.

this as evidence of her insanity even though she was "quiet" on admission.<sup>4</sup>

Suspected lunatics were also asked to follow simple directions, such as taking a deep breath, which may have been difficult to perform if flustered, embarrassed or edgy.<sup>5</sup> F.G. Ewington, an official visitor at the Auckland asylum commented that "the novelty of the situation or the excitement of the hour [could] seal [an alleged lunatic's] lips... How many businessmen of experience could keep calm and answer for themselves rationally if they were charged at the Police Court with lunacy?"<sup>6</sup> For most people the asylum held even more terror than the courtroom.

Additional factors operated in the case of women. Asylum doctors remarked as freely as GPs that women should stay within the boundaries of acceptable female behaviour. Even when women lived out the expectations of their gender role, they could still be accused of talking about "pots and pans and beefsteaks and subjects quite irrelevant to the question".<sup>7</sup> Words conferring emotional overtones such as "temperament", were used of women but not of men.<sup>8</sup> Note was also taken of the number of children a woman had.

The method of examination placed a case-history construction on the person's past life, demonstrating that all along she had been sick, that she had finally become

<sup>4</sup> Case 165, YCAA 1048/1, p.221a.

<sup>5</sup> Case 4067, YCAA 1048/11, p.373.

<sup>6</sup> NZH, 12 April 1886, p.6.

<sup>7</sup> Case 92, YCAA 1021/1.

<sup>8</sup> Case 138, YCAA 1048/1, p.202.

very sick, and that if not admitted to the asylum, worse would probably have happened.<sup>9</sup> In this the opinions of family and friends recorded on the medical certificate played a crucial role. Blanch A.'s husband offered as evidence the fact that she was "accustomed to ale at meals, occasionally whiskey, and at monthly periods a small bottle of schnapps. 7 years ago was treated for nerves and got a lot of Bromide and Sulphonal".<sup>10</sup> Thus he indicated that Blanche had for some time needed alcohol to get her through daily life and that she had needed specific medical treatment for her current illness before.

In several cases from the 1870 and 1890 samples, the asylum doctor relied very heavily on the family's opinion and GPs' verdicts and restricted himself to commenting on the patient's "aspect on admission"<sup>11</sup>, or drew conclusions from the behaviour of the patient after several days in the institution. This dependence on other views was partly the result of the fledgling state of the science of psychiatry, and asylum doctors were often not so confident in their judgements. It was also due to the nature of the admission process. Asylum doctors might question the decisions made and the reasons given for committal, but they could not refuse any admissions because theirs was a state institution.<sup>12</sup> Bridget H.'s case illustrates this dilemma.

<sup>9</sup> Goffman, pp.155-156.

<sup>10</sup> Case 3970, YCAA 1048/11, p.276.

<sup>11</sup> Case 157, YCAA 1048/1, p.215.

<sup>12</sup> All admissions were certified until 1910 when provisions was made for voluntary admission.

She was committed three times between 1868 and 1871 for violent behaviour and verbal abuse stemming from alcoholism. Each time she was pronounced quiet and rational upon admission and her general health "unimpaired". The superintendent eventually defined her condition as "moral insanity":

"[W]hether such a condition can be strictly defined I am unable to state, [it is] quite certain that a sound understanding and dissolute habits are not incompatible in the same individual".

His confusion is clear in a later entry: "I have no decided evidence of insanity in this case, the patient is manageable when treated in a civil and conciliatory manner".<sup>13</sup> There are numerous references to the admission of the wrong type of patient, such as the chronic and incurable, inebriates, idiots and "persons, who, though undoubtedly of unsound mind to a certain extent, do not require Asylum treatment; and who are detained, rather because they have no friends able and willing to take care of them, than because the nature of their diseases require Asylum treatment."<sup>14</sup> Small numbers of "not insane" were listed in the tables of assigned causes published in the annual reports.

The diagnostic sessions became more detailed over time and the asylum doctor's input increased. A patient's marital state, occupation and religion were more systematically recorded, as was the number of previous

<sup>13</sup> Case 125, YCAA 1048/1, p.114, 1048/2, p.63-64.

<sup>14</sup> Annual Report on the Lunatic Asylums of New Zealand, AJHR, 1878, H.10, p.8.

attacks. By the end of the period each case entry was headed up with a standard indication of whether the patient's behaviour indicated they were suicidal, epileptic or dangerous, as well as with a checklist similar to the following: "originally clever, good memory, strong will, passionate, affectionate, energetic, no vices, cause for grief in death of baby, not solitary, never insane before ...."<sup>15</sup> "Congenitals" and "idiots" began to receive the same treatment, as the physical and hereditarian nature of mental disease was stressed. Every patient or spouse of a patient was questioned about the family history and background. As well as questions and answers, types of behaviour and delusions and each patient's memory for recent and past events were tested routinely.

The second part of the diagnostic session concerned the patient's bodily and physical appearance. In contrast to the first part, the asylum doctor always made a significant contribution here and it was quite different to that of the GPs. Again, the nature of the diagnosis changed over time. The 1870 casenotes reveal that patients had a complete physical examination. Height, weight, age, pulse and the state of the bowels and tongue were recorded. A man's physique was scrutinised in terms of a masculine concern with muscular development and coordination: "This patient admitted today is a fine well developed muscular man about six foot high...."<sup>16</sup> Women, on the other hand,

<sup>15</sup> Case 3967, YCAA 1048/11, p.273.

<sup>16</sup> Case 164, YCAA 1048/1, p.221.

were written of in terms of more general bodily health. Ellen L. was "incidentally not in good physical health" when committed.<sup>17</sup> In some cases fitness or sturdiness in women caused special comment: Mary Jane P. appeared to be "of robust make".<sup>18</sup>

By 1910 the physical examination had become highly detailed and comprehensive. In addition to the measurements outlined above, a patient's urine, patellar and reflexes, pupils, teeth, heart, respiration, vision, hearing, appetite and gait were observed. The shape and structure of the head were scrutinised especially carefully.

A particular set of ideas and forces shaped these medical men as they sat down to make their diagnoses. These were already found, but to a lesser extent, in the opinions of the certificating GPs, who shared the asylum doctors' heavy emphasis on physical appearance. This must be placed in the context of the great nineteenth century interest in physiognomy, especially the stereotypes of the physiognomy of insanity. Faces were studied in order to fathom the inner workings of will and conscience, and doctors believed mental disorders revealed themselves in physical defects such as the set of an ear, shape of brow or even the quiver of an eyebrow.<sup>19</sup> Many alleged lunatics at Auckland were described as "wild-looking" or displaying "the familiar

<sup>17</sup> Case 165, YCAA 1048/1, p.221a.

<sup>18</sup> Case 134, YCCA 1048/1, p.198.

<sup>19</sup> Showalter, The Female Malady, p.106.

aspect of a lunatic", or had the face "of a type commonly seen among lunatics and the physical characteristics are well-marked".<sup>20</sup>

New Zealand "alienists", as those specialising in mental health called themselves, enlarged upon these views. They were heavily influenced by British developments in particular, and were increasingly characterised by eugenist and social Darwinist principles. As we saw in chapter two, the "moral management" school of insanity predominated in medical circles in the first half of the nineteenth century. By the 1870s in Europe and North America however, somatic or physiological pessimism was replacing the more optimistic theories of social causation.<sup>21</sup> We saw too that there were particular New Zealand issues, such as a wider concern with racial fitness and purity, the falling birth rate and fears of an Asiatic influx.<sup>22</sup> Education and training, which was foreign-based, bolstered this tendency. In 1904 for example, superintendent Dr Herbert Barraclough, writing in the New Zealand Medical Journal, said "[w]e all remember the time when the problems of the mind, both normal and abnormal, were expressed in metaphysical terms, until the genius of Maudsley [the leading English figure in psychiatric Darwinism] showed that they were dependent on the ordinary laws of physiological psychology".<sup>23</sup>

<sup>20</sup> Case 135, YCAA 1021/2; Case 1629, YCAA 1021/2.

<sup>21</sup> Digby, p.115; Showalter, The Female Malady, p.102.

<sup>22</sup> Fleming, pp.76-77.

<sup>23</sup> Herbert Barraclough, "Human Instincts, Normal and Pathological", NZMJ, 4 (July, 1905), p.199.

Given this intellectual background, the detection of insanity in Auckland in the late nineteenth century was increasingly seen in terms of a medical model of mental illness, which "locates the source of deviant behaviour within the individual, postulating a physiological, constitutional, organic, or, occasionally, psychogenic agent or condition" as its cause.<sup>24</sup> This medical model legitimates and necessitates medical intervention, and because of its expressly scientific basis it was also treated as morally neutral. Most significantly for this study, it put responsibility for the problem on individual causes and the solution to social problems on individual treatment. The role of social factors as elements in the problem are down-played or eliminated.<sup>25</sup> It was the asylum doctor who most clearly employed the medical model and there are examples of friction between GPs and psychiatrists in this respect.<sup>26</sup>

Before discussing the causes of insanity, some general statements can be made about diagnosis in this period. First, as Table 4.1 shows, large numbers of cases with "cause unknown" were recorded at the beginning of the

<sup>24</sup> Conrad and Schneider, p.35.

<sup>25</sup> *ibid.*, p.viii.

<sup>26</sup> The Inspector-General stated in 1910 that "neither of the certificates accompanying a patient on admission, is, as a rule, given by his ordinary medical attendant, with the result that, while fulfilling legal obligations, such certificates are of very little assistance to the medical staff". Report on the Mental Hospitals of the Dominion, *AJHR*, 1911, H.7, p.3.

period when nosology, or the classification of diseases, was relatively unsophisticated and doctors were free to put down any cause they wished. By 1910, when psychiatry had become a professional science with its own technical expertise, the percentage of "cases unknown" dropped from forty or more percent of annual admissions to less than ten percent. Yet despite increased specialisation of diagnoses, differences in classification between the sexes remained. Consistently fewer female cases were assigned this cause than were male cases.

Second, the committal records reveal an increasingly corporeal emphasis. With more control of mental health in the hands of a Darwinist medical profession, and the apparent failure of "moral treatment", physical rather than psychological factors were emphasised. By 1910 the case records systematically described size and shape of head and forehead, as well as other physical and psychological characteristics. For example, the head of Joseph T. a melancholic alcoholic, was described as "medium size, fuller left side than right. Forehead medium height and width. Palate highly arched...<sup>27</sup> Millie B. had a medium sized, symmetrical head. However her forehead was of medium height, narrow and prominent.<sup>28</sup> A eugenic strand of thought was mixed in with this physiognomical perspective. It was evident in earlier cases, as in the following entry from 1870: "...The family history is suggestive but not

<sup>27</sup> Case 3982, YCAA 1048/11, p.288.

<sup>28</sup> Case 3974, YCAA 1048/11, p.280.

encouraging. Henry?[sic] E 10 years an inmate of this asylum... John E now undergoing six months imprisonment in Auckland Gaol for larceny and a widow Mrs S at Kawa Kawa supported by the Charitable Aid Board".<sup>29</sup> By 1910 we read: "a sister - Mary R was in Mental Hospital (An aunt was insane, another suffered from neuralgia, a few relatives were consumptive, some were heavy drinkers...) ...."<sup>30</sup> Social failure was the result of genetic taint.<sup>31</sup>

Third, there was a marked reduction in the range of causes assigned. This trend is disguised in Table 4.1 because causes are grouped in categories. However Appendix B demonstrates that diagnoses became more standardised and tied more closely to physiology, the action of stress on the nervous system and later, the role of toxins.

Unsurprisingly in this era of "psychiatric Darwinism", the hereditary and congenital category<sup>32</sup> formed one of the biggest group of causes at Auckland. By the end of the period it constituted over a fifth of male and female admissions. Slightly more women than men were diagnosed with these failings, a reflection of the fact, discussed in more detail below, that women were seen as constitutionally more prone to such disorders.

Congenital insanity meant retardation or "arrests of mental development". Nancy O., for example, was described

<sup>29</sup> Case 1631, YCAA 1048/5, p.453.

<sup>30</sup> Case 4051, YCAA 1048/11, p.357.

<sup>31</sup> Fleming, p.83.

<sup>32</sup> These categories are based on those devised by Hilary Haines in her article "The Peculiarities of Their Sex".

**TABLE 4.1**  
**"Causes of insanity" of women and men admitted to the**  
**Auckland Asylum, 1879, 1890 and 1910**

Women	1879	1890	1910
All causes	100	100	100
Hereditary & Congenital	12	17	28
'Female Problems'	9	15	15
Medical	8	16	18
Interpersonal	12	13	
Mood-related	3	6	13
Senility	2	2	10
Alcohol	1	8	4
Previous Attacks		5	3
Miscellaneous	7	4	4
Sexual Vice		2	1
Money-related	1	1	
Religion	1	2	
Solitude		1	
Loneliness		1	
Sexual Assault		1	
Not Insane		1	
Unknown	46	5	4
Men	1879	1890	1910
All causes	100	100	100
Hereditary & Congenital	7	14	21
Medical	10	22	22
Interpersonal	3	4	
Mood-related	1	3	7
Senility	3	5	11
Alcohol	13	12	17
Previous Attacks		3	4
Miscellaneous	1	1	6
Sexual Vice		9	2
Money-related	5	7	
Religion	1	7	
Solitude		6	2
Not Insane			1
Unknown	56	7	9

1. 1879 is used instead of 1870 because not of all the early annual reports are available.

2. All percentages are averaged across five years centered on the sample years.

**Source:** AJHR, Report on the Lunatic Asylums of New Zealand, 1878-1882; Report on the Lunatic Asylums of the Colony, 1889-1893; Report on the Mental Hospitals of the Dominion, 1908-1912.

as a deaf mute, "possessing the least amount of intelligence".<sup>33</sup> Lydia Y. was "idiotic" from infancy and could not speak either. However, even with these supposedly indisputable physiological cases, social and cultural factors are also evident. Doctors assiduously recorded environmental or lifestyle influences. The superintendent noted that Lydia's mother was a "loose character" because she was living with a man to whom she was not married.<sup>34</sup> In an age of increasing anxiety about larrikinism, poor parenting was viewed with increasing disquiet. Mothers especially were supposed to provide good role models for their daughters.<sup>35</sup>

Race also coloured perceptions. A young Maori woman Taruke W. could not be made to follow directions at her examination. Despite the fact that she could not speak English, this failure was taken as a sign of congenital imbecility.<sup>36</sup>

The assignment of hereditary insanity focused more clearly on genetic traits. Asylum doctors asked of the existence in relatives of epilepsy, hysteria, sick headaches, severe neuralgia or rheumatism, chorea, asthma or tuberculosis. They also questioned relatives as to the temperament of the parents, and whether there was any family history of alcoholic excess or syphilis.<sup>37</sup> Mary A.,

<sup>33</sup> Case 160 YCAA 1048/1, p.217.

<sup>34</sup> Case 1616 YCAA 1048/5, p.438.

<sup>35</sup> Dalley, p.126.

<sup>36</sup> Case 4075, YCAA 1048/11, p.381.

<sup>37</sup> Herbert Barraclough, "The Causation of Insanity", NZMJ, (April, 1904), p.344.

described as an "old anaemic but rather wiry looking woman", was said to be dangerous to children and given to various unspecified delusions. The superintendent assigned hereditary insanity on the basis that she had a son in the same asylum, another in prison and a daughter supported by the Charitable Aid Board.<sup>38</sup> The cause of Elizabeth H.'s first incidence of insanity were diagnosed as parturition. But after enquiries into her family's history, the doctor learnt that "her father used to ill-use her mother so that she left him". Despite Elizabeth's difficult instrumental labour, "heredity and mental instability" were entered in her case file. When she was committed again in 1910 with "domestic worry" given as the cause by the GP who examined her, her previous admission confirmed in the asylum doctor's eyes an hereditary tendency.<sup>39</sup>

The next biggest category for women was "female problems", such as child-bearing, menopause and menstrual irregularities. It increased a little over the period to form fifteen percent of all causes, and reflected the nationwide average.<sup>40</sup> Theories of the different functions which biology performed in each sex meant gender had an important influence on diagnosis. Two guiding principles prevailed. First, the female nervous system was inherently unstable because of a woman's general constitutional

<sup>38</sup> Case 1631, YCAA 1048/5, p.453, 1044/1, p.40.

<sup>39</sup> Case 2893, YCAA 1049/9, p.399 and Case 4067, YCAA 1048/11, p.373.

<sup>40</sup> Haines, p.179.

weakness. Second, a related notion was that a woman's health was governed primarily by her biology, specifically her troublesome reproductive functions, which influenced both her nervous system and therefore the mind. Adhering to a strict biological model of sex differences, doctors believed the processes associated with the reproductive system were "unavoidably associated with pain and functional disturbances, or at least with diminished resistability".<sup>41</sup> Every woman faced "mental shipwreck" over one or more biological crises of menstruation, pregnancy, childbirth and menopause, and were victims of periodicity in a way men could never be.<sup>42</sup> Such ideas had a receptive audience here.<sup>43</sup>

Many clinical observations could have reinforced these views. Young women who were ignorant of the menstrual cycle could indeed have reacted with "morbid emotions". Such conditions as premenstrual tension or menstrual pain which were not recognised then may have contributed to

<sup>41</sup> Quoted in *ibid.*, p.180.

<sup>42</sup> Showalter, The Female Malady, pp.55-56; Vieda Skultans, English Madness: Ideas on Insanity 1580-1890 (London, 1979), p.76.

<sup>43</sup> According to a doctor speaking to an audience of New Zealand women, the menstrual function alone kept women more emotional than men: "the menstrual epoch is for all women, sane or insane, the period of greatest affectability". Montagu Lomax-Smith, Women in relation to physiology, sex, emotion, intellect (Christchurch, 1895), pp.57-59. Dr Barraclough stated that incipient signs of insanity were greatly aggravated during pregnancy and the puerperium (the period of confinement after giving birth). Barraclough, "The Causation of Insanity", p.341. These views were also held more widely. See Luke, p.108, for the views of a coroner that "pregnancy might lead to mental distortion bordering on insanity".

"functional disturbances". Furthermore, it is now also realised that it is not uncommon for amenorrhoea to accompany severe depression and other psychiatric disturbances, and doctors then may well have mistaken a correlation for a cause-effect relationship.<sup>44</sup> This last fact assumes a greater significance as the stress on the proper management of and regularity in menstruation became a feature of treatment in this period.<sup>45</sup> Doctors were ignorant of the role of infection in diseases of childbirth and its transference between cases by themselves. It is also clearly established that the post-natal period is a time of particular vulnerability, as much though by stressful new demands as physiological disturbances.

Puerperal insanity and insanity caused by pregnancy, parturition and lactation accounted for between half and two thirds of the "female problems" between 1879 and 1910, as Table 4.2 shows. This cause was highest during 1890, but overall had risen only slightly by 1910. The apparent anomaly of the middle sample year may be explained by other factors. Auckland was in the middle of a severe economic depression in 1890. Frequent childbirth, onerous housework and the struggle to make ends meet, could become overwhelming in periods of greater hardship: the birth of one more baby just too much. Moreover, having children at this time was more dangerous. Maternal mortality peaked

<sup>44</sup> Haines, p.181.

<sup>45</sup> By 1910 the state and regularity of menstruation was listed at the beginning of every female case file along with other physical descriptions.

again in 1890, at 5.5 per 1000 live births, a higher rate than in either 1879 or 1910.<sup>46</sup> More women were committed with puerperal insanity because maternal mortality rates were higher.

**TABLE 4.2**  
Nature of "female problems" of women admitted to the  
Auckland Asylum, 1879, 1890 and 1910

	Percentages		
	1879	1890	1910
Total "female problems"	9	15	15
Pregnancy	5	10	6
Climacteric		2	9
Uterine/Ovarian	4	3	*

1. 1879 is used instead of 1870 because not all of the early annual reports are available.

2. All percentages are averaged across three or five years centred on the sample years.

\* There was one case here but it is statistically negligible.

Source: AJHR, Report on the Lunatic Asylums of New Zealand, 1878-1882; Report on the Lunatic Asylums of the Colony, 1889-1893; Report on the Mental Hospitals of the Dominion, 1908-1912.

As its name indicates, puerperal insanity occurred during the puerperium.<sup>47</sup> According to an authoritative midwifery manual of the 1900s, such women displayed a wide range of symptoms. Some fretted without any apparent cause, were sleepless and had delusions of the mind and senses. Many had alternating bouts of violence and docility, and their "moral faculties" deteriorated.<sup>48</sup> Others were

<sup>46</sup> Phillipa Mein Smith, Maternity in Dispute New Zealand 1920-1939, (Wellington, 1986), Appendix I, p.145.

<sup>47</sup> "Puerperal" was used as a blanket term until 1890, when it was replaced by "childbearing", and from 1908, distinctions were made between pregnancy, partuition and the "puerperal state".

<sup>48</sup> Henry Jellett, A Short Practice of Midwifery, Fourth edition, revised (London, 1903), p.426. Jellett was the consulting obstetrician to the Department of Health from

withdrawn and depressed, especially women diagnosed as having insanity caused by over-lactation. This is not surprising, considering contemporaries and historians have pointed out that these women nursed their babies for long periods in order to save money and prevent conception, and developed malnutrition and anaemia.<sup>49</sup>

To the modern ear these symptoms sound like post-natal depression or infection from blood poisoning. Yet the midwifery manual stated that puerperal insanity was either the result of heredity, alcoholism, or epilepsy. The emphasis on heredity and other diseases as causal agents illustrates again the influence of the medical model which individualised the problem and blamed the "victim". Sepsis or an infection of the women's uterus was sometimes acknowledged by doctors as a cause, but without recognising their role in its transmittance via inadequately washed hands or instruments, or after delivery through infected sheets or sanitary towels.<sup>50</sup> The doctors' subsequent conversion to the bacteriological theory of puerperal fever "did not displace beliefs that the mental or economic condition of the patient could be responsible for the

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1924-1931. For more information see Mein Smith, Appendix IV, pp.150-151.

<sup>49</sup> Showalter, *The Female Malady*, p.54. Dr Barraclough also suggested that it was practised in order to save money. Barraclough, "The Causation of Insanity", p.341.

<sup>50</sup> Annette Rubenstein, "'Subtle Poison': The Puerperal Fever Controversy in Victorian Britain", *Historical Studies*, 20:80 (April, 1983), p.420.

disease, or the idea that pregnancy was a pathological state, in itself sufficient to induce sepsis."<sup>51</sup>

In my sample, eight of the forty five women were diagnosed as having puerperal insanity: two in 1870 and three each in 1890 and 1910. At least half of these women had the classic symptoms of blood poisoning, that is, "maniacal disturbance", violence and destruction, incoherence, sleeplessness and a hot and flushed countenance upon admission.<sup>52</sup> But it is not until 1910 that the connection with sepsis was noted in any case file.<sup>53</sup>

For the other women in my sample diagnosed with puerperal insanity, it appears that rather than infection, the nature of the labour and the number of children the women already had were problems. Jane E.'s case records tell us that she had three children under two and a half years and the last one was born after a "severe confinement".<sup>54</sup> Elizabeth H., who was admitted to the asylum in 1903, was diagnosed with puerperal insanity caused by "heredity and mental instability", even though she had a "tedious difficult instrumental labour" and the child weighed fourteen pounds.<sup>55</sup> Her experience shows that because of the prevailing view that women's reproductive systems were unstable and they were more prone to insanity, difficult deliveries could be seen as a product of insanity

<sup>51</sup> *ibid.*, pp.434-435.

<sup>52</sup> Case 170 YCAA 1048/1, p.235.

<sup>53</sup> Case 4051, YCAA 1048/11, p.357.

<sup>54</sup> Case 3997, YCAA 1048/11, p.303.

<sup>55</sup> Case 2893, YCAA 1048/9, p.399.

rather than being seen as something that might 'cause physical and emotional problems anyway. The trauma an ex-nuptial birth might cause was also overlooked, and other factors looked for, as hereditarian factors remained uppermost in the alienist mind. Thus it was noted that the parents of Mary S., one of two single mothers in my sample, were government immigrants. Concern about the mental and physical quality of immigrants that arrived in the 1870s, which had led to the Imbecile Passenger Acts of 1873 and 1879 was still apparent in 1890. The maintenance record book also revealed that her sister, a hotel cook, who was unable to contribute to Mary's care, appeared rather "soft".<sup>56</sup>

Not only did they fail to distinguish between sepsis and depression, but medical men here and overseas believed that puerperal insanity could continue after the puerperium and even last for the rest of a woman's life.<sup>57</sup> Thus the cause of other inexplicable, irrational behaviour could be identified and controlled. Dora T. was admitted in 1890 after the birth of her third child and again in 1902 by which time she had had two more, after having frenzied fits, threatening her husband and neglecting her family duties. Even though lack of money and estrangement from her husband were mentioned as immediate factors in her history, her certificating doctor stressed the lengthy nature of her problems: "[s]he has been known to me off and on for twelve

<sup>56</sup> Case 1653, YCAA 1048/5, p.497, 1044/1, p.3.

<sup>57</sup> Jellet, p.340; Barraclough, "Human Instincts", p.207.

years, since her first attack of puerperal origin". Her husband concurred, claiming that she had been "weak in her mind since in the Asylum 12 years ago."<sup>58</sup> The supposedly lengthy nature of puerperal insanity also accounted for such experiences as that of Amy G., who was admitted five times for puerperal mania.

Case evidence supports Elaine Showalter's claim that "cases of puerperal insanity seemed to violate all of Victorian culture's most deeply cherished ideals of feminine propriety and maternal love."<sup>59</sup> These women were violent, destructive, noisy, incoherent, would not eat or sleep, wandered around naked, swore and were suicidal. In the case of those who appeared to be suffering from depression, they were also withdrawn, depressed, taciturn and obstinate. One woman believed she was a man not a woman, which is immensely symbolic given the restrictive and taxing nature of a woman's role.<sup>60</sup> There were no examples of men thinking they were women.

One of the most shocking aspects of the puerperal maniac was her wilful attempts to ignore or harm her baby. Asylums doctors saw "the mother's natural love is turned to hatred, and she would damage her baby if she possibly could".<sup>61</sup> Comment on this tendency occurs first in my sample in 1870, when Mary Anne D. "refused to see her children in the room" and told her husband to take them

<sup>58</sup> Case 1626, YCAA 1048/5, p.448.

<sup>59</sup> Showalter, The Female Malady, p.58.

<sup>60</sup> Case 4051 YCAA 1021/5.

<sup>61</sup> Barraclough, "Human Instincts", p.207.

away.<sup>62</sup> No such comments are made in 1890, but by 1910 they had become regular, as the concern over the birth rate, racial fitness and child welfare grew. Elizabeth H.'s baby had to be taken away from her because she was so violent.<sup>63</sup> Jane E. took "very little notice of her infant" and was "self absorbed".<sup>64</sup> Ethel R. said her fortnight old baby was not hers and threatened to strangle it.<sup>65</sup> Women were judged on their adequacy as mothers as motherhood became a major element in the social construction of femininity from the later nineteenth century onwards.<sup>66</sup> In 1910, Inspector-General Dr Hay wrote in his annual report that the

work and example of Lady Plunket in exalting the ideal of motherhood will leave a beneficial impression on our future statistics. When dealing with heredity in a former report I stated that a lessened resistance, similar in its after-effects, might be created by ignorance of the nutritive needs of the rapidly developing organism for some months before and some years after birth, and that the subject was one of immense importance to the state.<sup>67</sup>

There were no cases of women who actually killed their children. But the desperation of some women is illustrated in the case of twenty-four year old Emma N., who had an puerperal "attack" after the birth of her first child and was admitted in 1870 after giving birth for the fifth time. She had obviously considered trying to obtain an abortion.

<sup>62</sup> Case 132, YCAA 1026/2.

<sup>63</sup> Case 2893, YCAA 1048/9, p.399.

<sup>64</sup> Case 3997, YCAA 1048/11, p.303.

<sup>65</sup> Case 4051, YCAA 1048/11, p.357.

<sup>66</sup> Erik Olssen, "Towards a New Society" in The Oxford History of New Zealand, eds. W.H. Oliver with Bridget Williams (Wellington, 1981), pp.258-260; Fleming, pp.9-10, 21-22; Matthews, p.87.

<sup>67</sup> Report on the Mental Hospitals of the Dominion, AJHR, 1910, H.7, p.7.

During her certificating examination, she told 'the doctor that

although some medical men here would procure abortions [he] was above it - was a very grand man, but came here transported with irons on [his] hands and legs, she did not see [him] with these on but 'knows it from her own sensations'.<sup>68</sup>

The other substantial "female problem" in numerical terms was insanity caused by the "climacteric" or menopause. The first case was not diagnosed until 1886 at Auckland, but by 1910 it accounted for two thirds of "female problems". It was also a consistent cause of committal at Seacliff.<sup>69</sup> This pattern can be partly explained in demographic terms. New Zealand's age-structure was maturing, with the middle-aged and elderly assuming a bigger proportion of the population.<sup>70</sup> However the key also lies in the hold of psychiatric Darwinism over the medical profession. Doctors saw in menopause further signs of a woman's subjection to her biology. An 1890 textbook states:

even when the fertile period of life reaches its close, the cessation of the reproductive function is attended by stresses that are inferior to those only which accompanied its development. At her climacteric, between the ages of forty and fifty, woman undergoes a process, as it were, of inverted puberty. The organs and functions which she acquired with so much disturbance, and which have been throughout her life so fertile a source of trouble and danger, now undergo involution. They subside once more into the quiescence

<sup>68</sup> Case 170, YCAA 1026/3.

<sup>69</sup> Hubbard, p.20. She did not analyse causes by gender, except in her appendix, p.84, where the list confirms the broad pattern at Auckland.

<sup>70</sup> Olssen, "Towards a New Society", p.251. R.J.Warwick Neville, "Sex and Age Distribution" in The Population of New Zealand: Interdisciplinary Perspectives, eds. R.J. Warwick Neville and C. James O'Neill (Auckland, 1979), p.156.

from which at puberty they emerged; but even when they go, they cannot go quietly.<sup>71</sup>

Climacteric insanity appears to have been a useful catch-all diagnosis that encompassed a range of symptoms and problems. It not only explained the heightened incidence of disease in older women, but also extreme delusions, irritability, depression and hysteria which seemed to characterise the period.<sup>72</sup> It even accounted for behaviour that appears to have had other causes. For example, doctors cited Dora T.'s previous eccentricity and puerperal attack when she was admitted in 1902 for climacteric insanity. Although her unhappy domestic life was detailed (she was described as "a stranger to her husband" and leading "a rather solitary life since marriage", which included neglecting her family,) the asylum doctor listed her delusions at length and noted her "weak will", "cold temperament" and "talkative, incoherent, excited" manner.<sup>73</sup> Some recognition of the role of social factors was made in the case of Paulina W., admitted in March 1910. Climacteric insanity was entered as the cause of her insanity in the admission register, but the cause was given as "shock" and "worry about death of child" who had died five months before in the casebook entry. Yet the doctor concentrated on her "despondent expression" and depressed, sullen and obstinate demeanour. He found her "very unreasonable and argumentative", when she blamed

<sup>71</sup> Quoted in Haines, p.180.

<sup>72</sup> Rosenberg, p.191; Showalter, The Female Malady, p.59.

<sup>73</sup> Case 2800, YCAA 1048/9, p.304.

unsuitable treatment for the death of her child' and charged her husband with unkindness and cruelty since her baby's death. The hereditarian and biologically-based views of the medical profession still guided their diagnoses.

While gender is obviously central to the definition of madness from a medical point of view, it does not appear that women at the Auckland asylum served as cultural exemplars of madness in quite the way that Elaine Showalter argues. Other "female troubles" that figure so significantly in European and North American studies, such as menstruation, uterine and ovarian disorders, were absent from the sample and accounted for a dramatically decreasing number of cases in the total female population. Hysteria, that archetypal female malady of the late nineteenth century, was listed in only seven years of the forty year period, clustered in the early 1880s. The possible class distribution of the asylum, discussed in chapter five, appears to provide an explanation. The Auckland Lunatic Asylum catered mostly for poor and working class patients, while hysterics in England and North America were mostly from the bourgeoisie, particularly the "rebellious women" campaigning for access to the universities, the professions and the vote.<sup>74</sup> The latter could afford to be treated at home for such "domestic" illnesses. Moreover women here faced less opposition in fighting for many of these rights. Similarly women in New Zealand women were not facing

<sup>74</sup> Rosenburg, p.198; Showalter, *The Female Malady*, p.145.

difficulty and delay in marriage,<sup>75</sup> a factor which has also been implicated in such diseases, affecting as it did a woman's self-esteem and health.<sup>76</sup>

Historians have also emphasised the gendered nature of adolescent insanity, demonstrating that the often otherwise inexplicable mood changes of puberty were explained in terms of the biological model of female behaviour: boys "gained strength, vigour and muscular development, girls received bodily weakness and the illness of menstruation."<sup>77</sup> Although adolescent insanity<sup>78</sup> was never more than seven percent of all causes in any sample year, there are marked differences in the distribution between men and women. For women it drops from seven percent in 1870 to four percent in 1910, while for men it never rises above one or two percent. The case of Margaret T., a fourteen year old schoolgirl who was committed in 1910 because of her refusal to eat, hints at other issues about the importance of social factors in this form of insanity and its relationship to the confines of the adult female role. Margaret was upset at leaving England, according to her parents, but other notions surrounding physical development may have been a factor. The case file records that she

<sup>75</sup> Fifteen percent of women over twenty remained single in 1874 and only two percent over the age of thirty, although by 1911 the proportions had risen to twenty seven and fourteen percent respectively. Census of New Zealand, 1874, Part V, Table VII, p.106 and 1911, Part VII, Table VII, p.299.

<sup>76</sup> Skultans, pp.82-83, 89-90.

<sup>77</sup> Rosenburg, p.186.

<sup>78</sup> Using Haines' categories it comes under miscellaneous.

menstruated only once, two weeks before her fourteenth birthday. Many girls were either ignorant of the menstrual cycle or like many members of the medical profession, regarded it with fear and loathing.<sup>79</sup> Moreover, it has been argued that upon the advent of menstruation, there was the distinct possibility that "a girl's growing awareness of [her] social dependence and constraint, the realisation of her immobility and disadvantage as compared with her brothers, and other boys, may well have precipitated a emotional crisis".<sup>80</sup> There is some, largely impressionistic, evidence that young colonial women felt less constrained than their English counterparts.<sup>81</sup>

Low numbers of this kind of insanity may also be explained by diagnostic rationales. While such other causes as religious excitement, heredity, injuries to the head, puerperal insanity and epilepsy were assigned as "exciting" causes, alienists nevertheless regarded that stage of development as especially traumatic. Auckland doctors believed "the great physical and mental changes" of puberty

<sup>79</sup> Showalter, The Female Malady, p.56; Rosenberg, p.189.

<sup>80</sup> Showalter, The Female Malady, p.57.

<sup>81</sup> Rollo Arnold describes the general independence and intrepidity of both boys and girls in this period in his article "The Country Child in Later Victorian New Zealand", Comment, (April, 1982), p.25. See also his book, The Farthest Promised Land: English Villagers, New Zealand Immigrants of the 1870s (Wellington, 1981), chapter 11. Erik Olssen writes of the greater "freedom and autonomy" of girls in early twentieth century New Zealand. Olssen, "Towards a New Society", p.260. Steven Eldred-Grigg makes similar comments, especially in relation to sexual matters and looser parental control. Stevan Eldred-Grigg, Pleasures of the Flesh: Sex and Drugs in Colonial New Zealand 1840-1915 (Wellington, 1984), pp.118-119, 139-140.

(12-18 years) and adolescence (18-25 years) were the underlying causes.<sup>82</sup>

Women also dominated the non-medical or moral categories of assigned causes, although if "female problems" were added to medical causes as one category, women would figure more strongly in it as well. The percentage of female "interpersonal" or "mood-related" causes of insanity was between two and four times that of men. The former included "blighted affections", "disappointment", "jealousy" and "domestic troubles". Of total female admissions in this period, domestic troubles accounted for nine percent in 1870 and eleven percent in 1890. (By 1910 "sudden" and "prolonged mental stress" replaced them as separate categories and together accounted for thirteen percent.)

The defining characteristic was non-performance of expected roles. Interestingly, in the sample female cases, doctors distinguished between "domestic worry" and "domestic trouble". "Domestic worry" was diagnosed if the husband and wife were still together, whereas if a woman was deserted or widowed and living in poverty, she would be assigned "domestic troubles". Thus whatever the actual contributing factors, women were classed under "interpersonal" categories, appropriate to their domestic and familial role.<sup>83</sup>

<sup>82</sup> Barraclough, "The Causation of Insanity", pp.335-337.

<sup>83</sup> Haines, p.185. For a similar pattern at the York Retreat in England, see Digby, Madness, Morality and Medicine, p.210.

In two male cases of a similar nature, "anxiety" and "family troubles and want of work" were diagnosed instead. This reflects a tendency for men's problems to be attributed to financial worry or troubles of a non-personal nature, as befitted their role as providers and public figures. Alexander S., it will be recalled, left his house and wandered in the bush for two days, and for three months prior to committal he was "quite incapable of looking after his business both domestic and farming". Yet "anxiety" was recorded in his case file, rather than "domestic worry" or "domestic trouble".

George K.'s troubles stemmed from lack of work, rather than an inability to do it. Admitted in August 1890, the 57 year old married gardener was a casualty of the depression. In such a powerless position, he believed "he was not a plain working man but a prince, that he had complete control over the whole world, could cure all ailments without drugs and was going to draw 25 000 pounds out of the bank".<sup>11</sup>

"Blighted affections" and "disappointment [in love]" were also women-dominated. As would be expected in an age where marriage carried great status, the women suffering from these forms of madness were either single or widowed, reflecting the intense desire to marry, pressure of prevailing ideology and perhaps confirming women's greater emotionality in the view of the doctors.

<sup>11</sup> Case 1648 YCAA 1021/2.

This latter factor seems to have influenced the doctor's judgements in such other non-medical causes as "discontent", "fright" and "grief", which have been classified as "mood-related". The single case of insanity caused by "discontent" was assigned because of Jane B.'s "wild violent demeanour without cause or any discoverable disease of organ to account for it".<sup>85</sup> In the case of Susannah E., who was admitted in 1870 after trying to escape her husband by boarding a ship, "fright" was assigned, although another common diagnosis of "domestic infelicity" would have been more apt according to the certificates of committal.<sup>86</sup> The greater attribution of apparently petty or trifling emotional causes to women should also be seen in the context of "the frequency and triviality of nervous disorders in women, [and] their much greater seriousness and fatality in men".<sup>87</sup> According to this doctor, "men having greater power of endurance than women, when they break down, break down more disastrously... the relief of tears has often saved a woman's reason".

The association of insane women with immoral, aggressive or unfeminine behaviour explains why other causes were male-dominated, as for example, alcoholism. Despite the plentiful evidence in the committal certificates that alcohol was not the sole province of male

<sup>85</sup> Case 161 YCAA 1026/3.

<sup>86</sup> Case 101 YCAA 1021/1 and 1048/1, p.172.

<sup>87</sup> Lomax-Smith, p.63.

society and was a major component of many women's lives, a reluctance to assign this cause to women can be illustrated by the case of Bridget H., a 25 year old soldier's wife, and known drinker. She was admitted four times between 1868 and 1897, initially it was claimed, because of the death of her brother. She was often violent and abusive and spent much of her time in prison, having had some forty convictions recorded against her by the time of her third admission in 1871. At that stage the medical superintendent redefined her case as one of "moral insanity", as suggested by the certificating doctor, who had recognised that her insanity was only intermittent. The superintendent had never seen her under the influence of alcohol and noted that "here she is quiet and apparently as rational in demeanour and conversation as most women of her station in life. Her general health is unimpaired by her [illegible] cause of dissolute habits".<sup>88</sup> He was subscribing to a novel theory. The diagnosis of moral insanity ran counter to traditional psychiatric theory, because it allowed delusion to co-exist with unimpaired intellect.

The incidence of moral insanity in Auckland suggests that women were particularly prone to be consigned to the borderline of insanity in this period because of deviant or independent behaviour.<sup>89</sup> Almost twice as many women as men were committed because of "moral depravity", "debauchery", "irregular life", "dissolute life and "prostitution",

<sup>88</sup> Case 125, YCAA 1048/2, p.63.

<sup>89</sup> Digby, Madness, Morality and Medicine, p.96.

although these remained a fraction of the total admissions. The first such case was diagnosed in 1888 and the distribution of cases reveals the impact of psychiatric Darwinism and fears about the physically and morally unfit.

An examination of the medical perspective on insanity through the asylum examination reveals a number of key things. At the beginning of the period the views of the certificating doctor and the patient's family and friends influenced the asylum doctor to a large degree, but by 1910 he took the initiative. He made a unilateral decision as to what the cause of insanity was after a single examination at the asylum. There was no observation period. The examination focused on behavioural symptoms and the patient's physical appearance. Throughout, women patients had to be careful not to depart from the feminine ideal of the day. Following overseas precedent the asylum doctor's perspective increasingly embraced psychiatric Darwinism and its associated hereditarian and eugenic theories. These viewed women as naturally weaker and subjugated by their troublesome reproductive cycles. This medical model of mental illness stressed the role of the individual in deviant behaviour, rather than recognising social factors as elements in the problem.

The causes of insanity themselves illustrate much about this period. Increasing numbers of causes of insanity were physical, appearing as either hereditary and

congenital, or medical, as psychiatric Darwinism took hold. When broken down by sex, the principle groups of causes reveal varying degrees of differences between women and men. As time advances a change in diagnosis towards more gender-specific causes is evident. Women dominated the hereditarian and congenital group and had their own substantial category of female problems. Proportionately more women than men were found in the interpersonal and mood-related categories, because they did not perform adequately in their expected familial and domestic roles or exhibited "typical", if extreme, emotionality. Beliefs about the particular immoral, aggressive and unfeminine proclivities of insane women also influenced the judgement of the asylum doctor.

Age: 26  
Status: Married  
Admission date: 11 August 1910  
Condition/previous occupation: Housewife  
Previous abode: Waihi  
Supposed cause of insanity: Puerperal  
Bodily condition: Poor health & condition  
Duration of existing attack: 3 weeks  
Date of discharge: 21 November 1910

**Source:** Text: Register of Committed Patient Admissions, YCAA  
1021/5  
Photo: Casebook, YCAA 1048/11, p.357.



Age: 21  
Status: Single  
Admission date: 23 November 1910  
Condition/previous occupation: Domestic Duties  
Previous abode: Auckland  
Supposed cause of insanity: Choreic Insanity  
Bodily condition: Good health & condition except for chorea  
Duration of existing attack: 3 weeks  
Date of discharge: On trial 21 October 1910  
Discharged 6 December 1911 recovered

Source: Text: Register of Committed Patient Admissions, YCAA  
1021/5

Photo: Casebook, YCAA 1048/11, p.10.



## Chapter Five

### The Patients

At this point in the study, before the experience of treatment inside the asylum is discussed, it is useful to pause and consider the nature of the patient population. The annual reports of the Auckland asylum provide a statistical profile of the inmates, which can be illustrated, where relevant, by sample cases. Drawing on the detailed statistics which were collected and published as appendices to the annual reports, a range of characteristics will be examined: the rates of admission to the asylum; the gender, marital status and age of female and male patients; their geographical and ethnic origin; and their occupations. The object of this chapter is thus rather different from the others. This discussion treats the patients as an aggregate static group, rather than as individual participants in a dynamic process. The analysis describes the social composition and personal characteristics of the women and men who were committed, and attempts to gauge their representativeness by comparing the patient population to the Auckland provincial population from whence most of the patients were drawn.

However, due to the idiosyncratic nature of the patient data and the censuses to which it has been matched (which were enumerated for different reasons), not all the desired characteristics could be measured. For example, the

religious adherence of patients was noted on admission files but published in the intermittent annual reports only during the provincial period. Similarly, given the high degree of anxiety over the perceived links between immigrants and insanity in the period, it would be interesting to see if these fears reflected the true situation at Auckland.<sup>1</sup> Yet the census figures on nationality are not controlled for age, and given that most adults were foreign-born in nineteenth century New Zealand, any comparisons between populations is therefore meaningless. Still, despite these constraints, a reasonably rounded statistical picture can be drawn.

There were 4037 cases admitted to the Auckland Lunatic Asylum between 1870 and 1910, of whom 1459 were women.<sup>2</sup> The first distinctive feature of the asylum population is that, contrary to contemporary English, Welsh, Irish and Australian experience, the rate of admission to the institution declined from 1870-1910, as Table 5.1 shows.<sup>3</sup>

<sup>1</sup> Richard Fox's study of Californian admissions notes the same conviction of a link between the foreign-born and the insane in the state's asylums but shows it to be illusory. Fox, pp.105-110.

<sup>2</sup> This includes readmissions and does not equate to 4037 individuals: each new case was given a new number regardless of whether the person had been committed before or not.

<sup>3</sup> For England and Wales see Scull, Museums of Madness, pp.222-226, for Ireland see Finnane, Insanity and the Insane, p.130, and for New South Wales see Stephen Garton, "The Melancholy Years: Psychiatry in NSW 1900-1940", in Australian Welfare History: Critical Essays, ed. Richard Kennedy (Melbourne, 1982), pp.141.

In the case of both sexes the rate was nearly halved between 1871 and 1911.

These figures contradict contemporary perceptions of the ever-growing numbers of the insane. In 1901, for example, H.W. Seager published an article on the statistics on insanity. He noted that "alarmist" articles on the great increase of insanity were appearing frequently in newspapers and magazines, and that "the greater strain of modern competition and the unhealthy conditions of city life" were generally held responsible.<sup>1</sup> It seems these fears were prompted by the declining cure rates and overcrowding of the colony's asylums, which produced the spectre of an increasingly defective population.

**TABLE 5.1**  
Rates of committal by gender per 10 000 male and female provincial population aged fifteen and over

	WOMEN	MEN
1871	13	22
1891	8	11
1911	8	12

1. All numbers are averaged across three or five years centred on the sample years.

Source: AJHR, Report on the Lunatic Asylums of New Zealand, 1871-1873; Report on the Mental Hospitals of the Colony, 1890-1894; Report on the Mental Hospitals of the Dominion, 1911-1913. Census of New Zealand, 1871, Table No. 1, 1891, Part IV, Table, X, p.144 and 1911, Part IV, Table XII, p.231.

The fact that women were slightly less vulnerable to committal than men is the second distinctive feature of the patient population. A concentration on total patient

<sup>1</sup> H.W. Seager, "On Recent Statistics of Insanity, Cancer and Phthisis in New Zealand", Transactions and Proceedings of the New Zealand Institute, 34 (1901), p.116.

numbers by contemporaries and later writers, rather than admission rates over time, has however led them to overemphasise this difference between women and men. The total asylum population was thirty six percent female and sixty four percent male. Thus, for example, Inspector-General Hay wrote in 1907 of the "markedly smaller numbers of women in our mental hospitals", and Hilary Haines writes that "women were admitted considerably less frequently than men".<sup>5</sup> Yet Table 5.1 shows that the degree of difference, while real, is not exceptionally large and that the gap closes over time.

Contemporary speculation explained the male dominance by, first, the greater adaptability of women to colonial circumstances and second, selection in the process of immigration, whereby "the degraded woman does not emigrate as a rule, that the drunken woman and the destitute woman are practically unknown to us, and that the man who brings a wife and family is presumably respectable, and his womenfolk are an asset".<sup>6</sup> Such writers did not ask whether the selection process of migration worked on men in the same way.

Looking at the issue from the vantage point of the present it is almost impossible to either confirm or deny the veracity of this explanation. The small number of cases at Auckland where problems with immigration are mentioned

<sup>5</sup> Report on the Mental Hospitals of the Colony, *AJHR*, 1907, H.7, p.8; Haines, p.186.

<sup>6</sup> Report on the Mental Hospitals of the Colony, *AJHR*, 1907, H.7, p.8; Lomax-Smith, p.61.

as a factor in a woman's insanity appear to suggest that woman may have had a greater ability to adapt. For example, there was only one case in the sample where such factors were mentioned and even then the cause of insanity was ascribed to marital problems. Jessie N.'s husband described her as "always bad when the home mail is due".<sup>7</sup> Yet the apparently greater ability of colonial women to survive transplantation to another land may owe as much to the reluctance with which women were given up. As chapter three suggested, the sexual division of labour was a crucial factor in the admission process. Necessary for the smooth running of colonial households through their unpaid cooking, cleaning and childcare, women were committed unwillingly and at great cost to husbands and employers.

When we turn to the marital status of the patients, there are more marked sex differences. As shown in Table 5.2, not only was the typical inmate male, he was most likely to be single. One would expect the asylum to contain more single men because at the 1874, 1891 and 1911 censuses there were slightly more unmarried men than married in the total Auckland provincial population.<sup>8</sup> However this factor was intensified because, as noted earlier, single people, who do not have as many family resources to call upon, tend to go into institutions. Widowers were also over-represented

<sup>7</sup> Case 1656, YCAA 1048/5, p.503.

<sup>8</sup> Census of New Zealand, 1874, Part V, Table VII, p.106, 1891, Part V, Table VI, p.176, 1911, Part VII, Table VII, p.299.

in the male asylum population, although in decreasing proportions.<sup>9</sup> Married men, on the other hand, were consistently under-represented.

**TABLE 5.2**  
Rates of committal by gender and marital status per  
10 000 provincial population aged fifteen and over

WOMEN			
	single	married	widowed
1874	13	18	26
1891	6	8	10
1911	9	7	18
MEN			
	single	married	widowed
1874	25	12	13
1891	12	8	22
1911	15	9	10

1. The 1874 census is used because the 1871 census figures are not broken down by age.

2. All numbers are averaged across three or five years centred on the sample years.

**Source:** *AJHR*, Report on the Lunatic Asylums of New Zealand, 1873-1877; Report on the Mental Hospitals of the Colony, 1890-1894; Report on the Mental Hospitals of the Dominion, 1911-1913; *Census of New Zealand*, 1874, Part V, Table VII, p.106, 1891, Part V, Table VI, p.176 and 1911, Part VII, Table VII, p.299.

The marital status of women in the Auckland asylum is considerably different. The proportion of single women committed is rather low, although the rate of single women's admissions increased towards the end of the period, despite the fact that the percentage of unmarried women of all ages in Auckland declined by 1911.<sup>10</sup> This trend appears

<sup>9</sup> These figures need to be treated more cautiously as the small numbers may have skewed the results slightly.

<sup>10</sup> *Census of New Zealand*, 1891, Part V, Table, VI, p.176 and 1911, Part VII, Table VII, p.299.

to tie in with the view that the role of wife and mother gained the increasing support and sanction of society by the early twentieth century. The role of unmarried women became marginalised.

Compared to the general provincial population, married women were over-represented, especially in the earlier years. The statistics suggest that men benefited more from marriage than women, in the sense that it protected them to a larger degree from being defined as insane and then being committed to an asylum. This is also a claim of recent studies by feminist writers, among them Jessie Bernard. She reported that married men had a superior mental health to unmarried men, that their marital status gave them an advantage in careers and earning power, and that they described themselves as happier than unmarried men. Married women, on the other hand, had a worse mental and emotional health than either single or married men, expressed in a greater likelihood to commit suicide, and the fact that they were more anxious, depressed and psychologically disturbed.<sup>11</sup> This possibility is also raised in Richard Fox's study of asylum admissions in early twentieth century California.<sup>12</sup> The marital status statistics at Auckland indicate that marriage did appear to enhance the prospects of married men being able to escape the label of insanity, compared with their single and widowed counterparts.

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<sup>11</sup> Cited in Matthews, p.142.

<sup>12</sup> Fox, p.119.

A number of reasons as to why this should be so have been presented already. Married men, as chapter three illustrated, could act in a violent and uncontrollable manner in a domestic situation with greater impunity than married women. Family members preferred, or felt compelled to tolerate such behaviour.<sup>13</sup> Men were also able to move outside the domestic situation - in leisure pursuits and work - and thus were able to experience some relief from any pressures of the married state, if these existed. It may also be that men were more likely to enjoy the benefits of family and married life, with daily activities organised around their needs. Finally, their role as "breadwinner" suggests that some families could not as easily afford to have male income earners committed. Families were of course reluctant to commit their married women "housekeepers" but money and therefore food and shelter was not involved in those cases.

Contemporary medical opinion supported this argument that the married state protected men and signified marriage as a factor encouraging sanity. Inspector-General Hay wrote in one annual report that: "the married are in some sense a selected population who have passed through the dangers of adolescence, and, as far as men are concerned, the initial hardships in the struggle for existence..."<sup>14</sup> Hay believed that it was also true for women. However, the evidence of

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<sup>13</sup> This point is also made by Fox, pp.119-120.

<sup>14</sup> Report on the Mental Hospitals of the Colony, AJHR, 1907, H.7, p.11.

the processes involved in admission point in the opposite direction. Married women had to live up to varying expectations of appropriate feminine behaviour, as wives, mothers and women.

Widows, like widowers, were consistently over-represented, and were sometimes committed at a higher rate than their male counterparts. Inspector-General Hay agreed that "the stress of social disabilities consequent on the death of a conjugal partner is more likely to be felt by the widow" but he did not explain why.<sup>15</sup> Three issues in particular are pertinent here. Firstly, economic pressures on younger women increased with widowhood, as Margaret Tennant's study of charitable aid recipients shows. "The far greater vulnerability of men to death by violence or accident could result in a sudden reversal of family fortunes, and was critical to families in rented accommodation, with minimal savings and few other supports". Tennant also notes that "the female equivalent [of violent or accidental death] was probably death in childbirth, but men who lost their wives tended to remarry with some rapidity, or to place their dependent children with relatives or in institutions."<sup>16</sup> One of the younger widows in my case sample was suffering from this lack of male support, which translated itself into an intense desire for remarriage. Thirty-five year old Agnes F. was always going to the fortune tellers, who told her she was

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<sup>15</sup> *ibid.*, p.10.

<sup>16</sup> Tennant, "Brazen Faced Beggars", p.38.

going to be married. She had five young children and had been widowed five years previously.<sup>17</sup>

Second, even though widows were more likely than men to have recourse to family support on into old age, they ran the risk of burdening and antagonising family and friends. Rebecca J., who as we saw was admitted for forming peculiar antipathies against her sister and nieces and nephews, was widowed ten months previously.

The third more general point links the vulnerability of widows to the expectations of femininity. As with unmarried women, there were fewer positive roles for widows in a society which increasingly sanctified the married woman.

If the number and marital status of women admitted to the Auckland Asylum shows significant differences from men, the ages on admission are broadly similar for both sexes. Most female patients were aged in their thirties and forties, while most male patients entered the asylum in their forties and fifties, although by 1910 the age distribution had become more even, as Table 5.3 shows. This evidence belies another popular notion. The public in Auckland and in the colony at large were convinced that most admissions were of the old and senile.<sup>18</sup> There was however a high rate of admission among both women and men aged sixty and over,

<sup>17</sup> Case 3935, YCAA 1048/11, p.241.

<sup>18</sup> For example, NZH, 7 May 1873, p.3.

with old men more likely to go in than old women. There were fewer elderly women in the provincial population and

**TABLE 5.3**  
Rates of committal by gender and age per 10 000 provincial population

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WOMEN			
	1874	1891	1911
	%	%	%
10-15			.8
15-20	3	6	3
20-30	12	6	5
30-40	24	10	11
40-50	37	10	11
50-60	7	6	8
60-70	17	5	8
70-80		12	18
MEN			
	1874	1891	1911
	%	%	%
10-15			.8
15-20	10	4	3
20-30	7	8	10
30-40	24	12	11
40-50	14	13	16
50-60	14	14	16
60-70	11	11	12
70-80		21	35
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1. All numbers are averaged across three or five years centred on the sample years.

Source: AJHR, Report on the Lunatic Asylums of New Zealand, 1873-1877; Report on the Mental Hospitals of the Colony, 1890-1894; Report on the Mental Hospitals of the Dominion, 1911-1913; Census of New Zealand, 1874, Part II, Table XIV, p.35, 1891, Part IV, Table X, p.144 and 1911, Part IV, Table XII, p.230.

women were more likely than men to maintain an acceptable domestic situation in old age, either through marriage and

children, or by having established an identity within a particular neighbourhood.<sup>19</sup>

The patients at the Auckland Lunatic Asylum came from a wide geographical area, confirming its use by both rural and urban individuals. There are unfortunately no comprehensive statistics available (unlike those for Dunedin<sup>20</sup>). Yet Appendix C, which shows the previous place of abode in the sample, demonstrates that the Asylum was a truly provincial amenity, although its catchment area concentrated on greater Auckland. The growth and suburbanisation of Auckland over time is reflected in the proliferation of place names where "Auckland" would have once sufficed. A few patients even came from as far afield as Gisborne, Ruapekapeka and Wanganui, a trend that reflects among other things, the closure of asylums at New Plymouth and Napier in 1880 and 1886 respectively.<sup>21</sup>

Because of the perennial problem of overcrowding that affected all New Zealand asylums, patients were sometimes transferred between asylums. Limited movement was encouraged by the establishment of the Porirua institution and the emptying of the old Wellington asylum between 1896 and 1902, and transfers continued until the end of the period. However, the Auckland asylum was nearly always severely congested and catered for fewer transfers. In 1872

<sup>19</sup> Tennant, "Brazen Faced Beggars", p.46.

<sup>20</sup> See Bloomfield, pp.40-43 and Hubbard, p.18.

<sup>21</sup> Annual Report on the Lunatic Asylums of New Zealand, *AJHR*, 1880, H.6, p.11 and 1887, H.9, p.3.

the Superintendent of Nelson Province wrote to the Auckland Superintendent requesting room for lunatics from Nelson. On this occasion the reply was negative because more dormitories were needed to cope with existing requirements. Two years later, the Auckland Asylum doctor notified the Colonial Secretary that a "monomaniac" from Taranaki was admitted to the institution on terms of twenty one shillings a week.<sup>22</sup> Although a fee is stated there, it does not appear that asylums sub-contracted space to take payments on a commercial basis. Later in the period the annual reports reveal that fifty three people were accepted on transfer from other asylums between 1905 and 1910.

Some comments can be made about the rates of committal for the Maori. They formed between three to four percent of all patients in any one year. Initially, as a comparison of Tables 5.1 and 5.4 show, the Maori rate of committal was far lower than the Pakeha rate. At least one contemporary source, which calculated that in 1887 twenty one out of 50 000 Maori were admitted to the colony's asylums, attributed the low figure to the "far less frequency of brain disturbance in the savage race".<sup>23</sup> But it is at least as likely that other factors operated. Mental hospitals, like general hospitals, were reluctant to accept Maori patients.

<sup>22</sup> Dr Aickin to Provincial Superintendent, 4 December 1872, AP2 1872/4099; W.H. Reynolds to Provincial Superintendent, 10 February 1874, AP2 1874/506.

<sup>23</sup> Alexander, p.159.

When the Auckland asylum was built for example, the Auckland provincial government argued that since the Maori

**TABLE 5.4**  
**Rates of Maori committal per 10 000 provincial population aged fifteen and over**

	WOMEN	MEN
1874	5	4
1891	5	15
1911	14	23

1. All numbers are averaged across three or five years centred on the sample years.

**Source:** AJHR, Report on the Lunatic Asylums of New Zealand, 1873-1877; Report on the Mental Hospitals of the Colony, 1890-1894; Report on the Mental Hospitals of the Dominion, 1911-1913. Census of New Zealand, 1874, Appendix A, Table I, pp.275-278, 1891, Appendix C, Table IV, pp.xIviii-Iiv and 1911, Appendix A, Table III, pp.iv-v.

did not pay taxes, it need not and could not pay for their medical care.<sup>24</sup> A newspaper account of court proceedings in 1876 reveals the certificating doctor's unwillingness to commit a Maori man, even though he had violently assaulted several persons after being released from gaol. Dr Lee declared that the man "might have been guilty of acts that would seem strange to Europeans, but he failed to trace the slightest sign of insanity in him".<sup>25</sup>

Maori behaviour within the asylum may have contributed to this disinclination. The only specific reference to Maori patients in any annual report is a complaint by the superintendent, Dr Aickin, about the noisiness of some of

<sup>24</sup> Auckland Provincial Superintendent to Colonial Secretary, 13 July 1868, IA1 1870/2581.

<sup>25</sup> NZH, 16 June 1876, p.3.

the women. He recommended a few whares be set apart from other patients for them.<sup>26</sup>

The second factor that fostered the low rate of committal early on was the likelihood that Maori had their own resources for dealing with aberrant behaviour (and their own ways of defining what that behaviour was), and would therefore choose not to use this Pakeha institution. Throughout this period the two groups co-existed but retained their distinctiveness.<sup>27</sup>

However by 1910, Maori committal rates had risen significantly, in direct contrast to non-Maori ones. The Maori were beginning to use the asylum in the early twentieth century. Male rates of committal rose earlier than female, and both had nearly double the rate of Pakeha committal by 1911. These figures suggest that new attitudes of both Maori and Pakeha to Maori insitutionalisation played their part. Maori women were also committed at a lower rate than were Maori men, but a different study from this largely Pakeha one is needed to suggest reasons for this.

Determining the proportion of the sexes in the Auckland asylum population and differences between them on the basis of age, marital status and regional and ethnic background

<sup>26</sup> The Seventh Annual Report of the State of the Auckland Provincial Lunatic Asylum, APGG, 1874, p.52.

<sup>27</sup> See M.P.K. Sorrenson, "Maori and Pakeha", in The Oxford History of New Zealand, p.192; Michael King, "Between Two Worlds", in The Oxford History of New Zealand, p.281.

is reasonably straight forward. Describing their occupations, and attempting to extrapolate social class from them are more difficult. Job designations for men are reasonably unambiguous, if rather vague and imprecise.<sup>28</sup> The nature of women's work and the words used to describe it complicate matters. Until the 1880s women were specified by their husband's occupation in the asylum records, if they were not in paid employment. Subsequently "housewives", "domestic duties" and "housekeepers" were used. Although these occupations can be clearly distinguished from "domestic servant" which was obviously paid work, the meaning of the other labels is problematic. "Housewife" is used in an isolated case as early as 1882 at the asylum, remaining absent until 1904 when it begins to be used regularly. "Household (or Domestic) Duties" crops up every year, and continued to be used along with "housewife". It seems fairly accurate to define the latter two as unpaid domestic work in the home. "Housekeeper" occurs intermittently in the asylum statistics. As it is grouped with "housemaids" as paid work in Erik Olssen's analysis of the female workforce in this period, that definition has been used here.<sup>29</sup>

<sup>28</sup> See Miles Fairburn, "Social Mobility and Opportunity in Nineteenth-Century New Zealand", *NZJH*, 13:1 (April, 1979), pp.43-46, for a discussion of the difficulties associated with occupational labelling. Mark Finnane discusses similar problems in the Irish context. Finnane, *Insanity and the Insane*, p.133.

<sup>29</sup> Erik Olssen, "Women, Work and Family 1880-1926", in *Women in New Zealand Society*, eds. Phillida Bunkle and Beryl Hughes (Wellington, 1980), p.163.

The biggest problem occurs when the occupational data in the asylum records is matched to the census data. Many men, for example, were described as "labourer" and some as "gentleman" or "settler". Yet the schedule of occupations laid out in the census distinguished between up to seven classes: professional, domestic, commercial, transport and communication, industrial, agricultural and indefinite. Where would those three "occupations" fit in? For women the task is even more complicated because of the change in the way they were classified in successive censuses. Before the 1891 census, work, employment or occupation in New Zealand, Australia and Britain had been defined according to productivity. Thus in the 1871 census women were mostly categorised under "No Occupation Stated", and in 1874 under "Domestic". But in 1891 remuneration became the principle determinant of what constituted "work". The New Zealand population was divided into "breadwinners" and "dependents", with most women falling (or being pushed) into the latter category.<sup>30</sup> Thus in the 1891 and 1911 censuses eighty five and eighty two percent of total female in the colony were regarded as dependents, while only thirty eight and thirty two percent of males were designated as such.

<sup>30</sup> Jill Matthews has called this the "conceptual alienation" of women from the world of work. Before 1891 types of work were distinguished, but no judgements made as to worth or social value. After 1891 mostly women became "non-workers" if they worked around the household or care for family members, without pay. Thus in ideological and economic terms women were restricted to the home. Matthews, pp.58-59.

Nevertheless although these problems preclude detailed assessments, some general impressions can be given.

Appendix D shows that women patients were mostly ascribed "domestic duties", "house duties" or were listed as housewives. They formed a total of sixty five percent of all females in the asylum. This figure, when compared to the 1891 and 1911 censuses, suggests that women working in the home were under-represented in the asylum. It supports the earlier finding from the sample data in chapter three, which argued that the value of women's unpaid labour to husbands and employers ensured they were committed more reluctantly.

Servants formed the next largest group at just over eleven percent. Compared with the general population, servants were over-represented. In 1891 and 1911 around seven percent of the adult female population in Auckland were classed as servants. There were also surprisingly large numbers of professional and commercial occupations represented, considering the number of women in these jobs at this time. Census figures suggest that agricultural and industrial occupations were under-represented.

Women employed in professional and commercial sectors constituted small percentages in the overall picture, but when they are considered together with servants, they draw attention to the greater vulnerability to being labelled mad of women of "independent means". Why is this so? Such women were not necessarily protected within a family

context, or considered integral to a family economy.<sup>31</sup> These occupations were also more likely to be urban, suggesting not only greater vulnerability but also greater visibility within the community.

Over half of the male patients, unlike the general provincial population, were labourers, gumdiggers, farmers and miners. The proportion of the first two grew by the end of the period as they were increasingly considered less respectable. Gum-digging in particular was the "last refuge for the destitute".<sup>32</sup> Again there were small but significant numbers of professional and commercial occupations represented, although these proportions were very much lower than for women.

The difficulties with the accuracy of occupational title affect its utility as a crude indicator of social class. Yet the preceding outline illustrates the variety of patient backgrounds, a characteristic that can be confirmed from another source. The asylum's inspector alluded to this diversity in his evidence to the Report of the Joint Committee upon Lunatic Asylums, which deliberated in 1870 on the feasibility of establishing a central asylum for the use of the whole colony. Inspector Turton believed that patients from the "lower orders" were in fact often "better behaved, use better language, are of cleaner habits, and show more intelligence and natural affection, than...

<sup>31</sup> The significance of "independent means" is noted by Mark Shepherd of England in the 1850s and 1860s, Shepherd, p.68.

<sup>32</sup> Mutch, p.59.

[those] of the more educated circle of society. Visitors generally... single out... what they call the 'respectable' patients, as if the rest were undeserving of remark and sympathy".<sup>33</sup> It was not until the 1880s that the demand for separate services for the well-to-do insane led to the establishment of New Zealand's first private asylum, which opened in Dunedin in 1882.<sup>34</sup>

Notwithstanding these comments, most male inmates, as is to be expected, were in fact from the semi- or unskilled working class. Because of the large number of women with "no occupation" or who were described as housewives, it is harder to gauge social class, as even that common resort to husband's occupation as an indicator cannot be made. Yet the case histories presented in chapters three and four point to the similar lower class situation of most of the women. Even female patients who were in paid employment held jobs of low social status. For example, female teachers, who boosted the numbers of women located in the professional occupational class within the asylum, "enjoyed a very dubious professional status, and much of the work was little more than child-minding". Salaries were very low.<sup>35</sup> The social and economic status of asylum patients is of course a reflection of the population outside the asylum and the susceptibility of the unskilled to poverty and social isolation.

<sup>33</sup> Report of the Joint Committee on Lunatic Asylums, *AJHR*, 1871, H.10, Appendix, pp.16-17.

<sup>34</sup> Brunton, "The New Zealand Asylum", p.9.

<sup>35</sup> Malone, p.75.

An aggregate picture of patients at the Auckland Asylum in this period reveals that slightly lower proportions of women than men were committed and that admission rates fell over time. A higher proportion of married women than men found their way in the institution and more widows than widowers were committed. The inmate population was also characterised by the high numbers of single men compared to single women. The most vulnerable age period for both sexes was between thirty and fifty. Maori committal rates exhibited a diametrically opposite trend and were increasing not decreasing over this period. In terms of social composition most patients came from the lower end of the social strata and they or their husbands were employed in semi- or unskilled jobs.

How do the Auckland inmates compare with those in other asylums? The only other New Zealand asylum for which a comparable profile has been made is Seacliff asylum near Dunedin. All variables there mirror its northern counterpart.<sup>36</sup> Overseas an interesting diversion occurs between the English and the Australian, Irish and Californian experience. The latter three areas conform to an identifiably colonial pattern. In New South Wales from 1880-1920 men outnumbered women in asylums and were predominantly single. There were roughly equal numbers of single and married women. The vulnerable age group, as in

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<sup>36</sup> Hubbard, pp.15-17; Bloomfield, pp.34-46. See also the brief references which paint a similar picture for the Wellington asylum in Williams, pp.65-66.

Auckland, was found to be between thirty and fifty. Labourers constituted fifty percent of male admissions and domestic servants and working class housewives seventy-eighty percent of women.<sup>37</sup> In another Australian study, Mark Finnane emphasises the range of social classes there and in Irish asylums, because as in New Zealand, the state was very much the leading provider of asylums and private care was largely unavailable.<sup>38</sup> The committal rate in Irish asylums was also somewhat male-dominated, as was the case in San Francisco at this time. The typical insane in California were single adult men without family. The occupational profile was different from Auckland however, with 20 percent listed as housewives compared with 62 percent in total at Auckland.<sup>39</sup>

In England the picture that has been drawn by historians is very different. In the 1850s there were more women than men in public asylums and by the 1890s the predominance included all classes of patients in both public and private institutions.<sup>40</sup> Elaine Showalter has termed this phenomenon the "feminisation" of English asylums. Nonetheless, in her study, the asylum population is not compared with its catchment area. Furthermore English women at this time were numerically preponderant in the general population and tended to live longer. Thus the

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<sup>37</sup> Garton, "Bad or Mad" pp.93-94.

<sup>38</sup> Finnane, "Asylums, Families and the State", pp.145-146; See also Robins, p.111.

<sup>39</sup> Fox, p.127, fn.27.

<sup>40</sup> Showalter, The Female Malady, p.52.

much touted revolution in the patient profile may be more apparent than real.

It is difficult to find other information on English patients in this period. Analysis is made extremely difficult by the fact that attempts to explain insanity in terms of social conditions declined markedly from their position of cultural hegemony in the 1850s, and tables of patients' occupations, religious affiliations, ages, educational and civil status began to disappear from subsequent annual reports.<sup>41</sup> Although it is not stated that this is the reason, this must be why Showalter's study has little to say about the social composition of patients. In a another article, she relies on impressionistic evidence of contemporaries, which claimed an over-representation of servants and governesses, with the former being committed because of the precariousness of their economic status.<sup>42</sup> J.K. Walton notes a disproportionate number of unskilled labourers and domestic servants in English asylums from 1840-1870.<sup>43</sup> However, we do know that in England, there was an extensive network of private asylums which would have presumably taken out many of the well-to-do and created a different patient experience in their public asylums. It is to that experience at Auckland that the study now turns.

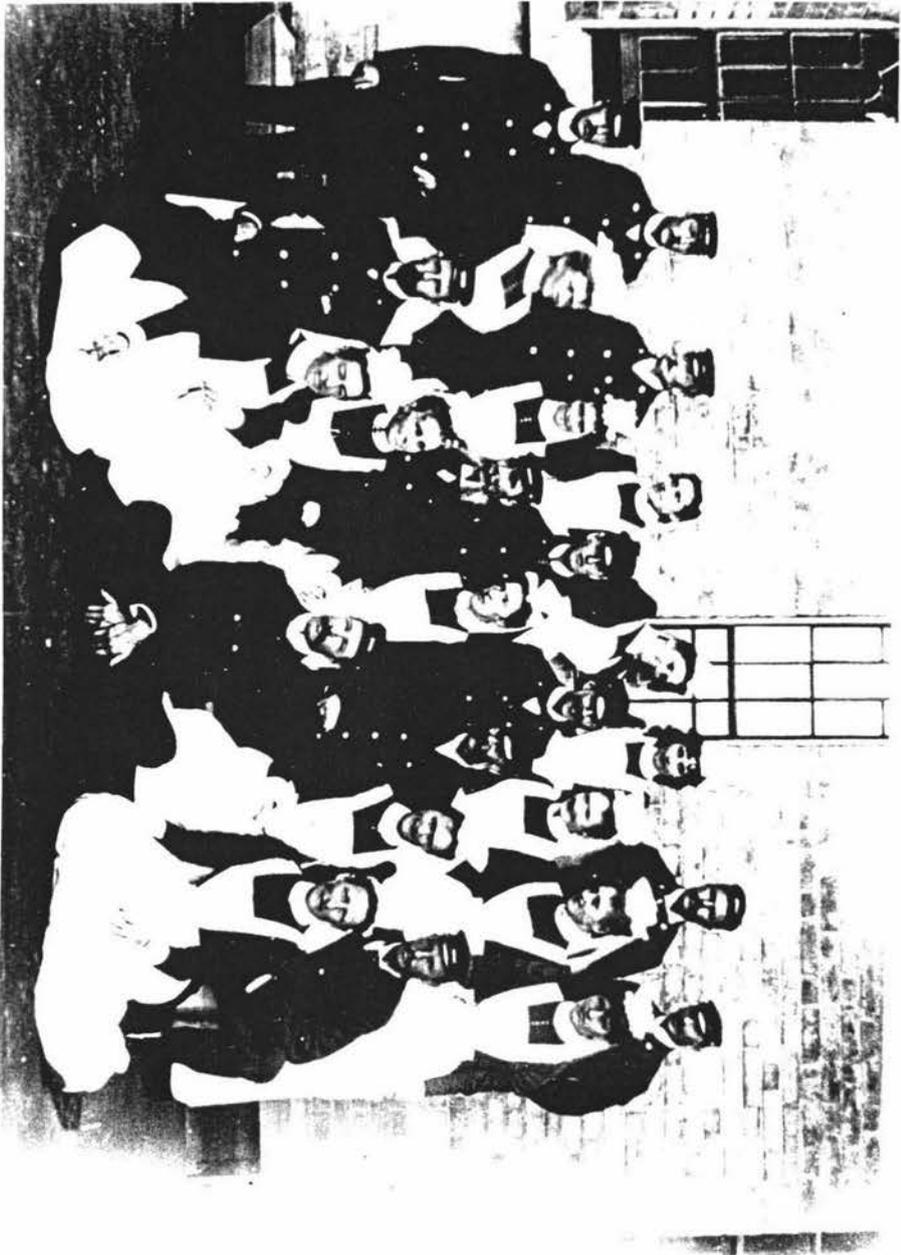
<sup>41</sup> Shepherd, pp.64-65.

<sup>42</sup> Elaine Showalter, "Victorian Women and Insanity", in Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era, ed. Andrew T. Scull (London, 1981), p.317.

<sup>43</sup> Walton, "Casting Out", p.138.

Group of female and male staff in the 1890s, Auckland Lunatic Asylum, photographed by Margaret Matilda White

**Source:** Auckland Insitute and Museum



## Chapter Six

### Treatment and Rehabilitation

Once they passed through the gates of the Auckland asylum, female lunatics entered a "women's world", which existed within a larger male universe. As we saw in the second chapter, a rigid segregation of the sexes within the institution was maintained, as a consequence of the Victorian ideology of separate spheres which informed asylum care. The only men that women patients had contact with were the medical superintendent, official visitors and inspectors, and perhaps a visiting relative or friend.

Yet the two worlds were not given equal consideration in therapeutic terms. While we saw that women often had a slightly more congenial environment than men, largely because of their smaller numbers, their treatment often took second place. Therapy at the asylum was principally organised in the interests of the male patients and the goal of rehabilitation served male needs, as the medical superintendent revealed in 1905 when he wrote that "[i]t is always much more serious to have an increase of the 'breadwinners' as patients than of the opposite sex, for various reasons."<sup>1</sup> Although he did not go on to elaborate why, the superintendent may have been concerned about the inadequate facilities men had in particular, and the problems increased numbers would cause. His comments may

<sup>1</sup> Report on the Mental Hospitals of the Colony, *AJHR*, 1905, H.7, p.11.

also reflect the great concern amongst welfare officials at that time about the social cost of providing for the women left behind who no longer had male providers. In charitable aid terminology, "no male support" was as important as "sickness" and "old age" as a cause of poverty in the late 1880s and early 1900s.<sup>2</sup>

The elimination of contact between the sexes, the concentration on the male patients and the content and aims of asylum treatment resulted in a much more limited life for women in the institution, both physically and ideologically, even if their environment was sometimes more pleasant and "domestic". This chapter discusses the treatment patients received within this carefully regulated environment. Therapy was multi-faceted and a number of its aspects will be examined: medical regimens, occupational therapy and the kinds of recreation available. The chapter concludes with an evaluation of the treatment's success and the quality of life within the asylum.

The treatment of patients at the Auckland Lunatic Asylum reflects general developments in psychiatry overseas. Eighteenth and early nineteenth century regimens in the manner of the philosophy of moral treatment paid less attention to the clinical dimension of therapy. Instead they emphasised occupational therapy, recreation and other environmental influences which might facilitate a patient's

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<sup>2</sup> Tenannt, Paupers and Providers, p.103.

own internal self-control and lead to more appropriate and socially-approved behaviour. By the 1870s however, English alienists were giving primacy to medical diagnoses and treatment. Even at the York retreat, one of the institutions where lay techniques of moral treatment had been pioneered, occupational therapy was trivialised into a means of amusing patients, bereft of any defined therapeutic value.<sup>3</sup> In other public asylums patient's work came to serve institutional needs, as much if not more than any curative considerations. A range of drugs and "useful employment" joined rest and a full diet, and increasingly became the standard treatment in asylums in the western world. Moreover, by the turn of the century scientific and medical developments and the attempt by the new psychiatric profession to be recognised by the general medical profession, encouraged the dissemination of the view that "mental disease" was a physical disease like any other. Thus, for example, the role of toxins and hereditary predisposition were given prominence, despite the doctor's failure to find a physical cause in many cases. Asylum treatment remained "haphazard, empirical, and not founded on any consistent theory of what was at the root of insanity".<sup>4</sup>

Gaining an idea of the specific nature of medical therapy practised at Auckland is more difficult, although by 1910 the New Zealand system was "practically the same"

<sup>3</sup> Digby, *Madness, Morality and Medicine*, p.115.

<sup>4</sup> Finnane, *Insanity and the Insane*, p.192.

as that which operated in New South Wales.<sup>5</sup> The available evidence is weighted in favour of the early years and becomes increasingly sketchy over time. There are a number of reasons for this, the principal one being the competing demands from both medical and administrative tasks on the medical superintendent's time. As the institution became more complex, and larger numbers of patients passed through its doors, case material became briefer and more standardised. Indeed the employment of an assistant medical officer at Auckland in 1893 was welcomed because more complete records would be able to be kept, and because it would extend the asylum's knowledge of the pathology of insanity.<sup>6</sup>

The issue of evidence is further complicated by the use of separate records for clinical matters. Medical details were more commonly reserved for the medical journal, as required by law, of which only one volume for 1902-1905 is extant. Moreover, the medical journal contained weekly entries accounting for all the movements of the patients and how they were treated, but in numerical terms only; no individual cases were cited. Case notes on the other hand frequently state cryptically "medical treatment continued".<sup>7</sup> As the number of chronic cases increased, entries were made in a separate series of "chronic case books" which no longer exist. In addition

<sup>5</sup> New Zealand Official Year Book, 1910, p.376.

<sup>6</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1894, H.7, p.3.

<sup>7</sup> For example, case 2893, YCAA 1048/9, p.399.

there is almost a complete lack of reference to medical practice in the annual reports and other material which would be read by largely lay audiences: medicine was deemed the sole province of the trained professional.<sup>8</sup>

Nevertheless the process of classification which patients underwent and an outline of the main methods of medical therapy used can be drawn from the patient sample.

After a medical examination to check for bodily ailments and marks, some attempts were made to classify patients according to the acuteness of the case. Behaviour was the first consideration, and the noisy and uncontrollable were separated from the quiet and amenable. It was intended that each sex would then be graded into classes according to the degree of potential curability,<sup>9</sup> but the appalling conditions outlined in chapter two meant this system was often an ideal to be aimed at, rather than a reality. The lack of space was, at times, different in degree for women. In 1904, for example, Dr Beattie commented that the new building under way for female patients would enable classification of all but twenty of them into five divisions, while there was no further classification for the men beyond the two categories already referred to.<sup>10</sup>

<sup>8</sup> As one inspector wrote in 1870: "as to the bodily condition and medical care of the patients, it does not become me as an unprofessional man to report". H.H. Turton to Provincial Superintendent, 27 February 1874, AP2 1874/683, p.5.

<sup>9</sup> *ibid.*, p.10.

<sup>10</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1904, H.7, p.7.

Some divisions for convalescent patients were instituted however. In 1882 an auxiliary building was established for male patients on probation prior to discharge, and in 1910 the Wolfe Home was opened, later described as "a home from home" and intended for mild female cases in a home-like atmosphere.<sup>11</sup> Only at the end of the period were medical officers systematically dividing all patients into "curable" and "incurable", consisting of those with more or less than a forty percent chance of recovery.

The poor physical health of many upon admission necessitated some sort of medical intervention from the beginning, in contrast with doctors' initial expectations. Superintendents were forced to rethink their approach and became increasingly conscious of the influence of a healthy body on the mind. Many of the sample cases were, as an early inspector described, "mere miserable remnants of mortality". He estimated that at least sixty percent of admissions were "far gone in bodily diseases of all kinds".<sup>12</sup> The asylum infirmary quickly proved itself to be an indispensable facility, in turn becoming overcrowded. Impressionistic evidence from sample casenotes confirms J.K. Walton's suggestion that "physical weakness of this kind was essentially a woman's problem".<sup>13</sup> Committed more

<sup>11</sup> A.H. Walker, Rangi Mata: Rau The Story of Point Chevalier 1861-1961 (Auckland, 1961), p.31.

<sup>12</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1876, H.4, p.3.

<sup>13</sup> John K. Walton, "Lunacy in the Industrial Revolution: a study of asylum admissions in Lancashire, 1848-50", Journal of Social History, 13 (1979), p.12.

reluctantly and often only when they were no longer fulfilling their role in the home, many women seemed to be in a worse state than the men. Sample female casenotes cite diarrhoea, bronchial catarrh, influenza, bedsores, rheumatic joints, leg oedemas and tuberculosis, besides any supposed mental illness.

Physical diseases in combination with overcrowding and poor sanitation resulted in periodic outbreaks of disease such as typhoid, measles, scarlet fever and gastro-enteritis, and there were few facilities for isolation.<sup>14</sup> In 1900 patients afflicted by measles were put in bathrooms on beds made up on the floor. Tuberculosis was a major problem. Dr Beattie noted in 1905 that "[p]atients, especially Maori patients, are either admitted in a more or less advanced stage of the disease or else the disease develops in those patients who for long have been hopelessly insane...."<sup>15</sup>

As well as the sick and diseased, the numbers of "chronic" patients were larger than expected. The asylum was originally envisaged as an institution for the treatment of acute cases. However, the annual reports began to refer regularly to large numbers of "very helpless" patients who could neither feed, dress, or care for themselves in any degree. Moreover, asylum staff and

<sup>14</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1883, H.3, p.6; 1903, H.7, p.8; "History of Oakley Hospital", lecture given by Dr Savage, July 1966, University Extension Course, Historical Records Collection, YCAA 1083/5e, p.4.

<sup>15</sup> Report on the Mental Hospitals of the Colony, *AJHR*, 1906, H.7, p.8.

officials were confounded by the considerable number of "dirty" women. Mrs Hendre, visiting in 1900, found this kind of debility "unaccountable... as well as very surprising."<sup>16</sup> Along with the pronounced rebelliousness of female patients discussed below, these habits were the very antithesis of the ideal domestic, morally-superior nineteenth century woman. This disconcerting conduct was undoubtedly a continuation of the behaviour that led to committal, and it reinforced the need for appropriate "training in the discipline of femininity"<sup>17</sup> which was the goal of the work and recreation provided for female patients.

Aperients, alcohol and sedatives were the main kinds of medicine dispensed. At least in the early years, both at Auckland and overseas, a "mechanistic" model of the body appears to have been the theoretical basis for treatment. Doctors attempted to control what was taken in, the extent of circulating fluids and what left the body, reflecting contemporary humoral theories. They believed that restricting circular liquid flows reduced congestion in the head. Constipation, for example, was associated with maniacal states and therefore its prevention was believed to improve nervous irritability.<sup>18</sup> Patients themselves

<sup>16</sup> YCAA 1049/1, 20 February 1900, p.6.

<sup>17</sup> A phrase used by Elaine Showalter in her discussion of similar rebellion and deviations from appropriate feminine behaviour among English women. Showalter, The Female Malady, p.81.

<sup>18</sup> This is discussed in more detail in Digby, Madness, Morality and Medicine, pp.120 & 132.

agreed with this view. Olive B. was given pills for constipation as she believed she would rest better "if her bowels were free".<sup>19</sup> Aperients such as castor oil and aloes, and enemas were used extensively in the belief that "[n]othing can be clearer than the marked influence of the bodily health over that of the mind. A loaded liver induces a state of hypochondria bordering upon melancholia; it is relieved by aperients having a special action upon the biliary secretion".<sup>20</sup> Purgatives were a major medical tool.

Alcohol was used extremely liberally as both a sedative and less frequently, in the form of stout, as a body builder.<sup>21</sup> Up to three glasses a day of wine, port, and ale were given to five of the sample maniacal women patients in 1870, while two of the men's casenotes contained references to brandy and porter. It was still a method of treatment in 1910, as the brief reference to the discontinuation of Elizabeth H.'s whiskey treatment testifies.<sup>22</sup>

Opiates came into more common use in the second quarter of the nineteenth century in England, replacing the soporific glass of porter and the application of mixtures directly to the shaved head.<sup>23</sup> Topical treatments were still in use in the 1870s at the Auckland asylum in cases

<sup>19</sup> Case 1607, YCAA 1048/5, p.428.

<sup>20</sup> Reports on the Lunatic Asylums in New Zealand, *AJHR*, 1873, H.23, p.6.

<sup>21</sup> "History of Oakley", YCAA 1083/5e, p.10.

<sup>22</sup> Case 4067, YCAA 1048/9, p.399.

<sup>23</sup> Digby, *Madness, Morality and Medicine*, p.127.

of "cerebral excitement" and "boggy scalps".<sup>24</sup>

Increasingly, however, the medical superintendent followed overseas trends, administering drugs such as morphia and potassium bromide to both treat "muscular excitement" and "restlessness"<sup>25</sup>, and to procure a good night's rest for everyone in the ward.<sup>26</sup> In an example of the speculative nature of treatment at this time, similar drugs were also used in cases which manifested opposite symptoms: "some of the worst and apparently most hopeless cases of melancholia have succumbed to the steady and properly graduated administration of opiates".<sup>27</sup>

Although there is insufficient evidence to draw any firm conclusions about the possibility of a gendered pattern in the dispensation of drugs, other writers have argued that there are indications in English and Irish asylums of "chemical restraint" rendering patients docile and obedient; previous methods of "mechanical restraint" had been denounced and yet the conditions of asylum life necessitated some kind of custodial response. More significantly, they discuss the particular use of drugs to control women.<sup>28</sup> Certainly, the general behaviour of many

<sup>24</sup> Case 132, YCAA 1048/1, p.195; case 134, YCAA 1048/1, p.198 and case 169, YCAA 1048/1, p.224.

<sup>25</sup> For example, case 135, YCAA 1048/1, p.199.

<sup>26</sup> Case 153, YCAA 1048/1, p.211 and case 130, YCAA 1048/1, p.193.

<sup>27</sup> Reports on the Lunatic Asylums in New Zealand, AJHR, 1873, H.23, p.6.

<sup>28</sup> Scull, Museums of Madness, p.203; Showalter, The Female Malady, p.81; Digby, Madness, Morality and Medicine, pp.128-129; Finnane, Insanity and the Insane, pp.192,205. The over-prescription of drugs became cause for concern in the 1920s and 30s at Porirua Hospital. Williams, p.158.

women at the Auckland asylum was as problematic as it was overseas. Official visitors observed that the mental condition of many women patients was "boisterous",<sup>29</sup> and doctors were surprised to find that the more obstreperous patients were usually women. Female patients at Auckland were more excitable, dirty, violent and restless than their male counterparts, thereby violating accepted gender characteristics. Among the sample cases there is some evidence of the use of enemas as an attempt to control behaviour as much as facilitate treatment. For example, Margaret Y., who was admitted for refusing to eat, had a soap and water enema every day.<sup>30</sup> Elizabeth H. refused all food and medicine and was also given an enema.<sup>31</sup>

As well as the treatment of bodily ailments and the administration of drugs, a "wholesome diet" of "nourishing food and tonics" was the third element in the Auckland asylum's medical therapy.<sup>32</sup> A patient's rate and level of food consumption was closely watched and taking food well was regarded as a sign of good health. Annual reports consistently describe the diet as "liberal". It consisted of bread and butter with coffee for breakfast; meat, soup, vegetables and bread for dinner; and tea with bread and

<sup>29</sup> YCAA 1049/1, 28 January 1899, p.84.

<sup>30</sup> Case 4006, YCAA 1048/11, p.312.

<sup>31</sup> Case 4067, YCAA 1048/11, p.373.

<sup>32</sup> Reports on the Lunatic Asylums in New Zealand, *AJHR*, 1874, H.2, p.1; Tucker, p.675.

butter for supper.<sup>33</sup> Even though this food was better in both quantity and nutritional value than many patients' usual diet, it was subject to the vagaries of contractors and often mediocre cooks. The meals were often served cold as patients were lined up and led into the hall while it lay waiting.<sup>34</sup> To add to the ignominy, it was not until the 1880s that patients were allowed to use knives and forks and ate off tablecloths.<sup>35</sup>

Portion size was lower for women, no doubt because of the perception that a greater amount of food was needed by men for their outdoor activities. Yet extremely strenuous work was performed by many female patients. In 1874 four female attendants petitioned the superintendent, complaining that "[t]he quality of the rations supplied [to staff and inmates]... is so inferior as to be totally unfit to properly nourish their bodies considering the arduous labour they have got to perform".<sup>36</sup> Catherine D. complained continuously in 1910 that she could not work on the food she received.<sup>37</sup> Women's meals were, nevertheless, generally better cooked. Smaller numbers to cater for in the female department and better-sized facilities meant women had

<sup>33</sup> Reports on the Lunatic Asylums in New Zealand, 1873, *AJHR*, H.23, p.10; The Seventh Annual Report of the state of the Provincial Lunatic Asylum, *APGG*, 1874, p.57.

<sup>34</sup> After 1892 the temperature of the food improved sufficiently to elicit a remark in the annual report. *AJHR*, 1893, H.4, p.3.

<sup>35</sup> *ibid.*, 1881, H.13, p.5.

<sup>36</sup> H. H. Turton to Provincial Superintendent, 31 December 1873, *AP2* 1874/200.

<sup>37</sup> Case 3947, *YCAA* 1048/11, p.253.

their meat roasted or baked three or four times a week, while the men's meat was invariably boiled.<sup>38</sup>

Poor health meant many of the patients required special diets and tonics. Quinine, iron tinctures, cod liver oil and beef tea were some of the remedies used, while extra milk, eggs and rice were given to the very delicate. Women were particularly afflicted. In 1900, for example, the annual report stated that a third of the women had to be kept on a special diet.<sup>39</sup> In my sample, only one of the men was on a special diet, while seven of the women needed some kind of extras or regulated foods.

Restraint was the final kind of physical treatment used at the Auckland asylum and its practice also demonstrates a gendered pattern. When the Auckland Asylum was established avoidance of restraint was the preferred treatment, as part of the "moral management" philosophy. Thus, early in the period, the medical superintendent advised that "the normal conditions and rights of the insane should be infringed upon in as small a degree as may be consistent with efficient management",<sup>40</sup> and the continued use of restraint on a small number of patients was publicly viewed with regret by most staff. Yet the problems associated with overcrowding led obedience, cleanliness and order to assume

<sup>38</sup> H.H. Turton to Provincial Superintendent, 6 July 1872, AP2 1872/2369; Annual Report on the Lunatic Asylums of New Zealand, *AJHR*, 1881, H.8, p.5.

<sup>39</sup> *ibid.*, *AJHR*, 1901, H.7, p.6.

<sup>40</sup> The Seventh Annual Report of the State of the Auckland Provincial Lunatic Asylum - 1873, *APGG*, 1874, p.51.

an equal priority with patient well-being, and the use of restraint was maintained and possibly increased.<sup>41</sup> When Dr Beattie returned from a visit to the Larbert Mental Hospital in Staffordshire in 1905, he endeavoured to follow the example there and stop using mechanical restraint altogether, but reconsidered the decision as he became "convinced... that the welfare of the patients and the discipline of the hospital are both thereby prejudicially affected."<sup>42</sup>

The preferred form of restraint was "seclusion", a formal period in a seclusion room or more commonly in a patient's own room. It was used in the sample cases for violent, uncontrollable behaviour and noisiness at night. The superintendent conceded that it was not "the proper treatment" but "necessary for the peace and quiet of the other patients".<sup>43</sup> "Mechanical" forms of restraint such as locked gloves, canvas or "strong" dresses and straightjackets were used according to the doctors as precautions against self-injury, violence, suicidal tendencies and to prevent patients from tearing off their surgical dressings. The periods of restraint appear to be quite long if a set of figures in one annual report is an

<sup>41</sup> Although there are insufficient records at Auckland to quantify this aspect of patient's treatment, studies of the Dunedin and Seacliff asylums argue that patient's subjection to restraint did increase in this period. Bloomfield, p.58 and Hubbard, pp.39-40.

<sup>42</sup> Report on the Mental Hospitals of the Colony, AJHR, 1906, H.7, p.8.

<sup>43</sup> Annual Report on the Lunatic Asylums of New Zealand, AJHR, 1878, H.10, p.7.

accurate guide: during a three month interval in 1893 four women were "treated" with mechanical restraints for lengths of anywhere from twelve hours to over two days.<sup>44</sup>

Assertions about the function of restraint as treatment for patients should however be interpreted with caution, on account of its perversion to both economic and disciplinary ends. For example, staff found strong dresses prevented "unnecessary waste of clothing".<sup>45</sup> Seclusion was held over patient's heads as a threat. In the case of the notorious Bridget H., who was found to be sane, if not repentant, self-control manifested itself "when under observation and liable to seclusion".<sup>46</sup>

Considerations of suitable feminine behaviour are also apparent in the use of restraint with female patients. It was used more frequently for them both here and overseas. Elaine Showalter notes that at England's Colney Hatch Asylum women were sedated, given cold baths, and secluded in padded cells up to five times as frequently as men.<sup>47</sup> At Auckland staff found that troublesome female patients had frequently to be kept in seclusion, whereas there were periods of several months when hardly any restraint was used in the male department.<sup>48</sup> Where figures are given in annual reports, more women were subjected to mechanical

<sup>44</sup> *ibid.*, 1894, H.7, p.3.

<sup>45</sup> *ibid.*, 1895, H.7, p.3.

<sup>46</sup> Case 125, YCAA 1048/1, p.64.

<sup>47</sup> Showalter, *The Female Malady*, p.81.

<sup>48</sup> YCAA 1049/1, 28 January 1899, p.84; Annual Report on the Lunatic Asylums of New Zealand, *AJHR*, 1878, H.10, p.7; 1879, H.4, p.6. The same pattern is evident at the Mt View asylum in Wellington. Williams, pp.23,30.

restraint.<sup>49</sup> Doctors explained this phenomenon with reference to women's greater emotionality and the influence of their menstrual cycle. "Every asylum superintendent bears witness to the fact that are much more violent and destructive lunatics than men. These 'breakings out', which are almost as characteristic of female criminals as they are of female lunatics, ...are generally periodic in character".<sup>50</sup> Yet, in part, this behaviour was an understandable reaction to the very act of confinement. Official visitors came nearer the truth when they realised that the greater opportunity for outdoor occupation among male patients meant that they were quieter and slept better.<sup>51</sup>

Conditions of work for the staff were another element in the continued use of restraint. Attendants and nurses feared for their personal safety. Medical theory recommended kindness and tolerance, but Dr Hassell conceded in his 1891 report that he had "never been able until now to get the attendants to see that patients who were supposed to be dangerous and unfit to be trusted with any kind of tools would in reality be quite tractable if treated with kindness and confidence".<sup>52</sup> Vigilant guarding,

<sup>49</sup> In 1910 42 women and 27 men were considered "dangerous" and in need of restraint. Report on the Mental Hospitals of the Dominion, *AJHR*, 1911, H.7, p.10.

<sup>50</sup> Lomax-Smith, p.59.

<sup>51</sup> YCAA 1049/1, 28 July 1898, p.76, September, 1899, p.96; *NZPD*, 123 (1903), pp.157-158. See also similar comments connected with Mt View and Seacliff asylums. Williams, pp.23,66 and Hubbard, p.29.

<sup>52</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1891, H.2, p.4.

which was a prerequisite of such treatment, was difficult to achieve when severely understaffed, as the asylum was for much of the period. Yet when conditions were alleviated later in the period, and Dr Beattie attempted to instill non-restraint, staff and officials resisted the new ruling. H. Wilding the official visitor, argued "that in cases of unprovoked assault... by partially sane patients, the superintendent should have some discretionary power enabling him to put some patient under temporary restraint".<sup>53</sup>

If the available evidence for medical treatment is thin, the same is not the case with the non-medical forms of therapy: work and recreation. In the mid-nineteenth century, the benefits of patient labour were considered even more important than medical adjuncts. In a belief consistent with moral treatment philosophy, alienists held that suitable employment enabled lunatics to display "industry, self-control, moderation and perseverance", or as Scull claims "something approximating the bourgeois ideal of the rational individual".<sup>54</sup> Rehabilitation was the goal. Asylum care aimed to restore "the unfortunate inmates to a state which would enable them to resume their calling, trade, or occupation".<sup>55</sup> The more workers in the asylum, the more successful its treatment was perceived to be. Even

<sup>53</sup> YCAA 1099/1, 9 March 1907, p.2.

<sup>54</sup> Showalter, The Female Malady, p.29; Scull, Museums of Madness, p.69.

<sup>55</sup> NZH, 14 September 1878, p.2.

with the increasing importance placed on medical therapy and physical cure by the turn of the century, medical superintendents retained this view.

There was an extremely strong sexual division of labour within the asylum. Women's work was, in the words of an early inspector, "of course of a more sedentary or feminine character".<sup>56</sup> A visiting expert recommended in 1872 that

the female patients should do all the work which would naturally fall to their share... viz. household work in their own division, washing, making and mending clothes for the whole establishment, and doing such fancy work for the decoration of the rooms as may come within the scope of their capabilities.<sup>57</sup>

Female patients were thus set to needlework, laundry work, making and mending ripped and torn clothes ("no inconsiderable item"), scrubbing, sweeping and dusting, bed making and assisting in the wards.<sup>58</sup> The women also made ticks and pillow covers and hemmed the sheets.<sup>59</sup> Despite the large number of tasks they performed, women's work opportunities were circumscribed both by contemporary ideology as to what feminine work entailed, and also the need to keep the sexes separate. Staff found it difficult to find enough suitable employment for them. The suggestion by the governor of the Mt Eden Gaol that the clothing of the hospital and asylum patients be made by female

<sup>56</sup> H.H. Turton to Provincial Superintendent, 25 February 1874, AP2 1874/683.

<sup>57</sup> General Report on the Lunatic Asylums in New Zealand by Dr Paley, [Inspector of Lunatic Asylums for Victoria] *AJHR*, 1874, H.1, p.5.

<sup>58</sup> Charge Attendants daily report sheets 1888, YCAA 1080/1.

<sup>59</sup> *WN*, 31 March 1877, p.10.

prisoners was turned down because of the lack of a substitute for asylum women.<sup>60</sup> In 1897 women took over the running of the kitchen and female patients were thus able to be employed there "in a congenial way, one of the perennial difficulties of asylum management".<sup>61</sup>

Men, on the other hand, had a wide variety of both indoor and outdoor occupations. They worked in the garden, cleared shrubbery and tended walks; split firewood and pumped water; and assisted in the kitchens and male wards. Later on workshops for industrial employment were erected and the farm became the biggest employer of asylum labour. In 1890 for example, 83 men were listed at work in the farm or garden, 60 were performing useful tasks in the house and 13 were employed in the workshops.<sup>62</sup>

As writers about similar institutions have pointed out, whatever the ostensible curative reasons for occupational therapy, the actual jobs performed derived from the financial and administrative needs of the establishment. The work was often open to exploitation.<sup>63</sup> At Auckland, patients washed out rooms, cleaned windows and did "everything that requires to be done, for there are no servants in the asylum".<sup>64</sup> Later on when servants were employed, patients continued to perform the work, sometimes

<sup>60</sup> Dr Aickin to Provincial Superintendent, 17 May 1873, AP2 1873/1395.

<sup>61</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1898, H.7; p.11.

<sup>62</sup> *ibid.*, 1890, H.12, p.2.

<sup>63</sup> Goffman, p.90; Crowther, p.201.

<sup>64</sup> H.H. Turton to Provincial Superintendent, 27 February 1874, AP2 1874/683, p.8.

supervised by the servants.<sup>65</sup> Surprise was expressed initially at how much work was done for so little remuneration, for wages were not paid.<sup>66</sup> The farm was a particularly important endeavour in this respect. The New Zealand Herald praised the farm manager in 1889 for the skillful manner in which he ran the farm to produce the best financial results.<sup>67</sup> Bribes of tobacco, extra food or ale were often given out as incentives. Work was also viewed as a reward for good behaviour; compliance meant consideration for release. For the men, at least, it enabled them to escape the confines of the building and made them feel they were performing a useful function. They would also see the transformation of the grounds, for example, before their eyes. George K., described as "reliable, quiet and industrious", worked with the plumber and was allowed "considerable liberty".<sup>68</sup>

The women were not so fortunate. No matter how hard they worked they were confined inside. Their employment was monotonous and devoid of much real therapeutic value. In 1877 the matron Miss Hamilton believed that "there is quite too much needlework done by the patients", and as late as 1899 the official visitor in 1899 declared that "[n]o patient should be allowed to sew, or knit, more than four

<sup>65</sup> Auckland Asylum: revised rules and regulations for the attendants, servants, etc (Auckland, 1886), p.8.

<sup>66</sup> Annual Report of the Provincial Lunatic Asylum, APGG, 1868, p.131.

<sup>67</sup> NZH, 9 November 1889, Supplement, p.1.

<sup>68</sup> Case 1648, YCAA 1048/5, p.487.

hours a day".<sup>69</sup> Despite the efforts of official visitors to institute such compulsory outdoor work as keeping fowls or milking cows for quieter women (all of which were traditional female farm occupations), the women had to be content with an old fashioned flower garden, which took a number of years to come to fruition and which remained a form of recreation rather than occupation. Yet even this had met with opposition. During a discussion in parliament over the introduction of "flower culture" into New Zealand asylums, the minister in charge of asylums, Mr Hall Jones, stated he "would be very sorry to see female patients using a spade and doing work of that nature" although he agreed outdoor work was desirable.<sup>70</sup> Women were to remain feminine and not to follow potentially rough outdoor pursuits.

Yet women did extremely heavy laundry work, described as "downright slavery". In 1899, twenty-three women ("not all robust either") did the weekly and daily wash, including blankets and quilts, for over 400 people.<sup>71</sup> Much of it was performed manually. Financial considerations were part of the reason as newer machinery was not bought at the Auckland Asylum until 1903, and even more up to date appliances only arrived from the Mt View asylum after it had closed in 1908.<sup>72</sup> Part of the reason also lay in the importance of this kind of work in definitions of

<sup>69</sup> WN, 31 March 1877, p.10; YCAA 1049/1, 28 January 1899, p.84.

<sup>70</sup> NZPD, 113 (1900), p.72.

<sup>71</sup> YCAA 1049/1, 13 June 1899, p.92, 29 July 1907, p.210.

<sup>72</sup> YCAA 1099/1, 19 November 1908, p.35.

femininity. As many of the women were not doing their domestic duties properly before they were committed, this was another way of inculcating the right qualities in recalcitrant females. It has also been suggested in regard to such other English institutions as orphanages, charity homes and Homes for Fallen Women that intensive domestic work was used as control and punishment.<sup>73</sup> The idea that work was a reward for good behaviour fits in here. Sample cases at Auckland show that there was a path of promotion from laundry work up to needle work and knitting.<sup>74</sup>

Recreation accompanied labour. As the medical superintendent Dr King told the New Zealand Herald in 1889, the aim was "to combine useful employment as far as possible, with suitable mental and physical recreation; to occupy their minds, so as to keep them from brooding over their condition, and to alleviate the monotony of their lives in every possible way".<sup>75</sup> More directly, as Mark Finnane has shown with regard to Irish asylums, recreation was "intended to counteract the depressing and tedious influence of institutional life, as much as be a positive therapy in itself".<sup>76</sup> Several annual reports noted however

<sup>73</sup> Leonore Davidoff, "Mastered for Life: Servant and Wife in Victorian and Edwardian England", Journal of Social History, 7 (1964), p.414.

<sup>74</sup> At the Te Oranga Reformatory in Christchurch the substitution of plain sewing for fancy needlework was considered by both the staff and residents to be a "great loss of privilege". Dalley, p.47.

<sup>75</sup> NZH, 9 November 1889, Supplement, p.1.

<sup>76</sup> Finnane, Insanity and the Insane, p.198.

that lack of space, the disinclination of attendants, an absence of musical instruments, reading matter or board games, and more pressing business in the house severely curtailed activities on a number of occasions. Still, patients often had the pleasure of picnics and walks beyond the airing courts in single-sex parties.

Women again had a more narrow range of activities, although recreation was regarded as especially helpful for them as they had few opportunities to enjoy themselves outdoors.<sup>77</sup> Men played bagatelle, draughts, cards, dominoes and read local and overseas papers and periodicals. Outside they played quoits, cricket and football. When female activities are mentioned in the annual reports (which is not very often), they consist of playing the piano, exercising in the airing courts or taking walks. With the shift into the old hospital in town, after the fire in 1877, opportunities were somewhat enlarged. On alternate Sundays "a party of ladies visit, sing sacred music, supply them with flowers and talk in a friendly way with them". These visits, no doubt encouraged by the closer proximity of the patients, appear to have ceased when the women moved back to the Whau at the end of 1881. In 1898, Mrs Hendre reported that "amusement, and a greater amount of variation, in the lives of the female patients; is a matter worthy of serious attention".<sup>78</sup>

<sup>77</sup> Garton, Medicine and Madness, p.167.

<sup>78</sup> YCAA 1049/1, 17 March 1898, p.66.

Attendance at religious services by convalescent patients was seen as another important part of moral treatment; a perfect opportunity to impart correct moral values. The superintendents described them as "mostly... didactic and descriptive", as they were adapted especially for the insane.<sup>79</sup> Inspector-General Skae believed such services were "always a source of good to the insane, even when attaining no higher object than to break the monotony of their lives, and to serve as a means of discipline".<sup>80</sup> Approximately equal percentages of both sexes attended services.

Entertainments, at times attended by members of the public, were another means of achieving self-control and relieving the tedium of institutional life. These events consisted of recitations, musical performances and sometimes dancing. They performed a similar function to the official visits and inspections, by assuring the outside world that the asylum had restored order and obedience in those who were previously uncontrollable.<sup>81</sup> Thus Dr Aickin assured the provincial government in 1875 that the patients' "decorous conduct on those occasions could not fail to strike the numerous visitors who kindly favoured us with their presence".<sup>82</sup>

<sup>79</sup> Annual Report of the Provincial Lunatic Asylum, APGG, 1868, p.132.

<sup>80</sup> Reports on the Lunatic Asylums of New Zealand, AJHR, 1877, H.8, p.22.

<sup>81</sup> Finnane, *Insanity and the Insane*, p.198.

<sup>82</sup> The Eighth Annual Report of the State of the Auckland Provincial Lunatic Asylum, 1874, APGG, 1875, p.208.

What effects did this treatment have on patients? This question can be approached in at least two ways. First, a statistical picture of cure and discharge rates can be enumerated. Second, we can consider the quality of life inside the Auckland asylum and the reactions of its inhabitants.

The annual published statistics listed raw figures of those "discharged recovered", "discharged not recovered" and those who died, as well as percentages of recoveries on admissions during the year.<sup>83</sup> Table 6.1 shows that although the cure rate was not consistent, nor high overall, female percentages were higher than those for males. Dr Beattie believed "this is partly due to the higher moral tone of the female patients previous to admission, leading to fewer hopeless wrecks; to the fact that amongst the females we have no general paralytics; and, as far as the death rate is concerned, to the better hospital accommodation and better nursing provided for the female patients".<sup>84</sup> His points about the physical health are the most plausible. For women, as we have seen, physical debility and an inability therefore to function normally around the house were major causes for others' perceptions of madness. In 1903 a Member of Parliament claimed, that

<sup>83</sup> There are differences in terminology between published figures and casebooks. In contrast to the annual figures, casenotes record patients as recovered; relieved or improved; or died. This discussion assumes relieved or improved corresponds to not recovered.

<sup>84</sup> Report on the Lunatic Asylums of the Colony, *AJHR*, 1900, H.7, p.4.

the medical authorities will tell you that a large percentage of insane cases among women are due to physical weakness; they are not mentally diseased, their mental weakness is the result of want of food, excessive lactation and other physical causes.... a majority would recover health after a brief period of rest and treatment..."<sup>85</sup>

TABLE 6.1

Numbers of "discharged recovered" and "discharged not recovered" as percentages of total admissions, 1878, 1890 and 1910

	Discharged recovered		Discharged not recovered	
	Female	Male	Female	Male
1878	45	35	29	17
1890	67	54	9	16
1910	54	38	1	2

1. All percentages are averaged across five years centred on the sample years.

Source: AJHR, Report on the Lunatic Asylums of New Zealand, 1877-1903; Report on the Mental Hospitals of the Colony, 1889-1893; Report on the Mental Hospitals of the Dominion, 1909-1913.

Although there was no precise definition as to what recovery meant in practical terms, the sample casenotes give a number of clues. For example, in the case of George P., who was admitted to the asylum in 1890, the superintendent wrote "he is such[sic] well behaved and rational in his conversation and his depressed state has quite passed away so that if he continues in his present mind he will be discharged as recovered".<sup>86</sup> The symptoms of improvement shown by Elizabeth M. were "a more intelligent expression" and clearer answering of questions. Before

<sup>85</sup> NZPD, 123 (1903), p.159.

<sup>86</sup> Case 1642, YCAA 1048/5, p.475.

discharge she was "now quite rational and expresses herself cheerfully, she is constantly engaged during the day at knitting and sewing".<sup>87</sup> More precise signs of "normality" were set out in another case. She "remains agreeable and orderly. She converses in a coherent and sensible manner and she expresses no delusions. Sleeps well and has a good appetite. Physical condition is good. She works well in the ward".<sup>88</sup> The recanting of delusions became more important by the end of the period, a trend that is apparent in the decline of the percentage of those "discharged not recovered". "Not recovered" or "relieved" as the case books phrased it, meant that the person had lost most of their delusions, was calm and could be looked after by family or friends. Martha L. was so discharged in September 1870, "the delusions being of a harmless character and her husband and family being most anxious to take charge of her". The family formally took responsibility for her safekeeping.<sup>89</sup>

The willingness of family to assume responsibility was an important element in the discharge of both recovered and relieved patients, particularly the women, who were frequently requested back by their husbands even before they were deemed ready to go. Complaints were frequently made about the unresponsiveness of relatives in the annual reports, which usually concentrated on male cases. "The

<sup>87</sup> Case 128, YCAA 1048/1, p.191.

<sup>88</sup> Case 3067, YCAA 1048/11, p.273.

<sup>89</sup> Case 155, YCAA 1048/1, p.213.

proportion of discharges... would undoubtedly be better if only the friends of the patients showed a natural and becoming anxiety to take them out when informed they were in a fit state to be committed to their care".<sup>90</sup> Otherwise, as one inspector feared, "if they are not removed at a certain favourable crisis of their malady, the natural tendency is to sink and end in becoming incurable lunatics".<sup>91</sup> Annual statistics confirm that most patients who recovered did so after a stay of under one year.

Moreover, the suggestion that all that many women needed was a break, regular food and relatives willing to take over care, serves to diminish even further medical pretensions to cure. This did not go unnoticed by the press. "In fact, the success of such establishments depends less on so-called lunacy experts, and even medical treatment in some cases, than upon having a medical superintendent who uses strong common sense and tact in dealing with patients, preserving harmonious relations among the staff, and in administrative and organising capacity".<sup>92</sup>

Mark Shepherd has argued that there is both quantitative and impressionistic evidence of a decline in treatment standards in English asylums that paralleled the shift to physiological diagnosis in the nineteenth century. He cites as evidence the degeneration of the non-restraint

<sup>90</sup> Reports on the Lunatic Asylums in New Zealand, *AJHR*, 1876, H.4, p.3.

<sup>91</sup> *ibid.*

<sup>92</sup> *NZH*, 9 November 1899, Supplement, p.1.

ideal, the decline in the number and thoroughness of case records and fictitious cure and death rates.<sup>93</sup> Similar evidence has been found for Irish and American institutions.<sup>94</sup> In the 1870s New Zealand officials had feared that proposed separate facilities for the "chronic and the incurable" and even the division of patients in general institutions on that basis, with accompanying differential treatment, would mean that the patients sank further and those who had some chances of recovery upon admission became hopeless. Moreover, they believed that such demarcations meant that interest was lost in treatment with routine and the safe and economical keeping of the patients becoming the ruling ideas.<sup>95</sup>

Their anxieties appeared to be justified. In the 1880s the Inspector-General claimed that New Zealand asylums "were being steadily converted into refuges for the mere safekeeping of chronic and incurable lunatics".<sup>96</sup> We have already seen that by 1910 asylums doctors were dividing patients upon admission into "curable" and "incurable"; and the "curable" into those with over (class A), and those with under (class B), a forty percent chance of cure. Nationally classes A and B totalled just over nine percent

<sup>93</sup> Shepherd, pp.62-63.

<sup>94</sup> Robbins, p.171; Gerald N. Grob, "Institutional Origins and Early Transformation: 1830-1855", in The Enduring Asylum: Cycles of Institutional Reform at Worcester State Hospital, eds. Joseph P. Morrissey, Howard H. Goldman and Lorraine V. Klerman (New York, 1980), pp.45-46.

<sup>95</sup> Statistics of New Zealand, 1873, p.7.

<sup>96</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1889, H.22, p.1.

of those resident in mental hospitals in 1910 and class A alone accounted for nearly four percent. The minority who were judged "curable" received "special treatment".<sup>97</sup>

The decline in those discharged not recovered and a trend to custodial care for the increasing numbers of "incurable" left, follows the experience in New South Wales, which began in the early twentieth century and developed most fully in the inter-war period. Mental hospitals there were increasingly differentiated according to their patient population, for example whether they held acute, chronic, or criminal patients, or retarded children. New South Wales' Inspector-General believed chronic patients required less medical, and more custodial, attention. The argument that declining rates of discharge and the increasing use of restraint were not just a result of overcrowding, but part of a policy of dividing patient populations according to their possibility of a cure,<sup>98</sup> has parallels with the Auckland experience.

The visitor's reports, casefiles and annual reports also provide some more general impressions of what asylum life was like for those incarcerated there. The majority of chronic, non-convalescent patients lived out a monotonous existence, rising at six in the summer and six-thirty in winter and retiring twelve hours later. It is no wonder

<sup>97</sup> Report on the Mental Hospitals of the Dominion, AJHR, 1911, H.7, pp.4-5.

<sup>98</sup> Garton, Medicine and Madness, pp.165,167,172.

that the atmosphere of the ground floor of the women's wing was described on one occasion as having a "heavy dead quality".<sup>99</sup> Irregular events such as repainting were seen as a welcome diversion: "What a break it must have afforded, in the monotonous life of patients; to watch the operations of the decorators at work!"<sup>100</sup> Conflicts between humane standards and institutional efficiency exacerbated the tendency for patients to be viewed by many staff as faceless cases in the vast, overcrowded institution. As one patient tried to convey to the female official visitor, "[the Inspector-General] just goes through, and doesn't say anything; and doesn't see anything".<sup>101</sup> When Dr MacKelvie was appointed medical assistant in 1902, his kindly manner and "somewhat jovial style of address" made him more popular with the patients.<sup>102</sup>

Committal to the Auckland Asylum involved "rituals of humiliation" and elements of self-mortification that have been delineated by Erving Goffman. These can be summed up by Charles J., admitted in 1890, who appeared to speak for many when he declared that he was an "inmate", not a "patient".<sup>103</sup> On arrival, all personal property, clothes and money were taken and passed to the Public Trustee, who also administered individual estates. Patients were then bathed,

<sup>99</sup> YCAA 1049/1, 30 December 1897, p.62.

<sup>100</sup> *ibid.*, 23 February 1898, p.64.

<sup>101</sup> *ibid.*, 18 April 1898, p.68.

<sup>102</sup> *ibid.*, 30 June 1902, p.156.

<sup>103</sup> Case 1637, YCAA 1048/5, p.468.

dressed and the men had their hair cut.<sup>104</sup> Patient clothing was, at best, "servicable and provided adequate warmth".<sup>105</sup> Although there was no conscious decision to create a uniform, the photographs on patients at the beginning of chapters three to six show that a standard dress became the norm. In the early years of the asylum's establishment superintendents and inspectors made numerous comments on the shabby and dowdy nature of the patients' appearance and the prison-like style of the dress.

There are few patients so far lost as not to be able to appreciate the distinction between the ordinary dress of civilians and that which is furnished to them on their admission. A consciousness of degradation owing to the change may exercise a prejudicial influence on many patients, and may obviate or retard their progress toward recovery".<sup>106</sup>

Men wore moleskin trousers and coats, and blue stripe or pink check shirts. Women had calico combinations, cotton petticoats and galatea cloth frocks that were "shapeless, heavy, dark, unattractive" with "dozens cut from the one pattern".<sup>107</sup> These comments again reflect contemporary perceptions of gender roles. Officials laid greater stress upon whether the women were neat and tidy, and urged nurses to provide a good example. The female official visitor, accustomed to standards in the women's division, noted in

<sup>104</sup> Dr Aickin to Provincial Superintendent, 22 May 1876, AP2 1876/1188. For example, Blanche A. had two gold bangles, a purse, her gold wedding ring, 11d cash and four stamps removed from her person. William N. handed over a watch and chain, his razor, Sunday papers, and a bag, swag and coat. Patients Property Book 1907-1911, YCAA 1047/1, p.300, 366.

<sup>105</sup> Hunter, p.19.

<sup>106</sup> The Eighth Annual Report on the State of the Auckland Provincial Lunatic Asylum, 1874, APGG, 1875, p.208.

<sup>107</sup> Hunter, p.19.

1897 that "male patients have the look of not being as carefully cared for as the females". She thought it might be their "untidy hair and beard" and suggesting clean shaving.<sup>108</sup> Flannels and jerseys were distributed in colder weather, although many patients suffered from leaky boots and were too lightly clad. Only in the mid 1880s did all patients receive a second set of clothing.<sup>109</sup> As M.A. Crowther has noted of the English workhouse, the "indignity of being bathed by an attendant", standard "convenience haircuts" and even a partial uniform "diminish the inmate's control over his appearance; he [sic] was always distinguishable from outsiders".<sup>110</sup>

Patients were moved around in regimented "batches", where the chief activity of the staff was not guidance or periodic inspection but surveillance.<sup>111</sup> Overcrowding and lack of staff strengthened this tendency. In 1873, for example, staff had to resort to overlooking the women from an upper window when they were in the yard behind.<sup>112</sup> A system of rewards and punishments also operated for convalescent patients, including bribes to work, differentiated employment and classified accommodation. The

<sup>108</sup> YCAA 1049/1, 9 December 1897, p.59.

<sup>109</sup> Annual Report on the Lunatic Asylums of New Zealand, *AJHR*, 1878, h.10, p.7, 1884, (S1) H.7, p.4, 1888, H.8, p.6.

<sup>110</sup> Crowther, p.196.

<sup>111</sup> Goffman, p.7.

<sup>112</sup> H.H Turton to Provincial Superintendent, 31 December 1873, AP2 1874/200.

latter meant that stages of recovery were contingent with both physical comfort and patient's attitudes.<sup>113</sup>

Together with overwhelming tedium and personal abasement, patients experienced much restriction and coercion. As one patient remarked, "Dr Beattie was very strict...."<sup>114</sup> At times this crossed over into violence. The rules of the Asylum quoted the relevant section of the current Lunatics Act, which stated that any officer, nurse, attendant or servant who ill-treated or wilfully neglected a patient was guilty of a misdemeanour and punished with fines or imprisonment.<sup>115</sup> Inspector-General Duncan MacGregor felt confident that

"[t]he regular visits of the Deputy Inspector and the Official Visitor, and the pains they take to find out how they are being treated by familiar converse with the patients without any official being present, are in themselves a very strong guarantee that nothing can take place in the nature of neglect or cruelty without their being informed of it, and applying, as the law empowers them to do, an instant remedy."<sup>116</sup>

Only a few instances of alleged ill-treatment were found, but whether this means the treatment at Auckland was all that it should have been is doubtful. As we saw in chapter two patient complaints were likely to be discounted, because it was believed that patients frequently complained without reason, and lay people rarely questioned medical

<sup>113</sup> Goffman, pp.48-51; Digby, Madness, Morality and Medicine, p.66.

<sup>114</sup> YCAA 1049/1, 11 May 1901, p.132.

<sup>115</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, s.191; The Lunatics Act, 1882, *ibid.*, 1882, ss.333,335; The Lunatics Act, 1908, *ibid.*, 1908, ss.334,336.

<sup>116</sup> Report on the Lunatic Asylums of the Colony, AJHR, 1892, H.4, p.3.

decisions. This tendency to ignore all other information meant that in some institutions "ostensibly founded for medical or humanitarian reasons" things were probably worse.<sup>117</sup> In 1877 the New Zealand Herald highlighted a letter from a male patient's father to the Commission of Inquiry then investigating conditions at the asylum. The man laid a complaint of abuse of the boy, including blistering. Inspector McLean referred it to Dr Aickin, who with the attendant involved, refuted it.<sup>118</sup>

Staff were sometimes transferred if trouble occurred. The use of this solution to staff-patient relations gives an indication of what was probably at the root of neglect or cruelty: problems familiar to those in a residential institution made worse by overcrowding and understaffing entailing long hours and hard work. Staff were expected to display "perfect self-control" and must not "resent either intemperate language or unruly behaviour".<sup>119</sup> Reporting a couple of months after MacGregor's investigations, the female official visitor attributed a "marked improvement in the general tone of the entire female wing" to "the newness, and freshness, of the staff... There is such a lack of grizzling...."<sup>120</sup> Scattered references hint that staffing problems may have had different effects on male and female patients, and thus their treatment. For example, inspector Turton observed in 1873 that "six women make as

<sup>117</sup> Crowther, p.270.

<sup>118</sup> NZH, 10 April 1877, p.2.

<sup>119</sup> Auckland Asylum: revised rules and regulations, p.6.

<sup>120</sup> YCAA 1049/1, 6 November 1899, p.100.

much work as ten men" because the female patients had to make their own clothes assisted and supervised by the Matron and attendants, whereas male clothing was provided ready-made".<sup>121</sup>

Of course, not all violence and difficulty was perpetrated from above. Life was also made trying by peers. One "semi-imbecile lad of 17" was assured that the doctors and attendants were very kind indeed. He replied "Oh yes, yes. I know that, dear lady! But it ain't them, its that lot!", meaning the other patients. Similarly, some women preferred to stay inside continually sewing, rather than mix with the more disorderly "aimlessly walking up and down in the court" outside.<sup>122</sup>

Relations with family and the community outside were regulated both informally through society's attitudes and formally through management. The isolation of the Auckland asylum was fostered by the stigma attached to incarceration and the reluctance of relatives to take patients back. Moreover, there was also difficulty in encouraging interaction in the form of patient visitors: in 1870, procedure was altered so that visits could be made "at all convenient hours" instead of on fixed days as before, although the doctor's permission still had to be obtained first.<sup>123</sup> From the sole remaining Visitor's Book for 1891-

<sup>121</sup> H.H. Turton to Provincial Superintendent, 31 December 1873, AP2 1874/200.

<sup>122</sup> YCAA 1049/1, 9 December 1897, p.60, 18 April 1898, p.68.

<sup>123</sup> H.H. Turton to Provincial Superintendent, 27 February 1874, AP2 1874/683.

1910, it appears that men were visited more often than women, although only two or three times each in that period, and at some interval apart. Of all the female sample patients there are references to visitors in only two cases, both from the 1870 sample. Amy G. was visited by her former nurse the day after committal and Mary Jane P. was visited five days after committal by her sister.<sup>124</sup>

Ironically, despite the wish to encourage interaction, most references to visitors concern attempts or wishes by staff to limit such contact. Patients were given "maximum freedom" with visitors, therefore it was felt that visitors should be refused at times, as they caused disturbances by unwise remarks.<sup>125</sup>

Communication in the form of letters was more tightly controlled. According to the law, letters addressed to a Minister of the Crown, Judge of the Supreme Court, inspector or official visitor were to be forwarded unopened. All others, if not sent on, were to be laid before the inspector or official visitor unopened.<sup>126</sup> These guidelines were intended to protect the patients. Letters were detained, in some cases, "owing to their alarmist nature..." and inspectors took great pains to emphasise the

<sup>124</sup> Case 57, YCAA 1048/1, p.101; case 134, YCAA 1048/1, p.198.

<sup>125</sup> YCAA 1099/1, 23 July 1910, p.63; YCAA 1049/1, 26 October 1906, p.201.

<sup>126</sup> The Lunatics Act, 1868, New Zealand Statutes, 1868, s.62; The Lunatics Act, 1882, ibid., 1882, s.147; The Lunatics Act, 1908, ibid., 1908, s.145.

fact that none were unnecessarily kept back.<sup>127</sup> Yet if patient complaints and testimony of ill-treatment were ignored, this claim appears more hollow.

Manifestations of institutionalisation were a consequence of the organisation of asylum life for many patients. Dr Aickin revealed in 1871 that the "quiet incurables... become, as it were, domesticated, and who, without any compulsion whatever, perform their allotted duties with hearty goodwill.... some of these chronic cases are really valuable servants in an asylum... in most instances they are life inmates".<sup>128</sup> Yet not all were passive recipients of prevailing treatment and conditions. The asylum regime provoked forms of protest and subversion, and they were "not an unfortunate anomaly, but an inevitable feature of institutional life".<sup>129</sup> Thus many refused to eat, destroyed clothing and objects around them, mutilated themselves and attempted, sometimes successfully, to escape.<sup>130</sup> Moreover, Nancy Tomes' study of the Pennsylvania Hospital for the Insane shows us that daily life was "profoundly affected by a gentler, less dramatic form of patient resistance: the act of complaining itself."<sup>131</sup> Most complaints appear to

<sup>127</sup> NZH, 9 November 1899, Supplement, p.1; Official Visitors Reports [Auckland Asylum] 1889 and 1904, H-MHD 90/52, 2 January 1889, p.4.

<sup>128</sup> Report of the Joint Committee on Lunatic Asylums, AJHR, 1871, H.10, Appendix, p.17.

<sup>129</sup> Garton, *Medicine and Madness*, p.181.

<sup>130</sup> For example, it was reported that a man was missing for four days in NZH, 11 January 1877, p.2.

<sup>131</sup> Tomes, p.243.

have been made to the official visitors. One noted that she had "spent entire day [there] but [it was] not long enough. Most patients expect to be interviewed personally during my visit, and are either angry, or else aggrieved in the event of not being". Not that much was achieved even if patients did make contact: on another occasion the visitor declared that "no complaints (except the standing one of being detained in the asylum) were made".<sup>132</sup>

The treatment and rehabilitation regimens at the Auckland asylum illustrate three key themes. First, a changing clientele, increasingly characterised by "chronic" rather than "acute" cases, forced adjustments in therapy. More medical intervention than anticipated was required for the poor physical health and "helpless" nature of many of the patients, most of whom were women. Aperients, alcohol, and increasingly, a range of drugs, were the favoured methods. A good diet was important too, especially for the many rundown women, who only needed tonics and extra nourishment to bring them back to health. Portion size was however lower for women. The third kind of "treatment" was restraint, either seclusion or mechanical forms, which generally was maintained and possibly increased over time. Women were subject to more restraint than men, and considerations of suitable feminine behaviour are evident in its use on them.

<sup>132</sup> YCAA 1049/1, 28 September 1898, p.78; 30 October 1890, p.120.

Second, the goal of asylum treatment was the maintenance of specific types of social order. A work ethic and a complementarity in gender roles were inculcated as the asylum maintained and extended the initial segregation of the sexes upon committal. Concentration on the larger group of males led to a much more limited life for the female patients. Useful employment was premised on the idea of what "normal" women and men did, that is suitable outdoor, manual and industrial work for men, and indoor, domestic work for women. Recreation was also conceived according to perceived gender roles. Cure rates were not high or consistent, but were slightly higher for women, because often they simply needed a regular diet, some rest and they had relatives willing to take them back.

Third, docile compliance with therapeutic regimens was not automatic. While self-mortification, monotony, control and violence were a patient's lot and interaction with the outside world was carefully managed, there is evidence of active resistance to institutional life. From the simple act of complaining to attempted escapes, patients tried to reassert a measure of control.

### Conclusion

The study of madness from a patient-based perspective shows that the detection and treatment of lunacy is greatly influenced by gender. In particular, the experience of patients at the Auckland Lunatic Asylum between 1870 and 1910 reveals that for women, to be labelled mad was inextricably linked to their crossing the boundaries of acceptable feminine behaviour, either in self-expression, housework, marital relations or maternal behaviour. Moreover, the changing importance attached to women as mothers and the many roles they had to live up to mean that the ideals of femininity varied. The ideal could never be attained because it was constantly shifting. Such an examination provides some additional clues as to the role of women in colonial New Zealand. In particular it offers a different kind of testimony to that of the strong colonial helpmeet ideal. Many either could not cope or were not behaving as a respectful or satisfied wife and mother should have been.

Moreover, there were differences between men and women in the modes of committal. The family was a primary initiator of committal for women, while men were more frequently committed due to police intervention. Spouses often took the initiative in the committal of women, but not for men. Finally, notions of gender affected the role of those who gave evidence of lunacy on medical

certificates. More often women acted as verifiers and supporters and male figures gave their pronouncements and interpretations.

Although questions of what it means to be female and feminine are central to constructions of "normality" and "abnormality", this study also suggests that the detection of madness in this period is part of what has come to be called "masculinism": "the specific, historical reality into which men were socialized, and within which they lived their lives".<sup>1</sup> Although this phenomenon is less marked than in the history of crime for example, women in the Auckland community were less vulnerable to committal than men. Analysis of committal patterns suggests that the sexual division of labour was a crucial factor. Because of their indispensable role in the household as unpaid cooks, cleaners and carers of children, women were committed very reluctantly and at considerable cost to husbands and employers. Similarly, inside the asylum, women formed around a third of inmates and modes of therapy were principally geared to their male counterparts.

It was not only lay people who were influenced by contemporary perceptions of appropriate sex roles. When general practitioners noted signs of insanity on the medical certificates and asylum doctors made their initial diagnoses as to the cause of insanity, they expected women

<sup>1</sup> Charlotte Macdonald, "Crime and Punishment in New Zealand, 1840-1913: a Gendered History", *NZJH*, 23:1 (April, 1989), pp.10-11. Macdonald also characterises nineteenth century crime as such.

to be submissive, pious and demure and reacted negatively if women did not stay within the boundaries of acceptable female behaviour. The increasing hold of psychiatric Darwinism and attendant hereditarian theories on medical thought exacerbated the asylum doctors' tendency to view women as naturally weaker and held captive by their reproductive cycles. Over time the assigned causes become more gender-specific. Women constituted larger numbers than men amongst those assigned hereditarian or congenital, interpersonal and mood-related causes. "Female problems" was a sizable category in its own right.

Alienists designed purpose-built institutions for the insane that kept the sexes strictly segregated, paralleling the ideological sexual division in general society. Each division was supposed to reflect feminine and masculine natures. Patriarchal authority was reinforced by the position of the superintendent and the matron. Female attendants were expected to be maternal and caring as well as competent. Military or penal experience and later agricultural skills were required of the male staff. Male inspectors and female official visitors judged administration and the general well-being of the patients.

Different treatment patterns for women and men were followed at the Auckland asylum. While general sickness was endemic among new admissions, more women needed physical cures and better food as an aid to recovery. A greater excitability and rebelliousness in the female patients led

doctors to use drugs such as enemas and restraint as forms of control. Both women and men were to be re-trained in their respective sex-roles with suitable employment and recreation: outdoor farming or industrial activities for men and indoor, domestic work for women.

However examining the influence of gender alone does not tell us the whole of the story of detection and treatment of nineteenth century lunacy. The process of committal in particular shows that complex pressures were at work. In the experience of Auckland patients, there were four main reasons for committal: threats to persons, property, articulated social norms and paranoid attitudes. In addition, there were two crucial background sources of tension that had a more material basis. Domestic crisis, whether as cause or symptom, ran through many cases. Often families were reluctant to have members committed, waiting until the perceived abnormalities got too bad to deal with or existing arrangements for care were no longer viable. For some women, who bore the brunt of regular childbirth, endless housework and family management, the family acted as a trigger in committal. Economic distress also figures repeatedly in the case records. Because it was not recognised by those involved in the committal process, especially in female cases, it is clear that "normal" people in nineteenth century New Zealand were not supposed to let hardship and financial problems overwhelm them. Perseverance and hard work were expected, even if better

conditions did not immediately manifest themselves. Some idea of the stresses and strains on working class lives is revealed.

This case study does show that gender is central to the definition and treatment of madness from a medical point of view. Yet even within the institution, perhaps because of their different class composition, Auckland women did not serve as cultural exemplars of madness in the way the Elaine Showalter claims for England. Some "female troubles" including hysteria accounted for only a handful of cases in the period. Often all that women at the Auckland asylum needed was some rest and adequate food to cause a change in behaviour. Material conditions in the form of overcrowding, underfunding and understaffing of the asylum worked against doctors' ideals. Despite what the asylum therapy achieved for individual patients, discharge was again dependent on the willingness of families to take patients back, and they were often censured for their recalcitrance.

The experience of institutionalised lunacy in nineteenth century New Zealand was predominantly a Pakeha one, as this case study reflects. Overall committal rates for Maori were far lower, although they risen substantially by 1910. Yet the handful of Maori sample cases suggest that race was also a factor in committal and diagnosis. Ideas that female Maori were naturally promiscuous and overly-friendly, and did not pay due respect to Pakeha authority

are evident. Similarly, for Pakeha men to support Maori systems of belief or Maori rights were seen as signs of abnormality. An inability to speak English and follow directions at the medical examination was viewed as congenital imbecility.

Mental illness in nineteenth century Auckland was thus largely socially-constructed. Clearly-defined sex roles, the material conditions of individuals and their families, social and familial conflict, notions of respectability and propriety were some of the multiple pressures involved in any one case. The process of detection involved intervention at a number of points in the community, with the family playing a fundamental role. Asylum doctors drew on contemporary social and scientific theory to employ a medical model of mental illness, which put responsibility for problems on individual causes and the solution to social problems on individual treatment. The role of social factors were diminished. Treatment involved minimal medical intervention and much prison discipline, in the attempt to reassert "correct" gender roles and inculcate respectability in far from ideal conditions. Patients often challenged medical authority and discharge was dependent on the families who had initiated committal in the beginning.

## Appendix A

## Committal forms as laid out in the 1882 Act

## No. 1.

ORDER FOR RECEPTION OF A LUNATIC INTO AN ASYLUM, ETC.

Secs. 5, 25.

I, A.B., the undersigned, having called to my assistance I.L. and M.N., two Justices of the Peace, also E.F. and G.H., medical practitioners, and having personally examined Y.Z., of [*Insert residence and occupation, if any*], and being satisfied that the said Y.Z. is a lunatic [*or a dangerous lunatic*], hereby direct you, J.K., the superintendent of the lunatic asylum [*or manager of the hospital, or keeper of the licensed house, or occupier of a house*] situate at \_\_\_\_\_, to receive the said Y.Z. as a patient into the said asylum [*or hospital, or licensed house*] [*or hereby order that the superintendent of such asylum or manager of such hospital as the Colonial Secretary shall appoint shall receive the said Y.Z. into the asylum or hospital under his superintendance or control*].

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_.

R.M.,

Resident Magistrate.

To J.K., superintendent of the lunatic asylum [*or manager of the hospital, or keeper of the licensed house, or occupier of a house*] situate at \_\_\_\_\_.

ORDER OF COLONIAL SECRETARY APPOINTING ASYLUM (OR HOSPITAL) FOR RECEPTION OF LUNATIC.

(*To be indorsed on the Order of the Magistrate.*)

WHEREAS I have satisfied myself that the within-named Y.Z. may be conveniently received into the asylum [*or hospital*] at \_\_\_\_\_; Now, therefore, I do hereby appoint the said asylum [*or hospital*] as the asylum [*or hospital*] to which the within-named Y.Z. shall be conveyed under the order made on the other side hereof.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_.

M.N.,

Colonial Secretary.

## No. 2.

CERTIFICATE THAT A PERSON IS A LUNATIC AND A PROPER PERSON TO BE DETAINED UNDER CARE AND TREATMENT. Secs. 5, 6, 10, 25.

I, the undersigned, being a medical practitioner in actual practice, hereby certify that I, on the \_\_\_\_\_ day of \_\_\_\_\_, one thousand eight hundred and \_\_\_\_\_, at \_\_\_\_\_ [*Insert the particulars of the place of examination, and the name of the city, town, or place, and the street, number of the house, or other particulars: where more than one medical certificate is required, add separately from any other medical practitioner, or jointly with, &c., if another medical practitioner*], personally examined A.B., of [*Insert residence and profession and occupation, if any*], and that the said A.B. is a [*dangerous*] lunatic, and a proper person to be taken charge of and detained under care and treatment, and that I have formed this opinion upon the following grounds, viz.:—

1. Facts indicating lunacy observed by myself [*Here state the facts*].

## Appendix A cont'd

2. Other facts (if any) indicating lunacy communicated to me by others  
 [Here state the information, and from whom].

Dated this           \* day of           , 18           .  
M.D.,  
Place of abode.

## STATEMENT.

[If any of the particulars in this Statement be not known, the fact to be so stated.]

Name of patient, with Christian name at length :  
 Sex and age :  
 Married, single, or widowed :  
 Condition of life and previous occupation (if any) :  
 The religious persuasion as far as known :  
 Previous place of abode :  
 Whether first attack :  
 Age (if known) on first attack :  
 When and where previously under care and treatment :  
 Duration of existing attack :  
 Supposed cause :  
 Whether subject to epilepsy :  
 Whether suicidal :  
 Whether dangerous to others :  
 Whether found lunatic by inquisition and date of commission, or order of inquiry :  
 Name of one or more of the relations of the patient (if possible) :  
 Special circumstances (if any) preventing the patient being examined before admission separately by two medical practitioners :

M.D.

## No. 3.

Sec. 6.

## CERTIFICATE THAT A PRISONER OR PERSON DETAINED IS A LUNATIC.

I, THE undersigned A.B., Resident Magistrate, having called two medical practitioners to my assistance to inquire with my aid as to the lunacy of E.F. a prisoner [or detained] at [Name place of imprisonment or detention], under [State cause of imprisonment or detention], do hereby certify (I, the said A.B., having inquired with such aid as to such lunacy) that the said E.F. is a lunatic.

A.B.,  
Resident Magistrate.

Dated this           day of           , 18           .

## No. 4.

Sec. 6.

## CERTIFICATE OF LUNACY WHERE REQUIRED BY THE COLONIAL SECRETARY.

I, THE undersigned, being a medical practitioner in actual practice, hereby certify that on the           day of           , one thousand eight hundred and           , at [Here insert the particulars of the place of examination, as the town, city, or place, the street, number of the house, or other particulars: where more than one medical certificate is required, add separately from any other medical practitioners] personally examined A.B., of [Insert residence and profession and occupation.]

\* The day of his examination.

## Appendix A cont'd

and that the said A.B. is a lunatic and a proper person to be taken charge of and detained under care and treatment; and that I have formed this opinion upon the following grounds, viz. :—

1. Facts indicating lunacy observed by myself [*Here state the facts*].
2. Other facts (if any) indicating lunacy communicated to me by others [*Here state the information, and from whom*].

M.D.,  
Place of abode.

Dated this\* day of , 18 .  
[Statement as in No. 2.]

## No. 5.

## ORDER FOR THE APPREHENSION OF A LUNATIC WANDERING AT LARGE.

Sec. 13.

Whereas it hath this day been made to appear to me, the undersigned, a Resident Magistrate [*or a Justice of the Peace*], by information upon oath, that A.B., a person wandering at large within the limits of my jurisdiction, is deemed to be a lunatic: Now, I require you, C.D., a constable, to apprehend the said A.B. and bring him before any Resident Magistrate.

Given under my hand this day of , 18 .  
To C.D., a constable of

E.F. [Signature]

## No. 6.

## ORDER FOR THE APPREHENSION OF A LUNATIC NOT UNDER PROPER CARE.

Sec. 16.

Whereas it hath been made to appear to me, the undersigned, a Resident Magistrate, upon information upon oath, that A.B., of [*Insert residence and occupation if any*], a person not wandering at large, is believed to be a lunatic and is not under proper care and control [*or is cruelly treated or neglected by C.D., a relative (or a person having the care or charge of him)*]: And whereas it appears to me upon a personal visit to and examination of the said A.B., and inquiry made by me into the matter so appearing upon such information [*or upon the report of E.J., a medical practitioner, directed and authorized by me by an order under my hand to visit and examine the said A.B. and to inquire into the matter so appearing upon such information, and to report to me in writing his opinion thereupon*], that the said A.B. is a lunatic and is not under proper care and control [*or is cruelly treated or neglected by the said C.D., a relative (or a person having the care or charge of him)*]: Now, I require you, E.F., a constable, to bring the said A.B. before any Resident Magistrate [*or two Justices*] having jurisdiction where the said A.B. shall be found.

Given under my hand this day of , 18 .  
To E.F., a constable of

G.H. [Signature]

## No. 7.

## ORDER FOR CONVEYANCE TO AN ASYLUM, ETC., OF A LUNATIC NOT UNDER PROPER CARE AND CONTROL, ETC.

Sec. 19.

I, the undersigned, Resident Magistrate at , having called to my assistance A.B. and C.D., medical practitioners, and having examined Y.Z., of [*Insert residence and occupation, if any*], who has been brought before me as being believed to be a lunatic, and made such inquiry relative to the said Y.Z. as I have deemed necessary, and being upon such examination [*If other evidence of the lunacy, add with other proof*] satisfied that the said Y.Z. is a lunatic and

\* The day of his examination.

## Appendix A cont'd

was wandering at large [*or that the said Y.Z. is a lunatic and is not under proper care and control (or is cruelly treated or neglected by N.O., a relative or a person having the care or charge of him)*], and that he is a proper person to be taken charge of and detained under care and treatment, do hereby direct you, G.II., the superintendent [*or the manager or keeper or occupier*] of the asylum [*or hospital or licensed house or private house*] situate at \_\_\_\_\_, to receive into the said asylum [*or hospital or licensed house or private house*] the said Y.Z.

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_.

R.M.,

Resident Magistrate.

To G.II., superintendent of the asylum [*or manager of the hospital or keeper of licensed house or occupier of a private house*] situate at \_\_\_\_\_.

## Appendix B

## "Causes of Insanity", 1879, 1890, 1910

1879	1890	1910
Hereditary Predisposition --and Domestic Troubles	Accident Adverse Circumstances	Hereditary Congenital mental deficiency
Intemperance --and Congenital weakness	Adolescence Cancer	Previous attack Puberty and Adolescence
--and Sexual Excess --and Loss & Calamities	Cerebral Lesions Child-bearing	Climacteric Senility
Emigration and Congenital Weakness	Congenital	Pregnancy
Excitement and -- Self Abuse	Disappointment Domestic Trouble	Puerperal state Lactation
Solitude (& probably self abuse)	Drink	Sudden mental stress
Domestic Troubles	Dyspepsia and constipation	Prolonged mental stress
Bereavements	Epilepsy	Privation
Anxiety	Excitement	Masturbation
Disappointment	Fright	Toxic:-
Ill Treatment	Financial difficulties	Alcohol
Religious Excitement	Grief	Tuberculosis
Love Disappointment	Heart disease	Influenza
Seduction	Hereditary	Syphillis
Remorse	Hysteria	Other Toxins
Fright	Ill-health	Injuries
Pecuniary Losses	Loss of sight	Sunstroke
Loss of Sight	Love	Lesions of the brain
Poverty and Want	Masturbation	Disease of the ear
Exposure and Overwork	Mental anxiety	Disease of the ear
Debility	Moral depravity	Epilepsy
Fever	Myxoedema	Other defined neuroses
Hysteria	Ovaritis	Graves' disease
Malignant Tumour	Overstudy	Cardio-vascular degeneration
Injury to Head	Overwork	General ill health
Sunstroke --& Rheumatism	Paralysis	No factor ascertained, history defective
Epilepsy	Physical causes	Religious excitement
Meningitis	Poverty	
	Prostitution & drink	
Puerperal condition	Religion	
Pregnancy	Senile decay	
Uterine disease	Sequele of acute disease	
Heart Disease	Sexual excitement	General paralysis

## Appendix B cont'd

1879	1890	1910
Syphilis	Softening of the brain	Solitary life
Organic Disease of the Brain	Solitude	Not insane
Climacteric Changes	Sunstroke	Transfers
Senile Decay	Syphilis	
Congenital (Decay & Imbecility)	Traumatic	
Unknown	Use of chlorform & opiates	
	Unknown	
	Not insane	

1. 1879 is used instead of 1870 because not all of the early annual reports consistently listed causes.

**Source:** AJHR, Report on the Lunatic of the Colony, 1880 and 1891; Report on the Mental Hospitals of the Dominion, 1911.

## Appendix C

## Previous place of abode of sample patients

	1870	1890	1910
Auckland	13	1	3
Awhitu			1
Arch Hill		1	
Avondale		1	
Shortland	3		
Parnell	1		
Thames			1
Onehunga	1	1	1
Whangarei	1	2	
Tauranga	1		
Gisborne		1	1
Newton		2	
Papakura			1
Bay of Islands		1	
Paeroa			1
Te Kopua		1	
Helensville		1	
Wanganui			1
Devonport		1	
Waihi			2
Surrey Hills		1	
Mongonui		1	
Tauramanui			1
Ponsonby		1	1
Waiuku			2
Napier		1	
Hamilton		1	
Newmarket		1	
Point Chevalier			1
Grey Lynn			2
Kawa Kawa		1	
Waitoa		1	1
Mt Eden		1	

Source: Committed Patient Case Files, 1870-1910, YCAA 1026/1-12

## Appendix D

## Occupations of total female patient population 1878-1910

Agent	1	Housewives	146
Artist	1	Housemaids	2
Barmaid	4	Lady Help	1
Bootmaker	1	Laundresses	4
Bookbinder	1	Machinists	2
Boardinghousekeeper	1	Milk Vendor	1
		Milliner	4
		Music Teacher	4
Companion	1	Nurse	8
Cook	5	Paperruler	1
Charwoman	3	Prostitutes	4
Cottonspinner	1	PupilTeacher	2
Domestic Duties	563	Servants	131
Dressmakers	28	Settler	35
Drapers Asst	2	Shopkeeper	6
Destitute	1	Saleswomen	3
Dairymaid	1	Schoolgirl	1
		Seamstress	8
Factoryhand	2	Strawworker	1
Farmer	1	Waitress	1
		Waterproofmaker	1
Governess/Teacher	13	Nil/Unknown	105
Hawker	3		
Housekeeper	10		
Houseduties	36		

1. 1878 is used because not all of the early annual reports consistently listed occupations.

**Source:** AJHR, Report on the Lunatic Asylums in New Zealand, 1879-1881; Report on the Lunatic Asylums of the Colony, 1882-1904; Report on the Mental Hospitals of the Colony, 1905-1907; Report on the Mental Hospitals of the Dominion, 1908-1911.

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- |         |                             |
|---------|-----------------------------|
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|         |                             |
| A475/2  | Register of Patients        |
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Series 2 Superintendent - General Inwards Letters 1866-177

- |           |  |
|-----------|--|
| 1872/2369 | Dietary Scale, lunatic asylum.   |
| 1872/2570 | Assault on lunatic patient, Williams, by attendant, Robertson.   |
| 1872/4079 | Elizabeth Harney to be appointed attendant Lunatic Asylum, Whau.   |
| 1872/4099 | Nelson to Auckland. Any room for Lunatics.   |
| 1872/4305 | Lunatic Asylum Whau. Job Humphries as attendant in place of W. Williams.   |
| 1872/4378 | Lunatic Asylum, Whau. Clarke resigned. Thomas Ussher appointed attendant.  |
| 1873/391  | Annual Report of the Provincial Lunatic Asylum.  |
| 1873/1395 | Resident Surgeon - Lunatic Asylum ref. to memo of Gaoler as to clothing for asylum being manufactured by female prisoners. |
| 1873/1989 | Appointment of P. Molloy as Senior Attendant and Jas. Cooper, night watchman of the Provincial Asylum.                     |
| 1873/3297 | Annual Report and Departmental estimates for Provincial Lunatic Asylum, 1874.  |

- 1873/3593 Report on Inspection of Asylum.
- 1874/200 Report on complaint of quality of food supplied to staff and inmates at lunatic asylum.
- 1874/506 Requests terms on which a monomaniac from Taranaki should be received into Lunatic Asylum.
- 1874/568 Forwards letter from lunatic H.J. Hawkins.
- 1874/683 Annual Report by Inspector of Asylums 1870.
- 1874/1203 Resignation of Turton from position as Inspector of Asylums and appointment of H.D. Morpeth in his place.
- 1874/1786 Staff of officials employed in Institution.
- 1874/2399 Mrs A. Monahan recommended as night nurse at lunatic asylum.
- 1874/2583 For removal of Maria Curtis from St Mary's Industrial School into a Government Asylum. That Maria Curtis may be admitted into the Public Hospital or the Old Women's Institute as a domestic servant.
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- 1876/37 Female Staff - Whau Lunatic Asylum. Correspondence with Resident Surgeon re appointments.
- 1876/76 Res Surgeon forwards letter from Mr Fox, Manager of an amateur entertainment group, offering to perform for inmates of Asylum. Approved.
- 1876/193 Res Surgeon, Lunatic Asylum, Whau, has accepted the invitation of Hobson band of Minstrels to give an entertainment at the Asylum.
- 1876/535 Correspondence with Daniel Lowry and Resident Surgeon re appointment of Lowry.
- 1876/712 Correspondence with Inspector & Prov

- Surgeon, re submission & publication of annual report.
- 1876/826 Correspondence with Inspector A.C. & J. Bidwell, Auckland, re Harriet Billies admitted to the Lunatic Asylum and shortly after discharged.
- 1876/1187 Correspondence concerning an inquiry into the conduct of Dr Aickin, Mrs Lawrence (Acting Matron) and other officers of the Lunatic Asylum. Report and recommendation of the Committee of Inquiry.
- 1876/1188 Resident Surgeon, Provincial Lunatic Asylum. Acknowledges receipt of a copy of Rules and Regulations in respect of the Matron and Female Attendants in the Asylum.
- 1876/1349 Asks for approval of offer of some of residents of Mt Albert and Whau to give an entertainment to the inmates of the asylum.
- 1876/2093 Correspondence re appointment of J. King, a convalescent patient, as gardiner.
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