

Respectability, Religion and Psychiatry in New Zealand

A Case Study of Ashburn Hall, Dunedin, 1882-1910

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Abstract

This thesis uses the patient case records from the private asylum Ashburn Hall in Dunedin, New Zealand, between 1882 and 1910 to unpick how and what the three medical superintendents of the asylum during this time thought about the patients they treated, the intellectual and cultural influences at play in forming these judgements, and the complexity of the role of Christianity within the asylum. These three medical superintendents were Edward William Alexander, medical superintendent from 1882 to 1897; Frank Hay, medical superintendent from 1897 to 1904; and Edward Henry Alexander, medical superintendent from 1904 to 1911. This thesis employs a qualitative approach to the doctors' writings about patients. These writings reveal a range of intellectual influences which can be traced back to their education and employment histories. A range of cultural influences are also present in their judgements about and treatment of patients. Throughout this thesis, the concept of 'bourgeois respectability' is used as a tool to gain insight into the three doctors' judgements of and discourse about their patients. Bourgeois respectability denotes the general system of values and norms which guided the middle-class members of colonial New Zealand's population. These norms played an important part in the definitions of sane and insane behaviour in the doctors' writings.

Bourgeois respectability also informed doctors' discourse and judgements about their patients' religious expressions and beliefs. The second main focus of this thesis is on religion within Ashburn Hall. Religion in the asylum has been under-examined by historians. In Ashburn Hall it was cast by the doctors as both pathological, in the case of patients with religious delusions, and as potentially therapeutic in some cases. Doctors' roles took on some aspects of clerical ones, but to characterise doctors as priests obscures the importance and complexity of the roles religion had to play within the asylum. The archives of Ashburn Hall provide a window through which to view the operation of trends in medicine and the operation of social and cultural values on medical judgement in colonial New Zealand.

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Introduction

The nineteenth century witnessed the expansion of English and Scottish methods of treatment of the insane throughout the British Empire. In New Zealand, a Crown colony from 1840, the second half of the century saw the foundation of public lunatic asylums at population centres throughout the colony, as well as the establishment of one private asylum in 1882. This thesis examines that private asylum, Ashburn Hall, located on Three Mile Hill near Dunedin. It uses the asylum archive to investigate the intellectual and cultural influences on the practices of the asylum's first three medical superintendents between 1882 and 1910. In particular, it focuses on the operation of standards of bourgeois respectability in forming doctors' judgements about patient behaviour, and on the role of religion within the asylum.¹ The three doctors whose practices are examined in this thesis are: Edward William Alexander, who was one of the founders of Ashburn Hall and its medical officer from October 1882, when it opened, until March 1897; Frank Hay, medical superintendent from March 1897 until April 1904; and Edward Henry Alexander, the son of Edward William, who was medical superintendent from June 1904 until 1911. Between the asylum's opening in October 1882 and the end of 1910, these three doctors treated more than 400 patients.²

This thesis argues firstly that the doctors were influenced significantly by their educational and employment backgrounds in Britain and Europe; by the continuing flow of medical ideas through intellectual networks; and by standards of respectability. Secondly, it argues that religion within the asylum deserves closer scrutiny from historians as it played a complex role. Although medical expansion over care of the insane sometimes intruded into clerical territory by the late nineteenth century and doctors cast some patient religious expression as pathological, religion still played important roles in patients' lives and in doctors' judgements about their patients. Piety was part of the bourgeois norm against which the doctors measured patients and the recurrence of religious ideas in patient case notes hints at the continuing importance of religion in New Zealand society in the period under study.

¹ The concept of 'bourgeois respectability' used in this thesis will be discussed further below and draws on George Mosse's scholarship on nationalism and sexuality in Germany and England, and Ann Goldberg's work on the lunatic asylum, religion and sexuality. See George Mosse, *Nationalism and Sexuality: Respectability and Abnormal Sexuality in Modern Europe* (New York: H. Fertig, 1985); Ann Goldberg, *Sex, Religion, and the Making of Modern Madness: The Eberbach Asylum and German Society 1815-1849* (New York: Oxford University Press, 1999).

² 436 official admissions took place between 1882 and the end of 1910. At least 40 of these were second admissions of the same patient. There were also a number of patients admitted as 'voluntary boarders' who were not assigned an admission number. Not all of these unofficial patients had information recorded in the 'Register of Admissions' so it is difficult to arrive at a conclusive total number of patients actually admitted and treated. Excluding second and subsequent admissions of patients, around 410 patients in total were treated at Ashburn Hall during the period of this study.

This introduction provides a brief survey of the historiography relating to the social history of insanity, with a particular focus on New Zealand and Australian asylums, Ashburn Hall, and the subject of religion in relation to insanity. The final section reflects on the sources and method used in writing this thesis then outlines the key aspects of the chapters to follow.

Accommodating Madness in Australia and New Zealand

Asylum Histories and Historiography

Scholarship about the history of insanity, the asylum and psychiatry has over the last few decades focused on an increasingly diverse range of themes and actors. The growth of the anti-psychiatry movement and the translation into English in the 1960s of Michel Foucault's groundbreaking work *Madness and Civilisation* was followed in the 1970s and 1980s by a number of histories revising the traditional assessment of the history of the lunatic asylum. These revisionist historians postulated extensive 'social control' measures and 'professional imperialism' on the part of the medical profession. The asylum, rather than being a humanitarian enterprise, was a way for the elite to control the poorer classes of society. 'Professional imperialism' involved the expansion into and creation of a monopoly by doctors over the care of the insane. These views challenged and sought to replace more traditional histories of the rise of asylum care as part of the triumphant progress of science and humanitarianism.³

Subsequently, a newer generation of historians, particularly those with an interest in the social and cultural history of insanity, have demonstrated that the roles of the asylum and psychiatry were more complex than mere progress or social control. As noted medical historian Roy Porter argues:

[The asylum] was many things all at once. And far from being a weapon securely under the control of the profession or the state, it was

³ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, first published in French in 1961, trans. Richard Howard (London: Routledge, 2007). One significant revisionist history arguing that the rise of the asylum represented invasive social control measures and the professional imperialism of medical men is Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979); see also Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993). The debate between the traditional 'progressivist' view of asylum history and the revisionist (or 'social control') view has been addressed by a number of historians. See, for example, Joseph Melling, 'Accommodating Madness: New Research in the Social History of Insanity and Institutions', in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 1-5; Roy Porter, 'Introduction', in *The Confinement of the Insane: International Perspectives, 1800-1965*, ed. Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), 1-5.

a contested site, subject to continual negotiation amongst different parties, including families and the patients themselves.⁴

These newer historical accounts emphasise the roles of families as consumers, and give weight to ‘bottom up’ histories of use and resistance as well as ‘top down’ histories emphasising domination.⁵

In New Zealand and Australia, historians of the asylum have explored a wide range of themes in the history of insanity and the asylum. These range from lunacy policy and institutional histories,⁶ through the social construction of patients, the processes of committal, the gendered and racial compositions and experiences of patients,⁷ to the uses of the asylum by families as consumers, and even the sounds of the asylum and patient entertainments.⁸

Insanity and committal in colonial Australia and New Zealand was intimately tied to criminality, at least in relation to the colonies’ public asylums. According to Catharine Coleborne colonial policing practices of ‘sex’ and ‘race’ were central to the definition of lunatics. Police in colonial Victoria were given the power of interpreting behaviour, thus playing a role in the medicalisation of madness.⁹ Bronwyn Labrum highlights the criminal and legalistic flavour of the response to insanity in New Zealand, stating that ‘control,

⁴ Porter, *Ibid.*, 4-5, quote at 4.

⁵ Examples include Mark Finnane, ‘Asylums, Families and the State’, *History Workshop*, no. 20 (1985): 134-48; David Wright, ‘Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century’, *Social History of Medicine* 10, no. 1 (1997): 137-55; Patricia E. Prestwich, ‘Family Strategies and Medical Power: “Voluntary” Committal in a Parisian Asylum, 1876-1914’, in Porter and Wright, *The Confinement of the Insane*, 79-99.

⁶ Examples include Warwick Brunton, ‘Out of the Shadows: Some Historical Underpinnings of Mental Health Policy’, in *Past Judgement: Social Policy in New Zealand History*, ed. Bronwyn Dalley and Margaret Tennant (Dunedin, N.Z.: University of Otago Press, 2004), 75-90; Wendy Hunter Williams, *Out of Mind, out of Sight: The Story of Porirua Hospital* (Porirua N.Z.: The Hospital, 1987).

⁷ See, for example, Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940* (Kensington, NSW, Australia: New South Wales University Press, 1988); Catharine Coleborne, ‘Passage to the Asylum: The Role of the Police in Committals of the Insane in Victoria, Australia, 1848-1900’, in Porter and Wright, *The Confinement of the Insane*, 129-148; Barbara Brookes, ‘Women and Madness: A Case-Study of Seacliff Asylum, 1890-1920’, in *Women in History* 2, ed. Barbara Brookes, Charlotte Macdonald and Margaret Tennant (Wellington, N.Z.: Bridget Williams Books, 1992), 129-47; Bronwyn Labrum, ‘Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum, 1870-1910’, M.A. Thesis, Massey University, 1990; Lorelle Burke, ‘“The Voices Caused Him to Become Porangi”: Maori Patients in the Auckland Lunatic Asylum, 1860-1900’, M.A. Thesis, University of Waikato, 2006.

⁸ See, for example, Emma Spooner, ‘Digging for the Families of the “Mad”: Locating the Family in the Auckland Asylum Archives’, MA Thesis, University of Waikato, 2006; Catharine Coleborne, ‘Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, 1880s-1910’, *Social History of Medicine* 19, no. 3 (2006): 425-42; Dolly MacKinnon, ‘“Hearing Madness”: The Soundscape of the Asylum’, in *Madness in Australia: Histories, Heritage and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia, Queensland, Australia: University of Queensland Press/API Network, 2003), 73-82; Dolly MacKinnon, ‘“Amusements are provided”: Asylum Entertainment and Recreation in Australia and New Zealand c.1860-c1945’, in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, ed. Graham Mooney and Jonathan Reinartz (Amsterdam, New York: Editions Rodopi, 2009), 267-88.

⁹ Coleborne, ‘Passage to the Asylum’, 129, 133-35.

discipline, efficiency and order were regarded with particular importance in the period that asylums were established in New Zealand'.¹⁰

Ashburn Hall, as a private asylum, does not fit within these trends, although occasionally patients were brought in by police.¹¹ Indeed, the need to attract a paying clientele led to the managers of Ashburn distancing the asylum carefully from association with criminality. They provided for a 'better class' of patient. As early as 1864, E.W. Alexander, in his role as part of a committee to investigate and report on the conditions of the Dunedin Hospital and Lunatic Asylum, saw the need for better provision for those who could afford to pay, stating that, 'To mix indeterminately, men or women holding good positions, with the insane poor, would be revolting to the feelings of friends, and detrimental to the recovery of the former class.'¹² Later in the century, E.W. Alexander and James Hume, who had been the lay-keeper at the public Dunedin Lunatic Asylum until 1882, were able to exploit associations of insanity with criminality and the lower classes and establish the private asylum. Patients' families were willing to pay to have them taken care of in a more 'suitable' environment for their station in life.¹³ Ashburn Hall was the only private asylum or 'licensed house' which operated in nineteenth- and early twentieth-century New Zealand.¹⁴

The existence of only one private institution in New Zealand is in direct contrast with the prevalence of private asylums in Britain, particularly before the mid-nineteenth century.¹⁵ Ashburn Hall was unique in New Zealand. Its private nature led to its exception from some

¹⁰ Labrum, 'Gender and Lunacy', 18-19; quote at 19.

¹¹ John P, admitted in January 1885, for example, spent the night before his committal to Ashburn in a police cell. See Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 1,' 69, (AG-447-6/04), HC.

¹² E.W. Alexander, 'Observations on Hospitals and Lunatic Asylums with Reference to the Dunedin Hospital and Lunatic Asylum', in 'Report of the Commission of Enquiry into the Constitution and Management of the Dunedin Hospital and Lunatic Asylum', *Appendix to Votes and Proceedings of the Provincial Council – Session XVIII, 1864* (Otago Provincial Council, 1864), 47.

¹³ The advertised fees of Ashburn Hall were £2/2 per week for ordinary cases, or £3/3 per week for cases requiring special care and for inebriates. Private sitting rooms and special attendants cost more again. See Alan Somerville, 'Ashburn Hall and Its Place in Society, 1882-1904', MA Thesis, University of Otago, 1996, 38.

¹⁴ It still exists today as a psychiatric facility named Ashburn Clinic.

¹⁵ In England, provision for the insane prior to the mid-nineteenth century was a mixed economy of charitable asylums and private institutions. The famous York Retreat was a combination of both types of administration, providing care at cheaper rates for Quaker patients as well as providing for wealthy private patients. See Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge; New York: Cambridge University Press, 1985). One of the most famous of England's private asylums, the Ticehurst Asylum, is the focus of Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London; New York: Routledge, 1992). In Scotland in the nineteenth century, public subscription asylums formed the basis of institutional care. These charitable institutions catered for both pauper and paying patients, although later in the century the asylums at Perth and Glasgow expelled their pauper patients in favour of catering for private patients only. See Jonathan Andrews, 'Raising the Tone of Asylumdom: Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century', in Melling and Forsythe, *Insanity, Institutions and Society*, 200-22.

trends in the history of New Zealand public asylums. It avoided overcrowding, and was able to be selective about who was admitted. The asylum's history is in some ways, however, representative of the history of New Zealand psychiatry more generally. It was still governed by the *Lunatics Act 1882*, the managers reapplying for a licence each year to allow them to legally have the charge of patients. The Inspector-General of Lunatic Asylums visited Ashburn, as he did the public asylums, and reported on the standard of treatment and any developments in the running of the asylum. The main method of treatment used at Ashburn, moral treatment, was that common to New Zealand's public asylums, and its doctors, like most of the doctors running the public institutions, were British trained. A case study of Ashburn Hall provides an opportunity to expand on a number of aspects of medical thought and its interaction with bourgeois culture and religion in the treatment of insanity in New Zealand.

There are several histories focusing on Ashburn Hall, mostly undertaken by graduate students. Cameron Duder's book, written to coincide with Ashburn's 125th anniversary in 2007, is one exception, although the focus of this work is largely on the mid-to-late twentieth century.¹⁶ Judith Medlicott's MA thesis provides a narrative of the running of Ashburn Hall from 1882 to 1947.¹⁷ Caroline Hubbard's 1977 dissertation compares patients admitted to Ashburn Hall and the public Seacliff Asylum between 1882 and 1911. She uses the 'Register of Admissions' for each asylum to compare patient characteristics such as age, occupation, and marital status.¹⁸ A social history of the asylum is offered in Alan Somerville's MA thesis. Somerville's focuses include the place of Ashburn Hall in society and the representations of its managers to attract clients; the social context of committal, and the relationship between the Ashburn Hall managers, families and patients; and the treatment regime in Ashburn Hall. Unlike the earlier theses, Somerville uses patient case files to uncover aspects of the experience of being committed to and treated in Ashburn Hall.¹⁹

Somerville's focus is largely on the social context of committal and the presentation of the private asylum by its managers. He does discuss, however, the widespread medical

¹⁶ Cameron Duder, *The Ashburn Clinic: The Place and the People* (Dunedin, N.Z.: Ashburn Clinic, 2007).

¹⁷ Judith Clare Medlicott, 'The History of Ashburn Hall, 1882-1947', M.A. Thesis, University of Otago, 1972.

¹⁸ Caroline Hubbard, 'Lunatic Asylums in Otago 1882-1911', BA (Hons) dissertation, University of Otago, 1977.

¹⁹ Somerville. All three theses have sections included as chapters in *Unfortunate Folk: Essays on Mental Health Treatment 1863-1992*, ed. Barbara Brookes and Jane Thomson (Dunedin, N.Z.: University of Otago Press, 2001).

acceptance of a somatic basis for insanity in Britain and New Zealand and an increasing preoccupation with heredity in the late nineteenth century. He does not offer any explanations for how these ideas were transplanted, merely stating that New Zealand ‘shared these ideas’.²⁰ There is an underlying assumption that the influence of British psychiatry was inevitable. Somerville also provides no exploration of developments in psychiatry outside Britain and how these may have influenced the doctors’ practices at Ashburn Hall, despite E.W. Alexander having travelled widely and undertaken postgraduate study in Europe.

How British, European or American medical thought actually reached New Zealand asylum practice is a significant research gap, on which a closer study of Ashburn Hall can shed some light. Catharine Coleborne and Dolly MacKinnon point out that historians agree that practices in New Zealand and Australian psychiatric treatment developed based largely on British principles and that this was part of a wider set of developments in the western or Anglo-American world.²¹ But few address how this actually happened in specific asylum contexts, or acknowledge that ‘British’ influences were not a homogeneous whole. Scottish psychiatry and methods of institutionalisation, for example, were not the same as English. Warwick Brunton provides a slight exception, highlighting that New Zealand’s lunacy policy owed much to English precedent in particular.²² His observations refer mostly to policy decisions, such as the statutory foundations and organisational framework of mental health care in asylums, rather than to specific intellectual advancement in methods of treatment or diagnosis.²³

Brunton’s discussion of the United Kingdom hints at some ways in which ideas and medical scholarship reached New Zealand. He mentions the continued influence of the United Kingdom through ‘professional journals, organised recruitment of specialist medical and nursing staff, and study tours’.²⁴ Official discourse was another vehicle through which ideas were transplanted to the colonies. Lee-Ann Monk, as part of her study of attendants in

²⁰ Ibid., 160-164, quote at 161.

²¹ Catharine Coleborne and Dolly MacKinnon, ‘Psychiatry and Its Institutions in Australia and New Zealand: An Overview’, *International Review of Psychiatry*, 18, no. 4 (August 2006): 371. The authors cite K. C. Kirkby, ‘History of Psychiatry in Australia, pre-1960’, *History of Psychiatry* 10, no. 2 (1999): 191–204; Brunton, ‘Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand’, in *Psychiatry and the Law: Clinical and Legal Issues*, ed. W. Brookbanks (Wellington, N.Z.: Brookers, 1996), 3-58; and Garton, *Medicine and Madness*.

²² Brunton, ‘Out of the Shadows’, 76. See also Warwick Brunton, ‘The Place of Public Inquiries in Shaping New Zealand’s Mental Health Policy, 1858-1996’, *Australia and New Zealand Health Policy* 2, no. 1 (2005): 24, <<http://www.anzhealthpolicy.com/content/2/1/24>>, accessed 8 December 2010.

²³ Brunton, ‘Out of the Shadows’, 77.

²⁴ Ibid., 76.

colonial asylums in Victoria, Australia, discusses the influential scholarship of the English psychiatrist and advocate for non-restraint of asylum patients, John Conolly. For reformers who wished to introduce non-restraint at Yarra Bend, Conolly's writings formed the basis for an archetypal attendant who could care for, watch over, amuse and provide a moral example for lunatics without resorting to mechanical restraint. Indeed, the colony's representative turned to Conolly for advice in selecting a new medical superintendent for Yarra Bend in 1862.²⁵

In New Zealand, the Inspector-General of Lunatic Asylums, a government official, appointed public asylum superintendents. Official discourse, therefore, had some influence on practices at New Zealand's public asylums as it did at Yarra Bend. This would have been the case at Ashburn Hall as well. The managers of the asylum sought to maintain a high reputation in order to attract clientele. They were also subject to official inspections by the Inspector-General.²⁶ The attendant staff, however, were selected by the medical superintendent, who was appointed by the proprietors of the asylum. Official discourse would have been less directly influential than at public asylums where the medical superintendents were selected by government representatives. The medical superintendents at Ashburn Hall were often the impetus behind changes in methods or treatment or diagnosis. The second medical superintendent of Ashburn Hall, Frank Hay, for example, increased the level of detail recorded about patients and introduced the first pro forma case book to Ashburn Hall in 1900.²⁷

There were other routes through which changes in the practise of asylum medicine reached colonial New Zealand. Barbara Brookes, in the historical introduction to a book on women and mental health, states that theories about women's limited nervous energy and constitutional fragility were brought to New Zealand in the latter half of the nineteenth century by European doctors.²⁸ While Brookes' point is made more as a contrast between settlers' ideas and pre-existing Maori ways of thinking about the world and insanity, it does suggest one avenue through which medical ideas could flow between colony and metropole: through the migration of metropolitan-trained physicians.

²⁵ Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam; New York: Editions Rodopi, 2008), 83-87.

²⁶ Somerville, 22-23.

²⁷ These developments will be discussed further in chapter one.

²⁸ Barbara Brookes, 'Women and Mental Health: A Historical Introduction', in *Folding Back the Shadows: A Perspective on Women's Mental Health*, ed. Sarah E. Romans (Dunedin, N.Z.: University of Otago Press, 1998), 15.

As Brookes' work indicates, the migration and educational histories of doctors involved in the running of any one of New Zealand's lunatic asylums will have had an impact on that institution's operation. The use of doctors' biographies to demonstrate developments in the history of psychiatry has been undertaken effectively in Britain by historians such as Andrew Scull, Charlotte MacKenzie and Nicholas Hervey in *Masters of Bedlam* and Michael MacDonald in *Mystical Bedlam*.²⁹ A biographical approach to Ashburn Hall's doctors forms part of the methodology of this thesis as it attempts to unravel the various intellectual and cultural influences at play in the diagnosis and treatment of patients at Ashburn Hall.

In New Zealand, biographical studies of Frederic Truby King, who was superintendent of the public Seacliff Asylum near Dunedin from 1889 to 1921, show that Scottish psychiatry was influential on his practice, while his famous views on infant welfare stemmed from theories on the prevention of insanity.³⁰ King trained in Edinburgh and took a course of lectures on the treatment of insanity given by Thomas Clouston, the Superintendent of the Royal Edinburgh Asylum at Morningside and Lecturer in Insanity at the Edinburgh medical school.³¹ King's practice at Seacliff was influenced by Clouston's somatic-pathological approach to the treatment of insanity and his rejection of 'psychological' approaches to mental disorder.³² Studies of asylum doctors can, therefore, demonstrate some ways in which metropolitan medical thought was transplanted and translated into the New Zealand context.

In an article examining the migrant patient population at the Auckland Asylum in the first decade of the twentieth century, Angela McCarthy points to the probability that doctors' migration experience and ethnic backgrounds as well as their British training were relevant in shaping their medical judgements about patients.³³ Doctors' perceptions of patients were

²⁹ Andrew Scull, Charlotte MacKenzie, and Nicholas Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, N.J.: Princeton University Press, 1996); Michael MacDonald, *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England* (Cambridge: Cambridge University Press, 1981), in particular chapter two which focuses on Richard Napier.

³⁰ Barbara Brookes, 'Frederic Truby King and the Seacliff Asylum', in *New Perspectives on the History of Medicine: First National Conference of the Australian Society of the History of Medicine, 1989*, ed. Harold Attwood, Richard Gillespie and Milton Lewis (Melbourne: University of Melbourne 1990), 5-12; Cheryl Caldwell, 'Truby King and Seacliff, 1889-1907', in Brookes and Thomson, *Unfortunate Folk*, 35-48; Matthew Philp, 'Scientific Pastors: The Professionalisation of Psychiatry in New Zealand 1877-1920', in Brookes and Thomson, *Unfortunate Folk*, 185-99. For a general overview of King's life and career, see Barbara Brookes, 'King, Frederic Truby 1858 – 1938', *Dictionary of New Zealand Biography. Te Ara – the Encyclopaedia of New Zealand*, updated 1 September 2010, <http://www.teara.govt.nz/en/biographies/2k8/1>, accessed 6 December 2010.

³¹ Clouston held the post of Lecturer in Insanity at the University of Edinburgh Medical School from 1879 to 1910.

³² Brookes, 'Frederic Truby King and the Seacliff Asylum', 6-10.

³³ Angela McCarthy, 'Ethnicity, Migration, and the Lunatic Asylum in Early Twentieth-Century Auckland', *Social History of Medicine* 21, no. 1 (2008): 47-65, at 48.

formed not only through the explicitly medical content of their education, and how and where they received it, but also through their ethnic identities and the cultural differences between themselves and their patients. Gender, class and religious biases also came into play.

Several historians emphasise gender, in particular, as important in the diagnosis and treatment of insanity.³⁴ The primary segregation of patients within the asylum was through gender, and many of the judgements made about patient diagnosis and recovery were gendered. In Ashburn Hall ideals of bourgeois femininity influenced doctors' attitudes towards patients. As Bronwyn Labrum highlights in relation to the Auckland Lunatic Asylum, women's reproductive cycle was linked to mental pathology in mainstream medical thought. Diagnoses such as puerperal and lactational insanity tied reproductive function to mental pathology. Doctors also saw the onset of menstruation and menopause as times when women's mental health was at risk.³⁵ Men's insanity was not linked to their biology, but they were also judged against masculine norms. In terms of treatment, too, the occupational therapy provided as part of the moral treatment regime of the asylum was divided into gendered types of work. Women undertook 'household duties' such as sewing, while men laboured outdoors.³⁶

Perceptions of 'race' as well as gender in colonial asylums were influenced by colonial standards of respectability. Chinese men committed in colonial Victoria, for example, were not 'feminised' but their bodies were marked differently from white male patients and their religion was often designated as 'pagan'.³⁷ In relation to the Auckland Asylum, Lorelle Burke considers that doctors' judgements about Maori and their enforcement of European norms on non-European peoples represented one branch of colonial expansion.³⁸ Doctors also defined patients of British and European background in terms of their race. McCarthy demonstrates that at Seacliff Asylum, doctors, influenced by developments in science and anthropology from the 1860s, commented on patients 'national characteristics', such as the case of a 'typical high spirited old Highlander' and 'A tall flaxen haired Swede with blue eyes'. English

³⁴ See for example Labrum, 'Gender and Lunacy'; Brookes, 'Women and Madness'; Catharine Coleborne, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848-1888* (Debut Book Series. Perth: Network Books, 2007).

³⁵ Labrum, 'Gender and Lunacy', 161-170.

³⁶ *Ibid.*, 219-223.

³⁷ Catharine Coleborne, 'Making "Mad" Populations in Settler Colonies: the Work of Law and Medicine in the Creation of the Colonial Asylum', in *Law, History, Colonialism: the Reach of Empire*, ed. Diane Kirkby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 116.

³⁸ Burke, 26-27.

and Australian-born migrants, however, were rarely discussed in this way.³⁹ In Ashburn Hall, by contrast, only patients of noticeably different ethnicities from the medical superintendents were defined in racial terms: Maori, Chinese and Jewish patients. Accepted medical thought and the doctors' own backgrounds, therefore, shaped their judgements of patients. The Assistant Medical Officer at the Auckland Asylum in the early twentieth century, Alexander McKelvey, for example, was a northern Irish Protestant. This may have produced a bigoted assessment of Irish Catholic patients. Alternatively, McCarthy suggests that McKelvey's background might have made him sensitive to the religious influences shaping the asylum population.⁴⁰

The role of religion in the nineteenth-century asylum forms a major part of the investigation of this thesis and has seldom been addressed by historians either in the New Zealand context, or overseas. Religion in nineteenth and early twentieth-century New Zealand society maintained wide social significance, with roles in major social campaigns, such as the temperance and women's suffrage movements.⁴¹ In recent years historians have focused on various aspects of the roles of religion in New Zealand society.⁴² Where historians of the asylum in New Zealand have addressed religion, however, it is generally a passing reference in a wider study. Warwick Brunton, in a paper addressing the genesis of New Zealand's lunatic asylums, briefly highlights the spiritual aspect of moral treatment. While the Auckland Asylum was the only institution with its own chapel, services were also read at and clergymen visited the other public asylums in New Zealand.⁴³

Angela McCarthy examines the religious affiliation of migrants in the Auckland Lunatic Asylum in the early twentieth century as part of her focus on migration and committal, finding that only about half of all Catholic patients were Irish, demonstrating the dangers of

³⁹ Angela McCarthy, 'A Difficult Voyage', *History Scotland* 10, no. 4 (July/August 2010), 30.

⁴⁰ McCarthy, 'Ethnicity, Migration, and the Lunatic Asylum', 59.

⁴¹ John Stenhouse, 'God's Own Silence: Secular Nationalism, Christianity and the Writing of New Zealand History', *New Zealand Journal of History* 38, no. 1 (2004): 52-71 at 57.

⁴² See for example, Rex Ahdar and John Stenhouse eds., *God and Government: The New Zealand Experience* (Dunedin, N.Z.: University of Otago Press, 2000); John Stenhouse and Jane Thomson, eds., *Building God's Own Country: Historical Essays on Religions in New Zealand* (Dunedin, N.Z.: University of Otago Press, 2004); John Stenhouse and G. A. Wood, *Christianity, Modernity and Culture: New Perspectives on New Zealand History* (Adelaide: ATF Press Australian Theological Forum, 2005); John Stenhouse, 'Christianity, Gender, and the Working Class in Southern Dunedin, 1880-1940', *Journal of Religious History* 30, no. 1 (2006): 18-44.

⁴³ Warwick Brunton, 'The New Zealand Lunatic 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, N.Z.: Waikato Postgraduate Medical Society, Waikato Hospital, 1987), 162.

equating Irishness with Catholicism.⁴⁴ Both Catholic and Protestant patients claimed to have suffered religious persecution. Patient claims of discrimination based on religion, although attributed by the doctors to delusions, might, according to McCarthy, be ‘suggestive of a subterranean sectarianism suffusing settler society’.⁴⁵

The historiographical lacuna with regard to religion and the asylum is in part due to a conception amongst historians of medicine and the asylum that doctors were taking over from the clergy as guardians of normality and morality. New definitions of mental disease incorporated behaviours which had previously been construed as sinful. Suicide, alcoholism and homosexuality had all made the transition from sin to sickness by the early twentieth century.⁴⁶ Charles Rosenberg, referring to American medicine prior to 1900, highlights a growing secularism which paralleled and lent plausibility to the framing of moral matters in medical terms; there was a growing attitude that ‘science not theology should be the arbiter of such questions’.⁴⁷

Additionally, asylum doctors in the late nineteenth century extended their influence beyond institutional confines in the name of the prevention of insanity. In England and Scotland famous asylum doctors such as Henry Maudsley, Daniel Hack Tuke and Thomas Clouston focused their attention on preventing ‘bad habits’ like ‘morbid introspection’, which might contribute to insanity.⁴⁸ In New Zealand too, asylum doctors such as Truby King and Frank Hay extended their influence into diverse areas such as mothercraft and modern art in the name of preventing insanity. Matthew Philp refers to these doctors as ‘scientific pastors’.⁴⁹

Mark Finnane, explaining the role of the asylum as the arbiter of social and familial conflict, extends the ‘well-known metaphor which characterises the modern doctor as the high-priest’ to depict the asylum as a church. According to Finnane, ‘it institutionalised its

⁴⁴ McCarthy, ‘Ethnicity, Migration, and the Lunatic Asylum’, 52-3.

⁴⁵ *Ibid.*, 58.

⁴⁶ See Michael MacDonald, ‘The Medicalization of Suicide in England: Laymen, Physicians and Cultural Change, 1500-1870’, in *Framing Disease: Studies in Cultural History*, ed. Charles E. Rosenberg and Janet Golden (New Brunswick, New Jersey: Rutgers University Press, 1992), 85-103; Bert Hansen, ‘American Physicians “Discovery” of Homosexuals, 1880-1900: A New Diagnosis in a Changing Society’, in Rosenberg and Golden, *Framing Disease*, 104-133; W. F. Bynum, ‘Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry’, *British Journal of Addiction* 79, no. 1 (1984): 59-70.

⁴⁷ Charles Rosenberg, ‘Disease and Social Order in America: Perceptions and Expectations’, *Milbank Quarterly* 64, Suppl 1 (1986): 44-5, quote at 45.

⁴⁸ Michael Clark, ‘“Morbid Introspection”, Unsoundness of Mind, and British Psychological Medicine, c.1830-c.1900,’ in *The Anatomy of Madness: Essays in the History of Psychiatry, III The Asylum and its Psychiatry*, ed. W. F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 1988), 71-101.

⁴⁹ Philp, ‘Scientific Pastors’, 198-9.

own secular moral order, it could be a sanctuary, it lived in constant relation to its environs'.⁵⁰ Such comparisons are useful to explain the importance of the asylum to patients and their families, or to demonstrate the extension of doctors' roles into the definition of normality and abnormality. This comparison, however, excludes recognition of the continuing role of clergy or Church in the care and treatment of lunacy, or of their importance in the lives of asylum patients.

Internationally, historians who have addressed religion and insanity, tend to focus on 'religious madness' or similar diagnoses; they examine the pathological side of religion rather than any potential therapeutic role of religious belief. Ronald and Janet Numbers, for example, address the history of 'religious madness' as a diagnosis, with a particular focus on the millenarian movement in 1830s and 1840s America.⁵¹ Definitions of religious madness were linked to bourgeois cultural conceptions of gender and self-hood as Ann Goldberg explores in her study of the Eberbach Asylum in Germany in the early-to-mid nineteenth century.⁵² Religious madness was symbolically gendered as feminine in scientific discourse and was tied to a lack of self-mastery or healthy expression of 'natural drives'. The bourgeois ideal of self was rational, autonomous, responsible and male.⁵³ 'Religious insanity' was a diagnosis applied by educated, male, bourgeois physicians to a primarily rural lower class. As such it redefined some forms of popular religious experience as pathological.⁵⁴

Goldberg finds that 'religious madness' as a diagnosis reached a peak in the first half of the nineteenth century in the Western world. It was discussed at length in professional medical literature and registered in asylum statistics across Europe and North America.⁵⁵ Numbers and Numbers also identify a decline in the incidence of 'religious insanity' by the late nineteenth century. After the death of Thomas Story Kirkbride of the Pennsylvania Hospital for the Insane in 1883, religion disappeared from the lists of supposed causes of insanity for that asylum.⁵⁶ Such a decline was likely common throughout the Western world although the Ashburn Hall admissions register records a small number of admissions between

⁵⁰ Finnane, 135.

⁵¹ R. L. Numbers and J. S. Numbers, 'Religious Insanity; History of a Diagnosis', *Second Opinion* 3 (1986): 57-77, particularly at 62-71. See also R. L. Numbers and J. S. Numbers, 'Millerism and Madness. A Study of "Religious Insanity" in Nineteenth-Century America', *Bulletin of the Menninger Clinic* 49, no. 4 (1985): 289-320.

⁵² Ann Goldberg, *Sex, Religion, and the Making of Modern Madness: The Eberbach Asylum and German Society 1815-1849* (New York: Oxford University Press, 1999).

⁵³ *Ibid.*, 40-41.

⁵⁴ *Ibid.*, 36-37.

⁵⁵ *Ibid.*, 36.

⁵⁶ Numbers and Numbers, 'Religious Insanity', 73.

1882 and 1910 with the diagnosis or cause of insanity recorded as ‘religion’, ‘religious excitement’ or similar. Most historians who focus on ‘religious madness’ have studied the early-to-mid nineteenth century or earlier periods.⁵⁷ Numbers and Numbers’ main focus is in the mid-nineteenth century, although their overview of religious insanity begins in the early seventeenth century.⁵⁸ James Donat’s study of the Protestant revival in Northern Ireland in 1859 provides a slight exception as his focus is in the second half of the nineteenth century. Donat found that representations of the revivalist movement as hysteria or a ‘moral epidemic’ used medical language and contained inherent judgements about the correctness or otherwise of the religious practises involved. Medical men, however, were likely to be critical of theories positing hysteria as the cause of the conversion experiences.⁵⁹ Donat’s chapter does illustrate that some forms of insanity were still attributed to religion in the second half of the nineteenth century.

In contrast to these studies focusing on the early-to-mid nineteenth century, Oonagh Walsh addresses religion and insanity in the later nineteenth century.⁶⁰ Her focus is also wider than ‘religious insanity’. In her study of the Connaught District Lunatic Asylum in Ballinasloe, County Galway, Ireland, she explores some of the roles religion had to play within the asylum itself and how these related to wider social and political developments in Ireland. In particular, Walsh focuses on the 1893 struggle over permission to build a Catholic Church in the asylum grounds. A weekly Catholic Mass was allowed in the grounds, but permission to build a church was denied. This refusal reflected wider Protestant concerns about Catholic takeover of power and authority.⁶¹

Walsh’s discussion over the struggle to build a Catholic church at the Ballinasloe Asylum also hints at the ambivalence of the medical profession toward religion. Ministers argued that religion was crucial in assisting recovery, but doctors worried about the effect religious ritual could have for already distressed imaginations. On the other hand, a respectful participation in religious ritual could signal recovery, justifying immediate release from the

⁵⁷ See for example, Michael MacDonald, ‘Religion, Social Change, and Psychological Healing in England, 1600-1800’, in *The Church and Healing: Papers Read at the Twentieth Summer Meeting and the Twenty-First Winter Meeting of the Ecclesiastical History Society*, ed. W. J. Shiels (Oxford: Basil Blackwell, 1982), 101-25.

⁵⁸ Numbers and Numbers, ‘Religious Insanity’, 58.

⁵⁹ James G. Donat, ‘Medicine and Religion: On the Physical and Mental Disorders that Accompanied the Ulster Revival of 1859’, in Bynum, Porter and Shepherd, *The Anatomy of Madness*, 125-50.

⁶⁰ Oonagh Walsh, ‘“The Designs of Providence”: Race, Religion and Irish Insanity’, in Melling and Forsythe, *Insanity, Institutions and Society*, 223-42.

⁶¹ *Ibid.*, 228-9.

asylum.⁶² In terms of religious insanity, Walsh ties discourse about this to wider sectarian social and political concerns in Ireland. She states that, ‘In a country where religion had frequently been used as a means of establishing superiority, the question of whether Catholicism or Protestantism inclined followers more toward insanity had broad implications.’⁶³ Walsh’s study highlights some of the more general roles religion had to play within the asylum and the medical ambivalence toward it. Such issues have relevance for this study. The roles of religion within Ashburn Hall were complex, and the doctors’ attitudes towards religion ambivalent, influenced by secular scientific thought, but also wider culture and sectarianism, as they were in the Ballinasloe Asylum.

Sources and Chapter Outline

This thesis uses the patient case records from Ashburn Hall between 1882 and 1910 to unpick how and what the three medical superintendents thought about the patients they treated, the intellectual and cultural influences at play in forming these judgements, and the complexity of the role of Christianity within the asylum.⁶⁴ The period 1882 to 1910 coincides roughly with legislative developments and the tenure of Ashburn Hall’s medical superintendents. Ashburn Hall was licensed under the *Lunatics Act 1882*. A new Act came into effect in 1911. The final of the three medical superintendents studied here, E.H. Alexander, left Ashburn Hall in mid-1911. Stopping at the end of a year provided a tidy finishing point with regard to recorded patient data.

The chief archival materials used in this thesis are five volumes of patient case notes for Ashburn Hall and a ‘Register of Admissions’, which runs for the years 1882-1948. The early case notes record the admission or transfer date, age, gender and occupation of each patient in a ruled ledger book, and an admission note detailing what the medical superintendent considered worth recording about the case. Notes on the progress of the case follow. The last two case books, from 1900 to 1907 and 1908 to 1927, are pro forma books. Each contains a number of categories to be filled out about the patient’s family and personal history, as well as

⁶² Ibid., 229 citing W.A.F Browne, “What Asylums Were, Are, and Ought to Be” reproduced in *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* edited with an introduction by Andrew Scull (London: Routledge, 1991), 208-212.

⁶³ Ibid., 230-231, quote at 230.

⁶⁴ The case records are stored in the Hocken Collections at the University of Otago, Dunedin. Ashburn Hall, ‘Report Book - Intermediate Case Book, Vol 1’, (AG-447-6/04) HC; Ashburn Hall, ‘Report Book - Intermediate Case Book, Vol 3’, (AG-447-6/05) HC; Ashburn Hall, ‘Report Book - Intermediate Case Book, Vol 4’, (AG-447-6/06) HC; Ashburn Hall, ‘Case Book 1882-1907’, (AG-447-6/01) HC; Ashburn Hall, ‘Case Book 1908-1927’, (AG-447-6/02) HC. The volume containing the case files for the period from mid-1890 until late 1895 is unfortunately missing from this archive.

a ruled ledger for notes on the progress of the case. The Ashburn Hall case records are unfortunately incomplete, with a patient case book from mid 1890 until late 1895 missing from the archive. Some basic information about these patients can be found in the 'Register of Admissions', however, including diagnoses and supposed causes of insanity.⁶⁵ Patient privacy in this thesis is respected by referring to all patients by a first name and an initial only, to prevent their being identifiable.

Several historians of the asylum have deployed qualitative approaches to asylum records using post-structural readings of patient casebooks, showing 'patients' lives and experiences to be highly circumscribed and mediated through these texts'.⁶⁶ This thesis also takes a qualitative approach, focusing on the doctors' opinions of and their discourse about patients, interrogating the influences behind the doctors recorded comments about gendered behaviour, patient ethnicity, and particularly patient religion. It seeks to make the archive an object of critical historical study in the social history of psychiatry.⁶⁷ The notes the three doctors entered in the patient case books provide insight into their judgements, which were medically, morally, religiously and culturally informed. There are several drawbacks, however, to using this material to gain insight into the doctors' subjectivity. One discursive function of the archive was to comply with statutory record-keeping requirements, so at times the notes taken are sparse, merely recording that there was no change to report. Additionally, the doctors did not record information about medical scholarship or other intellectual influences on their practices. Influences on the doctors' practices only become apparent through reference to other sources. The Ashburn Hall archives are, therefore, supplemented by additional primary sources enabling further insight into the doctors' practices at Ashburn Hall, and their backgrounds. The main additional sources are the Inspector-General's yearly reports in the *Appendices to the Journal of the House of Representatives* (hereafter *AJHR*). These contain details of improvements and plans the doctors had for Ashburn Hall, which are not entered in the case books and give some insight into the degree of regard government medical officials had for Ashburn Hall, and for these doctors' practices and education.

⁶⁵ Ashburn Hall, 'Register of Admissions, 1882-1948,' (AG-447-5/01) HC.

⁶⁶ Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke, UK; New York: Palgrave Macmillan, 2010), 10. Coleborne cites as examples of this type of post-structural reading, Sally Swartz, 'Lost Lives: Gender, History and Mental Illness in the Cape, 1891-1910', *Feminism and Psychology* 9, no. 2 (1999): 152-8; and Coleborne, *Reading 'Madness'*.

⁶⁷ Recent critical scholarship, especially that focusing on the colonial past in India, Africa and elsewhere, has increasingly problematised the archive, highlighting its fragmentary nature, discursive purposes and how it has been read by historians. See for example Tony Ballantyne, 'Archives, Empires and Histories of Colonialism', *Archifacts: Journals of the Archives and Records Association of New Zealand* (April 2004): 21-36.

Although this thesis takes a largely qualitative approach to the archive, quantitative information about patient characteristics such as gender, diagnosis or cause of insanity is provided where relevant to add weight to conclusions reached from a qualitative analysis of the doctors' writings. These statistical summaries derive almost entirely from an analysis of all entries in the 'Register of Admissions' between 1882 and the end of 1910. The 'Register' contains basic information about every patient certified, including name, age, sex, marital status, occupation, previous abode, diagnosis, supposed cause of insanity and dates of admission and discharge. At times the information from the 'Register' is supplemented with information from the case books, as in the analysis of patient religious denomination contained in chapter three of this thesis and with information from the 'Register of Discharges, Removals and Deaths' regarding causes of patient death in the asylum.⁶⁸ The 'Register of Admissions' is unfortunately incomplete with regard to information about non-certified patients, called 'voluntary boarders'. All statistical information provided in this thesis is therefore approximate, rather than exact.

Throughout this thesis, the concept of 'bourgeois respectability' is used as a tool to gain insight into the three doctors' discourse about their patients. Bourgeois respectability denotes the general system of values and norms which guided the middle-class members of colonial New Zealand's population, those who made up Ashburn Hall's patient population. 'Respectability', according to George Mosse, indicates "decent and correct" manners and morals, as well as the proper attitude toward sexuality'.⁶⁹ Bourgeois respectability, in Mosse's analysis, evolved as a set of norms in the early nineteenth century in Europe and Britain in conjunction with the rise of nationalism. Part of the impetus behind the evolution of these norms, particularly those of sexual restraint, moderation and control over the passions, were the Protestant revivals in Germany and England in the eighteenth century. Outward behaviour became an expression of inward piety. Respectability served the European and British bourgeoisie, first in legitimising and defining themselves against the aristocracy and lower classes, then as a way in which to seek stability amid social change. Standards of respectability did not remain confined to the bourgeoisie, but spread throughout European society to govern behaviour of all classes. By the early nineteenth century, standards of respectability were entrenched that endured into the twentieth century.⁷⁰

⁶⁸ Ashburn Hall, 'Register of Discharges, Removals and Deaths, 1883-1968' (AG-447-5/02), HC.

⁶⁹ Mosse, 1.

⁷⁰ *Ibid.*, 1-9.

The bourgeois respectable norms of late nineteenth-century New Zealand were constructed through reference to British models. Adherence to British standards of behaviour in the colonies was seen by settlers as a route to social acceptability.⁷¹ The Ashburn Hall doctors were members of the colonial bourgeois elite and applied the assumptions and norms of their class to the behaviour patients they treated. As Ann Goldberg argues of pauper insanity in early nineteenth-century Germany, the management and administration of public asylums was stamped with the concerns, assumptions and values of the developing bourgeois culture.⁷² Bourgeois values informed doctors' discourse and judgements about their patients in terms of sexually inappropriate behaviour and religious belief.⁷³ Asylum doctors projected their own ideals of behaviour on to lower-class patients. Those committed to Ashburn Hall were paying patients, members of the colonial middle class. Bourgeois respectability would, therefore, have held even more sway in doctors' judgements, with patients expected to conform to the norms of what was, at least nominally, their own class. In the case notes of Ashburn Hall, differences from or conformity to 'normal' behaviour appear, which can be tied to notions of respectability. This is particularly true of gender norms, but also of ethnicity, and religious adherence, expression and observance. Bourgeois respectability is, therefore, a useful conceptual frame to aid interpretation of the doctors' records of their patients.

Chapter one of this thesis addresses the influences on the doctors which can be loosely grouped as 'intellectual'. The three doctors' education and employment histories before their tenures at Ashburn Hall formed the basis of their medical knowledge in the treatment of insanity. This knowledge, however, continued to evolve through experience in the asylum, engagement with international literature on the treatment of the insane and correspondence with other practitioners around the world. Their own changing knowledge can be shown in their efforts to keep Ashburn Hall abreast of new developments in the diagnosis and treatment of the insane, and in research into causes of insanity.

Doctors' medical educations were not the only influences on their practices. They were part of a colonial, middle-class elite and were influenced by bourgeois values in their judgements about normality and abnormality. Chapter two examines some of the cultural standards by which the Ashburn Hall doctors judged their patients. Patient symptoms were often explained with reference to those patients' differences from the treating doctor, who

⁷¹ Kirsten McKenzie, *Scandal in the Colonies: Sydney and Cape Town, 1820-1850* (Melbourne: Melbourne University Press, 2004), 12-3.

⁷² Goldberg, 11.

⁷³ *Ibid.*, 36-58, 86-9, 95, 102-7.

represented the rational, male bourgeois norm. Gender norms especially, but also ethnicity and religion, formed important aspects of the doctors' judgements about what constituted sane or insane behaviour.

Religion, in particular, has been under-examined in relation to the asylum. The final two chapters of this thesis deal with medical views of religion, patient religious experience and the various roles religion had to play within Ashburn Hall. Chapter three covers those patients whose religious beliefs and experiences were pathologised by the Ashburn doctors. A handful of patients were diagnosed with 'religious insanity' or had the cause of insanity attributed to religion in the admissions register. A larger group of patients, however, exhibited religious delusions, which were recorded in the case books. The doctors' notes about these patients show concern with the potential negative influences of religion on mental health, while the incidence of religious delusions themselves and of religious language is suggestive of the continuing importance of religion in New Zealand society.

Although the asylum doctors defined some expressions of religion as 'bad', medical attitudes toward Christianity were not wholly negative. Chapter four highlights the complexity of the roles religion had to play in the asylum. Proper and appropriate worship could signal recovery. It was part of the bourgeois standard of respectability by which the doctors measured 'normality', especially in women. The medical superintendents provided for patient attendance at religious services and occasionally turned to clergy for help with patients. At the same time, the redefinition of several traditional sins as mental diseases, and the expansion of asylum doctors into general life through their advocacy of 'mental hygiene' represented a partial intrusion of medicine into clerical territory. Religion in Ashburn Hall played a complex role, and medical attitudes towards it were likewise complex, influenced by medical scientific thought, bourgeois culture and the doctors' own religious beliefs. The doctors' attitudes and judgements about bourgeois normality and particularly their ambivalent attitudes toward religion in the asylum find echoes in wider international medical trends. The archives of Ashburn Hall provide a window through which to view the operation of trends in medicine and the operation of culture on medical judgement in colonial New Zealand.

Chapter One: The Models of ‘Home’? Asylum Medicine and the Doctors of Ashburn Hall

Historians have emphasised that New Zealand’s asylum system and the laws under which lunatics were committed, like those in other white settler colonies of the British Empire, followed largely from British precedents.¹ Warwick Brunton states that New Zealand’s system of institutional care followed English precedent, rather than the Scottish system of mixed institutional care and boarding-out suitable cases with private families, thus distinguishing the type of ‘British’ or ‘Home’ model New Zealand adopted.² Because New Zealand’s lunacy policy borrowed heavily from English precedent, it is easy to assume that the treatment regimes in New Zealand’s asylums were also based on English models. English medicine, however, was not the only influence on psychiatric practice in British colonies as this chapter argues. The medical scholarship of other countries such as France, Scotland or North America also influenced psychiatry in New Zealand. Using an examination of the three doctors in charge of Ashburn Hall between 1882 and 1910, this chapter investigates some of the intellectual influences behind the treatment regime there. These doctors were influenced by and remained engaged with international networks of medical thought. A closer study of influences on the doctors’ practices at Ashburn reveals a much more complex picture than a simple adoption of English practices. Medical ‘webs of empire’, like other intellectual networks, wove back and forth around the world.³

The first aim of this chapter is to address the general context of asylum medicine and organisation in New Zealand at the time Ashburn Hall was founded. A number of aspects of lunacy provision borrowed heavily from English precedent, such as the institutionalisation of all lunatics in asylums. Other factors, such as the regime of ‘moral treatment’ originated more

¹ See for example Warwick Brunton, ‘Out of the Shadows: Some Historical Underpinnings of Mental Health Policy’, in *Past Judgement: Social Policy in New Zealand History*, ed. Bronwyn Dalley and Margaret Tennant (Dunedin, N.Z.: University of Otago Press, 2004), 76; Catharine Coleborne and Dolly MacKinnon, ‘Psychiatry and Its Institutions in Australia and New Zealand: An Overview’, *International Review of Psychiatry* 18, no. 4 (2006): 371.

² Warwick Brunton, ‘The Place of Public Inquiries in Shaping New Zealand’s Mental Health Policy, 1858-1996’, *Australia and New Zealand Health Policy* 2, no. 1 (2005): 24, <<http://www.anzhealthpolicy.com/content/2/1/24>>, accessed 8 December 2010.

³ The oft cited term ‘webs of empire’ comes from Tony Ballantyne, *Orientalism and Race: Aryanism in the British Empire* (Houndmills, Basingstoke, Hampshire: Palgrave, 2002). Ballantyne considers the ‘web’ to be a more accurate metaphor for how knowledge was transmitted around the British Empire than the previously traditional spoked wheel metaphor which placed the metropole at the hub, with all knowledge flowing through it. The web accounts for knowledge travelling from colony to colony without being mediated through Britain.

or less simultaneously in England and several European countries.⁴ The remainder of the chapter focuses directly on Ashburn Hall and the three doctors in charge of it between 1882 and 1910. These three men are: Edward William Alexander, who was visiting medical officer until August 1896, then resident at Ashburn as medical superintendent until March 1897; Frank Hay, who was medical superintendent from 1897 until mid-1904; and finally Edward Henry Alexander, E. W. Alexander's son and medical superintendent from mid-1904 until 1911. Their education and employment histories prior to their appointment to Ashburn Hall and their continuing engagement with medical scholarship in Britain, Europe and America reveal a more nuanced picture of New Zealand psychiatry than a direct translation of English medicine into the colonial context.

A fourth man also had charge of Ashburn Hall in this time period. James Hume was co-founder with Edward William Alexander and lay-superintendent from 1882 until his death in August 1896. It is, however, Alexander's handwriting which appears in the patient case notes. Hume's background as well as Alexander's was relevant to patients' treatment, but little survives in the asylum archive to reveal Hume's role. Accordingly, the focus of this chapter is more on the background and intellectual influences on the Ashburn Hall doctors than on its one lay-superintendent, although Hume's background will also be explored briefly.

Some general features of provision for the insane in New Zealand

By the time Ashburn Hall opened in 1882, care for the insane in lunatic asylums in New Zealand had existed for several decades. The first asylums opened in Auckland in 1853 and Wellington in 1854.⁵ Over the next two decades asylums were built throughout New Zealand's main centres. Some of the features of provision for the insane established in New Zealand by the foundation of Ashburn Hall in 1882 addressed in this section are: institutional provision and state control; moral treatment and non-restraint; and finally the medical control of asylums.

⁴ See Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge; New York: Cambridge University Press, 1985), 30-32.

⁵ Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914*. Basingstoke, UK; New York: Palgrave Macmillan, 2010), 26; Waltraud Ernst, 'The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes', in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, ed. Linda Bryder (Wellington, N.Z.: Bridget Williams Books, 1991), 67.

The model of state-run asylums was adopted both in New Zealand and in the Australian colonies. Institutional provision for lunatics followed English precedent, although central control was not a traditional feature of English asylum management.⁶ The public asylums in New Zealand were initially run by the Provinces, but came under the aegis of the Central Government in 1876 with the abolition of Provincial Government. As Catharine Coleborne tells us, Australian and New Zealand colonial asylums were based largely on an ‘English imperial model’. She goes on to claim that settlers were ‘eager to reflect developments in Britain’ by establishing the asylum on the colonial landscape.⁷ Coleborne seems to equate ‘English’ with ‘British’ here, as have other historians. The institutional response to insanity was, however, more prevalent in England than in Scotland, although in neither country were asylums centrally administered by the government.⁸

The desire to reflect English or imperial precedent in medicine is discussed by Alison Bashford, in her analysis of medicine, gender and empire. She links medical expansion to colonial expansion. She explains:

Expressions of a civilizing medical modernity often took the form of conspicuously large and grand asylums and charitable hospitals, built in colonies of white settlement. These not only differentiated British methods of health, welfare, and philanthropy from indigenous customs, but also marked cities such as Christchurch, Cape Town, Ottawa, or ... Sydney, as places of proper Victorian Government.⁹

Institutional care for the insane certainly became the norm in British colonies as well as in Britain, Western Europe and the United States. The medical profession, like the British

⁶ Brunton, ‘Out of the Shadows’, 76-77.

⁷ Catharine Coleborne, ‘Making “Mad” Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum’, in *Law, History, Colonialism: The Reach of Empire*, ed. Dianne Kirkby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 106, 109.

⁸ For discussion of Scottish systems of caring for the insane and differences between Scottish and English asylum administration see R. A. Houston, *Madness and Society in Eighteenth-Century Scotland* (Oxford; New York: Clarendon Press, 2000); Lorraine Walsh, ‘“The Property of the Whole Community”: Charity and Insanity in Urban Scotland: the Dundee Royal Lunatic Asylum, 1805-1850’, in *Insanity, Institutions and Society*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 180-99; Jonathan Andrews, ‘Raising the Tone of Asylums: Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century’, in Melling and Forsythe, *Insanity, Institutions and Society*, 200-22.

⁹ Alison Bashford, ‘Medicine, Gender and Empire’, in *Gender and Empire*, ed. Philipa Levine (Oxford: Oxford University Press, 2004), 117-21, quote at 121.

Empire, was extremely expansionist in the nineteenth century, becoming increasingly specialised and seeking authority and monopoly over more areas of life including insanity.¹⁰

The regime in asylums, those symbols of ‘proper Victorian Government’, was guided by principles of ‘moral treatment’. This combined a ‘therapeutic environment’ of kindness and good order in an attractive setting with a nourishing diet, occupational therapy, entertainment and a domestic milieu. Medical interventions were limited, with the emphasis on appealing to and strengthening patients’ moral sense.¹¹ Ashburn Hall as well as New Zealand’s public asylums used the elements of a moral treatment regime in the late nineteenth century, as did asylums in the Australian colonies. The main difference between the private asylum and the public ones was in size. Ashburn Hall when it opened was only licensed to receive up to 40 patients, 22 in the ward for male patients and 18 in the female ward.¹² This licence was later increased as new buildings were erected to house more patients. By October 1906 Ashburn was licensed for 66 patients and had six buildings in which to classify and accommodate them.¹³ In the public asylums, by contrast, there were problems of overcrowding, with the asylums being increasingly filled with chronic, hopeless cases. The emphasis in these situations necessarily became one of management of patients rather than on treatment and cure, while the Inspector-General’s reports on Ashburn repeatedly emphasised the high level of attention given to individual patients and the comforts of the private asylum.¹⁴

‘Moral treatment’ as a distinct therapeutic regime is most often associated with the York Retreat in England, opened in 1796 by Quaker merchant William Tuke to cater specifically for insane members of the Society of Friends, and with Philippe Pinel, who

¹⁰ By the early twentieth century, biomedical expertise held great authority over many social, legal and political issues. See Bashford, 118. Medical expansion of control over insanity took place during the nineteenth century and will be discussed further at the end of this section.

¹¹ See Digby, chapter three, for a full description of moral treatment as instituted at the Quaker-run York Retreat in England.

¹² ‘Lunatic Asylums of the Colony (Report on) for 1882’, *AJHR* (1883), H-3, 12.

¹³ ‘Mental Hospitals of the Colony (Report on) for 1906’, *AJHR* (1907), H-7, 32.

¹⁴ See for example, ‘Lunatic Asylums of the Colony (Report on) for 1886’ *AJHR* (1887), H-9, 13; ‘Lunatic Asylums of the Colony (Report on) for 1897’, *AJHR* (1898), H-7, 14; ‘Lunatic Asylums of the Colony (Report on) for 1902’ (1903), H-7, 7. The Inspector-General’s reports were also peppered with references to overcrowding in the public asylums. In 1888 Inspector-General Duncan MacGregor, after lamenting the overcrowding of public asylums with incurable cases, praised Ashburn Hall’s existence as government wards were unable to adequately provide for well-paying patients. See ‘Lunatic Asylums of the Colony (Report on) for 1887’, *AJHR* (1888), H-8, 4.

famously struck the chains from lunatics at the Salpêtrière asylum in Paris in 1793.¹⁵ In other countries, too, moral treatment evolved in the late eighteenth century. Vincenzo Chiarugi in Italy, for example, advocated treating mental illness through a kind, comfortable regime from the early 1790s.¹⁶ The origins of moral treatment, however, go back further. With regard to England, Roy Porter states that the increasing experience of madhouse proprietors in the eighteenth century gradually transformed the nature of psychiatry away from the assumption that the mad were little better than beasts to be whipped and chained. By the late eighteenth century, the elements of moral management were beginning to be worked out in a number of private institutions.¹⁷ Charlotte MacKenzie, in her study of the famous private Ticehurst Asylum in England, states that the treatment offered from the 1770s was predominantly moral management rather than medical intervention. Samuel Tuke's 1813 *Description of the Retreat*, which is generally associated with the popularisation of moral treatment in England, had a ready audience because it articulated a growing consensus amongst asylum proprietors rather than a revolutionary new method.¹⁸

In New Zealand, lunatics were committed to specialised asylums from the mid-1850s. Wendy Hunter Williams identifies a current of public opinion that in the asylum established at Karori, Wellington in 1854 the insane should be 'treated properly, without mechanical restraint and with appropriate regimes'.¹⁹ Moral treatment was, therefore, an aim of New Zealand's early asylums. By the 1860s moral treatment was well and truly entrenched in asylum practices in New Zealand. In 1864, E.W. Alexander sitting on a Commission of Enquiry into the management of the Dunedin Hospital and Lunatic Asylum observed of moral treatment that, 'The method of treating the insane, by a combination of occupation and amusement is so generally adopted as not to need special reference.'²⁰

¹⁵ Nancy Tomes, for example, gives both William Tuke at the Retreat and Pinel in Paris status as the originators of the moral treatment which was practiced in American asylums in the nineteenth century. See Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge; New York: Cambridge University Press, 1984), 62.

¹⁶ Digby, 30-1.

¹⁷ Roy Porter, 'Madness and Its Institutions', in *Medicine in Society: Historical Essays*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 289-90.

¹⁸ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London: Routledge, 1992), 25-6.

¹⁹ Wendy Hunter Williams, *Out of Mind Out of Sight: The Story of Porirua Hospital* (Wellington, N.Z.: Porirua Hospital, 1987), 5.

²⁰ E.W. Alexander, 'Observations on Hospitals and Lunatic Asylums with Reference to the Dunedin Hospital and Lunatic Asylum', in 'Report of the Commission of Enquiry into the Constitution and Management

The key idea underlying moral treatment at the York Retreat was that the insane patient should be treated and spoken to as a rational person as much as his or her state of mind would allow.²¹ Pinel's approach was similar. He advocated that patients be treated with 'kind and compassionate firmness' through a regular regime with good food, exercise, minimal restraint and work therapy. Pinel also, however, advocated a scientific approach to treating the insane, with controlled experimentation in choosing medication, careful observation of patients and the keeping of systematic case records. Pinel's aim was to construct a scientific nosology of mental disease, whereas the Tukes' approach was more pragmatic in working out how to treat their patients, and more selective in what was recorded of each case.²²

Nancy Tomes considers that although Pinel's work had a greater impact on medical theories of insanity, Tuke's model had a more immediate effect on the institutional practices of early asylums in North America.²³ Those who instituted moral treatment in New Zealand and Australian asylums saw themselves as intellectually indebted to the figures of both Tuke and Pinel. Indeed, when Ashburn Hall opened in 1882, James Hume and E.W. Alexander named the wing for female patients Pinel. The male ward was called Mitchell, most likely after the American neurologist Silas Weir Mitchell, who pioneered the 'rest cure' for nervous disease.²⁴ The second male ward, completed in 1896, was named Tuke, while an English asylum doctor, John Conolly, was the namesake for the second female wing completed in 1891.

Alan Somerville links Ashburn Hall's continued and consistent use of moral treatment to its mission as a private asylum to attract a clientele. Aspects of the moral treatment model such as comfortable buildings, nourishing diet, and a degree of freedom appropriate to patients' behaviour would have appealed to private clients. This may have led the proprietors of Ashburn, as well as private asylums elsewhere, to continue to apply moral treatment even when public asylums started to abandon it.²⁵

of the Dunedin Hospital and Lunatic Asylum', *Appendix to Votes and Proceedings of the Provincial Council – Session XVIII, 1864* (Otago Provincial Council, 1864), 46.

²¹ Digby, 29.

²² *Ibid.*, 31-2.

²³ Tomes, 63.

²⁴ Cameron Duder, *The Ashburn Clinic: The Place and the People* (Dunedin, N.Z.: Ashburn Clinic, 2007), 17-18.

²⁵ Alan Somerville, 'Ashburn Hall and Its Place in Society, 1882-1904', M.A. Thesis, University of Otago, 1996, 126. Somerville cites Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in*

Other English reforms in the practice of caring for the insane were gradually adopted in the colonies, either by those superintending the asylum or through governmental pressure. The non-restraint system introduced to the Hanwell Asylum in England by John Conolly in the early 1840s made it to both Australia and New Zealand, although with some delay from its inception in England. Lee-Ann Monk explores the adoption of the non-restraint practices advocated by Conolly in the asylums of colonial Victoria.²⁶ Reformers in the decade from 1852 wished ‘moral control’ to replace mechanical restraint. Non-restraint was ‘by this time the “orthodox doctrine” in English asylums, even if not universally applied in practice, and “a litmus test of progress and modernity”’.²⁷ The decade from 1853-64 in Victoria represented a contest between visions of the asylum. The Surgeon-Superintendent at the Yarra Bend Asylum did not wish to introduce total non-restraint.²⁸ In Victoria, at least, this reform was driven by official discourse rather than by an asylum superintendent. It was explicitly an adoption of a method of asylum practice from ‘Home’.

New Zealand asylums implemented non-restraint in the second half of the nineteenth century. By the time Ashburn Hall opened in 1882, it was normal practice for patients who were difficult to manage or violent to be secluded in their own rooms rather than mechanically restrained. The 45-year-old female patient Constance C, for example, was placed in seclusion for two hours due to violence and foul language.²⁹ Official discourse on the treatment of the insane would have been influential in Ashburn Hall. The private asylum was governed by the *Lunatics Act 1882* and was inspected every six months by the Inspector-General of Lunatic Asylums for New Zealand or one of his deputies. The opinions of New Zealand’s lunacy officials carried some weight with the managers of Ashburn. The asylum did not, however, receive government funding. The major changes made to Ashburn Hall over the years 1882 to 1910 were, therefore, driven by the medical superintendents in

Nineteenth-Century England (London: Allen Lane, 1979), 207 to support the claim that moral treatment was applied in public asylums in the late-nineteenth century, while disappearing in public ones.

²⁶ Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam; New York: Editions Rodopi, 2008), 83-7.

²⁷ *Ibid.*, 84, quoting Akihito Suzuki, ‘The Politics and Ideology of Non-restraint: The Case of the Hanwell Asylum’, *Medical History* 39 (1995): 1; Nancy Tomes, ‘The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century’, in *The Anatomy of Madness, III The Asylum and Its Psychiatry*, ed. W.F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 1988), 190, 196-7; Andrew Scull, Charlotte MacKenzie and Nicholas Herve, *Masters of Bedlam: the Transformation of the Mad-Doctoring Trade* (Princeton, N.J.: Princeton University Press, 1996), 69, 152.

²⁸ Monk, 86.

²⁹ Ashburn Hall, ‘Case Book 1882-1907’, Folio 94 (AG-447-6/01), HC.

conjunction with the proprietors of the Hall. Adoption of new medical practices, terminology or research was the prerogative of the men actually running the day-to-day asylum business.

Those running Ashburn Hall were, with the exception of James Hume, medical professionals. During the late nineteenth century in New Zealand there was a shift to medical control of the public asylums. Some degree of medical control over the treatment of insanity gained official support even in the early stages of New Zealand's asylum system. A Select Committee advised the appointment of a non-resident medical officer for the asylum at Karori in 1857, only three years after it opened.³⁰ The belief that the medical profession should have control over the treatment of the insane can be seen in the recommendation by an 1871 Parliamentary Joint Committee on Lunatic Asylums that the central government should appoint a medical officer from the United Kingdom 'who shall have the supervision and control of all the lunatic asylums in the colony'.³¹ In 1876, Dr. F.W.A. Skae, previously the superintendent of the Stirling Asylum at Larbert, Scotland, was appointed the first Inspector of Lunatic Asylums.³² The 1880s finally saw the shift to full medical control of public asylums with the appointment of resident medical superintendents, rather than non-resident medical officers.

Calls for increased medical control of New Zealand asylums followed English trends. The 1845 Lunatics Act, which required all counties and principal boroughs of England and Wales to make provision for the care of the insane, enabled doctors to establish a medical monopoly by requiring asylums to keep records of visits and treatments.³³ The growth of a medical monopoly of madness in Britain was, according to Andrew Scull, an intensely political process. Doctors were not more able to effect a reliable 'cure' of lunatics than laymen, and there was no specifically medical form of treatment.³⁴ However, by the mid-

³⁰ Ernst, 'Social History of Pakeha Psychiatry', 73; Otago Provincial Council, 'Report of the Commission of Enquiry into the Constitution and Management of the Dunedin Hospital and Lunatic Asylum', *Appendix to Votes and Proceedings of the Provincial Council – Session XVIII, 1864* (Otago Provincial Council, 1864), 5.

³¹ Warwick Brunton, 'The Development of Psychiatric Services in New Zealand', *Royal Commission to Inquire Into and Report Upon Hospital and Related Services* (Department of Health, Wellington, 1971), 2, quoted in Ernst, 'Social History of Pakeha Psychiatry', 74.

³² Ernst, *Ibid.*

³³ Bronwyn Labrum, 'Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum, 1870-1910', M.A. Thesis, Massey University, 1990, 15-16.

³⁴ Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993), chapter four. Moral treatment was just as easily administered by a layman as by a medical professional. It contained no explicit medical therapy, focusing instead on good diet, kind treatment, limited physical restraint, mild employment and amusement.

nineteenth century in England, the medical monopoly of madness was well established. Even the majority of private asylums had a resident doctor by 1858.³⁵

Medical control provided part of the impetus for Hume to found Ashburn Hall. His position as superintendent at the public Dunedin Lunatic Asylum was downgraded to house steward in 1881 with the appointment of Dr A.H. Neill to the position of resident medical superintendent. Hume chose to resign his post in 1882 and open Ashburn Hall. He was the resident superintendent there with E.W. Alexander as visiting medical officer.³⁶

A Biographical Approach to Asylum Practice

Hume and the Ashburn Hall doctors, like New Zealand's public asylum doctors, were educated in Britain. Indeed, with the exception of E.W. Alexander, they were Scottish educated. One way in which forms of treatment flowed to New Zealand was through the education and employment of the colony's asylum doctors in British medical schools and their previous employment in British or colonial institutions. This trend was common to the British Empire, at least in the nineteenth century, before settler colonies established their own medical schools. Anne Crowther and Marguerite Dupree, discussing medical training at Edinburgh in the 1860s-70s, point out that:

These were the years of high imperialism in which the medical profession played an important part. Britain trained doctors for colonial settlements and imperial administrations, as well as for the armed forces and medical missions. Medical networks operated across national boundaries, and the role of the doctor as an agent of Empire is a story still unfolding.³⁷

Lunatic asylums were no exception to the operation of these medical 'webs of empire'. Doctors for colonial asylums brought British medicine as part of the expansion of 'civilisation' to the new world. Public asylums, and the doctors in charge of them, operated as part of the colonial administration, and the existence of asylums in settler colonies linked methods of colonial government with those of Victorian government at 'home'.

³⁵ Somerville, 33. Somerville cites William Parry-Jones, *The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London and Toronto, 1972), 78 for authority that 73 of the 114 provincial and metropolitan licensed houses in England had a resident doctor in 1858.

³⁶ *Ibid.*, 16.

³⁷ M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), 5.

A significant way, therefore, in which the treatment of the insane at Ashburn Hall can be linked to the wider history of the treatment of insanity is through examination of the individuals running the asylum. Warwick Brunton claims that the United Kingdom has been and remains a significant reference point for Pakeha psychiatry. The link has been sustained through ongoing imperial sentiment and connection, cultural baggage, and assumptions about the comparability of the New Zealand and British health systems.³⁸ Medical appointments to New Zealand asylums in the nineteenth and early twentieth centuries were often of men who had trained in England, Scotland or Ireland.³⁹ This is true of Ashburn Hall. The remainder of this chapter will address the education and employment histories of Ashburn's superintendents and their continuing engagement with medical 'webs' of knowledge. The intellectual influences on the doctors' practices were more nuanced than a straightforward adoption of British medicine, although practices at Ashburn were influenced by British precedent.

James Hume: Superintendent (1882-1896)

Ashburn Hall's first superintendent, James Hume, was not a doctor. He was the co-founder of Ashburn Hall with Dr Edward William Alexander, and lived in the Hall as superintendent until his death in 1896. Hume was born in Scotland in 1823 and worked in asylums for over 30 years prior to his arrival in Dunedin in 1862.⁴⁰ His first position was at the Gartnavel Royal Asylum in Glasgow, Scotland. He was then employed at the Midland Counties Asylum in England.⁴¹ Once in Dunedin, he soon became involved with the public Dunedin Lunatic Asylum, becoming the keeper (or lay-superintendent) in 1864, leaving finally in 1882 after being downgraded to house steward. Hume's choice to found Ashburn Hall with Dr E.W. Alexander gave him the opportunity to continue earning a salary comparable to his earlier one, and to continue wielding a similar level of authority.⁴²

The division of labour between the founders of Ashburn Hall was Hume as live-in superintendent and Alexander as medical officer, visiting three times a week as required by

³⁸ Brunton, 'Out of the Shadows', 77.

³⁹ Ibid.

⁴⁰ 'The Late Mr James Hume', *Otago Daily Times*, 31 August 1896, 3.

⁴¹ Duder, 15.

⁴² Somerville, 18. Hume ended up earning about £600 per annum at Ashburn. His salary at the Dunedin Lunatic Asylum had been only £400.

the *Lunatics Act 1882*.⁴³ There was no resident medical officer at Ashburn Hall until after Hume's death in August 1896. The non-medical control of Ashburn Hall follows the pattern of the Scottish public subscription asylums, most of which were under non-medical control in the first half of the nineteenth century.⁴⁴ Lorraine Walsh considers that the ideas and opinions of laymen were central to the pattern of asylum development in Scotland due to their important roles in establishing, organising, financing and ideologically structuring the Scottish charitable asylums. Famous names in Scottish psychiatric medicine, such as David Skae, or Thomas Clouston, were not established until after the middle of the nineteenth century and the passage of Scottish lunacy legislation.⁴⁵ Hume, who had been employed for at one of Scotland's charitable asylums, was used to a structure of mixed medical and non-medical control, and a treatment regime favouring the moral over the medical, which he reproduced in his positions at Dunedin Lunatic Asylum and Ashburn Hall.⁴⁶

Despite Hume's non-medical status, he and Alexander hoped to keep up with developments overseas and provide accommodation and treatment superior to that offered at New Zealand's Government-run asylums.⁴⁷ The Inspector-General of Asylums from 1886, Duncan MacGregor, who advocated that mental hospitals be run 'along scientific lines', was not critical of the lack of a resident medical officer at Ashburn in his reports during the 1880s and early 1890s.⁴⁸ In fact, he commended the management of Ashburn Hall, and recommended that it should be taken better advantage of, stating:

There is no dearth in the colony of insane persons who would be benefitted by the advantages which this well-conducted establishment offers, and I feel sure that its merits only need to be more widely known in order to be appreciated.⁴⁹

⁴³ *Ibid.*, 21.

⁴⁴ Lorraine Walsh, "'The Property of the Whole Community'", 184. Walsh highlights that, in its first 40 years of existence, most of the Directors of the Dundee Royal Asylum were laymen, with only three medical men.

⁴⁵ *Ibid.*

⁴⁶ Walsh states that Scottish asylums adopted moral treatment from the mid-1830s on. W.A.F. Browne was the first to introduce it at the Montrose Royal Asylum, but other institutions were also quick to extol its virtues. Alexander MackIntosh, who was a medical officer at Dundee, and later at Glasgow Royal, favoured a regime of moral and intellectual treatment, and considered the value of medical treatment to be somewhat limited. *Ibid.*, 183-4.

⁴⁷ Judith Medlicott, 'The History of Ashburn Hall, 1882-1947', M.A. Thesis, University of Otago, 1972, 11-12.

⁴⁸ These views of MacGregor's are mentioned in the 'Report on Mental Hospitals of the Colony of New Zealand for 1906', *Journal of Mental Science* (January 1908), 199 cited in Coleborne, *Madness in the Family*, 36.

⁴⁹ 'Lunatic Asylums of the Colony (Report on) for 1883', *AJHR* (1884), H-7, 15.

The lack of a resident medical officer, in fact, did not become an issue for Ashburn Hall until February 1896, when a patient, Christopher Hume Macalister, committed suicide. In an inquiry into Macalister's death, Judge C.D.R. Ward found a complaint that there was insufficient medical supervision to be groundless.⁵⁰ Alexander and Hume, however, began inquiries for a resident medical superintendent to replace Hume on his retirement. Hume died in August 1896, before any appointment had been made. Alexander broke his leg about the same time, and Dr Thomas Burns took on the duties of medical officer until Alexander was again able to perform them.⁵¹

Edward William Alexander: Medical Officer (1882-1897)

Edward William Alexander was visiting medical officer then resident medical superintendent of Ashburn Hall from its opening in October 1882 until March 1897. He prescribed treatment for patients and recorded notes in the patient case files. These records were examined by the Inspector-General on his twice-yearly visits. They included notes about patients' physical and mental states, their behaviour in the asylum, treatments administered and any improvement in their conditions. As the diagnoses and treatment decisions recorded in the case record were made by E.W. Alexander, albeit informed by Hume's insights into patients, an examination of E.W. Alexander's background reveals the nuances of intellectual influences informing the treatment of insanity at Ashburn Hall during his tenure.

E.W. Alexander was born in 1828 on the island of St Helena, a British colony in the South Atlantic. He travelled to London for his education, training principally at King's College Hospital.⁵² He also trained in Paris. According to the *Cyclopedia of New Zealand* he 'attended the practice of the Hôpital-du-Midi' before qualifying as a Member of the Royal College of Surgeons in England in 1853.⁵³ Alexander's first appointment was as a civil servant, Colonial Surgeon to St Helena. He remained there until 1861. He was also appointed to positions as surgeon to the African Liberation Department, and to the Honourable East

⁵⁰ Somerville, 35.

⁵¹ Ibid., 36.

⁵² R.E. Wright-St. Clair, *Medical Practitioners in New Zealand, 1840-1930* (Hamilton, N.Z.: R.E. Wright-St Clair, 2003), 33.

⁵³ *The Cyclopedia of New Zealand: Volume 4, Otago and Southland* (Christchurch: Horace J. Weeks Ltd, 1905), 245.

India Company's Corps of Invalids.⁵⁴ It is unclear exactly what authority would have been vested in Alexander during his appointment as Colonial Surgeon at St Helena, but he is likely to have been involved in areas such as the treatment of troops and police, and the supervision of hospitals and sanitation.⁵⁵

After leaving St Helena, E.W. Alexander returned to London, becoming a Licentiate of the Royal College of Physicians in 1861. He then travelled through Europe, visiting a number of French, Austrian, Swiss and Italian hospitals.⁵⁶ It is unclear exactly how much experience E.W. Alexander had in the management of asylums and treatment of the insane before coming to Dunedin in 1863. There was no formal instruction on the treatment of mental disease available at any educational institution in Britain until later in the century. Alexander may, however, have attended an informal course of public lectures on the treatment of the insane. One asylum doctor, Alexander Morison, for example, had delivered a series of lectures on the treatment of mental disease in London in the 1840s.⁵⁷ The main educational influence on Alexander's treatment of the insane, however, was French. This impression is reinforced by his naming one of the first buildings at Ashburn after Philippe Pinel, rather than after an English asylum doctor. Part of Alexander's post-graduate study in the 1860s was undertaken at the Salpêtrière and Bicêtre asylums in Paris.⁵⁸ The names of these two asylums are commonly associated with Philippe Pinel and the birth of French 'moral treatment' in the late eighteenth century. The asylums remained significant in the development of the French psychiatric profession in the nineteenth century. The 1860s, when Alexander visited, was a relatively static period in French psychiatry, without great developments such as the monomania diagnosis. Championed by Jean-Étienne Esquirol, Pinel's most prominent protégé, 'monomania' had caused controversy in the 1820s and expanded the profession's

⁵⁴ R.V. Fulton, *Medical Practice in Otago and Southland in the Early Days: A Description of the Manner of Life, Trials and Difficulties of Some of the Pioneer Doctors, of the Places in Which, and of the People among Whom, They Laboured* (Wellington, N.Z.: Colonial Associates, 1983), 290.

⁵⁵ For a brief description of what a colonial surgeon's duties are likely to have included, see Australian Medical Pioneers Index: a Barwon Health Project Initiated by the Geelong Hospital Library, 'Colonial Medical Life' <<http://www.medicalpioneers.com/colonial.htm>>, last accessed 9 December 2010. The implication that E.W. Alexander's duties included the supervision of sanitation and hospitals is strengthened by his 1863 appointment to the Otago Provincial Council's Commission of Enquiry into the Constitution and Management of the Dunedin Hospital and Lunatic Asylum.

⁵⁶ Fulton, 290-1.

⁵⁷ Scull et al, *Masters of Bedlam*, 135-40.

⁵⁸ Medlicott, 9.

power and status by establishing asylum doctors as experts able to determine criminal responsibility.⁵⁹

Although there was no revolutionary development in psychiatric diagnosis or treatment, research continued in French psychiatry. Moreau de Tours, a doctor at the Salpêtrière, undertook some study of hysteria during the 1860s. He published several articles, making the suggestion that the baffling ‘protean’ quality of nervous diseases such as hysteria was due to their hereditary nature.⁶⁰ De Tours’ work hints at an emphasis on the hereditary nature of mental disease in medical circles in this period in France.⁶¹ Such an emphasis was also on the rise in Britain influenced by social-Darwinist ideas. French psychiatry was influenced more by neo-Lamarckian notions about inherited characteristics and species, rather than Darwinism with its natural selection emphasis.⁶² For psychiatry, the end result was similar, with an increasing emphasis on heredity and degeneration as predisposing causes for insanity.

Despite some knowledge of E.W. Alexander’s early experience as a physician, it remains unclear where his knowledge of the treatment of the insane was gained. He had some degree of experience in Paris, and possibly in England, St Helena, or other countries during his travels in Europe. The Otago Provincial Council selected him shortly after his arrival in Dunedin to be part of a Commission of Enquiry into Dunedin’s hospital and lunatic asylum in 1863-4. E.W. Alexander was further involved with the Dunedin Lunatic Asylum in the 1870s, acting as medical officer in 1870 and 1876.⁶³ Alexander’s experience, wherever it was gained, and the knowledge he brought with him to New Zealand, were valuable assets in the colony.

During Alexander’s tenure as medical officer for Ashburn Hall, 215 patients were admitted, including some ‘voluntary boarders’ who were not certified insane, and some

⁵⁹ The monomania diagnosis is discussed by Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge: Cambridge University Press, 1987), chapter five. Monomania was essentially a ‘mania’ focused on only one area. A person could be otherwise rational, but be obsessed with one idea or set of ideas. By the mid-1850s the profession had largely rejected this diagnosis. Goldstein argues that this was because it had served its purpose in establishing the authority of the professions. See 193-4 especially.

⁶⁰ *Ibid.*, 328. See chapter 9 for a discussion of the return to prominence of the hysteria diagnosis in the last third of the nineteenth century. Although the diagnosis had been in existence since the 5th century B.C.E., it underwent a more exact definition of the symptoms and progress of the disease by Charcot in the 1870s.

⁶¹ *Ibid.*

⁶² Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the Fin de Siècle* (Oxford: Clarendon Press, 1989), 64.

⁶³ Fulton, 291.

patients admitted for compulsory treatment under section 43 of the *Lunatics Act 1882* as ‘Habitual Drunkards’. For certified patients, the most common diagnosis listed by Alexander was some form of ‘mania’, followed by ‘delusional insanity’ then ‘melancholia’. There were also a number of less commonly used diagnoses such as ‘hysterical insanity’, ‘hypochondria’, ‘general paralysis’ and ‘imbecility’. The frequency of each diagnosis is shown in table 1 in the appendix to this thesis. The causes for insanity listed in the admissions register reveal the influence of hereditarian notions in Alexander’s practice. ‘Heredity’ was the most commonly listed cause of insanity, appearing in the entries for 45 patients. In nine of these patients, insanity the cause ‘heredity’ appeared in conjunction with another cause such as ‘lactation’, or ‘lonely life’ (see appendix, table 2).⁶⁴ Heredity increasingly gained priority in the list of causes for madness in the late nineteenth century in both France and in Britain.⁶⁵

Other causes listed for insanity during Alexander’s tenure were fairly varied. There were a number of physical causes, such as illness or injury, lactation, climacteric (menopause), child-bearing, adolescence and alcohol (see appendix, table 2). Alexander’s attribution of many cases to physical causes reflects the somatic basis for insanity commonly accepted by the medical profession in the nineteenth century. Insanity was seen as a physical disease of the brain, despite the continuing inability of pathologists to locate any consistently present brain lesion that could be linked to insanity. At the Salpêtrière psychiatry and neurology were linked from the 1860s. Theories which equated the mind with the brain, at least in relation to insanity, were reinforced by the existence of diseases such as general paralysis, in which brain degeneration could be linked to advancing insanity.⁶⁶ In England as well, a somatic basis for insanity was the most commonly accepted medical view.⁶⁷ The listing of a large number of physical causes for insanity by Alexander is, therefore, in keeping with contemporary international theories about mental illness.

E.W. Alexander also listed a number of non-physical, or ‘moral’ causes of insanity in the admissions register. Hilary Marland, discussing puerperal insanity, states that doctors disagreed over the importance of different influences, moral, organic or hereditary in ascribing causes to cases of puerperal insanity. Although the underlying cause of this type of

⁶⁴ Ashburn Hall, ‘Register of Admissions, 1882-1948’ (AG-447-5/01), HC.

⁶⁵ Harris, 51-64.

⁶⁶ *Ibid.*, 25.

⁶⁷ W.F. Bynum, ‘Tuke’s *Dictionary* and Psychiatry at the Turn of the Century’, in *150 Years of British Psychiatry, 1841-1991*, ed. German E. Berrios and Hugh Freeman (London: Gaskell, 1991), 167.

insanity, reproduction, was physical, non-physical causes such as ‘worry’ or ‘domestic trouble’ might combine with the stress of childbirth to trigger insanity.⁶⁸ This can be extended to other forms of mental illness. Nineteenth-century medical practitioners saw insanity as a physical illness with a somatic basis, but the trigger of the insane attack, the ‘exciting’ cause of insanity, might be non-physical. Such causes in Ashburn included loss of a loved one, disappointment in love, loss of property or money, ‘religious excitement’, and even in one case, ‘excess of pride’.⁶⁹

In determining the cause of attacks of insanity, doctors were often dependent upon a patient’s family or even on the patients themselves. It was the doctors, however, who determined how causes of insanity would be classified.⁷⁰ Where information was unavailable, the cause was listed as ‘unknown’ or left blank. 25 per cent of patients admitted during Alexander’s tenure did not have a cause of insanity recorded in the admissions register. Alexander listed fewer patients’ causes as ‘unknown’ as time went on. In the last three years of Alexander’s tenure at Ashburn, only three patients were admitted with cause ‘unknown’ recorded in the admissions register. Once Frank Hay took over management of Ashburn Hall, the listing of cause ‘unknown’ disappeared altogether, although Hay occasionally left the cause column blank. This seems to reflect an increasing drive for precise classification, part of the trend toward medicalisation of insanity in the later nineteenth century (see appendix, tables 2 and 4).

As well as being influenced by his education, E.W. Alexander remained engaged with trends in medical scholarship throughout his career. In 1888 he published an article in the newly established *New Zealand Medical Journal*, arguing that some features of the Scottish system of caring for the insane, notably the practice of boarding-out harmless lunatics to private families, should be given a trial in New Zealand.⁷¹ This represented a move away from the opinions expressed in his report to the Provincial Council in 1864. At that point

⁶⁸ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke, Hampshire: Palgrave Macmillan, 2004), 39.

⁶⁹ Ashburn Hall, ‘Register of Admissions, 1882-1948’ (AG-447-5/01), HC.

⁷⁰ Catharine Coleborne, ‘“His Brain was Wrong, His Mind Astray”: Families and the Language of Insanity in New South Wales, Queensland and New Zealand, 1880s-1910’, *Journal of Family History* 31 (2006): 53. For a discussion of the complex three-way negotiations between doctors, patients and patients’ families or friends in establishing causes of insanity see Akihito Suzuki, ‘Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century’, in Melling and Forsythe, *Insanity, Institutions and Society*, 115-36.

⁷¹ E.W. Alexander, ‘Insanity in New Zealand, with Suggestions for the Disposal of the Chronic Insane’, *New Zealand Medical Journal* 1, no. 3 (March 1888): 162-4. The *NZMJ* was first published in 1887.

Alexander had implicitly supported the provision of institutional care for all the insane in New Zealand. He analysed how many insane were likely to be in the Province, to determine how many patients a new Dunedin Asylum would need to provide for.⁷² His opinion had changed by 1888, and he pointed not only to the Scottish example of boarding out, but also to Belgium, which adopted a similar practice, recommending that New Zealand adopt such measures.⁷³ His article also made reference to the practice adopted in Wisconsin of providing 'county asylums' with fewer than 100 patients. Alexander argued that this would be more suitable in New Zealand than the large asylums already established.⁷⁴ E.W. Alexander's thoughts on treating the insane, therefore, did not remain static, but evolved with changing conditions in New Zealand, and with overseas medical thought.

In choosing a replacement as well as assessing the type of treatment most appropriate for the New Zealand context, Alexander showed a respect for Scottish psychiatry. He corresponded with Thomas Clouston, Lecturer in Insanity at the University of Edinburgh and the superintendent of the Royal Edinburgh Asylum, to ask him to recommend a suitable doctor for the position of superintendent.⁷⁵ Frank Hay, an assistant physician at the James Murray Royal Asylum in Perth, Scotland, arrived to take over as medical superintendent of Ashburn Hall in March 1897. Even after E.W. Alexander had handed the reins of medical superintendence over to Hay, he remained involved with keeping Ashburn Hall in step with international psychiatry. In February 1907, only three months before his death, E.W. Alexander discussed with the Inspector-General for Mental Hospitals the 'various projects he had for continuing to maintain [Ashburn Hall] in the van by anticipating up-to-date requirements'.⁷⁶

Frank Hay: Medical Superintendent (1897-1904)

E.W. Alexander's replacement, Frank Hay, came to Dunedin specifically to take up the role of resident medical superintendent at Ashburn Hall. He held this position from March 1897 until April 1904, when he left to become Deputy Inspector-General of Lunatic Asylums. Hay, like Alexander, was born outside Britain and returned to the metropole for his education. He was born in Lucknow, India, in 1867 and educated privately at Blenheim House in

⁷² Alexander, 'Observations on Hospitals and Lunatic Asylums', 46.

⁷³ Alexander, 'Insanity in New Zealand', 162.

⁷⁴ *Ibid.*, 160-1.

⁷⁵ Somerville, 36.

⁷⁶ 'Mental Hospitals of the Colony (Report on) for 1906', *AJHR* (1907), H-7, 32.

Wimbledon. His medical education took place at the University of Aberdeen in the 1880s, and he graduated Bachelor of Medicine Master of Surgery (M.B.C.M) in 1890. Between 1890 and 1896 he was assistant medical officer at the James Murray Royal Asylum in Perth, Scotland.⁷⁷

Hay sat a four-year university degree to obtain his qualification, which reflected the standardisation of entry to the medical profession in the later nineteenth century. The *Medical Act 1858* established a Medical Register in Britain, which legally defined qualified practitioners. It also set up the General Council of Medical Education and Registration (GMC), which oversaw the creation of the register and held some powers over courses of medical study and supervision of examinations.⁷⁸ At the University of Aberdeen, where Hay studied, there was no course of lectures on insanity available, although there was at Edinburgh.⁷⁹ Despite some standardisation following the 1858 Act, teaching at British universities still had a great deal of variation.

Hay's main source of knowledge on the treatment of insanity before his arrival in New Zealand was through his employment at the James Murray Asylum.⁸⁰ Psychiatric education in the late-Victorian period was largely a matter of on-site training as a resident-medical officer in a county asylum.⁸¹ Duncan MacGregor, Inspector-General of Lunatic Asylums in New Zealand, considered Hay's training under the superintendent of James Murray asylum, Dr Alex Reid Urquhart, to be a considerable point in his favour.⁸² Urquhart was the author on the article about asylum construction in Daniel Hack Tuke's 1892 *Dictionary of Psychological Medicine* and his influence can be seen in Hay's preoccupation with improving the asylum buildings and grounds at Ashburn.⁸³ In March 1899, for example, MacGregor recorded that Ashburn was undergoing extensive repairs and alterations.

The old kitchen is being greatly improved, the billiard-room is ready for occupation, a very convenient fire-escape has been provided, and

⁷⁷ 'Obituary: Dr Frank Hay', *New Zealand Medical Journal* 24, no. 123 (October 1925): 265-7.

⁷⁸ Carolyn Pennington, *The Modernisation of Medical Teaching at Aberdeen in the Nineteenth Century* (Aberdeen: Aberdeen University Press, 1994), 16.

⁷⁹ T.S. Clouston held the position of Lecturer on Insanity at the University of Edinburgh from 1879-1910. Crowther and Dupree, 385.

⁸⁰ 'Obituary: Dr Frank Hay', 265-7.

⁸¹ Bynum used Daniel Hack Tuke's *Dictionary of Psychological Medicine* (1892) as a window into the late-Victorian psychiatric profession in Britain. See Bynum, 'Tuke's *Dictionary* and Psychiatry at the Turn of the Century', 175-6.

⁸² 'Lunatic Asylums of the Colony (Report on) for 1903', *AJHR*, (1904), H-7, 12.

⁸³ 'Obituary: Alex Reid Urquhart', *British Medical Journal*, 2, no. 2955 (18 August 1917), 237.

a new airing court is being provided on the female side. A new day-room has quite transformed the male side.⁸⁴

Asylum architecture was an important aspect of moral treatment and included, 'maximum security, ample ventilation, efficient drainage, optimal visibility ... and, not least, efficient classification of the different grades of lunatics'.⁸⁵ Architecture was a uniform preoccupation of nineteenth-century asylum doctors, and Urquhart imbued his trainee Hay with ideas on the importance of asylum layout.

The move from E.W. Alexander's superintendence to Frank Hay's was marked by other changes as well. Under Hay's management, record keeping became more precise and detailed. In the admissions register, general bodily health and condition was described more fully. Under the Hume/Alexander regime entries had more often than not been a single word, such as 'good', 'fair' or 'poor'. Hay's entries, although occasionally only one word, often contained much more detail. One example read, 'Fair. Liver considerably enlarged & tenderness at costal margin'.⁸⁶

In case notes too, there was a difference in the level of detail recorded. Notes on patients' physical condition under E.W. Alexander had been brief unless there was a specific illness to be recorded. The admission note of the first patient admitted to Ashburn, for example, read:

Transferred from Dunedin Asylum, where he has been for eighteen or twenty years. Is rather stout and in excellent health. Has delusions about electricity affecting him and chemicals flying about. He describes some persons whom he may see as mischievous causing his teeth to loosen.⁸⁷

The notes on the first patient admitted after Hay took up his position at Ashburn Hall, Regina R, are considerably more detailed. Below is an extract of the admission note dealing only with Regina's physical condition:

General appearance – Feeble. Indifferently nourished & developed. Advanced Chronic Rheumatic arthritis with characteristic deformity of hands. Able to walk without support but of feeble muscularity & easily fatigued. Complexion somewhat waxy, occasional flushing of cheeks. Head, well shaped. Hair, fine in texture, white. Expression

⁸⁴ 'Lunatic Asylums of the Colony (Report on) for 1898', *AJHR* (1899), H-7, 12.

⁸⁵ Porter, 'Madness and Its Institutions', 297.

⁸⁶ Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC.

⁸⁷ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 2 (AG-447-6/04), HC.

care worn. Skin, [illegible] patches on limbs and trunk. Temperature 98°.

Circulatory System, Considering age, average. Some atheroma of arteries. Veinules on back of hands dilated. Pulse 100.

Respiratory system. Senile. Voice distinct soft & low.

Digestive Sytem. Appetite very fair. Tongue clean but tendency to become dry. Taste apparently normal. Teeth, a few decaying stumps.

Bowels slight tendency to constipation. Stomach. Easily disordered.

Nervous system.

Motor – making allowance for age, normal.

Sensory – somewhat acute.

Sight – [illegible] Left pupil larger than right.

Hearing – defective especially on left side.

Touch – apparently normal

Complaint of a feeling of fullness in head, something short of cephalalgia in frontal region & [illegible] but occasionally occipital parietal & unilateral. Has motor [illegible].⁸⁸

These notes regarding Regina's physical condition follow almost word for word the categories contained in the pro forma case book used at the James Murray Asylum in the 1890s while Hay was employed there.⁸⁹ The rest of the admission note dealing with Regina's mental condition and history is also detailed, and includes notes about birthplace, religion and education, before moving on to describe her present condition as 'extremely suicidal', and addressing her level of coherence, her memory and her reaction to being admitted.⁹⁰ Hay does not list the pro forma categories as exactly as he does for physical condition, but the general structure is very similar, beginning with the fact she is a gentlewoman, then listing general information before going on to discuss the supposed cause and duration of her attack of insanity.

Not all of Hay's entries in the case files were as detailed as Regina's. They were, however, generally more complete with regard to physical condition and family and personal history than the notes from Alexander and Hume's years managing the asylum. In 1900 Hay introduced the first pro forma case book at Ashburn with a large number of categories on all aspects of the patient's physical and mental condition, family and personal history to be filled out. These sections were followed by a two-page space for writing notes on the progress of the case. The pro forma Hay introduced contained similar categories to that at James Murray's Asylum, but was set out in a slightly different manner, with information about

⁸⁸ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 110-11 (AG-447-6/05), HC.

⁸⁹ Murray's Royal Asylum, Extract of patient case book, Folio 90, 1890 (THB 29/8/6/7), University of Dundee Archive Services, Dundee, United Kingdom.

⁹⁰ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 111.

family and personal history being recorded before information about physical condition. It also contained a category for recording a family tree, which was not introduced at James Murray until 1902, when their pro forma changed slightly.⁹¹ The detailed categories of the James Murray's and Hay's pro forma books reflect the increasing emphasis during the last decades of the nineteenth century on more 'scientific' approaches to mental medicine, which saw important changes being recommended for asylum case notes in England and Scotland.⁹²

The strong focus on physical condition in Hay's notes reflects the somatic orientation of late nineteenth-century psychiatry. Daniel Hack Tuke's 1892 *Dictionary of Psychological Medicine* contained a generous number of entries on the relationship between psychiatric and physiological issues.⁹³ W.F. Bynum considers that this underscored 'the extent to which psychiatrists believed that the diagnostic and therapeutic methods of late nineteenth-century medicine and surgery provided the firmest scientific foundations for psychiatry'.⁹⁴ The level of clinical detail in Hay's notes demonstrates an increasingly precise categorisation of cases and a faith in scientific observation, which were part of a medicalisation of madness in the late nineteenth and early twentieth century.

Diagnoses of patients were largely similar under Hay and E.W. Alexander's management (see appendix, tables 1 and 3). Under Hay, the main categories were still 'mania', 'melancholia', 'delusional insanity' and 'dementia'. Mania remained the most common diagnosis while Hay was superintendent. The causes of insanity listed for the 124 patients admitted to Ashburn Hall between 1897 and 1904 were similar to those listed by Alexander. Heredity was still a common cause, appearing as the sole cause in twenty-one cases, and as one of two or more causes in a further twenty-six. Causes such as the puerperal state, mental worry, loss of a loved one, or the climacteric also appeared, and a fairly high

⁹¹ The pro forma Hay introduced was Ashburn Hall, 'Case Book, 1882-1907' (AG-447-6/01), HC. For an example of the post-1902 pro forma at James Murray's Asylum see James Murray's Royal Asylum, Extract of patient case book, Folio 30, 1906 (THB 29/8/6/12) University of Dundee Archive Services, Dundee, United Kingdom.

⁹² Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine* 11, no. 2 (1998): 260. Although changes towards more scientific record-keeping were 'recommended', they were not always adopted. Andrews states the James Murray asylum was one of those which adopted much more systematic records in response to these recommendations and the impact of the highly classificatory approach to mental disease taken by the physicians at the Edinburgh Royal Asylum, David Skae and Thomas Clouston.

⁹³ Daniel Hack Tuke was one of British psychiatry's most prominent figures in the second half of the nineteenth century. He was the great-grandson of William Tuke, the founder of the York Retreat and the son of Samuel Tuke, whose *Description of the Retreat* (1813) had articulated the practice of 'moral treatment' and increased the profile of the Retreat.

⁹⁴ Bynum, 'Tuke's *Dictionary* and Psychiatry at the Turn of the Century', 167.

number of entries (thirty-nine) have the cause section left blank. A new cause which appeared during Hay's tenure was 'neurotic inheritance' (see appendix, table 4). This cause appeared only for a handful of patients, all of whom were women. The term denotes the inheritance of neurotic traits rather than outright insanity. The listing of this as a cause by Hay reflects the return to prominence of the hysteria diagnosis in the last two decades of the nineteenth century, although only one of the women with 'neurotic inheritance' listed as a cause was actually diagnosed with hysterical insanity.⁹⁵ Charcot co-authored an entry for Tuke's *Dictionary* on hysteria, which, by the nineteenth century had become associated with the nervous system rather than the womb.⁹⁶

One difference between E.W. Alexander's and Hay's entries in the causation column of the 'Register of Admissions', is the prevalence of multiple causes in Hay's entries. One entry, for example, reads: 'Heredity. Over-anxiety about work. Alcoholism. Syphilis.'⁹⁷ A further thirty-six cases have multiple causes of insanity listed in the Register. This can be compared with only ten patients before 1897 for whom more than one cause was listed. The number of cases listing more than one cause implies that Hay inquired more deeply into patients' histories, as does the absence of entries listing a cause as 'unknown' by Hay. Where a cause is left blank it is more often than not in the case of a 'voluntary boarder' or a patient admitted for compulsory treatment as a habitual drunkard (see appendix, table 4).

Like Alexander, Hay engaged with international medical scholarship throughout his career. Prior to his superintendence of Ashburn he had published a case study in the British psychiatric periodical the *Journal of Mental Science*; a 'Case of Epilepsy with Aphasia'.⁹⁸ Although he did not publish further case studies after his arrival in New Zealand, Hay's reports as Inspector-General, a post he succeeded to following Duncan MacGregor's death in December 1906, demonstrate that he kept abreast of developments in the field of psychiatric medicine and encouraged opportunities for New Zealand scholarship to contribute. He supported an initiative of E.H. Alexander's to establish a neuropathological laboratory at

⁹⁵ Only two patients (both women) were diagnosed with hysterical insanity during Hay's tenure as superintendent, while a third woman was given the diagnosis 'Melancholia & insanity of doubt. Hysteria.' See Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC.

⁹⁶ Bynum, 'Tuke's *Dictionary* and Psychiatry at the Turn of the Century', 167.

⁹⁷ Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC.

⁹⁸ Frank Hay, 'Notes of a Case of Epilepsy with Aphasia', *Journal of Mental Science* 41, no. 173(1895): 307-19.

Ashburn Hall to perform research autopsies on mental patients.⁹⁹ Hay also remained a member of the Medico-Psychological Association of Great Britain and Ireland, which he had joined in 1890. In 1910 he recommended the establishment of a Diploma in Psychological Medicine governed by Medico-Psychological Association guidelines.¹⁰⁰ Hay showed an active interest in keeping New Zealand psychiatry up to date and in increasing specialisation in New Zealand.

Edward Henry Alexander: Medical Superintendent (1904-1911)

Edward Henry Alexander, the last of the three medical superintendents, took over from Hay in 1904, staying at Ashburn Hall until 1911. He was the same age as Hay, born in Dunedin in 1867 and educated at Otago Boys' High School. He began his medical education at the new medical school at the University of Otago, and completed it at the University of Edinburgh.¹⁰¹ He graduated M.B.C.M. in 1890, the same year Hay graduated from Aberdeen, and served as an assistant in the Morningside and Fife Asylums in Scotland before returning to New Zealand in mid-1892.¹⁰²

Unlike Hay, E.H. Alexander studied at a university where there was instruction available on the treatment of insanity. A summer course on 'Medical Psychology: With Practical Instruction in Mental Diseases' had been available at the University of Edinburgh since 1859, taught by Thomas Laycock. This was the first course of its kind in a British university, and many appointees to positions in British asylums had attended it. From 1879 to 1910, Thomas Clouston, Laycock's former student and superintendent of the Edinburgh Royal Asylum at Morningside, held the post of Lecturer in Insanity at the University of Edinburgh, continuing to teach the summer course. It included clinical instruction in the

⁹⁹ The proposed laboratory and Hay's support for it is discussed in Hay's 1910 Report, 'Mental Hospitals of the Colony (Report on) for 1909' *AJHR* (1910), H-7, 5.

¹⁰⁰ *Ibid.*, 6.

¹⁰¹ The Medical School in Otago had been founded in 1875, but the first graduate in medicine from the University of New Zealand did not complete his degree until 1887. This is because for some years, the medical school could offer only the first two years of a medical degree, with completion being undertaken elsewhere. See Wright-St Clair, *Medical Practitioners*, 3. When E.H. Alexander attended medical school, therefore, it was possible to sit an entire degree in New Zealand. Perhaps the reason for undertaking study in Edinburgh was the prestige associated with a Scottish medical degree and the availability of a course on medical psychology under T.S. Clouston.

¹⁰² 'Lunatic Asylums for the Colony (Report on) for 1899', *AJHR* (1900), H-7, 11; Wright-St Clair, *Medical Practitioners*, 33

Royal Edinburgh Asylum, and demonstrations on the pathology of insanity using specimens and diagrams.¹⁰³

E.H. Alexander's position as an assistant physician at Morningside would have been gained through taking this course. His position at Fife Asylum may also have been gained through Clouston's influence. The choice of Edinburgh Medical School was due in part to the availability of the course on insanity, given his father's position as co-owner of Ashburn Hall.¹⁰⁴ An education in medicine from Edinburgh, however, also carried with it a high degree of prestige. It was at the time Britain's largest medical school.¹⁰⁵ A Scottish medical education was well respected, and students from all over the world, but especially Britain and the Empire, travelled to Scottish universities to study.¹⁰⁶

After E.H. Alexander returned to New Zealand he established himself in general practice at Blenheim before returning to Dunedin. He was an assistant medical officer to Hay in 1899-1900, but chose not to make the position permanent.¹⁰⁷ When Hay left Ashburn Hall in 1904, E.W. Alexander filled in as medical superintendent for about a month, until E.H. Alexander took over the position.¹⁰⁸ E.H. Alexander's case book entries are less detailed in some respects than Hay's were. In 1908 he introduced a new pro forma case book, which contained fewer categories. One particular difference was the reversion to only a small section on bodily condition. Hugh L, for example, was simply described as 'very stout'.¹⁰⁹ The Inspector-General's reports up to 1910 remained positive, however, about the treatment administered and level of care provided. In the 1907 Inspector-General's report, Hay wrote of E.H. Alexander's management of Ashburn Hall:

The entries in the case-book disclose a thoroughness and a scientific appreciation of the facts observed which is highly creditable, and Dr.

¹⁰³ Crowther and Dupree, 213.

¹⁰⁴ Somerville has found evidence to suggest Edward William Alexander wished his son to hold a permanent position in Ashburn Hall. E.W. Alexander likely encouraged his son to study at Edinburgh in the hope that Edward Henry would follow in his father's footsteps. See Somerville 78-9. Somerville cites E.W. Alexander, Rotorua, to Hay, 20 July 1903, Inward Correspondence of Ashburn Hall. Unfortunately this correspondence seems to have been lost from the archive when the records were moved to the Hocken Collections.

¹⁰⁵ Crowther and Dupree, 2.

¹⁰⁶ *Ibid.*, 22-6. The authors discuss explicitly the origins of students entering medical education in the 1870s.

¹⁰⁷ Somerville, 79.

¹⁰⁸ *Ibid.*, 178.

¹⁰⁹ Ashburn Hall, 'Case Book, 1908-1927', Folio 140 (AG-447-6/02), HC.

E.H. Alexander's personal knowledge of his patients is very complete.¹¹⁰

Contemporaries, therefore, praised E.H. Alexander's management of Ashburn Hall and there were several changes in the premises and care arrangements during E.H. Alexander's tenure as superintendent. In mid-1905 the male ward Mitchell was placed under the charge of a female nurse. This led to improvement in patient behaviour. By 1911, Mitchell was entirely run by female staff. Electric light was also installed at Ashburn Hall by 1908, in keeping with the aim to improve the premises, and a new cottage built for male patients requiring separate treatment.¹¹¹

Ashburn Hall's 'Register of Admissions' records the admission of 144 patients between May 1904, when E.H. Alexander took charge of the Hall, and the end of 1910. E.H. Alexander used many of the same categories for diagnosis as his predecessors, but some new diagnoses appear as well. 'Hebephrenia', appears once as a diagnosis. 'Paranoia' is diagnosed in five cases and 'maniacal-depression insanity' in thirteen (see appendix, table 5).¹¹² These newly appearing diagnoses reflect changing psychiatric nosology around the turn of the century. They also show that E.H. Alexander was influenced by European scholarship as well as Scottish practice. Bynum, referring to classifications used in Scotland and England in the 1890s, states that "'delusional insanity" was the diagnostic category favoured by British alienists for a variety of conditions which on the Continent were being dominated by such labels as "paranoia", "persecution mania", "hebephrenia", or "dementia praecox"'.¹¹³

'Dementia praecox' was a term popularized by German psychiatrist Emil Kraepelin in the mid-1890s along with the diagnoses of 'paranoia' and 'manic-depressive insanity'. It is unlikely that E.H. Alexander's use of these diagnostic categories was due to the continuing influence of his instructor, Clouston. Allan Beveridge states that Clouston 'remained critical of the concept of dementia praecox', a degenerative mental disorder beginning at a young age, which also appeared once as a diagnosis by E.H. Alexander. Clouston believed the term

¹¹⁰ 'Mental Hospitals of the Colony (Report on) for 1906', *AJHR*, (1907), H-7, 32.

¹¹¹ Medlicott, 40-41; 'Mental Hospitals of the Colony (Report on) for 1907', *AJHR* (1908), H-7, 21.

¹¹² Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC. 'Hebephrenia' would under twenty-first century diagnostic categories be referred to as disorganised schizophrenia, which is characterised by incoherence, delusions without an underlying theme and an inappropriate or silly affect. 'Hebe' refers to the commonly young age of onset. Hebe was the Greek goddess of youth.

¹¹³ Bynum, 'Tuke's *Dictionary and Psychiatry at the Turn of the Century*', 173.

‘dementia’ to be misleading.¹¹⁴ E.H. Alexander’s diagnoses at Ashburn were, therefore, informed by international scholarship.

By contrast, there was little change in the causes of insanity listed in the admissions register. The main cause E.H. Alexander listed was heredity, as it had been ever since Ashburn Hall began accepting patients. Other causes such as death of relatives, illness, alcohol or epilepsy were also used by E.H. Alexander’s predecessors. Yet the listing of multiple causes of insanity, common when Hay was superintendent, all but disappeared under E.H. Alexander’s management (see appendix, table 6). So too, the column in the register relating to physical health and condition did not generally contain as much detail as was given by Hay. The change from Hay to E.H. Alexander was not marked by any drastic increases in clinical detail such as those between E.W. Alexander and Hay. The change from Alexander senior to Hay was the entrance of a new generation of medical professionals to the management of Ashburn Hall. Hay and the younger Alexander were, however, contemporaries; both were university educated and had experience working in Scottish asylums before their appointments to Ashburn. The lack of a drastic shift in record-keeping similar to that between the first two medical superintendents is not, therefore, surprising.

Practices at Ashburn Hall did, however, continue to evolve under E.H. Alexander’s management. E.H. Alexander retained an interest in the progress of psychiatry as a field. The use of new diagnostic categories mentioned above is evidence of this, as is E.H. Alexander’s desire to keep Ashburn Hall in step with developments in psychiatric medicine. In 1907 Inspector-General Hay discussed E.H. Alexander’s intention to employ a medical man from Britain ‘engaged in scientific clinical research in psychiatry to be associated with him in his work’.¹¹⁵ In the end, the medical man from ‘Home’, Bernard Sampson of the City of Birmingham Asylum, did not take up the appointment.¹¹⁶ In 1909, the Inspector-General’s report again shows Alexander’s intention to add a research element into the running of Ashburn Hall. He planned to build a neuropathological laboratory at Ashburn Hall to perform research autopsies.¹¹⁷ This laboratory, once established, helped disseminate the latest medical

¹¹⁴ Allan Beveridge, ‘Thomas Clouston and the Edinburgh School of Psychiatry’, in Berrios and Freeman, *150 Years of British Psychiatry*, 376.

¹¹⁵ ‘Mental Hospitals of the Colony (Report on) for 1906’, *AJHR* (1907), H-7, 32.

¹¹⁶ Medicott, 42.

¹¹⁷ ‘Mental Hospitals of the Colony (Report on) for 1909’, *AJHR* (1910), H-7, 5.

theories and enabled New Zealand psychiatrists to contribute to research.¹¹⁸ E.H. Alexander, who resigned as medical superintendent in 1911, like his predecessors at Ashburn Hall was influenced by and sought to contribute to a wide international network of psychiatric medicine.

Conclusion

Practices at Ashburn Hall were part of the wider fabric of New Zealand psychiatry, which was heavily influenced by English precedent. Lunacy provision in New Zealand with its system of State-run asylums followed the English model established in the nineteenth century. Moral treatment was the norm in asylums around the United Kingdom and Europe, while non-restraint was a specifically English innovation transplanted into New Zealand and Australian asylums in the second half of the nineteenth century. A thorough examination of those doctors running Ashburn Hall, however, reveals a much more nuanced picture than an unmediated adoption of English medical practice.

The Ashburn Hall doctors were influenced by and remained engaged with continental and wider international medical trends. Medical ‘webs’, like other intellectual networks, wove themselves around the world. Non-British influences at play in informing the doctors’ practices and ideas include French, Belgian, German and North American. In terms of British influence, Scottish psychiatry had a high degree of bearing on developments at Ashburn Hall, with E.W. Alexander corresponding directly with a famous Scottish psychiatrist, Thomas Clouston. Additionally Hume and two out of three of Ashburn’s medical superintendents trained in Scottish universities and asylums. Owing to these factors, Scottish psychiatric developments may well have been more influential than English ones on practices at Ashburn. Indeed, a high number of New Zealand’s medical men were Scottish-trained. This is likely to have had an impact on New Zealand psychiatry more generally than just within Ashburn Hall, and requires further study.¹¹⁹

This chapter has examined the practices of the doctors who managed Ashburn Hall between 1882 and 1910 as well as devoting some attention to the only lay-superintendent, James Hume. It has argued that there was not a simple and direct translation of medical

¹¹⁸ Philp, 196, citing Frank Hay to the Hon. G. Fowlds, Minister of Mental Asylums, 27 June 1910, M.H. 1910/781, Archives New Zealand, Wellington Regional Office.

¹¹⁹ This call for further study of the Scottish impact on medicine in a wider New Zealand context echoes that made by Waltraud Ernst. See Ernst, ‘The Social History of Pakeha Psychiatry’, 75.

thought and practice from metropole to colony. Rather the doctors were part of a 'web' through which ideas on the diagnosis, causes, and treatment of insanity reached New Zealand from a variety of different countries. As well as being influenced by medical thought, the medical superintendents were also part of a colonial, white, Protestant, male medical elite. Some of the implications of the doctors' elite status for their judgements about patients will be considered in the next chapter.

Chapter Two: ‘Either Morbid or the Result of Ill-Breeding’: Bourgeois Respectability, Difference and Doctors’ Prejudices in Ashburn Hall

In 1897, 34-year-old Amy S, an epileptic, Catholic woman with a Jewish father and Scottish mother was admitted to Ashburn Hall. The doctor who treated her there, Frank Hay, was an Anglican man of British descent. Hay’s judgements about Amy centred not merely on her observable symptoms, but also on her differences from him and from what he perceived as the respectable bourgeois norm. His own migration, ethnic and cultural background shaped his judgements, as surely as his medical education did. Although Hay listed epilepsy and heredity as the causes of Amy’s insanity, thus giving ‘scientific’ explanations for her illness, her symptoms were at various times attributed to her gender, her religion and her ethnicity.

As chapter one has demonstrated, the three medical superintendents of Ashburn Hall, engaged with a wide intellectual medical network in their practices at Dunedin’s private asylum. Intellectual influences, however, combined with cultural ones in forming doctors’ ideas about what constituted the causes, diagnosis and symptoms of mental illness. The notion that science is contingent on culture is now far from controversial. Indeed one historian of science points out that ‘To speak about the social construction of science should be just another way of saying that people make science.’¹ The three doctors were all white, middle-class, Anglican men, members of the colonial bourgeoisie. This chapter argues that bourgeois values informed the doctors’ judgements about normality and abnormality. These judgements were at times explicitly linked to medical science, such as in the common medical association of woman’s insanity with her reproductive cycle. The doctors also judged patient behaviour against middle-class norms without direct reference to scientific thought. This chapter will investigate how the three doctors’ judgements about patients were informed by patient difference from the bourgeois respectable norm. It will do so through reference to gender, ethnicity, religion, and occasionally class within Ashburn Hall.

Establishing Colonial Respectability

Bourgeois respectability was even more precarious and contested in the colonial world than it was in Britain. Kirsten McKenzie, in an examination of scandal in Sydney and Cape Town, sees bourgeois respectability as constructed under the imagined gaze of Britain, with the colonial bourgeoisie seeking to prove themselves on an equal footing with British citizens at

¹ Margaret Jacob, ‘Science Studies after Social Construction: The Turn toward the Comparative and Global’, in *Beyond the Cultural Turn: New Directions in the Study of Society and Culture*, ed. Victoria E. Bonnell and Lynn Hunt (Berkeley: University of California Press, 1999), 115.

'Home'. Respectability was a weapon in colonial situations where there was more rapid social mobility than in Britain. 'Whether in material culture, housing style, gender relations or politics, the colonial middle class was aware that adherence to a British model held out the best hopes of social acceptability.'² McKenzie's observations can apply to the asylum as well. The very existence of asylums in colonial settings marked the colonies as self-consciously 'British'.³ The building of large asylums marked British methods of health and welfare as different from and superior to indigenous ones and symbolised the existence of proper British Victorian Government in the colonies.⁴ Asylums were an expression that colonial management of social and political life compared favourably with that 'at Home'.⁵ The asylum as a marker of British superiority symbolised one way in which British standards of respectable behaviour were transplanted to the colonies. Those who deviated from the respectable norm in such a way that their behaviour was considered insane could be 'cured', or at least managed within the space of the asylum.

Bourgeois respectability exhibited through 'normal' behaviour was a constant concern in defining sanity and insanity in colonial asylums. This was especially the case at Ashburn Hall. Founded as a private asylum for a better class of patients, Ashburn aimed to attract the 'right sort of people' and to 'keep the wrong sort of people out'.⁶ The patient base of Ashburn Hall was drawn largely from middle-class New Zealanders. If patients were too difficult to deal with or their families were unable to pay for their maintenance, they were either refused admission or transferred to one of the public asylums.⁷ At Ashburn Hall, therefore, patient behaviour was monitored and measured against middle-class ideals.

All three doctors at Ashburn Hall were born and spent much of their lives in British colonies. Medicine was a common choice of career amongst the nineteenth-century middle class, particularly for those who lacked the social connections and capital needed to make

² Kirsten McKenzie, *Scandal in the Colonies: Sydney and Cape Town, 1820-1850* (Melbourne: Melbourne University Press, 2004), 12-13, quote at 13.

³ See for example Alison Bashford, 'Medicine, Gender and Empire', in *Gender and Empire*, ed. Philippa Levine (Oxford: Oxford University Press, 2004), 112-33, in particular at 117-21; Waltraud Ernst, 'Out of Sight and Out of Mind: Insanity in Early Nineteenth-Century British India', in *Insanity, Institutions and Society, 1800-1914*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 245-67.

⁴ Bashford, 121.

⁵ Ernst, 'Out of Sight and Out of Mind', 245-6.

⁶ Alan Somerville, 'Ashburn Hall and Its Place in Society, 1882-1904', M.A. Thesis, University of Otago, 1996, 37.

⁷ *Ibid.*, 37-8.

their way in other socially acceptable professions like the military or the Church.⁸ The three Ashburn Hall doctors, like other middle-class colonial inhabitants, felt the value attached to maintaining and enforcing a respectable standard of behaviour in New Zealand. Examination of their patient case notes reveals what they perceived as the bourgeois ideals of behaviour in New Zealand society between 1882 and 1910. As Catharine Coleborne states, ‘It is in the observations of those who scrutinised patients in the asylum that glimpses of a range of social practices and attitudes towards them may be discovered.’⁹ The doctors commented on a number of patient behaviours showing a lack of respectability. These varied from patient to patient, but where patients were markedly ‘different’ from the bourgeois norm as perceived by the doctors, these differences sometimes became part of the pathology of their mental illness.

Gender

The standards of respectability against which the Ashburn Hall doctors measured their patients are most obvious in relation to gender, especially in the comments doctors made about female patient behaviour although male patient behaviour was also scrutinised and measured against a combination of gender and class standards. Coleborne, in her study of the operation of gender in the asylum in colonial Victoria, observes that the primary difference between patients was that of gender.¹⁰ The original classification of patients was based on gender rather than on type of mental illness. Men and women were separated in the space of the asylum and held to gendered standards of behaviour. Female behaviour, in particular, was closely scrutinised and variation from the bourgeois feminine ideal received comment. Amy S, mentioned at the beginning of this chapter, had ‘A tendency to be “forward” & occasionally [indulged] in meaningless sarcasm’.¹¹ Women were expected to be pious, maternal and demure. Forwardness, sarcasm, violence, foul language and inattention to husbands and children were only a few patient characteristics that received comment and condemnation from the Ashburn Hall doctors as symptoms of female madness.

⁸ Andrew Scull, Charlotte MacKenzie and Nicholas Herve, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, N.J.: Princeton University Press, 1996), 85.

⁹ Catharine Coleborne, *Reading ‘Madness’: Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848-1888* (Perth: Network Books, 2007), 63. Coleborne in her reading of the archive as both reflecting and producing wider views of colonial madness and its administration draws on the scholarship of James Mills. See James Mills, *Madness, Cannabis and Colonialism: The Native-Only Lunatic Asylums of British India, 1857-1900* (London: Macmillan and St Martin’s Press, 2000), 1-13.

¹⁰ Coleborne, *Reading ‘Madness’*, 2.

¹¹ Ashburn Hall, ‘Report Book – Intermediate Case Book, vol. 3’, 182, (AG-447-6/05), HC.

Coleborne considers two factors particularly significant in assessing women's experience of insanity in the nineteenth century: 'the perceived weakness of the female body, and the dangerousness of the woman outside the family/community.' Physical causes for women's insanity were often listed in the asylum in Victoria as bound to their reproductive cycle. A significant number of women, however, were also described as vagrant or alcoholic.¹² As Ashburn was a private asylum, few female alcoholics and no vagrants were admitted. Most women were admitted to Ashburn Hall from their positions within the family or community. The medical perception of the weakness of the female body, however, can be easily traced through the Ashburn case records and is one way in which medical visions of insanity overlapped with and normalised the bourgeois ideas of separate spheres for the sexes. The scientific 'discovery' of the biological opposition of male and female legitimated the gendered division of labour and authority within families in the nineteenth century. Men were breadwinners, supporting dependent wives and children.¹³ The medical belief that a woman's madness could be linked to her biological cycle reinforced the perceived superiority of men by casting women as inherently unstable.

Thirty women, approximately 14 per cent of all female patients between 1882 and 1910, were admitted with the cause of insanity assigned to some form of their biological function.¹⁴ May S, for example, was admitted with puerperal mania, caused by 'worry just after childbirth'.¹⁵ The diagnosis of puerperal insanity could cover many types of mental illness both acute and chronic, such as mania, melancholia, delusions and so on. Hilary Marland attributes the rise of puerperal insanity in England to increasing medicalisation of childbirth; reproduction was increasingly defined as taxing and full of risk, the province of male doctors rather than female midwives. Medicalisation of one area, childbirth, contributed to medicalisation of another, insanity. Women's minds, like their bodies, were increasingly defined as at risk and care for them became the province of medical men.¹⁶

¹² Coleborne, *Reading 'Madness'*, 58-62, quote at 61-2.

¹³ Barbara Brookes, Annabel Cooper and Robin Law, 'Situating Gender', in *Sites of Gender: Women, Men & Modernity in Southern Dunedin, 1890-1939*, ed. Barbara Brookes, Annabel Cooper and Robin Law (Auckland, N.Z.: Auckland University Press, 2003), 4, citing Thomas Lacqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, Mass.: Harvard University Press, 1990).

¹⁴ The percentage given includes only women who were legally committed under the *Lunatics Act 1882*. Voluntary boarders' gender is seldom recorded in the admission register.

¹⁵ Ashburn Hall, 'Register of Admissions, 1882-1948', (AG-447-5/01), HC.

¹⁶ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2004), 20.

Nine women were admitted to Ashburn Hall with some form of puerperal insanity listed as a diagnosis, or with childbirth listed as a ‘cause’ of insanity between 1882 and 1910.¹⁷ Sometimes this was in conjunction with another ‘cause’. Mary B, who was admitted with resistive melancholia in 1897, had given birth to triplets in late May. Two died at birth and the third nearly died in late June. Mary’s mother was also a patient at Ashburn Hall. Hay recorded Mary’s cause of attack in his admission note as ‘doubtless heredity’, accompanied by a weakening of the mental state by delivery.¹⁸

The medical profession believed that other stages of women’s biological cycle also caused or contributed to mental instability. Lactation was listed as the cause of insanity for seven women admitted, and the climacteric (menopause) was listed as the cause of insanity for a further fourteen women as well as for one man.¹⁹ Bronwyn Labrum points out that, ‘Doctors saw in menopause further signs of woman’s subjection to her biology.’²⁰ One 1890 textbook stated that ‘the cessation of the reproductive function is attended by stresses that are inferior to those only which accompanied its development’.²¹ Women’s biological cycles were heavily pathologised by the male medical elite and the link of a woman’s madness to her reproductive cycle was made not only in establishing a cause, but also in charting the progress of a case. Women’s menstrual periods were closely monitored in a number of cases, and linked to an increase in insane symptoms. In November 1886, for example, E.W. Alexander noted of Janet B that her ‘menstrual periods are always times of excitement’.²² In the admission note of the same patient, Alexander noted the cessation of menstruation and its

¹⁷ See appendix, table 2 for eight of these cases. The ninth, Mary B, appears in appendix, table 4 as one of the patients with multiple causes of insanity listed by Hay. Her supposed causes of insanity were listed as ‘Puerperal state. Mental shock. Heredity’. See Ashburn Hall, ‘Register of Admissions’.

¹⁸ Ashburn Hall, ‘Report Book – Intermediate Case Book, vol. 3’, 164.

¹⁹ See appendix, tables 2, 4 and 6. As with puerperal insanity, several of those patients admitted had multiple causes recorded by the treating doctor. Only six patients whose insanity was assigned to lactation had this listed as the sole cause in the “register of Admissions”, while eleven patients whose cause of insanity was attributed to the climacteric had this assigned as a sole cause. The others all had multiple causes listed. The use of ‘climacteric’ as a cause for male insanity still denotes a change of life. The *Oxford English Dictionary* defines ‘climacteric’ as ‘the period in life when fertility is in decline; (in women) the menopause’. See http://www.askoxford.com/concise_oed/climacteric?view=uk. Where ‘climacteric’ is listed as the cause of insanity for a man, William G, there is nothing in the case notes to explain this, other than his being about 50. He had shown peculiarities for about 9 months before admission and had started spending lavishly and making extravagant propositions. There is never any explicit link made to a change of life beyond the reference to climacteric in the admissions register. See Ashburn Hall, ‘Register of Admissions 1882-1948’; Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 104 (AG-447-6/04), HC.

²⁰ Bronwyn Labrum, ‘Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum, 1870 -1910’, M.A. Thesis, Massey University, 1990, 169.

²¹ Quote from 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): 180, quoted in *Ibid*.

²² Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 71.

eventual resumption as part of the progress of her illness before her admission to Ashburn Hall.²³

The link of female reproductive cycles to insanity was in line with psychological thought throughout the Western world. The majority of doctors in the late nineteenth and early twentieth century believed that insanity had a somatic basis. As mentioned in chapter one, Daniel Hack Tuke's 1892 *Dictionary of Psychological Medicine* contained a large number of entries on the relationship between psychological illness and physical factors. Psychiatrists in the late nineteenth century were eager to draw on medical and surgical diagnostic and therapeutic methods.²⁴ The notion that insanity had a somatic basis led to regular diagnosis based on women's reproductive cycle. This perception of women's biology as liable to cause mental instability in turn lent support to patriarchal authority, both within the asylum and more widely in society. Theories of biological sexual difference gave scientific weight to narrow Victorian bourgeois ideals of femininity.²⁵

As well as the attribution of insanity to the female reproductive cycle, the ways in which E.W. Alexander, Frank Hay and E.H. Alexander recorded patient behaviour give clues to how gender was constructed within Ashburn Hall. Medical practitioners, according to Ann Goldberg, were implicitly engaged in defining femininity and masculinity.²⁶ Medical 'normality' was informed by bourgeois gender norms. Medical discourse about patient behaviour in Ashburn Hall demonstrates some of the kinds of behaviours which deviated from bourgeois normality to the extent they were considered symptomatic of madness.

Josephine R's behaviour, for example, was constructed as symptomatic of her insanity where it deviated from E.W. Alexander's ideas of appropriate femininity. Josephine could appropriately be described as a 'new woman'. She was single and according to her case note 'well educated & very intelligent'.²⁷ She was admitted in 1888 suffering from 'acute mania' caused by 'over-excitement'. She stayed at Ashburn for just over a month before being discharged 'recovered'.²⁸ Part of the original entry on admission reads:

²³ Ibid., 6.

²⁴ W.F. Bynum, 'Tuke's *Dictionary* and Psychiatry at the Turn of the Century', in *150 Years of British Psychiatry, 1841-1991*, ed. German E. Berrios and Hugh Freeman (London: Gaskell, 1991), 167.

²⁵ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Pantheon Books, 1985), 121.

²⁶ Ann Goldberg, *Sex, Religion and the Making of Modern Madness: The Eberbach Asylum and German Society 1815-1849* (New York: Oxford University Press, 1999), 95.

²⁷ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 155.

²⁸ Ashburn Hall, 'Register of Admissions 1882-1948'.

Fond of studying phrenology and read books on physiology & psychology which *she says* enlightened her. She came to Dunedin 3 weeks back and consulted Dr Batchelor respecting a uterine derangement two days before admission, who found her mentally disturbed. In Dunedin stayed at lodgings during which time she advocated the case of a girl sentenced for theft who had pleaded impulse to steal. She visited the Gaol to see her and had interview with the Industrial School Keeper. She also was much interested in a deranged lady living at home.²⁹

The history of the patient recorded here was that considered significant by E.W. Alexander. The 'over-excitement' listed by E.W. Alexander as the cause of insanity seems to be that attendant upon Josephine's journey to Dunedin and interest and advocacy in the affairs of other women.

There is an implication in the case note that Alexander does not believe Josephine's study of physiology and psychology can in fact have 'enlightened her'. Scientific inquiry and education were considered a male-only domain by many in the nineteenth century. Elaine Showalter, in her feminist history of madness in England, considers that doctors influenced by social Darwinism linked the increase in nervous disorder in the late nineteenth century to women's ambition. Men and women, in doctors' eyes, had their natural spheres and mental breakdown might be the consequence of women defying their natures.³⁰ Education and advocacy on behalf of others seem in Josephine's case to be unhealthy and exciting, not appropriate pursuits for a respectable woman. The extract of the admission note reproduced above does not comprise the entire history given. On the day before her admission Josephine 'was excited, noisy, singing, screaming, praying, swearing, throwing objects and clothes about the room, threatening'.³¹ This behaviour would have been cast as deranged in any era. The case note, however, reveals attitudes about a woman's appropriate sphere and uneasiness about her stepping outside that sphere.

The nature of the note-taking at Ashburn often obscures how much of an entry made on a patient's admission consists of the medical superintendent's own opinion, and how much is repeated from the information provided in the medical certificates by the committing doctors, or supplied by the patient's family.³² Comments about forwardness, coarse language or any

²⁹ Ashburn Hall, 'Report Book – Intermediate Case Book', Vol 1, 155. Emphasis added.

³⁰ Showalter, 121-3.

³¹ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 155.

³² The case notes from 1908 onwards are an exception here. From this date, case notes were recorded in a pro forma book which contained a section for reproduction of the information contained in the medical

other ‘unfeminine’ behaviour in admission notes may well be based on judgements other than those formed through the Ashburn doctors’ own observation and opinions. Many patients were observed to transgress the bounds of ‘normal’ gendered behaviour in some way or another before their admission was ever sought. Jessie R, for example, had to be restrained by her family before her May 1904 admission to prevent her going to play the organ at a public house.³³ The weight attached to ‘normal’ gendered behaviour by the doctors Alexander and by Hay may well have differed from the weight attached by family, but it is difficult to judge the extent of this from the evidence available. In some cases there are hints that a family was less concerned with a wife’s, daughter’s or mother’s conformity to ‘normality’ than the doctors were. A husband or other family members might wish to take a female patient home despite the doctor’s judgement that she was not ready for release. Sophia P and Harriet B were both discharged ‘improved’ although E.W. Alexander did not think they were fit to be at home.³⁴ Amy M was taken out of Ashburn by her husband against E.H. Alexander’s advice. The younger Alexander noted, ‘the husband appears to me to be dominated by the patient’.³⁵ For a wife to dominate her husband ran contrary to the bourgeois ideal of patriarchal authority within the family unit.

The doctors commented on unfeminine behaviour throughout the course of a patient’s stay. Indeed, a major part of the improvement of many female patients in the doctors’ eyes was when they started to behave in a manner befitting their gender. It is in these comments made and judgements passed by the doctors about a patient’s condition that we can discover the prejudices of the doctors about what constituted femininity. The gender attributes displayed by patients were significant in assessing their level of illness or recovery. Sanity was equated with proper bourgeois femininity.³⁶ Two weeks before Josephine R’s discharge, E.W. Alexander considered that she was ‘quite rational, but a little imperious and exacting’.³⁷ These personality characteristics received comment in almost every note between her recovery and release, showing that E.W. Alexander considered them personality flaws, if not actually symptoms of mental disorder.

certificates on admission. This included comments from one or more witnesses, usually family members or friends, on the patient’s behaviour and mental state as perceived by them.

³³ Ashburn Hall, ‘Case Book 1882-1907’, Folio 108 (AG-447-6/01), HC.

³⁴ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 139-41.

³⁵ Ashburn Hall, ‘Case Book, 1908-1927’, Folio 143.

³⁶ Coleborne, *Reading Madness*, 88.

³⁷ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 157.

Imperiousness and forwardness in women, especially when expressed towards the superintendent, were considered flaws in part because the structure of authority in the asylum was similar to that within an ideal bourgeois family. The superintendent had all the authority which, in a bourgeois family, was reserved for the male head of the household. The patients were like children, and due deference to the medical superintendent ought, therefore, to be displayed. To do so might show improvement, while failure in this respect was seen as at best a character flaw, or at worst symptomatic of insanity. Hay described Felicia G's 'self-assertive manner & a tendency to show a want of respect for others' as 'either morbid or the result of ill-breeding'.³⁸ When female patients were quiet and well-behaved, working at feminine tasks such as sewing or knitting and giving the proper deference to that figure of authority, the medical superintendent, this showed an improvement in their condition. This family-like structure of authority was common to all asylums, but was even more explicit in private asylums such as Ashburn Hall, where the medical superintendent had a deeper knowledge and greater interaction with all his patients. Indeed, some private English asylums self-consciously advertised a family-like structure and home-like atmosphere in their asylums.³⁹ The doctors at Ashburn Hall sought to instil in their female patients behaviour befitting daughters, wives and mothers of bourgeois households.

One form of patient behaviour which was particularly troubling for doctors was masturbation. This occurred in patients of each sex. Part of the problem with masturbation was the secrecy with which it could be carried out. In women, doctors believed that masturbation led to violence and confrontation, which had the potential to undermine medical authority. Ann Goldberg in her study of the Eberbach Asylum in Germany observed that female masturbation was linked to energetic forms of mental disorder such as mania and violence.⁴⁰ The doctors were concerned with masturbation in both married and unmarried women at Ashburn Hall. The 24-year-old married patient Mary M was one of several female patients at Ashburn who masturbated. She was diagnosed as delusional, and her recorded symptoms included incoherent rambling and destructiveness. She cut off all her own hair, and raked ashes out of the fire into the room with her hands.⁴¹ The 18-year-old single patient Amy

³⁸ Ashburn Hall, 'Case Book 1882-1907', Folio 93.

³⁹ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London; New York: Routledge, 1992), 22-4.

⁴⁰ Goldberg, 89-91.

⁴¹ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 29.

M was suspected of masturbation because she was ‘destructive and immodest’.⁴² Other female patients who masturbated exhibited similar behaviours which violated the conventions of bourgeois feminine behaviour.

Doctors in the nineteenth century linked masturbation to a wide range of illnesses such as epilepsy, consumption, digestive disorders, impotence, hypochondria, imbecility, hysteria, and nymphomania. The association of masturbation with mental and physical illness gave a secular scientific rationale to its prohibition. It was a fear specific to the bourgeoisie, considered particularly insidious as it could be undertaken in secret and violated ideals of respectable behaviour such as female purity or male self-restraint.⁴³ Male masturbation, by contrast with female, was seen to cause effeminacy or weakness. It was linked to degeneration and to the enfeeblement of men.⁴⁴ Herbert P’s admission note bears this out. He was described as ‘A weak-minded young man’ with ‘Glance arrested, hands in pockets, not much to say for himself’. In the ‘Register of Admissions’ the cause of his dementia was assigned to ‘masturbation’.⁴⁵

In Ashburn Hall the presence of masturbation was noted in the case notes of several men, as disruptive of improvements to their mental state. E.H. Alexander recorded in September 1904 that Herbert P ‘continues to have periods corresponding probably with masturbational excess in which he dresses himself up & refuses to work’.⁴⁶ Working was an important part of moral therapy. Men were encouraged to work at gardening or farming, while women were limited to the more traditionally feminine tasks of sewing and knitting, or helping in the kitchen and laundry. Anne Digby draws a link between the work therapy offered as part of moral treatment and the nineteenth-century bourgeois work ethic.⁴⁷ Herbert P’s refusal to work shows masturbation as disrupting improvement and causing a breakdown of the bourgeois work ethic in an individual.

The Ashburn Hall doctors measured male patients against bourgeois standards in other ways too. Masculine forms of behaviour and labour were judged in order to assess degrees of illness and recovery, and men’s mental illness was generally seen as caused by different

⁴² Ibid., 129. Although both these women were relatively young, masturbation was not merely a youthful behaviour. Forty-five-year-old Charlotte M, diagnosed with ‘acute mania’, also masturbated. See Ibid., 180.

⁴³ Goldberg, 88-91.

⁴⁴ Ibid., 90.

⁴⁵ Ashburn Hall, ‘Case Book 1882-1907’, Folio 100; Ashburn Hall, ‘Register of Admissions, 1882-1948’.

⁴⁶ Ashburn Hall, ‘Case Book, 1882-1907’, *ibid.*

⁴⁷ Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge; New York: Cambridge University Press, 1985), 48.

factors than women's. Stephen Garton uses asylum case notes to study both men and madness and women and madness. He focuses, in particular, on the differing contexts for male and female committal, and the construction of madness for men and women in New South Wales in the late nineteenth to mid-twentieth century.⁴⁸ He notes a number of differences between the committal of men and women. While women's madness was often attributed to biological function, as it was in Ashburn Hall, Garton discovered a correlation between the committal of men and isolation, itinerant labour, poverty and alcohol, particularly in the nineteenth century.⁴⁹

In Ashburn Hall, there were few diagnoses or causes of insanity associated solely with men. 'Solitary life' appeared as a cause of male insanity in five cases, but not as a cause of female insanity.⁵⁰ This is somewhat in line with Garton's findings in New South Wales, although isolation was not as prevalent in Ashburn as it seems to have been across the Tasman. Few, if any, itinerant labourers or other men likely to live in isolation were admitted to Ashburn because they had no-one to pay for their upkeep in the asylum. Alcohol and drugs appeared as a cause of insanity for both men and women, although all those committed to Ashburn as habitual drunkards under the *Lunatics Act 1882* were men. Only one physical cause of insanity was unique to male patients at Ashburn Hall, that of general paralysis of the insane. G.P.I. was listed as either a diagnosis or cause of insanity in fourteen men, about seven per cent of all male cases between 1882 and 1910. It was also listed as the cause of death for three other men.⁵¹

Discourse about male patients shows varying standards of masculinity, particularly in relation to class. In general, in Ashburn Hall, the doctors made very little reference to class in forming their judgements about patients. Where there is reference to class it is seldom overt. This is because almost all the patients admitted to Ashburn Hall were middle class. Members of the lower classes in general would have nobody to pay their fees. Being a member of the middle class in Ashburn Hall was the dominant condition amongst patients, and was, therefore, largely invisible to those observing the patients. There were, however, some occasions when differing standards of class influenced the doctors' judgements about individual patients.

⁴⁸ Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940* (Kensington, NSW, Australia: New South Wales University Press, 1988), chapters 6 and 7.

⁴⁹ *Ibid.*, 148, and 118-9.

⁵⁰ Ashburn Hall, 'Register of Admissions 1882-1948'.

⁵¹ *Ibid.*; Ashburn Hall, 'Register of Discharges, Removals and Deaths, 1883-1968' (AG-447-5/02), HC.

William L, a barrister who was admitted after a suicide attempt, was described as ‘pale and soft’ and his father had been of a ‘nervous temperament’.⁵² He had money trouble and his suicide attempt was made to save his fiancée from the ‘dishonour’ of marrying a man who would drag her to misery. William claimed that his suicide attempt was inspired by a character in a novel in a comparable situation.⁵³ The story told in William’s admission note reveals a deep level of introspection, high notion of honour and emotional delicacy reminiscent of the romantic hero as described by Ruth Harris in her exploration of male crimes of passion in late nineteenth-century France.⁵⁴

These characteristics and his profession as a barrister separated William from other male patients, despite Ashburn admitting only those patients whose families could pay and who were, therefore, usually professionals or farm owners. William’s recovery was not judged by the same standards of many of the other male patients. Most men were expected to work as part of their recovery. An improvement was noted in William’s case, however, when he started ‘[coming] out into the ground constantly to watch work at some buildings’ and ‘[driving] himself about’.⁵⁵ Perhaps there was something to the idea expressed by Herbert P on his refusal to work in the garden that ‘gentlemen do not work’.⁵⁶ Herbert P was a farmer and his claim to be a ‘gentleman’ was regarded as part of his illness. William L, on the other hand, was a barrister. This profession involved no physical labour, was gained through undertaking tertiary education and carried a considerably more prestigious social status with it than that of a farmer. Doctors’ judgements about appropriate standards of gendered behaviour could, therefore, be influenced by the social status of the patient. For men, at least, the bourgeois respectable norm against which symptoms of mental illness were measured varied between patients. Gender combined with other markers of difference, such as class, in influencing the doctors’ judgements.

Ethnicity

Forms of difference other than gender and class also operated within Ashburn Hall to explain patient behaviour, either by themselves or in conjunction with others. Ethnicity was one such marker by which insane symptoms were explained and departures from the norm judged. As

⁵² Ashburn Hall, ‘Report Book – Intermediate Case Bok, Vol 1’, 7.

⁵³ Ibid. Unfortunately, the name of the novel was not recorded in the case note.

⁵⁴ Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the Fin De Siècle* (Oxford: Clarendon Press, 1989), 304.

⁵⁵ Ashburn Hall, ‘Report Book – Intermediate Case Bok, Vol 1’, 7.

⁵⁶ Ashburn Hall, ‘Case Book 1882-1907’, Folio 100.

Angela McCarthy highlights in relation to the Auckland Asylum, doctors' own migration experience and ethnic background have a great deal of relevance in shaping perception and labelling of patients.⁵⁷ The Ashburn Hall records show that this is especially true of patients who were more markedly different from themselves. The doctors sought to explain the behaviour and symptoms of the Maori, Chinese and Jewish patients of Ashburn Hall with reference to their ethnicity. In the case of Jewish patients, as the final section of this chapter will show, ethnicity combined with religious difference in the doctors' eyes to explain patient behaviour.

The recording of ethnicity or birthplace in the Ashburn Hall records was fairly sporadic. The pro forma case book used from 1900 to 1907 had spaces available to record birthplace, family history and family trees, but these were only occasionally filled out. From the information available it becomes clear that the ethnic origins of most Ashburn patients were either English or Scottish. Irish ethnicity was the largest minority, with fewer than ten patients recorded as born in Ireland. In 1882, it seems that many of the patients admitted were foreign born, although the information for this period is incomplete. As time progressed, more New Zealand-born patients were being admitted, although again the information about birthplace and ethnicity is far from complete. Indeed, the pro forma case book from 1907 onwards did not contain a category for birthplace or family tree, although it did for family history. When a patient was admitted before 1900 or after 1907, therefore, any information about their ethnic origins was only recorded if it was considered a relevant part of their history or was mentioned incidentally by the Medical Superintendent as part of the progress of their case in Ashburn Hall.

Unlike patients at Dunedin's public asylum, the behaviour or physical appearance of patients of English, Scots or Irish descent was seldom defined in ethnic terms.⁵⁸ Rather, in these cases, gender or sometimes religion was the primary marker of difference between patients. For other patients, however, ethnicity is commented upon in case notes. John G was discussed in heavily racialised terms, especially by Frank Hay, although he was treated by both E.W. Alexander and Hay. E.W. Alexander recorded on John's first admission in 1885 that he was a half-caste Maori farmer. He recorded the cause of insanity as heredity, stating

⁵⁷ Angela McCarthy, 'Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century Auckland', *Social History of Medicine* 21, no. 1 (2008): 48.

⁵⁸ Angela McCarthy, 'A Difficult Voyage', *History Scotland* 10, no. 4 (2010): 26-31.

that a paternal aunt was insane.⁵⁹ John G was eventually discharged recovered in 1890, but returned to Ashburn as a 'voluntary boarder' in 1900.

Frank Hay, on John G's admission as a voluntary boarder at Ashburn Hall, made several entries in the case book linking John's Maori ethnicity and insane symptoms. In the admission note Hay recorded, 'His gestures suggest the prepotency of the Maori parent. Very dirty, unwashed appearance.'⁶⁰ Lorelle Burke in her study of Maori patients at the Auckland Lunatic Asylum found that the colonial obsession with cleanliness and hygiene was reflected by comments about 'dirt' and 'dirty habits' in the notes of both Maori and non-Maori patients.⁶¹ This is true too of Ashburn Hall. 'Dirtiness' and 'dirty habits' received comment in many patients regardless of ethnicity. The juxtaposition of the two sentences quoted above, however, suggests a judgement by Hay that John G's dirtiness was due to the influence of his Maori mother as well as his gestures. Hay recorded that John's father, from whose family the heredity of insanity was thought to flow, was Irish. There are, however, no further references in John's case note to his Irish ethnicity although there are several to his Maori ethnicity. This is interesting given the contemporary concern of asylum doctors around the world with the high numbers of Irish committed to asylums.⁶² Hay identified John's insane symptoms with Maori rather than Irish ethnicity, perhaps because Maori descent represented more of a departure from the British bourgeois respectable norm than Irish ethnicity did.

Maori ethnicity had a more obvious physical appearance than Irish, which probably contributed to Hay's focus on it. Hay also recorded in the section for physical condition in the pro forma case book that John G had 'a distinct Maori cast'.⁶³ Lorelle Burke identifies that in the Auckland Asylum descriptions of Maori patients using terms such as the 'usual Maori features' were common. Medical observation defined and confined construction of patients

⁵⁹ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 90; Ashburn Hall, 'Register of Admissions 1882-1948'.

⁶⁰ Ashburn Hall, 'Case Book 1882-1907', Folio 37.

⁶¹ Lorelle Burke, "'The Voices Caused Him to Become Porangi'": Maori Patients in the Auckland Lunatic Asylum, 1860-1900', M.A. Thesis, University of Waikato, 2006, 35.

⁶² Elizabeth Malcolm states that concern was expressed as early as the 1840s in New York State, and in the 1880s in New South Wales. In England too, the Irish were overrepresented in figures for institutionalisation. See Elizabeth Malcolm, "'A Most Miserable Looking Object'": The Irish in English Asylums, 1850-1901', in *Irish and Polish Migration in Comparative Perspective*, ed. John Belchem and Klaus Tenfelde (Essen: Klartext, 2003), 121-32, particularly at 121-6. Institutionalisation of the insane in Ireland was also high, causing concern for officials and the circulation in medical and official circles of a number of theories about the reasons behind the high Irish insanity rate. See Elizabeth Malcolm, "'Ireland's Crowded Madhouses'": The Institutional Confinement of the Insane in Nineteenth- and Twentieth-Century Ireland', in *The Confinement of the Insane: International Perspectives, 1800-1965*, ed. David Wright and Roy Porter (Cambridge: Cambridge University Press, 2003), 315-33.

⁶³ Ashburn Hall, 'Case Book 1882-1907', Folio 37.

along ‘racial’ and gendered boundaries.⁶⁴ John G’s case was certainly constructed along ‘racial’ boundaries. With regard to gender, there was no explicit comment similar to those found by Burke in Auckland about male strength or masculinity. John G was, however, confined to those outdoor, masculine forms of work considered gender-appropriate. He helped as a groom in the stable and fed the pigs.⁶⁵

Later in John G’s case notes, Hay commented that his gestures suggested a haka. He also mentioned this patient talking about ‘big feasts of Pig & bean & potatoes – rubbing his stomach & going on like a Maori’.⁶⁶ The recording of these behaviours suggests Hay considered them as symptoms of insanity along with John’s violence, obscene gestures and foul language. John’s Maori descent cast him as ‘uncivilised’. The medical profession, in attempting to treat John and render him ‘sane’, was complicit in the colonial civilising process.⁶⁷ Because of his violence, however, Hay was unwilling to keep John G as a voluntary boarder. After several months at Ashburn, Hay recommended that John’s son take him out to have him certified and sent to Seacliff. His behaviour in conjunction with his descent was too far from the ‘norm’ for Hay to be willing for him to continue his stay. John became one of the ‘wrong sort of people’, who the managers of Ashburn wished to keep out.

John was the only Maori or half-caste Maori admitted to Ashburn Hall between 1882 and 1910. Maori were in general under-represented in asylums, particularly in Dunedin where the Maori population was small. The Auckland Asylum in the North Island had the highest concentration of Maori patients, admitting 72 between 1860 and 1900.⁶⁸ Hay arrived in the colony to practise at Ashburn Hall only three years before John’s admission. He likely had little contact with Maori outside the asylum. This may be why John’s case is discussed in more obviously ‘racialised’ terms than any other in Ashburn Hall between 1882 and 1910. There were other cases, however, where a patient’s ethnicity became significant in how their behaviour was analysed by the doctors. Wing K, a Chinese shop-keeper, was admitted in 1885 with delusional mania. The notes about his case are brief and most of the information contained in them seems to come from his brother.⁶⁹ This was likely due to language difficulties. His brother either spoke more English than he did, or Wing had reverted to

⁶⁴ Burke, 22.

⁶⁵ Ashburn Hall, ‘Case Book 1882-1907’, Folio 37.

⁶⁶ Ibid.

⁶⁷ Burke, 35-6.

⁶⁸ Ibid., 10-11.

⁶⁹ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 77.

speaking only Chinese while he was delusional. For this patient, ethnicity and particularly language marked him as different from the other asylum inmates.

Coleborne, examining Chinese patients within the colonial Asylum in Victoria, found that the medical discourse used about Chinese male patients reflected wider fears about Chinese. Chinese men's bodies were discussed differently from those of white male patients, while their religion was recorded as 'pagan'.⁷⁰ Wing K, by contrast, was not discussed much at all by E.W. Alexander in the asylum case book. He was described as 'thin, health good' in the Register of Admissions, but his physical appearance was not mentioned further in the case book. His religion was not discussed at all.⁷¹ Even his behaviour received little comment. He seems to have been left largely to himself. The only notes on his case were entered following visits by his brother who told E.W. Alexander what the patient had said. The following quote is one example: 'Seems to be quite delusional. Takes food well. Told his brother he wanted to kill a countryman whom he said had done something to him.'⁷² There were no notes about whether Wing K was working in the asylum, what he did for leisure or whether he interacted with any other patients. His ethnicity and language difficulties would have isolated Wing from the predominantly British patient population at Ashburn Hall, just as Chinese immigrants would have experienced some degree of isolation from the predominantly white settler society of New Zealand. Wing spent four months in the asylum. This was a short stay, but not unusually so.⁷³ The final note reads 'discharged to go home', but it is unclear whether 'home' is in New Zealand or a return to China.⁷⁴ Rather than the medical discourse about this particular Chinese patient reflecting wider fears, he seems to have been cast as a non-entity, with little agency or personality.

The examples of Wing K and John G show how 'race' or ethnicity could explicitly come into doctors' judgements about or treatment of patients. John G's 'Maori gestures' were considered symptomatic of his insanity, a hangover from an irrational and dying race. Wing K, on the other hand, seems almost a non-entity in the case book. The fact that he is Chinese seems to exclude him from effective interaction with the asylum doctors. His ethnicity and

⁷⁰ Coleborne, 'Making "Mad" Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum', in *Law, History, Colonialism: The Reach of Empire*, ed. Dianne Kirkby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 116.

⁷¹ Ashburn Hall, 'Register of Admissions 1882-1948'.

⁷² Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 77.

⁷³ Length of stay varied significantly. Herbert B remained in the asylum for over 20 years after his 1885 admission, while John L stayed just over six months. John P spent only 15 days at Ashburn before being discharged recovered. Ashburn Hall 'Register of Admissions, 1882-1948'.

⁷⁴ *Ibid.*; Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 77.

language barriers preclude gaining much insight into his experience in the asylum, beyond the supposition that it was an isolating one. The third ethnicity that the Ashburn Hall doctors explicitly commented on was Jewish. In terms of Judaism, ethnicity could overlap with religion as a marker of difference. This will be further explored in the final section of this chapter. There were four patients for whom religion was recorded as Jewish in the Ashburn Hall case notes, and a further patient of Jewish descent on her father's side, although her religion was Catholic. As previously mentioned, recording of birthplace or ethnicity is incomplete, so these five patients do not necessarily represent all those of Jewish descent admitted between 1882 and 1910.

Where John G had a 'distinct Maori cast', the Jewish patient Edward J's features were described as of the 'Semitic type'.⁷⁵ There was, however, no other explicit reference to his ethnicity or religion in his case notes. He was admitted in 1900 with general paralysis of the insane, and the cause was listed as a combination of heredity and syphilis.⁷⁶ Hannah L, an elderly Jewish woman diagnosed with dementia, also had 'Jewish features'.⁷⁷ Jewish patients were perceived through physical 'racial' difference by the Ashburn Hall doctors.

Ann Goldberg, in her examination of the Eberbach Asylum in Germany, uncovered a perceived link between Jewishness and criminality. Jewishness, in her words, 'represented a category of interpretation distinct from illness'.⁷⁸ The deep-set anti-Semitism prevalent in Europe was not played out in the medical discourse of Ashburn Hall in New Zealand, but occasionally some prejudice is evident in the doctors' writing. Jewishness was still at times considered a marker of difference or an explanation for parts of patient behaviour while in the asylum. Parts of Hannah L's conversations with Hay were paraphrased in the case book:

The repetition of a few Hebrew words is sure to elicit confidences, in which, if asked what she thinks of the guyem, (?) Christian, she will try to be very just but generally end by giving [illegible] the conversation jewish [sic] character.⁷⁹

This quote was part of a longer note, the ostensible purpose of which was to establish Hannah's state of mental confusion. Her senility, it would seem, caused her to give the conversation a 'jewish character' and to place confidence in someone merely because they used Hebrew words.

⁷⁵ Ashburn Hall, 'Case Book 1882-1907', Folio 52.

⁷⁶ At this time the link of syphilis with general paralysis was not yet confirmed.

⁷⁷ Ashburn Hall, 'Case Book 1882-1907', Folio 29.

⁷⁸ Goldberg, 162.

⁷⁹ Ashburn Hall, 'Case Book 1882-1907', Folio 29.

Another patient whose behaviour is partly explained with reference to her ethnicity is Amy S. The prejudice most evident in Hay's case notes about Amy, about the irrationality of Catholicism, will be explored further in the next section. Some of Amy's behaviour within the asylum was explained with reference to her ethnicity. When she took an interest in Hannah L, Hay attributed this to the fact that they were both 'Hebrew'.⁸⁰ This was the only similarity Hay could see between these two patients as an explanation for Amy's interest. This shared characteristic of the two women, however, was also one of the things which marked them as 'different' in Hay's eyes. When non-Jewish patients interacted or took an interest in each other, a shared Scottish or English ethnicity or shared Protestantism was never mentioned as the reason, although such patients might well share ethnic or religious ties.

Ethnicity, like gender and religion, was used by the Ashburn Hall doctors as a marker of patient difference and to explain some oddities of patient behaviour. The fact that the doctors at Ashburn Hall only commented upon non-British minorities in the patient population is, however, strange. Recording of patient physical features, for example, did not follow the ethnic stereotyping used at other institutions. At Seacliff Asylum, as McCarthy has found, patient physicality and personalities were linked to a range of 'national characteristics'. Patients described by ethnicity at the public asylum included a 'typical high-spirited old Highlander'; 'A big broad loosely built slouchy German. Typical German features', and 'A typical fair haired light complexioned Scandinavian'. Science and anthropology in the late nineteenth century characterised different ethnicities with particular emphasis on skin and hair colour.⁸¹ It is somewhat odd, therefore, that in Ashburn Hall ethnicities other than Jewish, Chinese or Maori were not characterised or discussed in ways which emphasised ethnic characteristics. Regina R, whose detailed admission note was discussed in chapter one, was 'Born in Germany but spent most of her life in the colonies'.⁸² Nothing Hay recorded about her physical characteristics, personality or behaviour in the asylum suggests any further judgement based on her ethnicity. At Seacliff, McCarthy found that English and Australian-born migrants were seldom discussed in relation to the characteristics of their ethnicity.⁸³ In Ashburn it appears that the 'characteristics' of an ethnicity were only recorded as part of patient physiognomy or behavioural patterns in non-British and non-European patients. A slight exception is Amy S. Hay recorded that she spoke in 'an exaggerated Scots' accent'

⁸⁰ Ibid., Folio 30.

⁸¹ McCarthy, 'A Difficult Voyage', 30.

⁸² Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 111.

⁸³ McCarthy, 'A Difficult Voyage', 30.

when her mental condition worsened. When her excitement diminished the accent was ‘not appreciable to any extent’.⁸⁴ Her Scottish ethnicity was not used to explain her behaviour to any great extent. Indeed, in Amy’s admission note, Hay recorded that her mother was a Catholic, but did not record that she was Scottish until switching Amy’s patient notes to the new standard form case book three years later. As the following section will demonstrate, the fact that Amy was Catholic weighed more with Hay than her Scottish or Jewish descent.

Religion

The third marker of difference within Ashburn Hall examined in this chapter is religion. Historians have seldom addressed religion within lunatic asylums. Some historians have observed that doctors in the nineteenth century began taking on the traditional role of the clergy as guardians of normality and morality, establishing a secular moral authority.⁸⁵ The Ashburn Hall doctors, however, were not dismissive of religion, although they pathologised it in some cases. The varying medical attitudes towards religion in Ashburn Hall will be the focus of chapters three and four. This section deals with religion where it became a marker of difference from the bourgeois respectable norm as interpreted by the doctors Alexander and doctor Hay.

Although the Ashburn Hall doctors were ‘men of science’ and engaged in establishing a secular moral authority over their patients, they were also Anglican. The two doctors Alexander are buried in the Anglican section of Dunedin’s Southern Cemetery. Hay was also buried in an Anglican service and the Ashburn Hall Case Books actually record his attendance at an Anglican church in Dunedin.⁸⁶ The doctors’ discourse about patient religion and religiosity reflects their attitudes and prejudices about religion, particularly Catholicism, and to a small extent Judaism.

In general Jewish patients were defined as ethnically, rather than religiously, different from the norm. A slight exception is in Hannah L’s case, discussed above. Hay directly asked her what she thought of ‘the guyem, (?) Christian’, and recorded her giving this conversation

⁸⁴ Ashburn Hall, ‘Case Book, 1882-1907’, Folio 30.

⁸⁵ See for example Mark Finnane, ‘Asylums, Families and the State’, *History Workshop* 20 (1985): 135. Finnane stretches the doctor/priest metaphor even further to include an equation of the asylum and the church.

⁸⁶ Ashburn Hall, ‘Case Book, 1882-1904’, Folio 94. Hay’s funeral took place at St Paul’s Anglican Cathedral in Wellington in September 1925. See ‘Obituary: J.F.S. Hay. M.B.C.M., Aberd., J.P., Inspector-General of Mental Hospitals for New Zealand’, *Journal of Mental Science* 72 (1926): 160-1.

a 'jewish character'.⁸⁷ The capitalisation of 'Christian' in the above note while 'jewish' is left in the lower case implies some lack of respect for Judaism, either in ethnic or religious terms. A rational old Jewish woman would not give the conversation a 'jewish' character. Hannah does not appear to have had any religious element to her mental illness other than the fact that she was a Jew. Hay's notes, therefore, indicate that this in itself was a departure from the bourgeois respectable norm.

As with ethnicity and gender, the doctors, Hay in particular, considered patients who were the same religion as themselves closer to 'normal' than patients who were different. This is most easily traced through an examination of their attitudes to Catholicism within the asylum. For some Catholic patients, religion was treated as incidental to their illness by the doctors, rather than as an exacerbating cause or an explanation of odd behaviours. In the case of a Dominican nun admitted in 1889, E.W. Alexander recorded her confusion. She thought that she was in the 'nunnery and [wondered] where Mass will be said'.⁸⁸ Other cases, however, reveal a presumption on the part of the medical profession about the irrationality of Catholicism. These cases are all female. Amy S, mentioned above, provides the prime example. In her case notes in December 1900, Hay stated, 'There is no bible reading or epileptic religiosity (she is a Roman Catholic)'.⁸⁹ It is unclear whether Hay considered her Catholicism the reason for the lack of religiosity, or if her being Catholic raised an expectation of epileptic religiosity. In the cases notes for other epileptic patients, religiosity does not appear and nor is its absence commented upon. The implication then is that Amy's Catholicism was assumed by Hay to render her more susceptible to insane religiosity. Oonagh Walsh in her study of the Ballinasloe asylum in County Galway, Ireland, in the late nineteenth century found a presumption on the part of Protestant clergy that Catholicism inclined its followers more towards insanity, especially religious excitement, than Protestantism.⁹⁰ This prejudice seems to have extended beyond the clergy, and may account for Hay's comment on the absence of religiosity in the case of Amy S. She was Catholic so insane religiosity could be expected.

⁸⁷ Ashburn Hall, 'Case Book, 1882-1904', Folio 29. The full quote is reproduced above in the section of this chapter dealing with ethnicity.

⁸⁸ Ashburn Hall, 'Report Book – Intermediate Case Book Vol 1', 229.

⁸⁹ Ashburn Hall, 'Case Book 1882 -1907', Folio 30.

⁹⁰ Oonagh Walsh, "'The Designs of Providence": Race, Religion and Irish Insanity', in Melling and Forsythe, *Insanity, Institutions and Society*, 230-1.

Another Catholic patient's behaviour was explained in part by reference to religion. Hay recorded that Ellen B, 'Feels that she cannot say her prayers, on one occasion knelt down & counted to 99 (She is a Roman Catholic)'.⁹¹ This parenthetic note about her religion seems intended to explain the oddity of counting to ninety-nine. Non-Catholic patients who exhibited religiosity or odd religious behaviour within the asylum do not have their religious denomination parenthetically inserted to account for it. William S, for example, read the Bible and argued with another patient about religion, but his specific religion was not commented upon.⁹² John B had delusions about conversing with the Devil. Although it is recorded that he was Presbyterian, E.W. Alexander never highlighted his denomination when discussing his religious delusions.⁹³ This suggests that Catholicism rather than the various forms of Protestantism was a mark of 'difference' within the asylum.

Ellen B's case is of further interest in that she was one of the few working-class patients admitted to Ashburn Hall. Hay listed Ellen's occupation as 'working class' in the 'Register of Admissions'.⁹⁴ In the notes about the progress of her case, however, there is little to differentiate her from the other female patients, who were members of the middle classes. Hay noted in recording Ellen's history that she had been in service as a teenager before returning home to nurse her sick mother. He did not make any other explicit reference to class differences between Ellen and other patients, however, and expected her to conform to the same standards of femininity.⁹⁵ It appears from this that while standards of masculinity could vary in relation to class, as in the case of William L, standards of femininity remained more constant.

With regard to the irrationality of Catholicism, however, the Ashburn notes suggest that this was a judgement that operated in conjunction with opinions about the irrationality of women. Male Catholic patient behaviour is not explained with reference to religion, although an equal number of male and female patients had their religion recorded as Catholic. A male Catholic, Patrick D, was admitted to Ashburn Hall in 1900 and again in 1909. Beyond recording that he was Catholic, the only reference made again to religion in his case notes was that he believed he had done a bad thing selling his house to nuns when there were loose

⁹¹ Ashburn Hall, "Report Book – Intermediate Case Book, Vol 3", 187.

⁹² Ashburn Hall, "Case Book 1882 – 1907", Folio 25.

⁹³ Ashburn Hall, "Report Book – Intermediate Case Book, Vol 1", 5.

⁹⁴ Ashburn Hall, "Register of Admissions, 1882-1948".

⁹⁵ Ashburn Hall, "Report Book – Intermediate Case Book, Vol 3", 187.

bricks in the chimney.⁹⁶ This is part of Hay's description of several delusions of Patrick's. Unlike the cases of Amy S and Ellen B, his religion is never parenthetically inserted into his notes. Likewise, although there were religious elements in Daniel O's delusions, E.H. Alexander never made an explicit link between the delusions and his Catholicism. He merely recorded Daniel's religion in the pro forma case book.⁹⁷ This contrasts directly with the absence of religiosity being commented upon in the case of Amy S. In the doctors' eyes, therefore, Catholic irrationality was more expected of female patients than male, even where there was some religious element to the patient's delusions. A Catholic female represented a further departure from the bourgeois respectable norm than did a Catholic male patient.

A further reason for the focus on Catholic women's religion may be that proper and appropriate religious worship was part of the bourgeois ideal, particularly in female patients. Nineteenth-century asylum doctors believed that while excess religiosity and undue pondering over questions of salvation was likely to impede recovery, the proper degree of piety and rational worship was a sign of improvement.⁹⁸ Because women were expected to be pious, demure and maternal, female patients' experience of religion was more likely to occasion comment than male.⁹⁹ Religion, like gender and ethnicity, was a marker of patient difference at Ashburn Hall and doctors' writings about it reveal the operation of bourgeois values within the asylum.

Conclusion

The doctors Alexander and Hay made judgements about their patients based not just on reference to scientific thought, but also on the differences they perceived from the bourgeois respectable norm. Patients' lives in the asylum were thus marked by difference. Classification might be based on differences between types of patient, with the primary segregation of patients being between male and female, but the differences between doctors and patients were also important. This latter type of difference was of great importance to patient treatment and to how patient behaviour was cast as symptomatic of illness or recovery. The asylum doctors were the guardians of normality. Once a person was committed to Ashburn, behaviour which differed from the 'norm', as perceived by the doctors, was commented upon as

⁹⁶ Ashburn Hall, 'Case Book, 1882-1910', Folio 50.

⁹⁷ Ibid., Folio 152.

⁹⁸ Walsh, 229 citing W.A.F Browne, 'What Asylums Were, Are, and Ought to Be' reproduced in *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* edited with an introduction by Andrew Scull (London: Routledge, 1991), 208-212.

⁹⁹ This will be discussed further in chapter four, which addresses the roles of religion in the therapeutic environment of Ashburn Hall.

symptomatic of insanity; a woman might be 'forward', a half-caste Maori might make haka-like gestures, or a Catholic might be thought more likely to suffer from excess religiosity. The doctors regarded these departures from appropriate norms as symptomatic of illness.

Behaviours which were 'normal', such as meekness in women, reasoned decisiveness in men and quiet and appropriate religious worship in either sex, were thus taken as signs of patient recovery.

The three doctors were members of the colonial bourgeoisie and in their writings about patient behaviour, the cultural influences on the doctors' practices become evident. Bourgeois respectability was the standard against which most patient behaviour was measured with patients expected to perform gender-appropriate tasks and act according to appropriate social mores. With regard to gender, prejudices about women's biology and appropriate feminine behaviour are more easily traceable than similar comments about men. Gendered standards combined with class standards, leading to a variation in the standards of masculinity to which different patients were expected to conform. Ethnic prejudices appear more obviously in the notes about patients who were obviously ethnically different from the doctors. Religious prejudices appear most forcefully in the notes about female Catholic patients, showing the perception of Catholicism as an 'irrational' belief system. With religion, however, while there was a perception that any excess of religiosity or religious prejudice on the part of patients was unhealthy, there was also the opportunity for appropriate worship to signal recovery, or perhaps even to aid it. The role of religion within the asylum, therefore, deserves closer examination both in its appearance as part of patient mental illness and in its other forms in the asylum as part of patient recovery. These different faces of religion in Ashburn Hall in the experience of madness and the asylum will form the basis for the final two chapters.

Chapter Three: ‘Her Delusions Are All of a Religious Nature’: Religion and Patient Pathology in Ashburn Hall

Charlotte M entered Ashburn Hall in June 1888, diagnosed with ‘mania’ caused by ‘religious excitement’. For three months prior to her admission she had been interesting herself in ‘religious controversy’, becoming concerned and argumentative regarding the religious views of her daughters.¹ Her family sought her admission when she became noisy, delusional and sleepless. E.W. Alexander recorded that Charlotte’s delusions were all of a religious kind. In the admission note he stated, ‘She gives herself and others Scriptural names says she has devils in her, that she is Eve, that she is Potiphar’s wife. Believes generally that she has done something wrong.’² Charlotte’s religious delusions mark an example of pathological or ‘bad’ religious expression in Ashburn Hall.

Christianity played an important role in the lives and illnesses of many patients, both male and female, in Ashburn Hall between 1882 and 1910. Several patients had specifically religious elements to their illness recorded in their case files, such as delusions of conversing with God or the Devil. Other patients used religious language to express themselves and to describe their feelings of hope or despair. Heaven and Hell, God and the Devil, and the language of sin or salvation recur frequently in the case notes of patients of all Christian denominations. This chapter examines religion as an aspect of the pathology of mental illness in Ashburn Hall in order to scrutinise more closely medical attitudes toward religion and patients’ own religious experiences and beliefs in the asylum. In doing so, it argues that the doctors, in pathologising religion, gave patient religious experiences secular explanations and defined appropriate and inappropriate expression of religion. Additionally, however, the recurrence of patient religious delusion and religious language reinforces that Christianity had an ongoing importance in New Zealand society. This chapter will first briefly address some of the historiographical context surrounding Christianity in New Zealand society. It will then examine the medical record regarding patient religion, before going on to deal with religion and patient pathology.

This chapter examines Christianity only. The case notes seldom touch upon the religious beliefs of non-Christian patients: Freethinkers, Jews, and in all likelihood the one Chinese man treated at Ashburn Hall. Those patients whose religious delusions and language

¹ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 161 (AG-447-6/04), HC. Potiphar’s wife appears in the *Book of Genesis* account of Joseph. Joseph, sold into slavery by his brothers, is a slave in Potiphar’s household. When he refuses her attempt at seduction, Potiphar’s wife accuses Joseph of rape and he is cast into prison, where he later comes to the attention of the Egyptian Pharaoh.

² Ibid.

were commented on by the doctors were Christian, whether Protestant or Catholic. For several of these patients religious denomination was not recorded, but their delusions or language express at some level an engagement with the tenets of Christian religion, either as basic as a belief in God and the Devil, or a more sophisticated engagement with Scripture. Some patients held 'superstitious' beliefs, such as in witchcraft, or spirits, which will also be briefly addressed.

Historiographical Context

Christianity, particularly the various forms of Protestantism, maintained wide social significance in New Zealand throughout the nineteenth century and into the twentieth. The churches had a role in all the major social campaigns of the late nineteenth century, such as women's suffrage, prohibition and the Bible-in-schools movement.³ Peter Matheson notes a tendency to write religion out of New Zealand history which is particularly evident in general histories. He states, however, that the closer historians have worked on particular issues, the less evident this secularising of history has been.⁴ In recent years a number of lectures, articles and books have sought to bring the various contributions of Christian churches in New Zealand society into the mainstream of New Zealand historiography.⁵ Maori Christianity,⁶ gender and religion,⁷ Christianity and the working classes,⁸ and some aspects of the

³ John Stenhouse, 'God's Own Silence: Secular Nationalism, Christianity and the Writing of New Zealand History', *New Zealand Journal of History* 38, no. 1 (2004): 52-71 at 57.

⁴ Peter Matheson, 'The Myth of a Secular New Zealand', *Pacifica: Journal of the Melbourne College of Divinity* 19, no. 2 (2006): 185-6.

⁵ *Ibid.*, 188. Matheson lists in particular, Rex Ahdar and John Stenhouse eds., *God and Government: The New Zealand Experience* (Dunedin, N.Z.: University of Otago Press, 2000); John Stenhouse Brett Knowles, and G. A. Wood, *The Future of Christianity: Historical, Sociological, Political and Theological Perspectives from New Zealand* (Adelaide: ATF Press, 2004); John Stenhouse and Jane Thomson, eds., *Building God's Own Country: Historical Essays on Religions in New Zealand* (Dunedin, N.Z.: University of Otago Press, 2004); John Stenhouse and G. A. Wood, *Christianity, Modernity and Culture: New Perspectives on New Zealand History* (Adelaide: ATF Press Australian Theological Forum, 2005).

⁶ Judith Binney, for example provides an insightful biography of the nineteenth-century Maori religious leader Te Kooti. See Judith Binney, *Redemption Songs: A Life of Te Kooti Arikirangi Te Turuki* (Auckland, N.Z.: Auckland University Press, 1995); see also Lyndsay Head, 'The Pursuit of Modernity in Maori Society', in *Histories, Power and Loss: Uses of the Past – A New Zealand Commentary*, ed. Andrew Sharp and Paul McHugh, 97-122 (Wellington, N.Z.: Bridget Williams Books, 2001). Head argues that changes in nineteenth-century Maori society need to be understood with reference to the relationship between Maori and Christianity. Both Binney and Head are cited in Stenhouse, 'God's Own Silence', 65.

⁷ See for example Caroline Daley, *Girls & Women, Men & Boys: Gender in Taradale, 1886-1930* (Auckland, N.Z.: Auckland University Press, 1999), 10-11, cited in Stenhouse, 'God's Own Silence', 66.

⁸ See for example John Stenhouse, 'Christianity, Gender, and the Working Class in Southern Dunedin, 1880-1940', *Journal of Religious History* 30, no. 1 (2006): 18-44.

relationship between science and religion⁹ are but a few of the areas in which religion has received attention from historians in the past two decades.

Religion in the realm of medicine and mental health, however, remains under-examined. None of the studies undertaken by New Zealand historians of the asylum have made more than a passing reference to religion. Bronwyn Labrum, for example, mentions piety as part of the ideal of femininity, but does not address women's religious beliefs or doctors' comments about them.¹⁰ Matthew Philp highlights asylum doctors' roles in defining morality and regulating behaviours outside the asylum. He refers to asylum superintendents as 'Scientific Pastors' in this respect. Men such as Truby King of Seacliff Asylum in Dunedin and Frank Hay critiqued the Government for being more interested in trade than social casualties and were interested in social engineering through eugenics, education and parenthood.¹¹ Philp does not, however, enter into any explicit exploration of the relationship between 'scientific pastors' and Christian pastors, or between medicine and religion.

Angela McCarthy's research on the Auckland Asylum provides a slight exception to this historiographical lacuna.¹² Her main focus is on what asylum records reveal about ethnicity and migration in relation to mental health, but she also calls attention to patients' beliefs of religious persecution, arguing that these may represent ongoing sectarian tensions in wider society. She also suggests that doctors' own backgrounds might influence their attitudes towards patients, referring specifically to the Irish Protestant assistant medical officer Alexander McKelvey, and his attitude toward patients who differed in religious denomination or ethnicity from himself.¹³ The actual roles of religion in the asylum, however, and the ways in which doctors interpreted patient religious expression have not been addressed in the New Zealand context.

⁹ See for example Ronald Numbers and John Stenhouse, 'Antievolutionism in the Antipodes: From Protesting Evolution to Promoting Creationism in New Zealand', *The British Journal for the History of Science* 33, no. 3 (2000): 335-50; John Stenhouse, 'Catholicism, Science, and Modernity: The Case of William Miles Maskell', *Journal of Religious History* 22, no. 1 (1998): 59-82

¹⁰ Bronwyn Labrum, 'The Boundaries of Femininity: Madness and Gender in New Zealand, 1870-1910', in *Women, Madness and the Law*, ed. Wendy Chan, Dorothy E. Chunn and Robert Menzies (London: Glasshouse Press, 2005), 68.

¹¹ Matthew Philp, 'Scientific Pastors: The Professionalisation of Psychiatry in New Zealand 1877-1920', in *Unfortunate Folk: Essays on Mental Health Treatment 1863-1992*, ed. Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), 198-9.

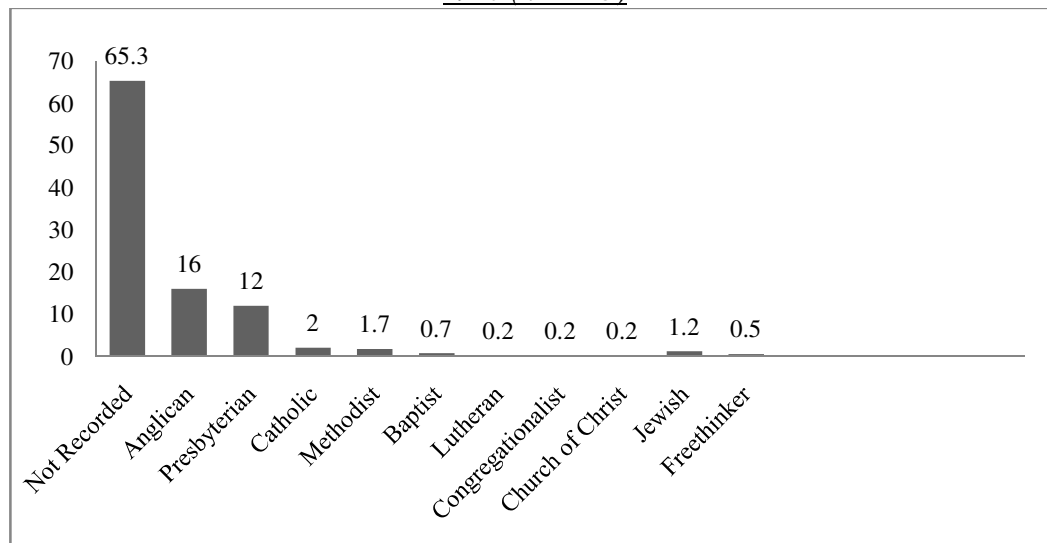
¹² Angela McCarthy, 'Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century Auckland', *Social History of Medicine* 21, no. 1 (2008): 47-65.

¹³ *Ibid.*, 58.

Patient Denominations and Medical Record-Keeping

The medical gaze at Ashburn Hall seldom gave much weight to patient religious beliefs. Only about 35 per cent of patients admitted between 1882 and 1910 had their religious denomination entered in their case note.¹⁴ Figure 1 below shows patients' religious denominations by percentage as recorded in the Ashburn Hall archive. The majority of these patients for whom religious denomination was recorded were those present in the asylum from 1900, after the introduction by Frank Hay of a pro forma case book with a category to record patient religion. Hay recorded religion in a number of cases prior to this; in 1897 in the notes of his very first patient, Regina R, he recorded that she was a Freethinker.¹⁵ E.W. Alexander, however, almost never recorded religious denomination in the case books. Before 1897, religious denomination appeared only when it was necessary to describe a patient's illness, or when it was implied through their occupation, as in the case of Maria S, a Dominican nun admitted in 1889. James M's religious denomination, for example, was not recorded, despite the religious character of his delusions.¹⁶ John M, on the other hand, thought he was being punished for being a Freethinker all his life.¹⁷ This belief could not be recorded without mentioning John's religious denomination, or rather, the lack of one.

Figure 1: Patient Religious Denomination by Percentage of Total Patient Population, 1882-1910 (n = 415)



Source: Ashburn Hall case books, AG447-6/01-6

¹⁴ The statistics on patient religious denominations come from a survey of all patient case notes available between 1882 and 1910, Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 1'; 'Report Book - Intermediate Case Book, Vol 3' (AG-447-6/05), HC; 'Report Book - Intermediate Case Book, Vol 4', (AG-447-6/06), HC; 'Case Book 1882-1907', (AG-447-6/01), HC; 'Case Book 1908-1927', (AG-447-6/02), HC.

¹⁵ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3', 110.

¹⁶ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 1', 11.

¹⁷ Ibid., 46.

Hay and E.H. Alexander recorded religion fairly frequently, but still far from uniformly, unlike, for example, gender, age or occupation. Because only a third of patients had their religion noted, any comparison between the proportions of patients of different denominations in Ashburn Hall and the proportions of denominational affiliation in the wider population is of limited value. It appears that Ashburn Hall's largest patient denomination in this period was Anglican, making over 40 per cent of recorded denominations, although this accounted for only 16 per cent of all patients admitted. This appears to correspond to the proportion of Anglicans in the general New Zealand population (45 per cent).¹⁸ Yet, Otago provincial census data from 1896 reveals that most of the provincial population was Presbyterian (47 per cent), rather than Anglican (less than 25 per cent).¹⁹ Ashburn Hall's patient population was drawn mostly from the Otago and Southland area, which although never uniformly Presbyterian, had been planned as a Free Church settlement and had an informal Presbyterian would-be establishment.²⁰ The visiting chaplain, Reverend R.R.M. Sutherland, who was appointed in 1888, was a Presbyterian minister. Such information suggests that a significant proportion of Ashburn Hall's patient population whose religion was unrecorded was in fact Presbyterian.

The doctors' recording of a patient's religious denomination was part of a process of gaining a complete picture of patients' personal histories, rather than having a direct influence on the diagnosis or treatment of psychological symptoms. Hay's contemporaneous introduction in the pro forma case book of the practice of recording birthplace, capacity at school and other facts which did not necessarily bear directly on the nature of a patient's mental illness supports this conclusion. His recording of religious denomination was part of his overall drive to document as much detail as was available about patients' personal histories: physical, mental, family, and social. One reason for recording denomination would be in order to provide appropriate last rites in the event of a patient's death in the asylum. Yet, in many cases treated by Hay and E.H. Alexander, religion was not recorded, showing that information was either not always available, or that they did not consider denomination of particular importance medically.

¹⁸ The statistics for the general population used here come from John Stenhouse, 'Religion and Society', in *The New Oxford History of New Zealand*, ed., Giselle Byrnes (Melbourne, Vic: Oxford University Press Australia & New Zealand, 2009), 343-4.

¹⁹ 'Part II – Religions of the People', Table VI, *New Zealand Census, 1896* (Wellington: John MacKay, Government Printer, 1897), 90.

²⁰ Stenhouse, 'Religion and Society', 341.

Despite failing to record the religious denomination of many of their patients, the doctors Alexander and doctor Hay at times directly pathologised patient religion, as in the cases of the Catholic patients, Amy S and Ellen B, discussed in chapter two. Treating some religion as pathological followed English trends. From the eighteenth century in England, religion, particularly enthusiastic forms of Christianity and claims of spiritual inspiration, was increasingly equated with irrationality by the Anglican ruling elite and the medical profession.²¹ The process of the medicalisation of madness continued throughout the eighteenth and nineteenth centuries. By the time Ashburn Hall opened in 1882, madness was well established as a medical rather than a spiritual problem. Religion, especially enthusiastic religion, might, however, act as a trigger or ‘exciting cause’ of mental illness. In cases where religion was a factor, medical explanations and explorations of patient behaviour usually involved at least an implicit, and sometimes an explicit, judgement about the correctness of patient religious beliefs. The Millerites in 1830s and 1840s America provide one example. This religious revival was associated with madness by some contemporaries.²² A number of nineteenth-century British monographs on madness also expressed a negative attitude toward religious enthusiasm or ‘fanaticism’.²³ Patient religion, when considered by asylum doctors, was implicitly divided into appropriate and inappropriate expressions: ‘good’ and ‘bad’ religion.

In Ashburn Hall, appropriate expressions of religion included regular and well-behaved attendance at Sunday services, moral behaviour and a certain degree of piety. ‘Good’ religious expression was part of the standard of respectability against which patients, especially women, were measured. ‘Bad’ expression of religion included excessive bible reading or loud prayer or hymn singing at inappropriate times. Profanity and blasphemy also received comment in patient case notes. Certain kinds of negative or excessive religious experience might also be viewed as an exciting cause of mental illness.

²¹ See for example Michael MacDonald, ‘Religion, Social Change, and Psychological Healing in England, 1600-1800’, in *The Church and Healing: Papers Read at the Twentieth Summer Meeting and the Twenty-First Winter Meeting of the Ecclesiastical History Society*, ed., W. J. Shiels (Oxford: Basil Blackwell, 1982), 101-25; Michael MacDonald, *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England* (Cambridge: Cambridge University Press, 1981).

²² R.L. Numbers and J.S. Numbers, ‘Millerism and Madness. A Study of “Religious Insanity” in Nineteenth-Century America’, *Bulletin of the Menninger Clinic* 49, no. 4 (1985): 290.

²³ James G. Donat, ‘Medicine and Religion: On the Physical and Mental Disorders that Accompanied the Ulster Revival of 1859’, in *The Anatomy of Madness: Essays in the History of Psychiatry, III The Asylum and Its Psychiatry*, ed. W.F. Bynum, Roy Porter, and Michael Shepherd (London: Routledge, 1988), 131.

Religion as a Cause of Mental Illness

More than seventy-five patients, about 19 per cent of the patient population admitted to Ashburn Hall between 1882 and 1910, had religious elements recorded in their illnesses. The incidence of these remained fairly consistent throughout the period. Prior to 1900, at least forty-five patients were admitted whose insanity was in some way linked to or expressed through religion. This number may have been higher as the case notes are missing between mid-1890 and late 1895. Between 1900 and the end of 1910, a further thirty-two patients admitted had symptoms such as religious delusions, or a belief that they had sinned deeply recorded in their case notes.²⁴ Despite the frequent recurrence of religious elements in patients' illnesses, the doctors only attributed eight of these patients' illnesses directly to religion in the 'Register of Admissions'. These patients were either diagnosed with 'Religious insanity', or the doctors supposed their mental illness to be caused by 'religious excitement' or 'religious enthusiasm' (see appendix, tables 1 and 2).²⁵ Where possible, however, the doctors listed causes of insanity as something other than 'religious excitement' even where patients exhibited religious delusions. The Presbyterian patient John B, for example, believed he conversed with the Devil, but E.W. Alexander thought John's delusions due to the death of his wife.²⁶

Of the eight patients whose insanity was attributed to religion, five were women and three were men. One male patient was admitted with a diagnosis of 'religious delusions'; a female was admitted with the diagnosis 'religious'. Another woman was diagnosed with delusions caused by 'religious enthusiasm'. The other five patients were diagnosed with mania caused by 'religious excitement', usually in conjunction with another causal factor.²⁷ The 'religious' diagnosis or cause of these eight patients' illness tells us very little about the nature of the patients' illnesses, or their religious beliefs. The case notes, and at times lack of them, obscure as much or more than they reveal about patient religion and why in these cases it was directly linked to mental pathology. The case histories as recorded seldom suggest why

²⁴ These numbers come from an examination of all the available patient case notes between 1882 and the end of 1910.

²⁵ As with those female patients, discussed in chapter two, whose insanity was assigned to biological causes, patients whose insanity was attributed to religious causes occasionally had multiple causes listed in the Register of Admissions. James M, admitted during Hay's tenure had his cause of insanity listed as 'religious excitement and constipation', meaning that his appearance in Table 4 was as a patient with multiple causes assigned. Jessie R, admitted in May 1904, is one of only three patients whose diagnosis or supposed cause is not included in the appendix. She was admitted in between the end of Frank Hay's tenure as medical superintendent and the beginning of E. H. Alexander's. The cause of her mania was attributed to heredity and religious excitement. See Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC.

²⁶ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol. 1', 5.

²⁷ Ashburn Hall, 'Register of Admissions, 1882-1948'.

the label ‘religious’ has been applied to these patients, but not to others who exhibited religious delusions.

Jessie R and Charlotte M are the only two of these patients with surviving admission notes linking their mental illness to the manner of their religious observance. The 45-year-old Charlotte M’s admission note links her insanity to her interest in ‘religious controversy’. Unfortunately E.W. Alexander did not record either Charlotte’s denomination or the type of ‘controversy’ she had become interested in.²⁸ The language in her admission note leaves it unclear who first noted that ‘her delusions are all of a religious kind’, although the information that she had been occupying herself for three months with religious ‘controversy’ must have been provided by family members.²⁹ The notes leading up to her final discharge are missing from the record. She was discharged ‘recovered’ in November 1889, but readmitted a month later. Her final discharge was in November 1894, when she was listed as ‘relieved’ rather than ‘recovered’.

25-year-old Jessie R attended ‘revivalist’ meetings, which her family and E.W. Alexander believed led to her insane attack in 1904. She had claimed she was going to Scotland to be married; that her father had insulted her; and she attempted to leave the family home to play the harmonium at a public house.³⁰ Alexander also entered the comment in the case file that Jessie and her parents were religious people, ‘Baptists, without excessive views’.³¹ It was the revival meeting, rather than Jessie’s normal religious observance which was cast as the exciting cause of mental illness. The information about the exciting influence of religion on her mental state came from the family members who brought her to Ashburn Hall, her brother and sister. They, rather than E.W. Alexander, were the first to cast her illness as linked to religious enthusiasm and revival.³²

The families of the other patients whose diagnoses or causes of illness were ascribed to ‘religious excitement’ or similar may also have been those responsible for identifying their illnesses as religious. Unfortunately the patient case book covering mid-1890 to late 1895 is

²⁸ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 161.

²⁹ *Ibid.*, 161.

³⁰ Ashburn Hall, ‘Case Book 1882-1907’, Folio 108. When Frank Hay left Ashburn Hall to take up the appointment as Deputy Inspector-General of Lunatic Asylums for New Zealand in early 1904, E.W. Alexander performed the duties of medical superintendent until E.H. Alexander took up the position in June 1904. Jessie R was admitted in May. The notes on her case, therefore, start out being written by E.W. Alexander and are taken over by E.H. Alexander.

³¹ *Ibid.*

³² *Ibid.*

missing from the archive. Of Mary P and Eleanor S, then, we will never know more than is recorded in the 'Register of Admissions'. Mary P was admitted in July 1894, with the diagnosis 'religious'. She was 46 years of age. The supposed cause was the loss of her husband. Death of a loved one might well invoke recourse to faith, but because her case file is missing, it is impossible to know what form her faith took or how this was linked to the death of her husband. She was discharged 'relieved' in September 1894. Eleanor S was admitted in January 1894, aged 30, with mania caused by 'religious enthusiasm'. She too only stayed in the asylum for a few months, being discharged in August of the same year. The listing of the cause as 'religious enthusiasm' rather than 'religious excitement' hints that Eleanor may have become involved with some form of evangelical movement, but the missing records mean her religious denomination, and the meaning of 'religious enthusiasm' in this context, remain unknown.

Another three patients whose illnesses were ascribed to religion have missing admission notes, as they were admitted between 1890 and 1895. Later notes on their cases, contained in subsequent case books are, however, available. Adele H entered Ashburn Hall in July 1895 diagnosed with 'mania', caused by 'worry with religious excitement'.³³ Her case notes are available from November of that year. No mention of religion is made in the extant notes. E.W. Alexander simply stated that Adele was delusional in the surviving notes, without outlining the content of her delusions.³⁴ Cross-cultural researchers using medical analysis to explore broader cultural trends have found that the content of delusions was often superficial and changed rapidly.³⁵ If Adele had suffered religious delusions on her admission, their content may well have changed while she was in the asylum. Later in Adele's case notes, Alexander mentioned that she had been undergoing treatment for retroflexion of the uterus prior to committal. He stated that she had removed the pessary given her by her treating doctor on becoming insane. Alexander wrote that 'the symptoms are no doubt due to an increase of displacement'.³⁶ When a physical explanation for Adele's illness was available, Alexander favoured it over a religious one.

The other two patients whose admission notes are missing from the surviving record were male. The 57-year-old Thomas P was admitted in December 1890 with 'religious

³³ Ashburn Hall, 'Register of Admissions, 1882-1948'.

³⁴ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 2.

³⁵ J.C. Burnham, 'Psychotic Delusions as a Key to Historical Cultures: Tasmania, 1830-1940', *Journal of Social History* 13, no. 3 (1980): 372.

³⁶ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 44.

delusions', the supposed cause of which was 'alcoholic excess'. He remained in the asylum until his death in 1903.³⁷ Thomas had been transferred from Sunnyside Asylum in Christchurch.³⁸ In the notes which survive of the progress of his case, E.W. Alexander did not expand on Thomas' delusional content. But after Hay succeeded Alexander in March 1897, he recorded the following note in the case book:

Asserts that the only way to heaven is through the Episcopal Church, that being the only body that bases its religion on the Bible. Talked with an air of authority, & as a zealot, but did not [illegible] his delusions. Regarding Rev. Sutherland's discourse of last Sunday on the woman with the issue of blood he was very annoyed and said that the preacher took an entirely erroneous view in regarding the woman's disease as physical when anybody reading the Scripture aright must know that it was 'a spiritual issue of blood'.³⁹

While this note does not directly reveal delusional content, it is clear that Thomas was preoccupied with religion and with the correct interpretation of scripture. His religious denomination was later entered as Church of England in the pro forma case book.⁴⁰ Hay's recording of the content of Thomas' religious language is also in keeping with the move towards more detailed note-keeping that Hay instituted on taking up the position of medical superintendent. As well as recording more physical, clinical detail, Hay was inclined to note with more specificity the content of patients' delusions and their conversations with him. Hay's paraphrasing of Thomas' statements does not explicitly show them as mental symptoms. It is likely, however, that they were recorded to demonstrate Thomas' general mental state. There is an implicit judgement that Thomas' religious sentiments and disagreements with the chaplain Reverend Robert Sutherland were pathological.

Later in the case notes, Hay mentioned that Thomas' delusions were chiefly religious in character, giving the example that he believed he had been to Heaven.⁴¹ Hay also recorded that 'He believes himself Divine & converses with the Deity', as well as further instances of Thomas' disagreeing with, or being angered by the content of the services delivered by Rev. Sutherland.⁴² Thomas' preoccupation with matters religious was clearly long-lasting. Hay, however, preferred physical explanations for Thomas' insanity to religious ones. When his

³⁷ Ashburn Hall, 'Register of Admissions, 1882-1948'.

³⁸ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 14.

³⁹ Ibid.

⁴⁰ Thomas' religion is recorded in Ashburn Hall, 'Case Book 1882-1907', Folio 14. The chaplain at Ashburn was a Presbyterian minister, Reverend Robert Sutherland, minister in charge of the Kaikorai Presbyterian Church in Kaikorai Valley, Dunedin.

⁴¹ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 108.

⁴² Ibid., 108 and 283.

case was entered in the pro forma case book in February 1903, Hay recorded heredity of vice and alcoholism as the causes for Thomas' attack of insanity. Religion was not mentioned, despite the persistence of religious delusions.⁴³

Fifty-six-year-old George C, the final patient whose admission note is missing, was admitted in September 1895 with 'mania' supposed to be caused by 'religious excitement'.⁴⁴ The only comment made about religion in the extant notes by E.W. Alexander was in November 1896 that George was 'still disposed to extravagant religious views'.⁴⁵ Most available notes on the case were about George's noisiness, foul language, singing and abusiveness. He was eventually transferred to Seacliff in December 1896 several days after a failed trial removal to his home.⁴⁶

These admissions are clustered in a similar time period, the mid-1890s. Only two cases were admitted with 'religious excitement' as a supposed cause of insanity after E.W. Alexander's tenure as medical officer ended. E.W. Alexander was more inclined than his successors to record religion as an exciting cause of insanity. Indeed Jessie R, the patient admitted in May 1904, was admitted while E.W. Alexander temporarily filled the role of medical superintendent, before it was taken by his son.

Ann Goldberg situates the heyday of religious madness across Europe and North America in the early-to-mid nineteenth century.⁴⁷ Asylum doctors in this period recorded large numbers of patients suffering from varying forms of religious madness and discussed these illnesses at length in professional journals.⁴⁸ In the German context discussed by Goldberg, this was a diagnosis applied by the male, bourgeois medical elite to primarily lower-class and to some extent female middle-class patients. Medical discourse turned popular religious experience into 'superstition' and pathology.⁴⁹ Goldberg's characterisation of the period as the 'heyday of religious madness' implies that by the later nineteenth century, religious madness as a diagnosis was no longer common. This is supported by the scholarship

⁴³ Ashburn Hall, 'Case Book 1882-1907', Folio 14. The heredity of vice was that Thomas had been born out of wedlock and did not know who his father was.

⁴⁴ Ashburn Hall, 'Register of Admissions, 1882-1948'.

⁴⁵ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 63.

⁴⁶ *Ibid.*, 76.

⁴⁷ Ann Goldberg, *Sex, Religion, and the Making of Modern Madness: The Eberbach Asylum and German Society 1815-1849* (New York: Oxford University Press, 1999), 36.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*, 36-37.

of Ronald and Janet Numbers, who situate the disappearance of ‘religious insanity’ as a diagnosis in the late nineteenth century.⁵⁰

The Ashburn Hall statistics also suggest that the diagnosis of ‘religious insanity’ was uncommon by the late nineteenth century, as only eight patients during the entire period had their insanity directly attributed to religion. E.W. Alexander, who admitted seven of the eight patients with a diagnosis or cause ascribed to religion, had received his medical education a generation earlier than his successor Frank Hay. Chapter one pointed to a generational shift in medicine, with Hay concentrating far more attention on the physical condition of patients than E.W. Alexander had. The decline of religion as a cause or diagnosis in the ‘Register of Admissions’ is another aspect of the generational change between the medicine of E.W. Alexander and Frank Hay and is reminiscent of the disappearance of the diagnosis of religious insanity from the Pennsylvania Hospital for the Insane after the death of its first superintendent, Thomas Story Kirkbride, in 1883.⁵¹

The impression of a generational shift in asylum medicine is reinforced by the fact that ‘religion’, ‘religious excitement’ or ‘religious mania’ disappeared as a cause of insanity in the official statistics in 1907, when Hay became the Inspector-General of Mental Hospitals for New Zealand. Before this, several asylum patients each year had the cause of their insanity ascribed to ‘religion’ in one or more of New Zealand’s asylums. The highest number was 28 patients in 1896. Sixteen of these patients were male and twelve were female. Nine were admitted to the Auckland Asylum, and another ten to the Wellington Asylum, while the others were spread across other New Zealand asylums.⁵² The lowest was in 1906, with only two male patients in all of New Zealand.⁵³ The disappearance of ‘religious excitement’ as a supposed cause of insanity in the early twentieth century represents another facet of the increasing emphasis on physical and secular causes for insanity amongst the medical profession. The latter two Ashburn Hall superintendents, Hay and E.H. Alexander, were contemporaries, both graduating from Scottish universities in 1890 in a time when insanity was increasingly linked to heredity and degeneration, and when neuropathological and other physical explanations for insanity were being increasingly researched. Frank Hay, E.H. Alexander and their generation of asylum superintendents lent less credence to ‘religious

⁵⁰ R.L. Numbers and J.S. Numbers, ‘Religious Insanity; History of a Diagnosis’, *Second Opinion* 3 (1986): 73.

⁵¹ *Ibid.*

⁵² ‘Lunatic Asylums of the Colony (Report on) for 1896’, *AJHR* (1897), H-7, 18.

⁵³ ‘Mental Hospitals of the Colony (Report on) for 1906’, *AJHR* (1907), H-7, 42.

excitement' as a cause of insanity than had the earlier generation, which included E.W. Alexander.

Hay only listed 'religious excitement' as the cause of insanity for one patient, James W, who was admitted in April 1898 and diagnosed with mania. This was in conjunction with a second supposed cause of insanity, constipation. Hay's notes on James' case reveal that many of his delusional thoughts were religious. He had been ill prior to his admission and Hay recorded that, 'Of his illness he says that he passed through the pain of crucifixion & asked to be bathed & annointed [sic] with oil – all [illegible] to a vague subjective condition of putting on a Christ-like nature.'⁵⁴ James was discharged in June 1898, but admitted for a second time in May 1899, again with mania, which in the case file took the form of religious delusions.⁵⁵ For his second admission, however, religion was not listed as a supposed cause of insanity. Rather, Hay listed as supposed causes, appendicitis and James' previous attack.⁵⁶

All three of the Ashburn Hall doctors, although they viewed some patient expressions of religion as pathological, remained eager to assign physical causes rather than religious where possible, even though religious delusions or religious language were recorded in the case files of a significant minority of patients whose illness was attributed to causes other than religion. Some of these patients' cases will be explored further in the following section. The doctors preferred instead supposed causes such as heredity, worry, financial difficulty, grief or a physical cause such as alcohol, masturbation, pregnancy or the climacteric to name only a handful of the more common supposed causes listed in the 'Register of Admissions'. This is in line with the findings of Jonathan Andrews and Andrew Scull in their study of the eighteenth-century case book of John Monro, the physician at Bedlam.⁵⁷ Monro, like the Ashburn Hall doctors, was more preoccupied with the physiological or hereditary predisposition of his patients than with the actual nature or content of their spiritual thoughts and feelings, although he did comment on some religious behaviours or delusions.⁵⁸ These

⁵⁴ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 210.

⁵⁵ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 4', 115-18.

⁵⁶ Ashburn Hall, 'Register of Admissions, 1882-1948'.

⁵⁷ Jonathan Andrews and Andrew Scull, *Customers and Patrons of the Mad-Trade: The Management of Lunacy in Eighteenth-Century London* (Berkeley; Los Angeles; London: University of California Press, 2003), 87.

⁵⁸ *Ibid.*, 87-8.

doctors rationalised and medicalised patient expressions of the metaphysical, and by casting mental illness as physical rather than spiritual, secularised patient sensibilities of sinfulness.⁵⁹

Religious Delusions and Language in Ashburn Hall

While only eight patients had their insanity directly attributed to religion, almost seventy other patients in Ashburn Hall had religious elements to their illnesses.⁶⁰ They exhibited religious delusions, or used the language of religion explicitly to express their feelings of suffering. In these cases, as well, the Ashburn doctors showed a secularising impulse, recording ‘inappropriate’ expressions of religious faith as symptomatic of insanity and seeking to explain them through reference to hereditary or physical causes rather than engaging with their patients’ spirituality. Madeline M, diagnosed with manic-depressive insanity, claimed ‘she [had] crucified Christ & [made] a lot of disjointed remarks on religious subjects’.⁶¹ The cause of her insane attack was, however, listed as ‘influenza’ by E.H. Alexander in the ‘Register of Admissions’.⁶²

The asylum records from Ashburn capture snapshots of individuals, many of whom would otherwise be absent from the historical record. The religious content of some patients’ delusions suggests the importance of religion in late nineteenth- and early twentieth-century New Zealand society. Although the medical gaze at Ashburn Hall was strongly secular in most cases and the doctors seldom linked patient delusions explicitly to their denominations or general spiritual beliefs, the repeated incidence of religious delusions and religious language amongst the patient population of Ashburn Hall is suggestive of a strong undercurrent of Christianity persisting in wider New Zealand culture.

Both Goldberg and Michael MacDonald, in their studies of earlier time periods, discovered the continuance of popular religion in varying forms of witches, spirits and faith healing, which were pathologised by asylum doctors.⁶³ This popular ‘superstition’ can be contrasted against the rational Protestantism of the bourgeois elites in Germany and England. In general Ashburn patients expressed religious ideas in keeping with conventional, middle-

⁵⁹ *Ibid.*, 88.

⁶⁰ The numbers of patients with religious elements in their illnesses, given at the beginning of the previous section, included the eight patients whose insanity was directly attributed to religion. Sixty-nine other patients expressed religious delusions, or used religious language which was recorded in their case files in the course of their stay at the asylum.

⁶¹ Ashburn Hall, ‘Case Book, 1908-1927’, Folio 41.

⁶² Ashburn Hall, ‘Register of Admissions, 1882-1948’.

⁶³ Goldberg, 37-39; MacDonald, ‘Religion, Social Change, and Psychological Healing in England’, 101-25.

class religious beliefs, even within their delusional ideas. In the cases of a few patients at Ashburn Hall, however, continuing currents of popular ‘folk’ religion and ‘superstition’ or engagement with forms of ‘spiritualism’ that were not typically Christian are hinted at in some of the delusions recorded by the doctors. One of the early admissions, the 65-year-old single woman Mary L, had delusions about witches and spirits and had at some stage before her admission taken part in ‘so-called spiritual séances’.⁶⁴ The supposed cause of insanity listed for Mary was in fact ‘spiritualism’, the belief that the living can communicate with the dead.⁶⁵ E.W. Alexander recorded several months after her admission, that Mary was ‘Conversing with spirits, hears them and answers’.⁶⁶

Mary was the only patient who had her cause of insanity ascribed to spiritualism, but she was not the only patient whose delusions centred on spirits, or some kind of religious view which might be termed ‘superstition’. In the ‘previous history’ section of Eleanor D’s case note in the pro forma case book, E.H. Alexander recorded that she had for many years prior to her 1910 admission ‘been generally addicted to mystic practices, seances [sic] have been held regularly at her home & she has herself done faith healing with success’.⁶⁷ Spiritualism, although not particularly common in the Ashburn Hall case notes, still appeared occasionally. In terms of delusions which might be classed as ‘folk religion’, Hannah B, who was admitted in 1885 aged 24, believed that one of her sisters had bewitched her.⁶⁸ Mary L’s delusions about witches and Eleanor D’s practice of faith healing also evidenced engagement with some of those older forms of popular ‘superstition’ identified by Goldberg and MacDonald, while Harry P also was ‘continually feeling and seeing spirits’.⁶⁹

There were, therefore, cases at Ashburn Hall between 1882 and 1910 which reveal some forms of religion or spirituality deviating from the norm of middle-class piety. Unfortunately, in none of these patients’ case notes was their birthplace recorded, and only one, Harry P, had his religious denomination recorded. He was a member of the Church of England. There is nothing in the case notes to point to why these patients in particular engaged with ‘superstitious’ ideas more than others, or whether these beliefs were at all shared by their family members. On the whole, patient delusions in Ashburn Hall did not hint at the survival

⁶⁴ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 9.

⁶⁵ Ashburn Hall, ‘Register of Admissions, 1882-1948’.

⁶⁶ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol. 1’, 9.

⁶⁷ Ashburn Hall, ‘Case Book, 1908-1927’, Folio 190.

⁶⁸ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 85.

⁶⁹ *Ibid.*, 174.

of popular folk religion or superstition in late nineteenth-century New Zealand. The recording of these beliefs does, however, show that the Ashburn Hall doctors considered these forms of belief pathological, particularly in female patients. The doctors scrutinised female religious expression more closely than male. Piety as part of the bourgeois feminine ideal will be addressed further in the next chapter.

The religious undercurrents most often shown in the notes of Ashburn Hall were those typical of middle-class rational forms of Christianity. Although they might believe themselves divine or damned, behaviours associated with rational religious expression, such as bible reading, were characteristic of many of those patients with religious fixations as features of their mental illness. William S read his Bible and hymn books at the ‘most unusual times’, while Catherine F was not allowed a Bible because she had set herself on fire believing she was acting under a command found in scripture.⁷⁰ Catholic patients as well as Protestant ones expressed religious delusions which generally fell within the confines of scriptural teaching. Agnes M believed she had died and been born again.⁷¹ Although heretical, Agnes’ delusion was an adoption of scriptural ideas rather than folk religion.

Ten days after James M’s admission in December 1882, E.W. Alexander recorded in the case book: ‘Believes the Devil has changed him, letting him down to Hell by a trap door and sending up someone like him.’⁷² James had been admitted suffering from delirium tremens and mania brought about by alcoholic excess.⁷³ He was kept in seclusion for several days and had sedatives administered to try and calm his excited state. While this belief of the Devil changing him was the expression of a delusion under which James was labouring, it could also be read as an expression of his feelings during his illness and time in the asylum. Committal to the asylum would necessarily have involved the forfeiture of control over his body and perhaps a feeling that he was not himself. It was, however, the Devil rather than any other agency who he thought had done something to him. His expression of the delusion that his body was not his own was articulated through the language of Christian religion.

Later on in his stay James M refused to eat. E.W. Alexander recorded, ‘He considers that he ought not to take food because he has caused the extinction on [sic] the sun, moon and

⁷⁰ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 3’, 124; ‘Report Book – Intermediate Case Book, Vol 1’, 226.

⁷¹ Ashburn Hall, ‘Case Book 1882-1907’, Folio 79.

⁷² Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 11.

⁷³ Ashburn Hall, ‘Register of Admissions, 1882-1948’.

of God.’⁷⁴ A number of patients’ religious delusions were expressed when they gave reasons for not eating. Sarah F refused to eat stating that God had told her not to.⁷⁵ Betsy C claimed that the soup at dinner was the blood of Jesus and ought not to be eaten.⁷⁶ Marion D, of whom Hay recorded ‘Her delusions are all of a religious nature’, thought she had sinned by eating.⁷⁷ Still other patients believed that God directed them to do things, such as commit arson in the case of Elizabeth R, or attempt to murder a fellow patient in the case of the Anglican clergyman Charles L.⁷⁸

The uses of delusional content for the historian are fairly limited. As Stephen Garton points out, delusional themes and images do not necessarily represent psychic reality. Rather, they are situated at the level of the symbolic, and our systems for decoding them have varied over time. Sigmund Freud’s interpretation of delusions of persecution as representing homosexual desire, for example, differs from Elias Canetti’s interpretation, that persecution is a means of gaining power in a society composed of crowds.⁷⁹ The subjective psychic meaning of the various religious delusions displayed by patients is, therefore, nearly impossible to determine. The repetition of religious ideas and imagery in patient delusional expression does, however, provide evidence for a strong continuing undercurrent of religious worship and belief in wider New Zealand culture.

Delusional content often has some basis in reality; in the social context of the sufferer. J.C. Burnham, in his study of the asylum in Tasmania in the nineteenth and twentieth centuries, found that the immediate environment often dominated the contents of many patient delusions. The asylum walls themselves, for example, appeared in different ways in the delusions of different patients.⁸⁰ Burnham discusses how previous studies attempt to investigate changes in culture through changes in delusional content and themes, such as the decline of religious delusions showing the increasing secularisation of society, and that

⁷⁴ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 13.

⁷⁵ Ibid., 111.

⁷⁶ Ibid., 183.

⁷⁷ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol. 3’, 1.

⁷⁸ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 1’, 189 and 47 respectively.

⁷⁹ Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940* (Kensington, N.S.W.: New South Wales University Press, 1988), 116-17. Garton cites S. Freud, ‘Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia’, *Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol 12 (London, 1958), 1-82; and E. Canetti, *Crowds and Power* (Harmondsworth, 1981), 505-40.

⁸⁰ Burnham, 376.

religious people were becoming more sophisticated, abandoning ideas of witchcraft and spirits.⁸¹

Although Burnham dismisses these findings, highlighting that historians have already at their command ‘a substantial literature documenting the growth of secularism, materialism, and technology in the West’, the existence of a large historical literature detailing cultural change should not necessarily rule out a closer examination of the content of delusions, and indeed language used by non-delusional psychiatric patients.⁸² To take the example of Charlotte M, mentioned at the beginning of this chapter, we can see from the content of her delusions a fair grasp of scriptural content and a high level of religious devotion. Her focus on specific sections of scripture betrays an engagement with biblical text which hints at piety in her general life and habits when ‘sane’, and the specific examples mentioned, Eve and Potiphar’s wife, show a use of religious language to express a feeling of sin or wrongdoing, which may have been independent of the delusional nature of her illness. In giving herself and others scriptural names Charlotte demonstrated an engagement with the scripture over other potential influences in her life. Similarly, James M was convinced that the Devil had changed him, and Charles L that God had directed him to stab a fellow patient in order to put him out of his misery. Both these men considered the figures of Christian religion as those acting upon them, showing a familiarity with and some belief in Christianity.

Religious language was used by non-delusional patients as well, and by delusional patients for whom religion was not directly tied to their delusions. As Hilary Marland has claimed regarding puerperal insanity, the language of religion provided women with a means of expressing themselves and terms for giving voice to their suffering.⁸³ In Ashburn, both women and men expressed themselves using the language of religion. In fact, for those with religious delusions at least, the gender split was roughly even. It is more difficult to quantify the use of religious language by patients to express other feelings, such as depression or hopelessness in melancholic patients. Mention of sin was common, but so too was wickedness or the idea that a patient deserved to die. The recording of these feelings often makes it unclear whether or not the patient made any explicitly religious reference. Both men and women, however, were explicitly recorded as mentioning sin, damnation and Hell to express their hopeless or suicidal feelings.

⁸¹ Ibid., 372.

⁸² Ibid.

⁸³ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2004), 123.

Christopher M, whose suicide in 1896 while a patient at Ashburn resulted in an inquiry into the running of the hall, had semi-religious delusions connected with his melancholia. He believed he had ‘committed an unpardonable sin to be expiated by seven years in a gaol’. He also thought that he must sacrifice his life to atone for the sins of his relatives.⁸⁴ Other melancholic patients too referred to their supposed sins and unworthiness to express their despondency and hopelessness. Mary M, admitted with ‘excited melancholia’ in 1900, was:

In great distress about the state of her soul. Not only was it damned because she did not answer one of her dying daughters when she spoke but God had told her that on account of this sin the two daughters who were already in Heaven were to be cast out.⁸⁵

Mary and Christopher expressed their feelings of guilt over real or imaginary sins in the language of sin and damnation. In Mary’s case, in particular, a specific act is mentioned as the sin committed, which may have had a basis in fact and in the feelings of grief over the loss of her two daughters whom she had been nursing before their deaths. That the idea of ‘sin’ was a common way for patients to express their depression and anguish shows that religious language, and by extension some degree of religious belief, was still common amongst the middle-class section of New Zealand society from which Ashburn Hall drew its patients.

The incidence of religious delusions and the use of religious language by patients in Ashburn Hall remained common throughout the period between 1882 and 1910. Constance H, who was admitted in 1903, believed she was ordered to do things by the Devil and that Hell had been prepared especially for her.⁸⁶ Daniel O’s delusions also involved the Devil.⁸⁷ Agnes M believed not only that she had died and been born again, but at the onset of her insane attack she thought that ‘her mother, priest & doctor were devils sent from Hell to destroy her soul’.⁸⁸

The main change which took place in the early twentieth century was in the frequency of recording religious delusions rather than in their incidence. E.H. Alexander’s notes in general contain less specificity than Hay’s when discussing patient delusions. The nature of Jessie M’s delusion that she was Jesus Christ, for example, was never described beyond the copying of the information given in the medical certificates.⁸⁹ This can be contrasted with Hay’s fairly frequent recording of patient delusions and language. Even though E.H.

⁸⁴ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 3’, 8.

⁸⁵ Ashburn Hall, ‘Case Book 1882-1907’, Folio 51.

⁸⁶ Ashburn Hall, ‘Case Book 1882-1907’, Folio 94.

⁸⁷ Ibid., Folio 152.

⁸⁸ Ibid., Folio 79.

⁸⁹ Ibid., Folio 181.

Alexander recorded fewer specifics of patient language, there are still instances of religious language being used right up to the end of the study period in 1910.

Patients' Religious Prejudices

Patient expressions of religious sentiment within the asylum took forms other than delusional or despairing. Patients conveyed varying degrees of religious prejudice, as indeed did the doctors. Chapter two highlighted how Frank Hay's note-taking cast Catholic female patients as inherently irrational by explaining aspects of their behaviour through reference to their religion. Patients too saw religion as a marker of difference, both within Ashburn Hall and in wider society. Rebecca C believed that Catholics persecuted her and were responsible for all her woes. She voiced her dislike of her sister-in-law with whom she had been staying before her admission, by stating that the sister-in-law's mother was a 'Roman Catholic'. Hay wrote: 'the natural inference one is supposed to draw is that they were part of the conspiracy against [Rebecca]'.⁹⁰ Hay also used Rebecca's prejudice against Catholics to account for her sudden violent dislike of one of the nurses in March 1903. Hay recorded that she 'Has probably discovered that Nurse C is a Roman Catholic.'⁹¹ Comments such as this make Rebecca's prejudice against Catholics appear irrational. Hay, however, was also prejudiced against Catholicism, as the previous chapter showed. To some extent the three doctors' recording of patient religious prejudices makes all religion seem irrational.

The medical gaze in casting religious prejudices as irrational may have obscured kernels of truth. McCarthy found that both Protestant and Catholic patients in the Auckland Lunatic Asylum commented on religious discrimination against them. She considers that the testimony of these patients 'is suggestive of a subterranean sectarianism suffusing settler society'.⁹² Religious interaction in New Zealand has generally only been discussed at isolated points of conflict, particularly between Catholic and Protestant.⁹³ While the Ashburn Hall records provide a snapshot into only a small section of New Zealand society, the prejudices of patients like Rebecca C suggest the possibility of everyday prejudice governing interactions between those of different denominations. Looked at through this lens, John M's belief that he

⁹⁰ Ibid., Folio 99.

⁹¹ Ibid.

⁹² McCarthy, 'Ethnicity, Migration and the Lunatic Asylum', 58.

⁹³ Ibid.

was being punished for being a Freethinker hints at prejudices he may have been subjected to by those whose opinions and beliefs differed from his own.⁹⁴

Patients sometimes used the expression of religious prejudices as an outlet for their feelings. Felicia G was a Methodist, but she expressed the idea that Methodists were out to cheat her father. She also expressed a desire to confess to a Catholic priest, as 'she had given up all claim on her family'.⁹⁵ Felicia's dissatisfaction with her family seems to have found a scapegoat in her religious denomination. Felicia was first admitted as a 'voluntary boarder' in March 1903 and in December 1907 was certified and officially admitted as a patient. She had been sent from her home in Melbourne by her husband rather than choosing to come to Ashburn herself. The 'voluntary' part of her admission, like that for many other patients who were not officially certified, was illusory.

Felicia's early notes state that she attended the Wesleyan church in 'the valley'.⁹⁶ She also originally made a point of asserting her social superiority and of being Wesleyan in her conversations with other patients. This changed fairly quickly. Her wish to confess to a Catholic priest came just three weeks after her admission, along with a belief that her family was trying to get rid of her.⁹⁷ This belief may have had some basis in reality. In May 1904 Felicia was judged well enough for discharge, but her relations would not consent to have her leave Ashburn unless 'she [was] quite certain to be capable of taking home duties with safety to herself & others i.e. children'.⁹⁸ Felicia was not visited by any relatives during her stay in the asylum. She left the asylum briefly from August to December 1907, when she was certified and formally admitted as a patient. She remained in the asylum until her death in the early 1930s.

Felicia's comments about Methodists and her wish to confess to a Catholic priest are cast as symptoms of her illness by Hay. The circumstances of her case, the lack of contact with her relatives and their unwillingness to have her released, raise the possibility that she used a change of religious denomination to express her feelings of alienation from and blame of the family who had sent her away. Where Rebecca C had accused her sister-in-law, the family member she did not get along with, of being descended from a Catholic and plotting

⁹⁴ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 46.

⁹⁵ Ashburn Hall, 'Case Book 1882-1907', Folio 93.

⁹⁶ Ibid. 'The valley' is most likely Kaikorai Valley on the way toward Dunedin city from Ashburn Hall.

⁹⁷ Ibid.

⁹⁸ Ibid.

against her, Felicia distanced herself from her family's religion as part of distancing herself from her family.

Patient prejudices regarding religion occasionally showed more trust in medical science than in religious faith, at least as a method of healing mental illness. Jane P was admitted to Ashburn Hall several times between 1887 and her final admission in 1900. This last was as a 'voluntary boarder' at her own wish. She had before this admission been placed at a 'so-called nursing home' (the patient's own words) run by a Mrs W in Christchurch. Jane told Hay that Mrs W 'had some quack methods & and prayed with her to [Jane's] immense disgust'.⁹⁹ Despite her disgust with prayer as part of a 'quack' method of treatment, Jane was devout. During one of her previous stays she had played the organette in the chapel. She had also written to Hay after her discharge in 1897, before embarking on a journey to London then Edinburgh. She wrote:

Yesterday forenoon the Captain took us to the Cathedral where we heard the service well rendered & had a capital sermon from Dr S. He is a great student of Shakespear [sic] & Ruskin, & drew some forcible lessons from the characters of Herodias, Jezebel & Lady Macbeth.¹⁰⁰

This shows Jane's respect for the clergy and attention to scriptural lessons. During her stay as a voluntary patient she even showed some religious exaltation, singing hymns at night.¹⁰¹

Jane, however, preferred to be under the care of the Ashburn Hall doctors than that of a 'quack' who prayed with her. The doctors at Ashburn prescribed drugs such as sedatives, but in general left prayer and spiritual well-being up to the Ashburn chaplain Reverend Sutherland or the churches in Dunedin that some patients were allowed to attend.

Conclusion

Patients with religious delusions or expressions explicitly recorded were a minority of cases admitted to Ashburn, only about 19 per cent of all cases admitted between 1882 and 1910. There may well, however, have been more patients who expressed themselves through the language of religion without it being noted in the case book. The nature of record-keeping led the doctors to record only what to them seemed relevant to the diagnosis, pathology and treatment of the case at hand. Those patients who were not recorded as expressing themselves

⁹⁹ Ibid., Folio 36.

¹⁰⁰ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 3', 137.

¹⁰¹ Ashburn Hall, 'Case Book 1882-1907', Folio 36.

in religious language or experiencing religious delusions were still likely to be part of the 95 per cent of New Zealanders who identified as adherents of a religious denomination.¹⁰²

This chapter has scrutinised how patient religion appeared in the asylum in ways which the doctors thought of as pathological or ‘bad’ religion. The Ashburn Hall doctors cast much religious expression as pathological and the religious prejudices of patients as irrational. The medical gaze was in general profoundly secularising. Although the doctors recorded varying amounts of detail about religious delusions, they sought to attribute these patients’ insanity to physical causes where possible. Religious delusions, to the doctors at least, had secular explanations, although religion might act as an exciting cause of mental illness. The doctors secularised and pathologised patient religion, painting some expressions of it as ‘bad’ and others as ‘good’ religion.

The recurrent incidence of Christian ideas in patients’ delusions at Ashburn Hall throughout the period 1882 to 1910 also reinforces that religion, in particular Christianity, had an enduring importance in New Zealand society, despite the lack of an established church in the colony. This enduring role in New Zealand society more generally can be seen in the active role of Protestant Christians, especially women, in the great social movements of the same time period. As John Stenhouse points out, prohibition and temperance, Bible-in-schools, and women’s suffrage were all numerically dominated by Protestant Christians.¹⁰³

Although the doctors pathologised certain types of religious expression, proper and appropriate religious worship was part of the ideal of bourgeois respectability especially in women. As Oonagh Walsh has pointed out, while excess religiosity and undue pondering over questions of salvation was seen as likely to impede recovery, the proper degree of piety and rational worship was a sign of improvement.¹⁰⁴ Patient experience of religion within Ashburn Hall was, therefore, encouraged as long as it was not ‘excessive’ or did not exacerbate insane symptoms. At times religious worship or the intervention of the clergy was considered as being of material therapeutic benefit to a patient’s mental state. The next chapter will further examine the roles religion had to play in the therapy offered at Ashburn Hall including how

¹⁰² Stenhouse, ‘Religion and Society’, 343.

¹⁰³ Stenhouse, ‘God’s Own Silence’, 57.

¹⁰⁴ Oonagh Walsh, “‘The Designs of Providence’: Race, Religion and Irish Insanity”, in *Insanity, Institutions and Society, 1800-1914*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 229 citing W.A.F Browne, ‘What Asylums Were, Are, and Ought to Be’ reproduced in *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry*, edited with an introduction by Andrew Scull (London: Routledge, 1991), 208-12.

the 'good' religious observances of the patients were seen by the Doctors Alexander and Doctor Hay to denote an improvement in mental state on the road to recovery and discharge.

Chapter Four: ‘He Has Been Very Friendly with the Chaplain ... Who I am Sure Has Had a Good Influence’: Religion, Therapy and ‘Scientific Pastors’ in Ashburn Hall.

In September 1897, Thomas Q was committed to Ashburn Hall for one year of compulsory treatment under Section 43 of the *Lunatics Act 1882* as a ‘Habitual Drunkard’.¹ During Thomas’ stay at Ashburn Hall, the treating physician, Frank Hay, recorded that Thomas attended the Presbyterian church in Kaikorai Valley on Sundays. The final entry in Thomas’ case notes reads: ‘He feels a little nervous about entering with business, but is determined to do well. He has been very friendly with the Chaplain (Dr Sutherland) who I am sure has had a good influence in this case.’² Hay, therefore, recognised the potential benefit of clerical influence. In defining some forms of religious expression as pathological, the doctors encroached on traditionally clerical territory, but religion in Ashburn Hall was not merely pathological in the eyes of the doctors. It could be positive, even therapeutic in some cases. Although the three Ashburn Hall medical superintendents made judgements about the morality and propriety of patients’ religious expressions they did not seek to exclude religion from their patients’ lives or explicitly to take over the role of the clergy.

This chapter examines the doctors’ definitions of ‘good’ or appropriate religion within Ashburn Hall, and seeks to nuance our understanding of the ways in which doctors’ roles overlapped with clerical ones. The first two sections deal with religious services in Ashburn Hall and the doctors’ recognition of the therapeutic value of religion. Sunday services were provided and clergymen were sometimes consulted about or aided in the treatment of individual patients. Proper religious observance was considered a sign of recovery, while excessive religiosity was perceived by the doctors as a symptom of madness, whatever the patient denomination. The moral standards inherent to Christianity, especially Protestantism, also helped form the basis for those bourgeois values applied by the doctors when judging normality and abnormality. The model of moral treatment was based on religious values, and could include a religious component.

The third and fourth sections of this chapter address the ways in which asylum doctors’ roles overlapped with and occasionally intruded into clerical territory. Some medical

¹ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol. 3’, 174 (AG-447-6/05), HC. Part II of the *Lunatics Act 1882* dealt with the detention and treatment of habitual drunkards. Section 43 allowed a High Court judge to order a habitual drunkard to be placed in compulsory treatment in a lunatic asylum for a period not exceeding twelve months.

² *Ibid.*, 175.

historians consider that throughout the nineteenth and into the twentieth century doctors took over from the clergy in various ways. Matters which had previously been construed as essentially moral were framed in medical terms.³ This is particularly evident in the realm of mental health treatment. Nineteenth-century asylum doctors were marking out a territory for themselves which included parts of the churches' traditional role.⁴ Doctors, in redefining traditional 'sins' such as masturbation, homosexuality and alcoholism as 'illnesses', were becoming the moral guardians of society. So too, theories of mental hygiene and the prevention of insanity gave asylum physicians justification for extending their influence beyond the institution's walls into all areas of life. New Zealand's asylum superintendents extended their influence into areas as diverse as proper parenting or the morality of the cinema. These doctors became 'scientific pastors' and their judgements extended beyond those under their care to encompass the behaviour and health of society more generally.⁵ The picture that emerges from this examination of the tensions and interactions between medicine and religion is a complex one. The idea that medicine encroached on clerical territory needs to be treated with caution. It was not a mere takeover. Religion remained important in therapeutic life at Ashburn Hall throughout the period from 1882-1910.

Religious Observance in Ashburn Hall

Sunday service was a regular aspect of life at Ashburn Hall which held varying degrees of importance for individual patients. The asylum was for the first few years of its existence without a regular chaplain, but sometime in the first half of 1888 the Revd. Robert Sutherland, minister of the Presbyterian church in Kaikorai Valley, was appointed as the Visiting Chaplain to Ashburn Hall.⁶ Revd. Sutherland conducted a regular Sunday service at the asylum, which all patients could attend provided the staff thought they could be trusted to behave appropriately. The Sunday service at Ashburn Hall is mentioned in a variety of contexts in patient case notes. Often the doctors only mentioned it incidentally. One note Hay recorded in Rebecca C's case file in January 1901 reads, 'Sleeping fairly well. Church Service

³ See for example Charles Rosenberg, 'Disease and Social Order in America: Perceptions and Expectations,' *Milbank Quarterly* 64, Suppl 1 (1986): 45.

⁴ Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993), 176-7.

⁵ Matthew Philp, 'Scientific Pastors: The Professionalisation of Psychiatry in New Zealand 1877-1920', in *Unfortunate Folk: Essays on Mental Health Treatment 1863-1992*, ed. Barbara Brookes and Jane Thomson, (Dunedin: University of Otago Press, 2001), 198-9.

⁶ 'Lunatic Asylums of the Colony (Report on) for 1887', *AJHR* (1888), H-8, 8.

as usual. Out in the evening with Mother'.⁷ Another patient, Regina R, was mentioned as being put out for an airing in her chair after service.⁸

The provision of a chaplaincy, or at least of a Sunday service in lunatic asylums, was an aspect of the moral treatment regime, based on English and French models, which was used in Ashburn Hall and other colonial asylums.⁹ According to Henry Rollin's interpretation, the provision of religious services and the status of the asylum chaplain was an index of the rise and fall of moral treatment throughout the nineteenth century in England. The English lunacy reform movement had been headed in part by prominent Evangelicals, who saw bringing lunatics within the compass of the Church as a Christian duty. The *Treatment of Insane Persons Act 1828* instructed the Lunacy Commissioners and Visitors to asylums to enquire into whether and at what times Divine service was rendered, implying that lack of Divine service would be met with official disapproval, without actually compelling superintendents to make it available.¹⁰ In Scotland, the introduction of Sunday service in asylums was also linked to moral treatment. W.A.F. Browne was the first physician superintendent to institute a regular church service for patients in the mid-1830s at the Montrose Royal Asylum. This was one of a number of innovations Browne cautiously introduced in making moral treatment, which he had observed in Parisian asylums, the foundation of Montrose's institutional routine.¹¹ Moral treatment, even in France where it had always come under a medical aegis, included recognition of the importance of religious observance to patient comfort. According to Rollin, the role of religion in English asylums reached its zenith in mid-century, and then steadily declined owing to the loss of influence of the Evangelical movement, the retirement of the generation of asylum superintendents who had first put moral treatment into practice, and the overcrowding of asylums with incurable cases, which resulted in therapeutic pessimism. By the beginning of the twentieth century, active encouragement for patients to seek solace in religion had tapered off although facilities were still available.¹² This may have

⁷ Ashburn Hall, 'Case Book 1882-1907,' Folio 49 (AG-447-6/01), HC.

⁸ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3,' 193.

⁹ Chapter one of this thesis dealt with the intellectual influences on asylum practice in the context of Ashburn Hall. Moral treatment was, by the time Ashburn Hall was founded, so widespread that it is difficult to trace whether the superintendents were more indebted to French, English or other models. Lunacy policy in New Zealand borrowed largely from English precedent, but medical thought was influenced by English, Scottish and European trends.

¹⁰ Henry Rollin, 'Religion as an Index of the Rise and Fall of "Moral Treatment" in 19th Century Lunatic Asylums in England', *Psychiatric Bulletin* 18, no. 10 (1994): 627.

¹¹ Andrew Scull, Charlotte MacKenzie, and Nicholas Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, N.J.: Princeton University Press, 1996), 89.

¹² Rollin, 629-30.

been the case in other countries too, with incurable patients overcrowding asylums, and the resulting therapeutic pessimism engendered by the inability to cure patients.

In New Zealand, however, Sunday services were uniformly provided in the colony's public asylums in the 1880s when Ashburn was founded. Auckland Asylum was the only asylum equipped with a chapel, but services were also held at and clergymen visited the other public asylums in New Zealand.¹³ Sunnyside Asylum in Christchurch even had a Sunday-school class held by the visiting chaplain every week.¹⁴ In 1882 Wellington Asylum had both Catholic and Protestant services on a Sunday. The Protestant services were normally attended by 87 patients and the Catholic by 31. The total patient population of the Wellington Asylum was 139, meaning that 85 per cent of the patient population regularly attended service.¹⁵ Attendance at Sunday service was voluntary, and might even be prohibited for some of the more badly behaved patients. The patient population at the Wellington asylum was devout, at least at first glance, although regular attendance at services probably had social aspects as well, and would have been a change from everyday asylum routine. Dolly MacKinnon addresses the provision of Divine service in the broader context of asylum recreation and amusement in Australian and New Zealand asylums.¹⁶ She points out that Divine service was simply one aspect of the recreational side of a moral treatment regime, albeit an important one. Divine service was considered essential for the treatment of mental patients as 'something is wanted even with insane people to mark distinctly the Sunday'.¹⁷

At Ashburn Hall, as in public asylums, church services were voluntary. William S did not go to the service provided at Ashburn one week because he was 'not happy'. The following week he was allowed to attend the Presbyterian church in Kaikorai Valley.¹⁸ Betsy C wrote to E.W. Alexander one week in May 1890 requesting him to ask another patient, Mr P, privately whether he intended to attend the church service the next Sunday afternoon. She wrote, 'I do not feel inclined unless he does, so please let me know'. The letter has been kept with her case notes. E.W. Alexander recorded several days later that Betsy had formed a

¹³ Warwick Brunton, 'The New Zealand Lunatic 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, N.Z.: Waikato Postgraduate Medical Society, Waikato Hospital, 1987), 162.

¹⁴ 'Lunatic Asylums of the Colony (Report on) for 1883', *AJHR* (1884), H-7, 5.

¹⁵ 'Lunatic Asylums of the Colony (Report on) for 1882', *AJHR* (1883), H-3, 10-11.

¹⁶ Dolly MacKinnon, "'Amusements Are Provided": Asylum Entertainment and Recreation in Australia and New Zealand c.1860-c.1945', in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, ed. Graham Mooney and Jonathan Reinartz (Amsterdam, New York: Editions Rodopi, 2009), 269.

¹⁷ *Queensland Votes and Proceedings* (1873), Lunatic Asylum Woogaroo Report, 1306, quoted in *Ibid.*

¹⁸ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3,' 127.

violent attachment to Mr P, believing him to be a young seaman she had thought attached to her on the voyage from England. Betsy's delusions mostly centred on imaginary lovers and marriage.¹⁹ Although Betsy wrote her letter labouring under a delusion, it is clear that she did not feel her absence from service would be disapproved of by Alexander. Church service was merely part of asylum life to her, which she could attend or not as she chose.

To the Ashburn Hall doctors, however, regular attendance and proper behaviour at church service could be a sign of patient improvement. Attendance at church service in Ashburn Hall and other asylums was available in part because it might aid a return of sanity. The Scottish asylum reformer and author W.A.F. Browne, although concerned with the potentially exciting effect of religious ritual for already distressed imaginations, claimed in the mid-nineteenth century that respectful participation in religious ritual should be considered grounds for immediate release from the asylum. He thought that 'when patients have advanced so far towards restoration as to be intrusted [sic] with such high and holy privileges, that they should not longer be detained in an asylum'.²⁰

Not all shared Browne's views. Indeed, medical professional opinion varied in the nineteenth century over the usefulness of religious practice in asylums.²¹ In his 1864 Report to the Otago Provincial Council, E.W. Alexander stated that in Dunedin's asylum, 'Regular religious services by a clergyman are found of value in the treatment of the insane.'²² Although the Report was written eighteen years before the founding of the private asylum, Ashburn Hall's first medical superintendent believed religion could be useful. The availability of regular worship in New Zealand's public asylums, and the need for a private institution such as Ashburn Hall to keep its patrons satisfied, also led to religious service being made available in the private asylum.

In Ashburn Hall, the doctors recognised that proper and appropriate participation in religious observance might have some therapeutic value. Patient behaviour at service received

¹⁹ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 1,' 183 (AG-447-6/04), HC.

²⁰ W.A.F. Browne, *What Asylums Were, Are and Ought to Be* (first published 1837), in *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry*, ed. Andrew Scull (London: Routledge, 1991), 231, quoted in Oonagh Walsh, "'The Designs of Providence": Race, Religion and Irish Insanity', in *Insanity, Institutions and Society, 1800-1914*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 230.

²¹ Oonagh Walsh, 229.

²² E.W. Alexander, 'Observations on Hospitals and Lunatic Asylums with Reference to the Dunedin Hospital and Lunatic Asylum', in 'Report of the Commission of Enquiry into the Constitution and Management of the Dunedin Hospital and Lunatic Asylum', *Appendix to Votes and Proceedings of the Provincial Council - Session XVIII, 1864* (Otago Provincial Council, 1864), 46.

comment as good or bad. Several female patients played the organ for services, which was an encouraged activity. The medical profession considered hymn singing, as well, to be especially beneficial for female patients.²³ Hay observed of Janet B in March 1897 that she was at her best. In the same note he stated that she ‘was at Service this afternoon’. The improvement in Janet’s case although not necessarily attributable to attendance at Sunday service, was still evidenced by this in Hay’s eyes. Two weeks later, Janet had undergone a relapse of her mental symptoms and though allowed to go to service she ‘did not behave well’.²⁴ Poor behaviour at service was evidence of deterioration in mental condition.

No records survive recording how many patients attended Sunday services at Ashburn Hall. It is likely, however, that the majority of patients at Ashburn Hall attended service at least occasionally. 95 per cent of all settlers in New Zealand identified as adherents of a Christian denomination at the end of the nineteenth century.²⁵ Although many of New Zealand’s population did not regularly attend church, the statistics given in the 1883 Inspector-General’s Report show that the majority of patients at Wellington Asylum commonly attended services.²⁶ Patients who identified themselves as Christian might be more likely to attend church services while they were within the asylum than when they were out of it. It was a change in routine, other patients were attending, and for those allowed to attend churches in Dunedin it was a trip away from the confinement of the asylum buildings and grounds. The fact that the Ashburn Hall service was Presbyterian also seemed not to deter patients of other denominations from attending. Thomas P was a member of the Church of England, but regularly attended the Sunday service at Ashburn Hall.²⁷ Agnes M, a Catholic, also attended.²⁸ Finally, Regina R, who was placed outside in her chair after attending the

²³ Dolly MacKinnon, ‘“A Captive Audience”: Musical Concerts in Queensland Mental Institutions c.1870-c.1930’, *Context: Journal of Music Research* 19 (2000): 43-56; Dolly MacKinnon, ‘Jolly and Fond of Singing: The Gendered Nature of Musical Entertainment in Queensland Mental Institutions c.1870-c.1930’, in *Madness in Australia: Histories, Heritage and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia, Queensland: University of Queensland Press, 2003), 157-68, both cited in MacKinnon, ‘“Amusements are Provided”’, 269.

²⁴ Ashburn Hall, ‘Report Book – Intermediate Case Book, vol 3’, 79.

²⁵ John Stenhouse, ‘Religion and Society’, in *The New Oxford History of New Zealand*, ed. Giselle Byrnes (Melbourne: Oxford University Press, 2009), 343.

²⁶ ‘Lunatic Asylums of the Colony (Report on) for 1882’, *AJHR* (1883), H-3, 10-11; Stenhouse contests the claim that New Zealand’s churches were poorly attended and socially marginal. He reconnects them to Old World traditions. In England, most Anglicans used the church for rites of passage (baptism, weddings, burials), without attending every Sunday. In New Zealand, too, most lay-Anglican settlers continued to use the church for rites of passage, send their children to Sunday School and consider themselves Christians. See Stenhouse, ‘Religion and Society’, 343-4.

²⁷ Ashburn Hall, ‘Report Book – Intermediate Case Book, Vol 3’, 14; Thomas’ religion is recorded in Ashburn Hall, ‘Case Book 1882-1907’, Folio 14.

²⁸ Ashburn Hall, ‘Case Book, 1882-1907’, Folio 79.

service, was a Freethinker, while several other patients who attended services did not have their denomination recorded in their case files.²⁹ Denominational differences, therefore, did not necessarily impede patients' attendance at the Ashburn Hall services.

Another factor which may have led some patients to attend the service was the realisation that the doctors considered appropriate behaviour at religious services to be a sign of improvement. There is no evidence of this in the information available in the archive, but the Ashburn Hall doctors, Hay in particular, commented on the church attendance of patients as a sign of improvement. There were significant gender distinctions in this regard. While the church attendance habits of only four men were recorded in their case notes, the doctors recorded attendance or prohibitions from attendance at church service in more than four times as many women. This is intriguing as female patients only slightly outnumbered male patients at Ashburn Hall over the time period between 1882 and 1910, accounting for 52 per cent of the total patient population.³⁰ Furthermore, the total patient population in any given year during this time period was roughly even, although with slightly more male than female patients in its first few years. Indeed, 1890 was the first year when female patients outnumbered male. In that year there were 24 certified female patients resident at Ashburn Hall and only 18 male.³¹ In the years following, the patient population remained relatively evenly divided along gender lines. The greatest differences were in 1895 and 1909, when there were six more men than women, and in 1904-5 when there were six more women than men certified and undergoing treatment.³²

The more frequent recording of female attendance at Sunday worship does not necessarily mean that the incidence of church attendance was higher amongst female than male patients, merely that female worship was more closely scrutinised than male. In more than one woman's case notes Hay recorded her taking an active role by playing the organette in the chapel. No men adopted this more active role in church, although at least one male patient, Thomas P, expressed strong opinions about how the service was rendered by Revd.

²⁹ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3', 193; As discussed in chapter three, the three doctors recording of religious denomination was sporadic. Only about 32 per cent of all patients treated at Ashburn Hall had religious denominations entered in their case files.

³⁰ These statistics are taken from Ashburn Hall, 'Register of Admissions, 1882-1948', (AG-447-5/01) HC.

³¹ 'Lunatic Asylums of the Colony (Report on) for 1889', *AJHR* (1890), H-12, 1.

³² 'Lunatic Asylums of the Colony (Report on) for 1895', *AJHR* (1896), H-7, 1; 'Mental Hospitals of the Colony (Report on) for 1909', *AJHR* (1910), H-7, 2; 'Mental Hospitals of the Colony (Report on) for 1904', *AJHR* (1905), H-7, 1; 'Mental Hospitals of the Colony (Report on) for 1905', *AJHR* (1906), H-7, 1.

Sutherland.³³ The greater attention paid to women's church attendance reinforces that religious worship and pious behaviour were more expected in women than in men. As evident outside the asylum, women formed the backbone of most Christian congregations and of much household and community religion.³⁴ Piety was a part of the bourgeois feminine ideal against which the doctors judged patient behaviour. Sane femininity was, therefore, associated with some degree of religious observance.

Although most patients were allowed to attend services within Ashburn Hall if they wished to, the doctors sometimes prevented patients whose behaviour was particularly unpredictable from attending the service. Mary M, who suffered from excited melancholia, was not allowed to go in January 1901, because she was 'Not quite so well as the day before & [it was] decided not to trust her at Church Service'. This applied to her mental, rather than physical, state. Four days later she was transferred to Conolly ward because of deterioration in her mental condition.³⁵ Prevention of patient attendance at the Sunday service seems to have arisen more from the doctors' concern over the likelihood of exacerbating patients' symptoms than as a punishment for bad behaviour. Georgina F escaped the asylum one Sunday in September 1900, but was captured in time to play the organ at the service. Hay remarked that 'she did not play well'.³⁶ Georgina's escape did not lead to her exclusion from, or active participation in worship. Interestingly, only female patients' exclusion from the religious services at Ashburn Hall is noted in the case books. When the doctors recorded male patients not going to service, it was of the patients' own volition. This again implies that female behaviour was more closely scrutinised than male in relation to religion, and that the doctors perceived women as more likely to be excited, and their symptoms exacerbated by religious service than men.

A number of male and female patients were allowed out of the asylum to attend their own denominational services in churches around Dunedin, despite Ashburn Hall's distance from the city. The nearest church, the Kaikorai Presbyterian Church, was about two and a half kilometres away. Patient behaviour in order to be allowed to attend public services had to be better than that required for attendance at Ashburn Hall's service. Patients who were allowed on excursions outside the asylum were automatically on public display. 'These patients,' observes MacKinnon, 'through their actions and behaviour, reflected the medical success or

³³ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3', 14.

³⁴ Stenhouse, 'Religion and Society', 14.

³⁵ Ashburn Hall, 'Case Book 1882-1907', Folio 51.

³⁶ *Ibid.*, Folio 43.

failure of the institutions they represented.’³⁷ The public reputation of Ashburn Hall rested in part on the behaviour of those patients who were allowed out of the asylum. Attendance at church service, or at amusements outside the asylum, such as the theatre, was a privilege granted to only well-behaved patients. Agnes M, after one attempt to take her to a Catholic church service in Dunedin, was not taken back for four months because she had been poorly behaved on the journey in front of passers-by in Roslyn.³⁸ In that next excursion to church, once her behaviour had improved, she ‘behaved very well, dressed herself very nicely & looked as if she were taking an interest in her appearance’.³⁹ The standards for Agnes’ behaviour when attending church service are noticeably gendered. By dressing nicely for church, Agnes conformed to Hay’s conception of bourgeois respectable norms of femininity. Proper behaviour for Agnes to attend a church outside the asylum included looking like a respectable woman. Behaviour to attend services within the asylum clearly did not have to be as good as to attend churches in Dunedin. Without public observance, respectable behaviour was not as important as the potential benefit to a patient’s mental state of the church service.

The doctors’ willingness to allow patients to attend services, and to have them transported there and back, reflects Ashburn Hall’s position as a private asylum. As Charlotte MacKenzie has pointed out, ‘attention to inmates’ spiritual needs, and opportunities to worship, were expected by the clientele of private asylums’.⁴⁰ A slight exception seems to be for non-Christian patients. There is no mention, for example, of the few Jewish patients in Ashburn Hall being visited by a rabbi or attending services in Dunedin. This does not necessarily mean that these patients did not attend religious services; simply that the doctors did not record it if they did. Hay’s notes about one Jewish patient, Hannah L, however, imply that he did not respect her Jewishness as much as he did the religious beliefs of Christian patients. He wrote that when asked her opinions about the Christian, she would ‘generally end by giving [illegible] the conversation jewish [sic] character’.⁴¹ The implication is that a Jew in a healthy state of mind could be expected to adapt their views to conform to Hay’s. Hay also stated in Hannah’s notes, however, that if there was someone to care for her outside the asylum, there would be no necessity of her being kept inside it.⁴² The lack of a ‘suitable

³⁷ MacKinnon, “‘Amusements are Provided’”, 281.

³⁸ Ashburn Hall, ‘Case Book, 1882-1907’, Folio 79. The specifics of Agnes’ poor behaviour are not given in the case note, just that it was in front of ‘passers-by’.

³⁹ Ibid.

⁴⁰ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London; New York: Routledge, 1992), 28.

⁴¹ Ashburn Hall, ‘Case Book 1882-1907,’ Folio 29.

⁴² Ibid.

guardian' beyond the asylum walls implies that her family was not actively involved in her case. Lack of family interest, combined with her deteriorating mental state (she was diagnosed with dementia), may have kept Hay from sending her to the synagogue in Dunedin more than any lack of respect for her religion.

Family certainly played an important role in some decisions about patient attendance at church services. For proprietors of a private asylum, keeping patients' families content with treatment was crucial. This included attending to patients' spiritual needs in a manner which families considered appropriate. Negotiations between families and the asylum superintendents were complex, with family sometimes making decisions that the doctors disagreed with. Some families took patients out against medical advice, as addressed in chapter two. In the context of religious worship, the involvement of the family in decisions regarding patient attendance at religious worship was made explicit in Agnes M's case notes. When Agnes first arrived at Ashburn, transferred from Porirua Asylum in Wellington, she complained that at the public asylum she had not been allowed to go to church. Her brother arranged with Hay to take her to the Catholic church in town. When she behaved badly on the journey back from church, her brother became convinced that her complaints about not being allowed to go were unjustified. Once the brother was so convinced, decisions about whether to allow Agnes to attend church services outside the asylum were left up to Dr. Hay.⁴³

Hay again referred to the wishes of Agnes' family when she expressed a desire to attend the Presbyterian service at Ashburn Hall. She was allowed to do so, 'her relatives not having objected in the past'. Several months later, she attended the Protestant church in Roslyn. She '[insisted] that there [was] nothing unlawful in this but it [was] certainly peculiar'. When her behaviour was good enough to be allowed out of the Hall, it seems that Agnes was permitted to more or less please herself about which denominational services she attended in the absence of any objection from her relatives.⁴⁴

The doctors' attention to family wishes, and to patient inclinations which did not conflict with family directives, was in keeping with the nature of private asylum care. Alan Somerville stresses the role of the family in patient committal to Ashburn, and the Ashburn doctors' concern to promote confidence in the comforts, respectability, and to a lesser extent

⁴³ Ibid., Folio 79.

⁴⁴ Ibid. 'Protestant Church' in the notes probably refers to St John's Anglican Church in Roslyn, although Roslyn Presbyterian Church had been built by the time Agnes was admitted in 1902. Most patients who attended Presbyterian services, however, went to the Presbyterian Church in Kaikorai Valley.

the effectiveness of private asylum care.⁴⁵ Patient comfort and attention to patients' spiritual needs were dwelt on by nineteenth-century private asylum proprietors in an effort to make the asylum a more attractive option for those with mad relatives.⁴⁶ Doctors at private asylums were interested in keeping patients as comfortable and content as possible in order to maintain a good reputation and have families continue sending relatives there.

Recognition of the Therapeutic Value of Religion

Attention to patients' spiritual needs was not merely about keeping patients content and maintaining a high reputation for Ashburn Hall. Piety was part of bourgeois respectable norms, especially in female patients. Additionally, the doctors themselves, although trusting mostly to science for diagnosis of insanity and believing in its somatic basis, recognised the potential therapeutic value of religion for some cases. Thus, if insanity involved a loss of 'moral consciousness', proper religious observance could encourage its return. Recognition of the therapeutic role of religion can be seen in New Zealand's public asylums. Warwick Brunton found, for example, that a patient at Sunnyside Asylum in Christchurch began the return to 'moral consciousness' after hearing the strains of an organ before the evening service.⁴⁷

In most patients' cases the doctors' recognition of the therapeutic value of religious observance was implicit rather than explicit. The potentially therapeutic value of religion was, however, explicitly recognised by Frank Hay in two cases while he was medical superintendent. In 1903, Hay sought help from the Very Rev. Patrick Murphy, the administrator of St Joseph's Catholic Cathedral in Dunedin. When Murphy came to visit Agnes M, Hay told him 'that Miss M. said recently that she was dead & alive again & that he [should] point out the heresy'.⁴⁸ Hay thought that the priest might have some influence with Agnes as, according to her family, she had always been very devout, even beginning training as a nun at one stage. The priest was likely to occupy a position of trust greater than Hay as her doctor and keeper did. Although asylum doctors did seek a position of trust and influence over their patients, Hay at least still admitted the importance of other influences on his patients' minds.

⁴⁵ Alan Somerville, 'Ashburn Hall and Its Place in Society, 1882-1904', M.A. Thesis, University of Otago, 1996). See chapter two in particular, which deals with the family's role in committal.

⁴⁶ MacKenzie, 23-8.

⁴⁷ Brunton, 'The New Zealand Lunatic Asylum: Conception and Misconception', 162.

⁴⁸ Ashburn Hall, 'Case Book 1882-1907', Folio 79.

In another case Hay considered that the visiting chaplain the Revd. Sutherland had a positive influence. When Thomas Q, mentioned at the beginning of this chapter, was discharged, Hay noted that the clergyman had contributed to Thomas' improvement. Thomas had been drinking for years and Hay considered the case one of dipsomania. Thomas left the asylum after his year of confinement determined to do well and Hay attributed this determination at least in part to Revd. Sutherland's influence.⁴⁹ This is in keeping with the findings of Tanaquil Taubes' study of the annual reports of asylums in the Eastern United States in the mid-nineteenth century. Superintendents there emphasised the capacity of religious worship to inspire rational behaviour and self-control in patients.⁵⁰ Hay, by considering the Revd. Sutherland's influence to be positive, recognised some potential for religion to play a part in maintaining mental health, while his request for Father Murphy to point out a patient's own blasphemy to her shows a recognition that religiously devout patients would be likely to respect and accept things told to them by clergy that they would not believe from doctors.

Hay's explicit recognition of the therapeutic value of religion appears in the patient case files because Hay in general recorded more explicit detail in patient case notes. He documented more information about patients' delusional content and supplied a great deal more physical information about patients than either his predecessor or successor as medical superintendent did.⁵¹ Although the two doctors Alexander did not record explicit recognition of the therapeutic value of religion, they did provide for patients' spiritual well-being through services at the asylum or at churches in Dunedin. All three asylum superintendents, therefore, allowed room for religion as part of asylum life and in the care and treatment of the insane at Ashburn Hall.

'Scientific Pastors': the Overlap between Medical and Clerical Roles

Religion played a complex role in asylum practice. The three medical superintendents of Ashburn Hall between 1882 and 1910 provided opportunities for patients to attend religious

⁴⁹ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3', 175.

⁵⁰ Tanaquil Taubes, "'Healthy Avenues of the Mind': Psychological Theory Building and the Influence of Religion During the Era of Moral Treatment,' *The American Journal of Psychiatry* 155, no. 8 (1998): 1003.

⁵¹ Chapter three of this thesis mentioned Hay's recording of patients' delusional content, while chapter one showed the difference in the amount of physical information recorded by the different doctors. The level of detail in Hay's case notes was part of the drive towards more 'scientific' approaches to insanity and by extension record-keeping about patients in late-nineteenth century Scottish psychiatry, the context in which Hay was trained. See Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine* 11, no. 2 (1998): 255-81

services, and good behaviour at these could signal recovery. The moral treatment regime in place at Ashburn Hall, a regime Taubes described as the ‘backbone of nineteenth-century asylum care’, had strong religious underpinnings, although it was also influenced by humanism and the empiricism of Locke and other Enlightenment thinkers.⁵² Moral treatment’s kind and respectful approach to patient care was inspired by Protestant ethics, while the Christian virtues of self-discipline and work were encouraged by the inclusion of occupational therapy, a structured agricultural life and amusements designed to distract patients from irrational and unhealthy preoccupations.⁵³

Hay and the doctors Alexander should not be seen as merely ‘men of science’. There is no evidence any of them were atheistic or even agnostic as a result of their medical training and practice. Hay attended services at the Anglican church in Roslyn at least occasionally. In March 1904, Constance C was ‘Taken to Church of England service by [Dr Hay] & sister because Miss N was being taken’.⁵⁴ The regularity of Hay’s attendance and whether he went there without patients is unknown. E.W. Alexander and his son E.H. Alexander were both Anglican, at least nominally, although neither recorded as attending services in patient case notes.⁵⁵ This does not mean that they never went, merely that they did not go with patients, or that they did not consider it worth mentioning in the case notes. Indeed, these doctors made more infrequent mention of patient attendance at services or at churches outside the asylum than Hay did. They may well have attended services with patients, but not thought it worth recording in the case notes.

Whatever their levels of personal devotion, these three doctors did not overtly seek to take over clerical territory. In spite of this, their roles often overlapped with and occasionally superseded the role of the Church. As shown in the previous chapter, the doctors Alexander and doctor Hay pathologised religious expression in many cases. They occasionally even considered it to be an exciting cause of insanity. Inappropriate religious expression was a cause for concern in the asylum. This was not, however, a conscious territorial expansion at the expense of the Church in late nineteenth- and early twentieth-century New Zealand. In deciding what constituted pathological expression of religion, and whether patients should be permitted to attend services, the doctors considered patient well-being first and religious expression second. Mary M, for example, was not allowed at service because her mental state

⁵² Taubes, 1002.

⁵³ *Ibid.*, 1002.

⁵⁴ Ashburn Hall, ‘Case Book 1882-1907’, Folio 94.

⁵⁵ They are both buried in the Anglican section of the Southern Cemetery in Dunedin.

had deteriorated.⁵⁶ It seems that Hay was concerned with the damage the excitement of church service might do to her. Medical definition of ‘good’ and ‘bad’ religious expression, although it was not directly intended to take over from the Church, was one way in which the Ashburn Hall doctors’ roles extended into traditionally clerical territory.

Even though the expansion of asylum medicine was not explicitly intended at clerical expense, there were a number of other areas in which medical and clerical roles overlapped in the nineteenth century. Several behaviours traditionally considered sinful were recast as forms of mental illness instead. The earliest of these was suicide. From the late seventeenth century in England lay juries in suicide inquests began to return more and more verdicts of *non compos mentis*. This had more to do with the political and religious strife in seventeenth-century England than with medicine seeking explicitly to extend its jurisdiction, although medical opinion that the mental illness melancholia could lead to suicide did provide the rationale for suspending old common law and religious penalties for suicide. The change was brought about by lay juries rather than by medical men.⁵⁷ By the time Ashburn Hall was founded in 1882, suicide had for more than two centuries fallen under the aegis of the medical profession. Although it was still a sin, the commonly accepted view was that suicide was caused by mental illness. Suicidal patients at Ashburn sometimes believed themselves to be unworthy of salvation, as in the case of Christopher M. There is no evidence in his, or any other suicidal patient’s case note to suggest, however, that the doctors also regarded self-destruction as sinful.⁵⁸ To them suicidal feelings were a result of mental illness.

Other traditionally sinful forms of behaviour were more explicitly and intentionally redefined as illnesses by the medical profession. By the latter part of the nineteenth century medicine intersected more directly and frequently with the tendency of society to prescribe and proscribe behaviour. Alcoholism, drug-addictions and homosexual acts became diagnoses rather than sins.⁵⁹ Charles Rosenberg has stated that:

⁵⁶ Ashburn Hall, ‘Case Book 1882-1907’, Folio 51.

⁵⁷ Michael MacDonald, ‘The Medicalization of Suicide in England: Laymen, Physicians and Cultural Change, 1500-1870’, in *Framing Disease: Studies in Cultural History*, ed. Charles E. Rosenberg and Janet Golden (New Brunswick, New Jersey: Rutgers University Press, 1992), 85-103.

⁵⁸ Ashburn Hall, ‘Report Book – Intermediate Case Book, vol. 3’, 8, 36.

⁵⁹ George L. Mosse, *Nationalism and Sexuality: Respectability and Abnormal Sexuality in Modern Europe*, 1st ed. (New York: H. Fertig, 1985), 10, 25-40; Bert Hansen, ‘American Physicians ‘Discovery’ of Homosexuals, 1880-1900: A New Diagnosis in a Changing Society’, in *Framing Disease: Studies in Cultural History*, ed. Charles E. Rosenberg and Janet Golden (New Brunswick, New Jersey: Rutgers University Press, 1992), 104-33; W.F. Bynum, ‘Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry’, *British Journal of Addiction* 79, no. 1 (1984): 59-70.

A growing secularism paralleled and lent emotional plausibility to this framing in medical terms of matters that had been previously construed as essentially moral. Science not theology should be the arbiter of such questions.⁶⁰

Many of the bourgeois ideals which the Ashburn Hall doctors used to judge their patients show how science became the arbiter of morality. As discussed in chapter two, many women who transgressed the bourgeois gender norms could be labelled as insane. Felicia G's 'self assertive manner & a tendency to show want of respect for others', Hay described as 'either morbid or the result of ill-breeding'.⁶¹ The characterisation of this behaviour as morbid lent scientific authority to an otherwise moral judgement.

Doctors also encroached on clerical territory in the definition of normal and abnormal sexuality. Starting from the ideas of late nineteenth-century European sexologists, such as Richard von Kraft-Ebbing, homosexuality moved from being classed as merely a sinful act, to an 'illness' not necessarily tied to the sexual act itself.⁶² Bert Hansen, considering the American context, posits that homosexuals were willing to seek out and consult American neurologists in part because that science had, by the end of the nineteenth century, come to hold a position of social authority: 'One consequence for some Americans was that physicians replaced the clergy as authoritative personal consultants in the realm of sex.'⁶³ By recasting traditional sins as mental diseases, medical science did indeed come to take over some aspects of the traditional clerical role.

No case examples dealing explicitly with homosexual acts exist in the Ashburn Hall archive between 1882 and 1910. Chris Brickell, however, has shown that one New Zealand asylum superintendent in the 1890s, Truby King of Seacliff asylum, by contrast with European and American sexologists of the late nineteenth century, followed traditional views on homosexual acts as sinful, rather than considering an interest in sodomy to be the result of congenital predisposition. King considered his patient Percy Ottywell's interest in sodomy in purely moral terms as 'a form of sexuality that was "filthy", "dirty" and "bad"'.⁶⁴ Although medicine in Europe and America was redefining homosexual behaviour as an illness, this

⁶⁰ Charles Rosenberg, 'Disease and Social Order in America: Perceptions and Expectations', *Milbank Quarterly* 64 Suppl 1(1986): 44-5, quote at 45.

⁶¹ Ashburn Hall, 'Case Book, 1882-1907', Folio 93.

⁶² Mosse, 10, 25-40.

⁶³ Hansen, 104-33, quote at 118.

⁶⁴ Chris Brickell, 'Same Sex Desire and the Asylum: A Colonial Experience', *New Zealand Journal of History* 39, no. 2 (2005): 166-7.

redefinition was not universal, and may not have reached New Zealand asylums until the twentieth century.

An act present in several cases at Ashburn Hall which was sometimes associated with 'deviant' sexualities was masturbation. From the late eighteenth century, the medical profession associated masturbation with a number of mental and physical problems including epilepsy, consumption, digestive disorders, impotency, hypochondria, imbecility, hysteria, and nymphomania.⁶⁵ As explored in chapter two, the Ashburn Hall doctors listed masturbation as a cause of insanity in several cases. The association of masturbation with mental and physical illness gave a secular scientific rationale to its prohibition in addition to a moral one. In this way, as through the redefinition of sins to sicknesses, the asylum and medical profession instituted a secular moral order. These areas show an extended influence of doctors in society in the very definition of patients.

The growth of scientific authority in the determination of morality has led to characterisations of doctors as priests. Mark Finnane extended this association to include the lunatic asylum taking on the role of the Church. According to Finnane '[the asylum] institutionalised its own secular moral order, it could be sanctuary, it lived in constant relation to its environs'.⁶⁶ Ashburn as an asylum did live in constant relation to its environs. It was removed from, but still reliant on, the Dunedin community. Patients who were well enough attended churches in town, the theatre and any special events or parades. The managers of Ashburn also relied on maintaining a high reputation in the surrounding community and throughout New Zealand in order to retain a client base.⁶⁷ Asylums in general also acted as sanctuaries, particularly for women.⁶⁸ There is evidence of both male and female patients using Ashburn as a sanctuary, especially those who sought admission as voluntary boarders. One male patient, for example, stayed just one night after a quarrel with his wife. He had taken some drink and believed that 'unless he were taken in hand he would go on drinking'.

⁶⁵ Ann Goldberg, *Sex, Religion, and the Making of Modern Madness: The Eberbach Asylum and German Society 1815-1849* (New York: Oxford University Press, 1999), 88.

⁶⁶ Mark Finnane, 'Asylums, Families and the State,' *History Workshop* 20 (1985): 135.

⁶⁷ Somerville, 22-33.

⁶⁸ See for example Barbara Brookes, 'Women and Madness: A Case-Study of Seacliff Asylum, 1890-1920', in *Women in History* 2, ed. Barbara Brookes, Charlotte Macdonald, and Margaret Tennant (Wellington, N.Z.: Bridget Williams Books, 1992), 129-47; Janice Chesters, 'A Horror of the Asylum or of the Home: Women's Stories 1880-1910', in *'Madness' in Australia: Histories, Heritage and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia, Queensland: University of Queensland Press, 2003), 135-44.

He left the next day to return home. For this patient, the asylum was a temporary sanctuary to gather his nerves and strengthen his resolve to do right by his family.⁶⁹

As well as offering sanctuary for some patients, asylums and asylum doctors did institutionalise their own secular moral order as Finnane suggests. Judgements doctors made about normal and abnormal behaviour were justified through secular, scientific means, although the types of behaviour considered abnormal or sick were often behaviours which were morally wrong by any contemporary standards: promiscuity or lack of modesty in women; violence, masturbation and foul or blasphemous language in either sex.⁷⁰ There was sometimes a morally disapproving element in doctors' writings. Those who were diagnosed with illnesses such as dipsomania (alcoholism), for example, although sick, lacked self-restraint, one of the important virtues of the bourgeois ideal. For many alcoholic cases, E.W. Alexander did not record notes in the regular patient case book. Only one or two of those admitted as 'habitual drunkards' were mentioned in regular case notes. E.H. Alexander also did not make any notes about 'habitual drunkards' in the regular case book. Alcoholic patients committed for treatment as 'habitual drunkards' were treated differently from other patients. Section 44 of the *Lunatics Act 1882* specified that 'habitual drunkards' were to be treated in a part of the lunatic asylum separate from those certified insane. They were not well, but not quite insane either.

Dr. Hay recorded detail about 'habitual drunkards' admitted under the *Lunatics Act 1882*, including their cravings for alcohol and how they were gradually weaned from reliance on it. He was positive about the case of the dipsomaniac Thomas Q as Thomas had chosen to apply for a judge's order admitting him for one year of treatment. Hay's notes about Thomas were positive about his employing himself in the asylum, his regular attendance at church, his determination to do well and the good influence the Ashburn chaplain appeared to have had in helping form this resolution.⁷¹ Thomas showed attempts at self-restraint in one unused to it before. Thomas Q's case was also one where Hay believed that the Revd. Sutherland had exerted a positive influence, as discussed earlier in this chapter. Although he showed some form of moral assessment in Thomas' case, Hay did not exclude religion, or consciously seek to substitute secular rather than religious morality. Instead, Hay's judgements were both

⁶⁹ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol 3,' 162.

⁷⁰ Some of these behaviours were explored in chapter two with reference to bourgeois gender norms.

⁷¹ Ashburn Hall, 'Report Book - Intermediate Case Book, Vol. 3', 175.

moral and medical. Although his role overlapped with a clerical one, he still recognised the value of religious and clerical influences on patients.

Beyond the Asylum Walls: Doctors, Morality and Mental Hygiene

The expansion of psychological medicine into the traditional realm of the clergy was not confined to the diagnosis of patients already committed to the asylum, but extended further into society as the nineteenth century progressed. Asylum doctors sought influence over social issues and morality in the name of the prevention of insanity. In England and Scotland asylum doctors such as Thomas Clouston, Henry Maudsley and Daniel Hack Tuke increasingly focused on the exciting causes of insanity with a view to prevention of mental illness. The ‘bad habits’ of individuals such as ‘morbid introspection’, which in conjunction with habitual self-absorption and unnatural egoism formed the basis for ‘unsound mind’, received attention in the writings of these doctors. As Michael Clark has explained:

In [the doctors’] view, introspection and self-absorption, persistent abstention from ordinary social intercourse, and neglect of active pursuits all tended to weaken the will, undermine the ‘natural’ moral affections, and encourage idleness, eccentricity, and the growth of perverse or immoral tendencies.⁷²

The focus on these characteristics as causative of poor mental health amounted in part to a determination of what ‘healthy’ behaviour should be. Much of the Victorian standard for respectable behaviour had originally grown out of rational Protestantism. From the mid to late nineteenth century, medicine increasingly supplemented and supplanted these standards by defining healthy and unhealthy behaviour.

This expansion of psychological medicine into general behaviour was in part due to a shift in focus in the late nineteenth century from cure to prevention of mental illness. This transition arose from a therapeutic pessimism brought about by continual failures to effect reliable cure rates amongst the insane in Britain’s public and private asylums. From the mid-nineteenth century the hereditarianism of French psychiatrist Benedict Morel increasingly influenced French, German and to some extent British and American psychiatry.⁷³ Thomas Clouston, the superintendent of the Royal Edinburgh Asylum at Morningside from 1873, emphasised the hereditary transmissibility of mental as well as physical characteristics. Clouston’s emphasis in his writings from the 1880s was on ‘mental hygiene’ and education in

⁷² Michael Clark, “‘Morbid Introspection’, Unsoundness of Mind, and British Psychological Medicine, c.1830-c.1900,’ in *The Anatomy of Madness: Essays in the History of Psychiatry, III The Asylum and its Psychiatry*, ed. W. F. Bynum, Roy Porter, and Michael Shepherd, (London: Routledge, 1988), 72.

⁷³ Bynum, ‘Alcoholism and Degeneration’, 61-2.

order to prevent insanity, thus expanding the role of psychological medicine to include giving advice on many aspects of normal life.⁷⁴ The hereditarian model in psychiatry, according to W.F. Bynum, provided a reading of human behaviour that was both secular and scientific, but one that remained ultimately moral. Alcoholics, for example, could pass on alcoholism or cause other congenital problems in their children. Moderation in relation to alcohol took on a medical as well as moral justification.⁷⁵ Charlotte MacKenzie states that ‘hereditarianism posited an innate potential for disease, which it was the physician’s responsibility to inhibit or, when a mental disorder had already developed, undermine’.⁷⁶ The perceived responsibility to inhibit mental disease gave physicians a moral role in demarcating the bounds of acceptable behaviour.

Clouston’s writings, his position as superintendent of Morningside and his appointment from 1879 as Lecturer in Mental Diseases at the University of Edinburgh, made him one of the most influential British psychiatrists of the late nineteenth century. He taught E.H. Alexander at Edinburgh University and employed him for a time at the Morningside Asylum, thus having some direct influence over psychiatry at Ashburn Hall, as explored in chapter one. A cottage for housing some of the more convalescent patients erected at Ashburn Hall during Hay’s tenure as medical superintendent was named Clouston Cottage following the tradition of naming the Ashburn buildings after prominent alienists.

A number of New Zealand psychiatrists, like Clouston and his British peers, also extended their influence into wider realms of morality and social engineering. The most famous example is Frederic Truby King who is better known for his views on mothercraft than he is for his tenure as the superintendent of Seacliff Asylum in Dunedin. His views on mothercraft, however, stemmed from ideas on the prevention of insanity. He considered that ‘Education in parenthood offers the main hope for the reduction of insanity.’⁷⁷ Other areas in which psychiatrists in New Zealand were vocal social critics included eugenics, specifically the aim to control the breeding of the feeble-minded, and education.⁷⁸

⁷⁴ MacKenzie, 172-3. Clouston’s main published works were *Female Education from a Medical Point of View* (London: J&A Churchill, 1882); *Clinical Lectures on Mental Diseases* (London: J&A Churchill, 1883); *The Neuroses of Development* (Edinburgh: Oliver & Boyd, 1891); *The Hygiene of Mind*, (London: Methuen & Co., 1906); *Unsoundness of Mind* (London: Methuen & Co., 1911); and *Before I Wed* (London: Cassell & Co., 1913).

⁷⁵ Bynum, ‘Alcoholism and Degeneration’, 63.

⁷⁶ MacKenzie, 173.

⁷⁷ ‘Lunatic Asylums of the Colony (Report on) for 1896’, *AJHR* (1897), H-7, 6; quoted in Philp, 198.

⁷⁸ Philp, 199.

Frank Hay, during his tenure as Inspector-General of Lunatic Asylums for New Zealand from 1907 to 1924, strongly supported King's views and offered his own analysis of society. According to Hay, the mental and moral health of the community was largely determined by the way society's young were cared for.⁷⁹ He addressed matters as diverse as the importance of proper nourishment of the young through breastfeeding in the prevention of mental illness and the dangers of the cinema with its glamorous depiction of vice and lawlessness, and modern art.⁸⁰ Hay's position as Inspector-General gave him the opportunity to address his views on morality and mental hygiene directly to the Government in his annual reports. Engagement in social commentary took psychiatrists' spheres of influence well beyond the immediate task of caring for the insane, although the commentary was still linked in some way to the prevention of insanity. Correct parenting and the proper nourishment of the young, for example, would lead to fewer asylum admissions. These areas of social criticism and prescription of behaviour were the most significant ways in which medicine encroached on clerical territory in this period.

E.W. Alexander and his son were not vocal social critics in the manner of Truby King and Frank Hay. Their chief realm of influence remained within the walls of Ashburn Hall. E.W. Alexander's 1888 article in the *New Zealand Medical Journal* dealt with insanity in New Zealand, with particular reference to the chronic insane.⁸¹ His focus was on how to deal with those members of society who had already become insane, rather than on preventing the development of insanity through social intervention. His son, E.H. Alexander, showed interest in research on the causes of insanity and, therefore, implicitly on its prevention. As mentioned in chapter one he set up a neuropathological laboratory at Ashburn Hall to research this.

Matthew Philp considers the social interventionist ideas of nineteenth-century New Zealand psychiatrists such as King and Hay to be linked by the same key assumption: 'when it came to treating mental illness, the medically trained expert was always to have the last say.'⁸² Psychiatrists, having established a monopoly and role as expert authority over mental illness, were able from this position to act as social critics. Their pronouncements on morality and social policy led them to extend their authority into many different areas, a number of which had previously fallen under the aegis of clerical authority. Psychological medicine had

⁷⁹ 'Mental Hospitals of the Colony (Report on) for 1919', *AJHR* (1920), H-7, 5, quoted in Philp, 199.

⁸⁰ Philp, 199.

⁸¹ E.W. Alexander, 'Insanity in New Zealand, with Suggestions for the Disposal of the Chronic Insane', *New Zealand Medical Journal* 1, no. 3 (1888): 159-65.

⁸² *Ibid.*, 198-9.

a role in the late nineteenth and early twentieth century in New Zealand in establishing secular scientific grounds for the existing moral order.

Conclusion

Doctors and medical science did become guardians of morality and normality to some extent. They defined appropriate and inappropriate expressions of religious belief within the space of the asylum. Newly named mental diseases supplanted existing sins, and asylum doctors extended their role into proscribing and prescribing behaviour outside the asylum walls as well as within them. Alcohol, sexuality, mothercraft, art and cinema were merely some areas where the asylum superintendents' authority began to extend beyond the asylum walls. Medical men were indeed taking on roles as 'scientific pastors'.

The idea of the doctor as priest should not, however, be taken too far. E.W. and E.H. Alexander did not become vocal social critics like Frank Hay, or Truby King. Also, even though all three of Ashburn Hall's medical superintendents were involved in defining morality and appropriate and inappropriate religious expression within the asylum, churches and churchgoing retained importance for the patient population and wider New Zealand society. The doctors recognised the importance of religion to their patients. The Protestant churches, particularly the non-conformist ones, had roles in all the major social movements of the late nineteenth and early twentieth century, including the temperance movement, Bible-in-schools and women's suffrage campaigns.⁸³

Although moral precepts against excess were backed up by medical science's degenerationist theories, few contemporaries placed complete faith in science over religion. Medical doctors such as those at Ashburn Hall certainly did not see science as having this role. The medical gaze at Ashburn was in general profoundly secular in making diagnoses, attributing causes of insanity and in prescribing treatment. The three medical superintendents did evince significant concern with religion and its potentially pathological effects, as seen in the previous chapter. They also, however, attached significance to the appropriate expression of religious belief and recognised the potentially therapeutic value of religious observance and clerical influence. All three doctors, for example, recorded patients' religious attendance at the Sunday services at Ashburn Hall or at churches outside the grounds. Although this does not show any of the doctors themselves as explicitly devout, it does imply that they

⁸³ John Stenhouse, 'God's Own Silence: Secular Nationalism, Christianity and the Writing of New Zealand History', *New Zealand Journal of History* 38, no. 1 (2004): 57.

considered religion and religious practice an important part of what constituted 'normality' or sanity. The idea that medicine took over from the clerical profession should, therefore, be treated with caution. New Zealand's doctors did not seek to take on all the roles of clerics, nor did they exclude religion entirely, even in the area where they had the most firmly established monopoly, the treatment of mental illness. Although mental illness was increasingly medicalised, a close reading of the Ashburn Hall archive shows that there were still religious elements at play in the definition of insanity, its treatment, and in general asylum life.

Conclusions

The psychiatry practised by the doctors Alexander and Hay at Ashburn Hall was subject to a range of complex influences, both intellectual and cultural. The three doctors made assessments of each patient admitted to Ashburn Hall between 1882 and 1910 and their behaviour. These judgements were based on the doctors' medical education and their perceptions of the patients' differences from the bourgeois respectable norm. The doctors judged patients' behaviour through reference to their gender and occasionally their ethnicity, class or in particular their religion. Patient religious expression, in the doctors' eyes, was either pathological or positive depending on what form it took. Asylum medicine as practised at Ashburn Hall provides a window into the ideas, attitudes and prejudices of the medical profession in late nineteenth- and early twentieth-century New Zealand, while the recurrence of religious ideas and language in patient case files reinforces the importance of religion in colonial middle-class New Zealand.

The education and employment histories of the three doctors, and their engagement with medical scholarship, reveal the complexity of intellectual influences on medical practise at Ashburn Hall. Although New Zealand asylum medicine followed English precedent, there was not a straightforward translation of English ideas into the New Zealand context, and the three doctors each brought new developments in medical scholarship to their practise of psychiatric medicine. The period 1882 to 1910 saw some significant changes in asylum medicine as practised at Ashburn Hall. One change during this period was the increase in all kinds of detail recorded about patients which came with the transition from E.W. Alexander to Frank Hay as medical superintendent. As chapter one showed, Hay recorded far more physical clinical detail than his predecessor, E.W. Alexander, had. His recording of detail was not confined to patients' physical condition. He also recorded more detail about patient delusional content and church attendance, as mentioned in chapters three and four. The first pro forma case book was introduced by Hay in 1900, and contained a large number of categories relating to patients' personal and family history, and to their physical and mental condition. This change represents a generational shift in asylum medicine. In the late nineteenth century doctors focused increasingly on the physical causes for insanity and the hereditary nature of mental illness.

Ashburn Hall and practices within it were heavily influenced by English and Scottish precedent, as was New Zealand psychiatry at the public asylums in the late nineteenth and early twentieth century. The very existence of asylums in British colonies, observes Alison

Bashford, was a symbol of ‘proper Victorian Government’.¹ The Ashburn Hall doctors were all trained in Britain. E.W. Alexander trained at Kings College Hospital in London and Frank Hay and E.H. Alexander were university trained at medical schools in Scotland, while the non-medical superintendent, James Hume, had first been employed at the Glasgow Royal Asylum. Scottish medical influence in the area of treatment of the insane in New Zealand merits further attention from historians. Ashburn Hall was not unique in hiring Scottish-trained physicians. Many medical practitioners who migrated to New Zealand had been trained in Scottish institutions and universities.²

The university education of the two younger medical superintendents further represents the generational shift in asylum medicine between E.W. Alexander and his successors. Hay and E.H. Alexander were contemporaries. Although educated at different universities, their educations were more standardised than E.W. Alexander’s had been. The increased detail in note-taking and heightened emphasis on the physical clinical characteristics of patients after E.W. Alexander’s retirement reflects an emphasis on these factors in university medical training and in the Scottish asylums at which Hay and E.H. Alexander were employed in the 1890s. The educational and employment backgrounds of all three doctors informed their practices at Ashburn Hall, as did their ongoing engagement with scholarly networks. E.W. Alexander’s writings show an engagement with European and North American as well as English and Scottish psychiatry. He trained in France as well as Britain, and although it is difficult to trace any definitively French influence on his practises at Ashburn, he did name one of the first wards after the French founder of moral treatment, Philippe Pinel. European asylum medicine was also influential for E.H. Alexander. He used diagnoses defined by German psychiatrist Emil Kraepelin, even though his main teacher in the field of caring for the insane, Scottish psychiatrist Thomas Clouston, disagreed with some aspects of Kraepelin’s system of classification.³

The intellectual influences of the three doctors’ education and employment backgrounds and their continuing engagement with scholarship were not applied in a vacuum to patients

¹ Alison Bashford, ‘Medicine, Gender and Empire’, in *Gender and Empire*, ed. Philipa Levine (Oxford: Oxford University Press, 2004), 121.

² This call for further study of the Scottish impact on medicine in a wider New Zealand context echoes that made by Waltraud Ernst. See Waltraud Ernst, ‘The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes’, in *A Healthy Country: Essay on the Social History of Medicine in New Zealand*, ed. Linda Bryder (Wellington, N.Z.: Bridget Williams Books, 1991), 75.

³ Allan Beveridge, ‘Thomas Clouston and the Edinburgh School of Psychiatry’, in *150 Years of British Psychiatry, 1841-1991*, ed. German E. Berrios and Hugh Freeman (London: Gaskell, 1991), 376.

with no characteristics other than obvious insane symptoms. Rather, medical training combined with cultural influences in forming the doctors' judgements about individual patients' behaviour and illnesses. In their writings about patient behaviour, the cultural influences on the doctors' practices become evident. These men were part of the New Zealand colonial bourgeois elite and judged their patients against bourgeois norms of respectability. For the colonial middle classes, according to Kirsten McKenzie, 'adherence to a British model held out the best hopes of social acceptability'.⁴ Bourgeois respectability in British colonies was constructed under the imagined gaze of 'Home'. Ashburn Hall, like other private asylums, sought to provide a respectable environment of homelike comfort modelled on the bourgeois family.⁵ As part of their treatment of patients in this atmosphere of respectable comfort, the three medical superintendents measured patient behaviour against what they perceived bourgeois respectable norms to be. Differences from the bourgeois respectable norm were often cast as symptomatic of insanity.

Gender was the main marker of difference within the space of the asylum.⁶ Patients were separated according to their gender and expected to perform gender-appropriate tasks. Female patients, in particular, were judged against bourgeois gender norms. The doctors commented negatively about female behaviours such as foul language, forwardness and inattentiveness to husbands and children. Male patients, too, were held to gendered norms, although these could vary in relation to class. Professionals, such as William L, whose case was discussed in chapter two, did not necessarily have to work at the same manual tasks as other male patients.⁷

As well as gender and class, ethnicity occasionally appeared in the case file as a marker of patient difference from the bourgeois norm. Ethnic prejudices appear most obviously in the case notes for patients who were obviously ethnically different from the three medical superintendents. Maori, Chinese and Jewish patients were differentiated from other patients within the asylum and, in the cases of Maori and Jewish patients, their physical appearance and behaviour was occasionally explained through reference to their ethnicity.

⁴ Kirsten McKenzie, *Scandal in the Colonies: Sydney and Cape Town, 1820-1850* (Melbourne: Melbourne University Press, 2004), 13.

⁵ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London; New York: Routledge, 1992), 22-4.

⁶ Catharine Coleborne, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848-1888* (Perth: Network Books, 2007), 2.

⁷ Ashburn Hall, 'Report Book – Intermediate Case Bok, Vol 1', 7 (AG-447-6/03), HC.

The final marker of difference addressed in chapter two of this thesis was religion. Dr Hay's notes, in particular, contained evidence of an assumption about the inherent irrationality of Catholicism, especially in women. In two female patients' case files the words 'she is a Roman Catholic' are inserted parenthetically as explanation for their behaviour. This was never the case with male patients. Male delusions or other symptoms of their illness were never explained through reference to their Catholicism, even where those delusions concerned religion. Hay's religious prejudices, therefore, also operated along gendered lines. Both women and Catholics were more inherently irrational than men or Protestants. To Hay, the combination of these two characteristics in patients could explain their symptoms or lead to an expectation of certain behaviours. The absence of epileptic religiosity received comment in Amy S' case because she was Catholic.⁸ In Hay's eyes, these two forms of difference from himself, or the bourgeois norm as he perceived it, should lead to certain types of behaviour in the insane.

Religion was only one of the many factors relevant to how the doctors measured patient behaviour, but the complexity and ambivalence of the roles of religion within Ashburn Hall and the lack of detailed study on religion within New Zealand or Australian asylums justifies a close examination of the place of religion in the asylum. As well as the doctors showing prejudice towards Catholicism as an irrational belief system, they pathologised religious expression in other ways and in patients of all denominations. The doctors also, however, recognised the beneficial value of religion in some patient cases. Proper and appropriate religious expression was a sign of returning sanity. A certain quiet and rational degree of religious observance was part of the ideal of bourgeois respectability, particularly in female patients. The role of religion in Ashburn Hall was complex and ambivalent.

Chapter three of this thesis undertook a close examination of the religious expressions which were pathologised by the doctors. Christianity clearly played an important part in the lives of many patients in Ashburn Hall between 1882 and 1910. Although the content of patient delusions is of limited use in assessing the subjective experience of patients, these delusions do show a clear engagement with scripture on the part of several patients. Charlotte M called herself Potiphar's wife, expressed the idea that she had done something wrong, and gave people around her scriptural names, showing a working knowledge of the Bible.⁹ Other patients acted out commands they believed they had found in the Bible; had delusions about

⁸ Ashburn Hall, 'Case Book 1882 -1907', Folio 30 (AG-447-6/01), HC.

⁹ Ashburn Hall, 'Report Book – Intermediate Case Book, Vol 1', 161 (AG-447-6/04), HC.

death and rebirth or crucifixion; or took issue with the scriptural interpretations of the Ashburn Hall visiting chaplain, Reverend Robert Sutherland. Religious delusions occurred fairly frequently amongst the patient population of Ashburn Hall, as did the use of religious language to express feelings of suffering and unworthiness. As Hilary Marland points out, the language of religion provided patients with a frame of reference for giving voice to their suffering.¹⁰ The recurrent incidence of religious elements in patient case files shows that religion had an enduring importance in New Zealand society in the late nineteenth and early twentieth centuries, despite the lack of an established church in the colony. So too the sectarian prejudices of some patients, or instances where their delusions of persecution linked to their religion suggest sectarianism in wider society, which further study of similar trends in other institutions may shed light on.¹¹

As well as suggesting the enduring importance of religion in New Zealand society, patients' religious expressions were of significance to the doctors in interpreting patient behaviour. The doctors determined what constituted appropriate and inappropriate religious expression within the space of the asylum. A certain degree of piety was 'normal' and to be expected from the middle-class members of New Zealand society who made up Ashburn Hall's patient population. But religious delusions, the religious language patients used to give voice to their suffering, and the religious prejudices of patients and their beliefs in persecution on religious grounds were all recorded by the three doctors as instances of pathological religious expression in Ashburn Hall. E.W. Alexander even diagnosed a few patients' illnesses as religious, or caused by 'religious excitement'. This was not a common diagnosis. Frank Hay only ascribed one patient's insanity to religion. All three doctors preferred to assign physical causes for insanity rather than religious ones.

The medical gaze at Ashburn Hall was in general secular. The doctors sought to attribute patients' insanity to physical causes rather than metaphysical ones. Religious delusions, to the doctors at least, had secular explanations, although religion might act as an exciting cause of mental illness. In defining what constituted inappropriate religious

¹⁰ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2004), 123.

¹¹ Angela McCarthy considers that patients' delusions of religious persecution in the Auckland Asylum in the early twentieth century may be suggestive of actual persecution and sectarianism in New Zealand. See Angela McCarthy, 'Ethnicity, Migration, and the Lunatic Asylum in Early Twentieth-Century Auckland', *Social History of Medicine* 21, no. 1 (2008): 58.

expression that was symptomatic of insanity, the doctors extended their territory into the traditional realm of the clergy.

The Ashburn Hall doctors, and other psychiatrists in this period, extended their influence into clerical territory in other ways as well. They became guardians of morality and normality in wider society to some extent. New mental diseases such as alcoholism and homosexuality supplanted traditional sins. Doctors also sought to extend their influence beyond the asylum walls. They sought to encourage breastfeeding, regulate education and proscribe certain behaviours all in the name of the prevention of insanity. They took on something of the role of 'scientific pastors'.

This idea of the doctor as priest should be treated with caution. Of the three Ashburn superintendents, only Frank Hay became a vocal social critic, using his role as Inspector-General of Lunatic Asylums to advocate certain reforms and behaviours. All three doctors were involved in defining 'good' and 'bad' religion within Ashburn Hall, but they all recognised the potential benefits of religion to patients as well. Moral treatment had a religious element, with all New Zealand's asylums providing opportunities for Sunday worship. Religion operated on patients' 'moral consciousness', and might, therefore, be therapeutic. All three doctors at Ashburn Hall recorded patients' religious attendance at the Sunday services at Ashburn Hall or at churches outside the grounds. Although this does not show any of the doctors themselves as explicitly devout, it does imply that they considered religion and religious practice an important part of what constituted 'normality' or sanity. Indeed, a certain degree of piety was part of the bourgeois norm and was, therefore, to be expected and encouraged as a sign of recovery, particularly in the cases of female patients.

Patient behaviour at services was monitored and male and female convalescent patients were allowed to attend services at churches in Dunedin. The doctors even occasionally explicitly acknowledged that the influence of religion had been beneficial in a particular case. Hay also recognised that a devout patient would be more likely to listen to and respect a clergyman than the doctor treating her when he asked a priest to point out the heresy of a patient's delusion to her. The archive of Ashburn Hall shows that the role of religion was a complex one. Although the three doctors showed concern with the potential pathological effects of religion, they also recognised its potential therapeutic value. These doctors did not seek to take on the roles of clerics, nor did they exclude religion entirely. Although mental illness was increasingly medicalised, a close reading of the Ashburn Hall archive shows that

there were still religious elements at play in the definition and treatment of insanity and in general asylum life.

The Ashburn Hall archives contain the doctors' writings and have, therefore, been instrumental in gaining insight into the operation of trends in asylum medicine and the influence of the doctors' cultural prejudices on the assessment and treatment of patients. In their judgements about patient religious expression, as in the other judgements they made, E.W. Alexander, Frank Hay and E.H. Alexander were influenced by ideas of bourgeois respectability and normality as well as their medical education and employment histories and their continuing engagement with medical intellectual networks. The ambivalent position religion held in the asylum represents one important aspect of the complex negotiations of medicine and culture involved in the definition of sanity and insanity. The doctors' medical training in combination with their position as members of the colonial bourgeoisie, and their religious affiliation as members of the Anglican Church informed their judgements about and their treatment of patients at Ashburn Hall.

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Appendix: Diagnoses and Supposed Causes of Insanity Recorded by Each Doctor

The tables in this appendix relate to the diagnoses and causes of insanity assigned by the three medical superintendents, which were discussed in chapter one of this thesis. The numbers in these tables come from an analysis of all admissions during the tenure of each doctor as medical superintendent of Ashburn Hall. Information regarding these admissions is taken from the 'Register of Admissions, 1882-1948', (AG-447-5/01), Hocken Collections. Second and subsequent admissions of patients have not been deleted, as the diagnosis or cause listed could vary between admissions of the same patient. Jane P, for example, was certified on three occasions in 1887, 1889 and 1894, and re-entered Ashburn Hall of her own accord as a 'voluntary boarder' in 1900. In the first two admissions her diagnosis was 'acute mania' and the cause listed was 'heredity'. For the third admission, however, she was diagnosed with 'melancholia' rather than mania, although the cause was the same. Her final admission as a 'voluntary boarder' did not have any diagnosis or cause listed in the 'Register of Admissions'. Second or subsequent admissions account for 44 admissions listed in these tables. 17 were during E. W. Alexander's tenure, 18 during Hay's and 11 during E. H. Alexander's tenure as medical superintendent.

Three patients appear in the 'Register of Admissions', but have not been included in any of these tables. These were those patients admitted in May 1904, after Frank Hay left Ashburn Hall to become Deputy Inspector-General of Asylums in April 1904, and before Edward Henry Alexander became medical superintendent in June 1904. Only one of these patients, Jessie R, is discussed in any detail in this thesis. She was one of the eight patients admitted to Ashburn Hall whose insanity was in some way attributed to her religion.

The categories supplied in these tables do not reflect the precise wording in the 'Register of Admissions'. To take one example from Table 2, the category 'puerperal' for 'supposed cause of insanity' includes diverse listings by E.W. Alexander of 'puerperal', 'childbirth', 'child-bearing', and 'worry just after childbirth'.

Table 1: Diagnoses Given by Edward William Alexander (October 1882- March 1897)

GENERAL CATEGORY OF MENTAL DISORDER	TYPE OF MENTAL DISORDER (SPECIFIC)	NUMBER OF PATIENTS
Mania		55
	Mania (including 'acute' and 'chronic')	37
	Alternating/ recurrent mania	2
	Adolescent mania	1
	Puerperal mania	4
	Delusional mania	11
Delusional		44
	Delusions/ delusional	28
	Delusional insanity	8
	Hallucinations delusional	2
	Delusions of suspicion	4
	Delusions (religious)	1
	Delusional extravagance of ideas	1
Melancholia		39
	Melancholia	31
	Melancholia with delusions	3
	Melancholia (suicidal)	1
	Melancholia (hypochondriacal)	1
	Puerperal Melancholia	1
	Agitated/ resistive melancholia	2
Dementia		23
	Dementia	14
	Partial dementia	1
	Senile dementia	6
	Dementia with torpor	1
	Acute dementia	1
Suicidal		1
Hysteria		4
	Hysterical mania	3
	Hysterical stupor	1
Adolescent Insanity		1
Hypochondria		1
Religious		1
Amnesia		2
GPI		4
Imbecile/epileptic		6
Dipsomania/ delirium tremens		23
Multiple diagnoses		6
Other		3
Blank		2
TOTAL ADMISSIONS	215	

Source: Ashburn Hall, 'Register of Admissions, 1882-1948' (AG-447-5/01), HC.

Table 2: Supposed Causes of Insanity Assigned by Edward William Alexander (October 1882- March 1897)

SUPPOSED CAUSE OF INSANITY	NUMBER OF PATIENTS
Unknown or blank	53
Heredity	36
Heredity and another cause	9
Multiple causes listed (excluding heredity)	5
Congenital	4
Physical illness or injury	9
Epilepsy	1
Alcohol	14
Puerperal	8
Lactation	6
Climacteric	8
Old age	3
Adolescence	2
Masturbation/self-abuse	7
Sexual excess	1
Financial or business problems	8
Overwork/ over-study	5
Worry/anxiety	7
Disappointment	6
Domestic worry	2
Death of a loved one	5
Solitary life	4
Religion/spiritualism	5
Other	6
Illegible	1
TOTAL ADMISSIONS	215

Source: Ashburn Hall, 'Register of Admissions, 1882-1948', HC.

Table 3: Diagnoses Given by Frank Hay (March 1897-April 1904)

GENERAL CATEGORY OF MENTAL DISORDER	TYPE OF MENTAL DISORDER (SPECIFIC)	NUMBER OF PATIENTS
Mania		33
	Mania (including 'acute mania')	22
	Adolescent mania	2
	Acute, delirious mania	1
	Mania with suicidal impulse	1
	Mania transitoria	1
	Recurrent mania	3
	Delusional mania	3
Delusional		11
	Delusional Insanity	9
	Delusional stupor	2
Melancholia		30
	Melancholia	20
	Excited melancholia	4
	Delusional melancholia	3
	Melancholia, simple - insanity	1
	Resistive melancholia	1
	Suicidal melancholia	1
Dementia		8
	Dementia	5
	Dementia with delusions	2
	Senile Dementia	1
Hysterical Insanity		2
Confusional Insanity		1
Stupor		3
Imbecile/epileptic		3
GPI		1
Dipsomania/ delirium tremens		13
Other		2
Multiple diagnoses		5
Voluntary Boarder (cause blank)		12
TOTAL ADMISSIONS	124	

Source: Ashburn Hall, 'Register of Admissions, 1882-1948', HC.

Table 4: Supposed Causes of Insanity Assigned by Frank Hay (March 1897-April 1904)

SUPPOSED CAUSE OF INSANITY	NUMBER OF PATIENTS
Blank	11
Blank because patient was a 'voluntary boarder'	12
Heredity	21
Heredity and other cause(s)	24
Multiple causes (excluding heredity)	12
Neurotic Inheritance	4
Illness or Injury	7
Epilepsy	2
Recurrent illness or previous attacks	5
Alcohol or drug habit	14
Climacteric	1
Masturbation	2
Financial or business problems	2
Over-study	1
Mental worry	1
Domestic trouble	1
Death of a loved one	1
Mental shock	1
Melancholia	1
Illegible	1
TOTAL ADMISSIONS	124

Source: Ashburn Hall, 'Register of Admissions, 1882-1948', HC

Table 5: Diagnoses Given by Edward Henry Alexander (June 1904-December 1910)

GENERAL CATEGORY OF MENTAL DISORDER	TYPE OF MENTAL DISORDER (SPECIFIC)	NUMBER OF PATIENTS
Mania		15
	Mania	10
	Acute mania	1
	Simple mania	1
	Recurrent mania	1
	Confusional mania	2
Delusional Insanity		6
Melancholia		33
	Melancholia	29
	Hypochondriacal melancholia	1
	Excited melancholia	2
	Melancholia with stupor	1
Dementia		12
	Dementia	3
	Dementia precise	5
	Organic dementia	1
	Paranoid dementia	1
	Senile dementia	1
	Dementia praecox	1
Confusional Insanity		3
Stupor		2
Imbecile/epileptic		3
GPI		3
Alcoholic/delirium tremens		3
Senile Insanity		4
Paranoia		5
Manic-depressive insanity		14
Other		4
Multiple diagnoses		2
Voluntary boarder (cause blank)		35
TOTAL ADMISSIONS	144	

Source: Ashburn Hall, 'Register of Admissions, 1882-1948', HC.

Table 6: Supposed Causes of Insanity Assigned by Edward Henry Alexander (June 1904-December 1910)

SUPPOSED CAUSE OF INSANITY	NUMBER OF PATIENTS
Blank or unknown	10
Blank because patient was a 'voluntary boarder'	35
Heredity	48
Heredity and other cause(s)	4
Multiple causes	4
Congenital	1
Illness or Injury	8
Syphilis or GPI*	6
Epilepsy	3
Alcohol or drugs	7
Climacteric	2
Senility	7
Pre-senility	4
Masturbation	1
Financial or job loss	3
Death of a loved one	1
TOTAL ADMISSIONS	144

Source: Ashburn Hall, 'Register of Admissions, 1882-1948', HC.

*The link between syphilis and GPI became generally accepted in the late-nineteenth and early-twentieth century in Europe following Richard von Kraft-Ebbing's experiment which proved that a GPI patient could not be infected with syphilis. The Wasserman test for syphilis was created until 1906, confirming the presence of syphilis in GPI patients.

