# MADNESS IN THE FAMILY

## Insanity and Institutions in the Australasian Colonial World, 1860–1914

Catharine Colebourne

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*Also by Catharine Coleborne*

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## Insanity and Institutions in the Australasian Colonial World, 1860–1914

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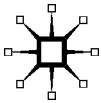



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*For my own little family: Craig and Cassidy, with love*

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# Acknowledgements

I first envisioned this research topic in Melbourne, Australia during 1997, and sketched out a plan for a project about the 'empire of madness'; it would be a study of the different experiences of insanity in colonial contexts, with a specific focus on families and their relationships with institutions. Since then, my understanding of insanity and families has been transformed and in the course of the research, I have accrued many personal and scholarly debts to friends, colleagues and institutional funds. I wish to acknowledge and express my gratitude to all of them here.

This work would not exist without the Royal Society of New Zealand's Marsden Fund. Between 2004 and 2006, I was funded by a Marsden Fast Start Grant to conduct travel for research, and the award also provided me with some teaching relief to enable progress on the project, allowing me to undertake the extensive archival research upon which this study rests. The Faculty of Arts and Social Sciences at the University of Waikato provided additional support for research assistance in this period. Both funds enabled me to travel to international conferences to present my preliminary findings. In 2008 I received a Harold White Stipendiary Fellowship at the National Library of Australia in Canberra to finish research for the project and continue writing first drafts of parts of the manuscript. The University of Waikato also granted me two periods of Study Leave to enable me to continue work on the project in 2005 and 2008.

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and the asylum, and Maori patients and insanity in the nineteenth century. Adrienne Hoult also wrote an excellent and important thesis about intellectual disability at the Tokanui Hospital. Each thesis makes a significant contribution to the field in its own right, and while I draw on the students' findings in this book, their work deserves separate publication. They have made enormous contributions to my overall intellectual framework and its development during the life of the project.

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Two chapters are based on previously published articles. I acknowledge them here: ' "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* (SAGE) 31: 1 (January 2006), pp. 45–65; and 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, 1880s–1910', *Social History of Medicine* (Oxford University Press) 19: 3 (December 2006), pp. 425–42. Other material has appeared in a different form in 'Families, Insanity and the Psychiatric Institution in Australia and New Zealand, 1860 to 1914', *Health and History*, 11: 1 (2009), pp. 65–82; and 'Pursuing Families for Maintenance Payments to Hospitals for the Insane in Australia and New Zealand, 1860s–1914', *Australian Historical Studies* (Taylor and Francis), 40: 3 (2009), pp. 308–322.

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# Introduction

In 1904, writing from the suburb of Brighton, Melbourne, to the Medical Superintendent of Gladesville Hospital for the Insane in Sydney, one father described his daughter's experience of 'family':

> Practically an orphan at 12 years old; with relatives not of a character to elevate her; at the drudgery of domestic service; and yearning for her own home and her own flesh and blood, scattered about over two colonies: it is not difficult to conclude that such an experience must tell upon a girl of her temperament. She feels, as some of the others do, that 'there is no place like home' even 'without a mother'.[1]

This young woman, a 'tall, rather anaemic girl' known as Lissie, was 23 years old when she was admitted to Gladesville Hospital. Born in New South Wales, she had, reportedly, 'no home', and had been a servant until bouts of 'acute mania' led to her committal. Her mother had committed suicide by drowning, her brother was reputedly insane, and her sister was an imbecile. Her father's letter followed her admission, and offered the authorities her history, and his own opinions about the causes of her illness.[2] The letter's tone suggests that he was defending himself against any allegation that his own parenting had been less than admirable; he blamed the sorry story of Lissie's mother, her abandonment of him, and her subsequent suicide, for his daughter's state of health; the hint that heredity was a factor in her illness is also present here.

The language this father used to comment upon the various relationships Lissie experienced is important. 'Relatives' was a term frequently used by asylum inspectors in their reports on colonial asylums.[3] Colonial institutional authorities sought relatives when they were tracing maintenance payments, and the assorted individuals who constituted family

networks in the colonies were all relevant contacts for the asylum. The meanings attached to 'flesh and blood', or kinship, were multiple and contested in this context. Lissie's own kin were 'scattered' across the colonies, like so many of the asylum inmates who appear in the case records of different institutions. Lissie's father comments on how this affected her, and created the conditions which allowed her condition to worsen, perhaps also hinting that proximity to some of her relatives was less than desirable. 'Home' was a place where she might feel safe; but where was 'Home'? And did 'Home' stand in for family, or the lack of extended networks of family, in the colonial world?

By reading cases like this in their specific contexts, this book seeks to link two areas of social and cultural history often treated as discrete, and yet which are highly complementary: histories of the family and histories of the insane asylum. Highlighting the value of official records and patient cases from four public institutions from each of four colonies, New South Wales, Victoria, Queensland and New Zealand, between 1860 and 1914, I argue that analysis of these sources can contribute significantly to historical investigations of the European family in the colonial context. I explore the colonial world of insanity, institutions and the family, situating the different public asylums in their social and cultural settings. I then examine the ways in which families appear inside official asylum writing, and in letters to the institution, also commenting on how their stories can illuminate historical readings of insanity in this context; and finally, I show that new insights about families in the colonial period can be gained through the use of asylum records.

Influenced by a wide range of international social histories of medicine, I investigate colonial families and their responses to illness, aiming to understand the formation of responses to insanity as an illness problem.[4] What kinds of exchanges took place between families and institutional personnel? What kinds of language did families and asylum authorities use to describe states of mental disorder? What happened to inmates after confinement? Were their relationships with family members encouraged by institutional authorities, or did these fail? As many historians have already shown, nineteenth-century records of the psychiatric institution are rich sources of information about families. Nancy Tomes argues that asylum populations tell historians more about families than they do about insanity itself. She suggests that, in the nineteenth century the asylum's major achievement was its function as an outlet for families facing the burdens and stresses associated with insanity.[5] Mark Finnane goes as far as saying that the institution of the asylum can be viewed as an 'arbiter' of familial conflict.[6]

Finnane highlights the inherent tensions in the field of asylum history. After a significant period of inquiry influenced by the debates around social control, he points out that a close examination of the way families used institutions would reveal more about the complexities of asylum committal, and perhaps explain the appeal of institutional confinement to members of nineteenth-century society. Later studies have explored industrialisation and social change as a context for institutional confinement. Citing a range of historical studies around the Western world, David Wright argues that this set of conditions might explain the high volume of traffic in and out of psychiatric institutions during the nineteenth century, as well as shed light on their social roles.[7] Wright acknowledges a debt to Finnane, who also argues for attention to 'agency' among families in their negotiations with the institution, and that by the 1870s families in Australia were persuaded about the asylum's efficacy.[8]

In *Medicine and Madness*, Stephen Garton also raises questions about the relationship of colonial families with institutions. His work draws upon the patient records and correspondence of several different psychiatric institutions in New South Wales and examines these in their social, political and medical context. Garton concludes his study with the observation that future research into asylum confinement should consider families in more depth, in part to interrogate the widespread belief that Australian families were 'marked by strong affective ties'.[9] He finds evidence of highly fractured families whose experiences of institutional committal in the nineteenth century highlighted the circumstances of poverty, violence within families, and gendered structures of isolation and dependency. Although a full account of families and institutions is beyond the scope of his work, Garton's use of the institutional source material continues to inspire scholarship in this field. My book represents a significant engagement with his study of insanity in colonial New South Wales.

Asylums were established to confine individuals for a variety of reasons: to keep them safe, to 'cure' them, and sometimes to relieve relatives of difficult household situations, thus separating the insane from the rest of the world. Yet the borders between the institution and the outside world were not impermeable. Asylums often sought help from families, thereby acknowledging a role for families in treatment and possible cure. The asylum authorities wanted families to provide maintenance payments, but increasingly they also sought family perspectives on mental breakdown and the patient's history. Numerous historical studies of the different roles played by families all insist upon

the more complex meanings of institutional confinement, teasing out an increasingly nuanced reading of the mental hospital in history.[10] Some historians suggest that families 'dominated' the committal process. Ellen Dwyer, writing about institutions in the state of New York, and Cheryl Krasnick Warsh, whose study focuses on the Homewood Retreat in Ontario, Canada, both argue that families exercised control over the hospital system.[11]

One strand of this type of inquiry explores 'lay' descriptions of insanity. This theme has allowed historians to examine the intersections between family and clinical discourses around madness. In particular, Akihito Suzuki contends that changing record-keeping practices at Bethlem Hospital in London provide evidence of changing attitudes of medical personnel towards the roles of families in institutional committal and the treatments of patients.[12] Other historians have examined lay descriptions of insanity in some depth, seeking to plot the relationships between the world of medicine and the social world of lay observations of the mentally ill. James Moran attempts to identify perceptions of insanity in the nineteenth century through a detailed analysis of New Jersey legal sources; and, using English records, Wright has also investigated the relationships between lay identification and clinical diagnosis.[13]

Both Suzuki and Hilary Marland focus on the 'domestic' realm, and on the place and role of the family in managing psychiatric illness. Suzuki acknowledges that his study of the Commissions of Lunacy, or legal declarations of insanity in England, concentrates on the propertied and wealthy classes, because the commission of lunacy, until its 'democratization' in the middle of the nineteenth century, reflected the priorities of the 'social elite'.[14] Yet Suzuki contends that the commission is the major source of information about the private lives of families. His work is therefore rich in evidence about the wealthy family, which helps to reinforce Suzuki's assertions about the 'ideal' family as a template for the asylum's own domestic ideology as the nineteenth century progressed. However, while he suggests that public institutional records in the English context do not reveal much about the care and control of the insane 'at home', I argue in this book that there is evidence in other contexts, including the settler colonial context, to indicate that more can be gleaned from the records of public institutions about families' attitudes to mental disorder, including lay descriptions of insanity.

As Hilary Marland demonstrates, families became the sites of gendered relations of power. Acknowledging this, Suzuki has advocated that historians must work towards a more complex explication of gender roles

and insanity.[15] In her study of puerperal insanity, Marland does not specifically set out to examine the many different relationships between families and British institutions. Nevertheless, her study locates the family as both a site of healing, and a site of conflict, in psychiatric discourse. There is an ambiguity and tension here, as Marland herself notes, between the belief that the household and family were women's rightful places when well, and the notion that the family and domestic pressures might cause mental disorder.[16] I take up these themes in this book as I uncover the stories of patient and family negotiations with colonial institutions, and the ideas that the institutions and asylum superintendents themselves held about families, which were described both as sites of recovery and as sites of familial disorder and mental disease. Lissie's case, described at the start of this Introduction, is one such example.

* * *

In Australasian colonies, far from simply becoming docile subjects of public institutions such as hospitals for the insane, families and individuals actively encountered and utilised specific public institutions. Among these institutions were the four hospitals discussed in this study: Gladesville Hospital for the Insane in Sydney, the Yarra Bend Hospital for the Insane in Melbourne, Goodna Hospital for the Insane, located between Brisbane and Ipswich in Queensland, and 'The Whau', or Auckland Mental Hospital, in New Zealand's North Island.[17] Families and individuals who lived in the respective colonies knew the ways in which these places operated, and they sought medical advice about family members in trouble or ill with insanity. They looked for assistance from police and magistrates. They also knew, often more obviously by the later 1880s and the early 1900s than in earlier decades, how to apply to the asylum for access to their sick relative. There is evidence that some families negotiated mental illness like any other forms of illness, especially as the stigma of the old name of 'asylum' was replaced by the word 'hospital'. When he stepped down as asylum superintendent in 1879, Dr Frederic Norton Manning, a prominent figure in the history of mental health in New South Wales, said he found it 'striking' that the new name of 'hospital' was adopted by the patients 'who gladly addressed their letters from Gladesville Hospital'.[18]

Public institutions were the mainstay of the asylum system. The public institutions in the colonies housed a large cross-section of society, although tensions between 'classes' of inmates sometimes elicited comment.[19] Significantly, few options for the institutional differentiation

of patients based on wealth existed in the Australasian colonies. There was no network of private institutions, unlike the situation in Britain; a few licensed houses had short-lived roles, containing small numbers of patients in New South Wales and Victoria, and there was also one private institution operating in New Zealand.[20] Finnane suggests that the functioning of Australian colonial asylums for all classes of patient further disturbs the theory that the asylum was a site of social control for the poor. Nevertheless, distinctions were being made within public asylums between different classes of inmates, with provisions for paying patients of a 'better class' created in the late 1880s at Callan Park in Sydney, and in the 1890s at Kew Asylum for the Insane.[21] The American context was different again; there, hospitals for the insane theoretically catered to all, but in reality, only a wealthy class supported their insane in elite institutions.[22]

Despite some significant scholarship in the field of welfare history, psychiatric hospitals figure very little in the work of welfare historians, perhaps because of the perception that these institutions are the province of historians of medicine.[23] Relatively few historians in Australia and New Zealand have explored the nature and meaning of the colonial family, especially when compared with the vast international scholarship in the field of histories of the family. The colonial family itself presents further challenges; it changed in several ways in the period under investigation, in its demographic characteristics, its social and political meanings, and in its very culture. The changing relationship between the 'family' and the Western 'state' around the turn of the nineteenth century is also relevant to the discussion here, as historians suggest.[24]

Assessing patterns of fertility and reproduction, historians and demographers have viewed the household and family as economic units.[25] Histories of the colonial family have tended to emphasise the themes of family economies, class, settler communities, migration, gender all themes which are relevant to this study.[26] For instance, the effects of poverty, colonial dislocation and family separation, and the expectations and pressures of the conjugal family unit and their impact on the asylum-family relationship, are discussed in different chapters of this book. European families in new settler societies also occupied a different relationship to the state compared to older societies with established patterns of charitable and state-provided poor relief.[27]

Aside from their economic and demographic functions, families were also emotional sites with specific cultures. Histories of private life, including the 'sentiments' approach to the family, have been produced about the British and European context, but few such accounts exist of

the emotional worlds of colonists for Australia or New Zealand. In part, this book seeks to make a contribution to understanding families in the colonial period from this angle.[28] In many ways this book also echoes the findings of the literary scholar Penny Kane, who explores fictional families in Victorian Britain to highlight the 'inherent demographic, social and economic instability of nineteenth-century families', using textual representations of families written from a variety of perspectives.[29] I identify the ways that families occupy textual spaces inside asylum records and official discourses, and also create their own textual representations of asylum confinement.

In addition, institutions recorded a range of attitudes towards both European and indigenous colonial families. Dr Manning's own public reputation aside, psychiatric institutions were not usually defined by compassionate and successful superintendents. Asylum powers could be used to rebuff or confuse families, even if politely. Where patients died in the institution we might imagine that the authorities were sometimes simply unable to fully comprehend the grief and puzzlement expressed in family letters. In the present, a poorly explained institutional death would cause uproar; in the past, aside from official inquiries in some colonies, usually prompted by internal institutional scandals, any family concerns remained silent and were hidden from public attention.

* * *

This book brings a complex set of perspectives to a field often imagined in more limited ways. Historians have taken asylums in both the old and new worlds as subjects for scholarly inquiry and explored them by examining patient population characteristics, asylum management and the institutional worlds of the insane. These kinds of studies have included for instance, the institutions at Auckland and Melbourne.[30] Without such studies, broadly defined comparisons between places and institutions would be impossible. However, the scholarly field now requires reimagining and reconceptualising as historians seek to rethink their approaches to micro-level analysis and begin to shift their attention to the discussion of larger historical networks and patterns.

The south-eastern Australian colonies and the colony of New Zealand have a shared history of the management of insanity and families in the period to 1914. Several historians have suggested that comparative historical studies might prove to be more fruitful than narrowly conceived historical studies of single institutions. By this they mean that historians might start to investigate the international phenomenon of

the asylum. Most studies of the asylum, as Nancy Tomes has remarked, have been 'national' in their focus, and yet the phenomenon of institutional confinement, Wright argues, crossed national lines.[31] Many studies of single institutions, patient populations and institutional dynamics already exist. Wright goes so far as to describe institutionalisation as a 'transnational drama'.[32] Finnane's seminal work on the family and the asylum brings together research from two sites, New South Wales and Ireland, to argue for the comparative dimension in histories of incarceration. In particular, Finnane asserts, focusing on settler societies raises new questions of the encounter between institutions and families.[33] Yet, since his study appeared in 1985, there has been little substantive research which has attempted this type of work, perhaps because of the difficulties collecting archival data from geographically scattered physical sites. In this book, I suggest that historians might use new theoretical and methodological approaches to examine the interactions between families and asylums. In doing so, I contribute to an examination of the development of a colonial psychiatry inside asylums, which defined their patient populations in new societies through settler expectations.

To do this, my research does not confine itself to one locality or institution. Instead, it uses four colonial sites for analysis, the four institutions named earlier in the Introduction. Arguably, this type of inquiry, which seeks to escape the boundaries imposed by 'national' histories, enriches our understanding of the variety of familial responses to institutions, allowing us to capture the way that the colonial 'family' as a category was being drawn into asylum management and its discourses of insanity over time. Part of a relatively new international interest in the histories of colonial asylums and their populations, and drawing from the trend towards 'transnational' histories, it deliberately seeks to define a transcolonial world of psychiatry rather than simply measuring this colonial world of institutional practices against imperial, metropolitan experiences.[34]

Although the present study does not deploy the terms 'transnational' or 'trans-Tasman', the debates around the problem of national history and exceptionalist histories in Australia and New Zealand are relevant to this project. Historians in both national contexts have been discovering the potential for shared histories and inclusive, regional histories, hoping to disturb the patterns of nationalistic history writing which tend to ignore commonalities and exchanges across national boundaries.[35] Yet in my study, the four colonial sites interact and occupy the spaces of the colonial world before nationhood exists, at least until 1901

when the Australian colonies joined a Federation and became states; their systems of managing the colonial insane derived from the governance of colonial populations and health at least until 1914. The movement and mobility of populations in this colonial world prior to the turn of the century is also far more important than some historians, preoccupied with the reshaping of histories of nationhood after 1901 within a transnational framework, might suggest.[36]

Historians have been exploring the uses of the term transnational because the term 'comparative' is problematic. 'Comparative' suggests strict lines of comparison, with the emphasis on similarities and differences between sites of analysis.[37] Transcolonial, on the other hand, opens up new possibilities for the discussion of settler societies, which, as postcolonial scholars argue, lend themselves to a new kind of interpretation because they offer up an 'entanglement of imperial and colonial experiences and identities' for analysis by historians.[38] Therefore, it provides a more appropriate geographical, temporal and cultural frame for this study. Allied to this approach is the identification of the 'the complex and shifting relationships that constituted the empire'.[39] Elsewhere, I have suggested that despite the relationship between metropole and colony, 'asylums in colonial settings may have had more in common with each other than historians have previously imagined or explored'.[40]

Models for this kind of approach already exist. Other historians share my discomfort with the notion of comparison and instead engage in cross-colonial studies of disease and empire.[41] Tony Ballantyne describes a 'mobile approach, an analysis ... [that] travels between locations',[42] which I argue can be adapted to examine another feature of the colonial world: the insane asylum, and its attention to the problem of insanity. Warwick Anderson suggests that medical historians become 'nomadic themselves' by investigating the 'mobility of ideas, models, and practices' to create 'dynamic, multisited histories of medicine'.[43] The value of this approach is two-fold: first, it enables a less parochial perspective at the same time as engaging with the dynamics of colonialism; and second, for the purposes of this study, it helps to foreground the possibilities in the archival materials, including giving voice to families and patients. In particular, I examine the transcolonial world of insanity and institutions for the south-eastern Australian colonies and New Zealand, and family interactions with the four selected institutions. To understand these interactions, my intention is not so much to *compar*e colonies and their asylum populations, as it is to examine this colonial world of provisions for the insane, including the transactions or encounters of families with institutional authorities.

As part of my examination of the transcolonial world of medicine, I also foreground questions raised by other historians in the field. As the first chapter of the book explains, the important scholarship in this field has most recently considered colonial psychiatry and institutional expressions of this psychiatry as a distinct area of historical investigation. What inter-colonial and intra-colonial meanings of the asylum and its populations circulated among medical practitioners between the 1860s and 1914? How did new populations adapt this institution and utilise it, by giving local expression to it? Was there a colonial discourse of madness, and therefore a peculiarly colonial inflection to imperial institutional practices? The scholarly dimensions of this discussion are explored in Chapter 1, which places the present study within a critical investigation of the international secondary materials. Chapter 1 also shows how the transcolonial setting of the Australian and New Zealand colonies fits into a wider, British imperial context for psychiatry's history.

* * *

Archival material, in particular patient case records, family and institutional correspondence, and committal papers, form the basis of this study. Asylum records in their different archival forms, and found in their specific repositories, I argue, present both opportunity and risk for historians intent on discovering 'what happened' to the insane and their families. Histories of psychiatry overwhelmingly rely upon official sources: asylum records. For some time now, historians of the asylum have taken distinct approaches to these records. Some have adopted a quantitative approach, conducting statistical analyses of asylum admission registers, legal depositions and patient casebooks. Taking large samples of case notes has enabled historians to create asylum population profiles, to track committals and discharges from asylums, and to examine types and treatments of mental illness. David Wright's research exemplifies this approach. His findings rest on very detailed analyses of large numbers of patient cases. Writing about Canada, he concludes that while families and individuals were sometimes vulnerable to state controls, more often they were active in decisions about institutional confinement, and even used asylums as 'public, quasi-medical institutions' in nineteenth-century Ontario.[44]

Other historians have deployed qualitative approaches through post-structuralist readings of patient casebooks. Their works have made use of patient casebooks, but have shown patients' lives and experiences to be highly circumscribed and mediated through these texts.[45] As I have

indicated earlier in this Introduction, the present study draws upon the growing literature which includes families as part of this reinterpretation of patient records, with new emphasis placed on the positive dealings of individuals and families with institutional authorities and agencies. Most recently, historians have begun to approach the 'archive' as a space that produces source material in deliberate ways; for instance, as colonial writing about the ordering of the colonial world, its institutions and populations. The 'asylum archive' is no exception, with significant work on the archive as a site of knowledge production appearing in disciplinary developments and shifts.[46] In the concluding chapter, I examine the impact of these ideas about the nature of the archive and their implications for my own study. Taken together, this assemblage of distinct approaches to the field, from the problematising of patient cases as linguistic representations and reinterpretations of families and their strategic behaviours around institution committal to a critical appraisal of the archival productions of the psychiatric institution, are suggestive of a new methodological apparatus.

This book explores a diverse array of archival sources in a qualitative study based on a selection of 215 patients and their case notes and associated case files from four institutions.[47] I chose to examine one large public asylum in each of the colonies. These institutions, all close to a growing urban centre, were the foundation institutions in their contexts; they were all operating in the 1860s, and still operating by 1914. Each established institutional protocols and patterns of reporting, under the guidance of leading medical personnel, such as Dr Manning at Gladesville. Other institutions, including Callan Park in Sydney, and the Kew Asylum in Melbourne, were established in the 1870s or in later decades, and came to follow, and in some cases, modify, the practices of the original institutions. Goodna Mental Hospital was the first and largest institution in Queensland for the duration of the period under investigation. In New Zealand, Auckland Mental Hospital was chosen in preference to institutions in the South Island, partly to reflect the pattern of settlement in the colony, and also because the population of the insane, first housed at Auckland Hospital in 1853, was among the earliest in the colony as a whole.[48] Changes to the psychiatric hospitals following the end of World War I, a diversification of therapeutic practices, also attributable to war, and a rise in voluntary admissions, along with issues around access to patient case material in the twentieth century, made 1914 a suitable point at which to end my study.[49]

The patient cases from each institution were chosen using different methods designed to shed light on family processes in dealing with the

institutions. Given that archives are arranged differently in each place neither was it possible to choose an even number of patients from each decade, and nor was it possible to replicate the sampling technique in each archive. I traced patients from selected asylum archival material, depending upon the particular extant archival sources available in the period, back to patient casebooks. In the entire patient sample there is a concentration of cases from the 1880s to the 1900s, which reflects, in part, asylum bureaucratic practices in those decades. It also draws attention to subsequent archival practices, as Chapter 7 argues. While this is not a quantitative study, I describe the sample of patients from each archive in broad terms and in relation to official reports of the period to draw conclusions about patient populations, families and individuals in the institution, but always contextualise these within broader patterns of committal and discharge. Therefore, the book also draws upon official statistics from asylum inspectors' reports and colonial asylum population statistics across the whole period under examination. My findings about patients, including official diagnoses, places of birth, named religious denomination, marital status and so on, are all consistent with the overall patterns of the asylum's patient population, as Chapter 2 discusses. Arguably, while patients from the later period in the study are over-represented in my samples, these offer rich detail about the workings of the asylum in the latter decades of the nineteenth century when economic hardship and depression affected large sectors of the colonial population, and families and individuals were encountering medical and social institutions in large numbers.

* * *

The book begins with a discussion in Chapter 1 of the particular meanings of colonial psychiatry in Australasia. By the 1860s, each of the four institutions providing data for this study had been established and had begun to play a prominent role in the confinement of colonial populations of the insane. Medical superintendents were instrumental in the ongoing work to establish the professional world of psychiatry in white settler colonies. The evidence used here and in the following chapter supports Richard Keller's claim that psychiatry offers 'a privileged site for the study of the relationship between knowledge and power under colonialism'.[50] Chapter 2, which provides an account of families and the mental hospital system, explores the administration of families and insanity in the Australasian colonies, with a special focus on the way families were brought into the discursive work of the asylum itself. The

chapter also explores the particular aspects of colonial family life which produced the conditions, as far as the authorities could tell, for mental breakdown: social dislocation and lack of intimacy shaped some experiences of colonial family life. The very nature of colonial families, their identities and characteristics, including observations about their ethnicity, class and gender, underpins the discussion in this chapter, which also examines concepts of hereditary insanity.

Families and lay language around insanity, and how that language became part of asylum clinical discourse, is the subject of Chapter 3. This chapter seeks to understand the interplay between lay descriptions by family and friends and the asylum's use of these descriptions in its profiling and diagnosis of patients. It argues that patient case notes, along with the language used by ordinary people to describe mental states, can be re-examined as rich sources of information about families and households, and the ways that diagnoses were formed through expectations of gender and class. Chapter 4 investigates the emotional lives of families and patients through asylum case records and correspondence. The traces of emotion found in patient case-histories are a moving, disturbing and yet inconsistent set of reminders of the calamity of insanity. Letters to and from family members of the insane, patients themselves, and medical authorities, available in the archives, offer the possibility of a deeper reading of the emotions surrounding asylum confinement. The chapter argues that families provided their own textual accounts of insanity inside families. Together with Chapter 3, it also asserts that historians might look for new ways of interpreting institutional and clinical records to find evidence of the impact of mental illness upon families and family life.

The institutions tended to determine certain types of relationships between families and authorities that were formed at the time of the patient's admission. But in looking beyond institutional committal, I have found ways of locating other important family-institutional dynamics and relationships to show that the institution had porous boundaries. Chapter 5 examines the theme of maintenance payments to the asylums, finding that institutional authorities and the police made significant attempts to locate families to recover maintenance costs. This chapter also raises questions about the extent to which some families were sufficiently troubled by the costs to try to avoid them, or to evade their familial responsibilities more generally, suggesting this was a form of resistance to institutional authority. Chapter 6 makes a new contribution to the debates about colonial institutional confinement, describing methods of extra-institutional care including trial leave and

boarding-out, and like the previous chapter, shows that families had multiple interactions with colonial institutions in this period. It aims to find out how families and communities coped with insanity back inside the space of the private household, and how patients themselves coped with this transition. The chapter demonstrates that the outcomes for patients who were able to navigate the spaces between the asylum and the community are an important reminder of the institution's historical function and meanings.

The book ends with Chapter 7. Here, I interrogate my own theoretical and methodological practices around the 'asylum archive' and argue that what we can ever know about the colonial family and the asylum is mediated, and both enabled and circumscribed, by the archival materials themselves. I set out to understand the different roles played by families in relation to psychiatric confinement in the nineteenth century. One of the major purposes of this inquiry has been to find out how visible families are in the historical records of the hospitals for the insane, and to what extent their presence in the official record might shed light on their actions and presence in the past. By looking across colonial and archival sites, I demonstrate both their visibility and their invisibility; their multiple engagements with, and absences from, the problem of mental illness in the past.

# 1
# Colonial Psychiatry in the Australasian World

A deliberate attempt to define imperial practices of the management of insanity had begun by the 1860s. A report about colonial asylums, commissioned by the Colonial Office, was circulated to colonial governments in 1863.[1] Initially acting as an envoy of the psychiatric empire as he took up his appointment as Superintendent to Gladesville Asylum in New South Wales, Dr Frederic Norton Manning conducted his own investigations into institutions around the world, which were published in that colony in 1868.[2] Others had similar interests. Henry Burdett's four volume *Hospitals and Asylums of the World* appeared in the 1890s, the result of fourteen years of research. It included a section on the institutions for the insane in the British Empire and its colonies; the 'Australasian and Eastern Division' included the Australian colonies, New Zealand and Fiji.[3] Despite this catalogue of accounts of colonial institutions for the insane being produced from the imperial centre, it is important to note that the exchanges of ideas about psychiatry taking place within the colonial world of Australasia were as important as those occupying the minds of Europeans. Perhaps most significantly, as this chapter demonstrates, the wider world of 'Australasia' was viewed as one entity by its professional community, and was defined by colonial medical personnel through their intellectual debates over the problem of insanity in the colonies.

This chapter situates the debate about insanity in the Australian colonies and New Zealand within a larger set of ideas about 'colonial psychiatry'. Drawing upon international scholarship in the field, it argues that a re-reading of the colonial asylum invites new questions about the relationships between families and institutions. Nancy Tomes suggests that Anglo-American psychiatry and its history reveals a pattern of the development of a variety of arrangements for the insane, including

home care, boarding-out, and institutional care, with more household care of the insane in existence than historians may have uncovered.[4] Yet the new colonies of Australia and New Zealand, and other settler colonies formed in the late eighteenth and early nineteenth centuries, did not draw upon these well-established Anglo-American patterns of care. What were the options for colonists when insanity struck? The roles of institutions for the insane in settler societies were more pronounced than they were in older countries, and Australasian ideas about insanity were formed largely in their expression, through reports and policies and their enactment.[5]

This chapter first outlines the meanings ascribed by historians to 'colonial psychiatry'. It also outlines the way that studies of other places have raised issues about families. It then examines the four colonial sites chosen for this study, and includes discussions about the institutions, their locations and physical characteristics. In addition, the chapter also describes the roles of medical personnel, showing how ideas about the management of insanity were exchanged between colonies and medical experts in those colonies. Colonial medical superintendents played important roles in the formation of ideas about families and mental health policy. The primary focus of the local medical profession was the colony, and although branches of the British Medical Association spread throughout the empire, medical practitioners were busy developing their own new spheres of influence.[6] Efforts to grow a culture of medicine in the colonies were strong, and the various personalities among the asylum superintendents who practiced in the colonies played a part in its formation. The colonial culture of insanity, too, grew up around the institutions and in the medical worlds which surrounded them.[7]

The populations of colonial institutions are also an important means to understanding the function of colonial psychiatry in settler colonies. The discussion below examines these populations of the insane across four colonies with reference to the official reports made in each of the four sites.[8] In colonies where the dominant ruling class was white, but the wider population was made up of indigenous peoples and other groups who were subject to colonialism, such as indentured labourers, the effects of state policy on practices of health have been examined by a range of scholars. For example, writing about colonial Malaya and its health population, Lenore Manderson explores the 'official epidemiological record' of colonialism, showing that statistical knowledge, and its collection, was crucial to new forms of governance around the British Empire, as Alison Bashford and others also demonstrate.[9] By exploring

the asylum's practices of enumeration and its reporting of population in white settler colonies, this chapter both situates the investigation of families and their negotiations with the asylum, and also suggests that this was a dissemination of ideas about the asylum's efficacy which influenced family decision making. Mark Finnane asserts that the institution's perceived role and success originated in its own history in the colonies.[10] The growth in the epidemiological knowledge about patients and institutions reinforced beliefs about the roles of white families in relation to institutions. In addition, some scrutiny of official reporting practices demonstrates changes in the colonial institutions and their identities over time. Finally, in covering these themes, the chapter provides a rationale for the study of four colonial sites in a transcolonial framework.

## Psychiatry in the British colonial world

Historians have been attentive to the themes of medicine and colonialism, sometimes exploring comparisons between places.[11] 'Medicine and colonialism' is conceptualised as a distinct sub-field in the history of medicine and articulated as such by historians including David Arnold and Alison Bashford.[12] Researchers have also located psychiatry as one aspect of imperial medicine, most successfully examining it as an 'imperial' practice in parts of Africa, including South Africa, and India.[13] There is now a broad acceptance of the way that psychiatry was part of imperial medicine; it can be read, therefore, as Roy Porter puts it, an 'intrinsically *colonial* pursuit' which colonised patients and their very bodies.[14]

'Colonial psychiatry' took a variety of forms in different parts of the world before 1914.[15] It might be broadly defined as a complex of ideas and practices around the management of mental health in the colonies which reinforced the goals of the dominant class. In India, the long presence of the British as a powerful political, administrative and cultural force meant that institutions for the insane had existed since the late eighteenth century.[16] Racial differences in the population proved instrumental for British authorities in several ways in the nineteenth century, as Mrinalini Sinha notes. Authorities kept the European insane separate from 'native' populations, and often repatriated them, leading Waltraud Ernst to see the role of colonial psychiatry inside institutions for the indigenous as a form of social control. This interpretation is reinforced in the study of native-only asylums in British India by James Mills.[17] A number of studies, then, illustrate the different meanings of

'colonial', including those which focus on contexts where an indigenous, non-white population was made subject to the 'European model' of psychiatry.[18]

Like the populations of institutions in Australia and New Zealand, the patient populations of institutions for the European insane in India were composed of different social groups. Therefore, class distinctions did not shape India's asylums for the insane to the same extent as they did in England and other parts of Britain.[19] From these colonial institutions, some stories of family life emerge from cases of women and men hospitalised following grief, loss and disappointment. European women admitted to institutions were less likely than men to be discharged from the Calcutta Asylum in the first half of the nineteenth century. Ernst speculates about the precarious place and role of these women in a militarised, colonial society.[20] Aside from these observations, the families of European patients confined in India in this period have not been examined in any depth by historians.

The role of psychiatry in settler colonies was, as Sloan Mahone and Megan Vaughan point out, slightly different among histories of psychiatry and empire. In settler colonies, 'distinctive psycho-pathological discourses' were elaborated and these drew upon the 'adaptable' language of racial difference.[21] In South Africa, several institutions for the insane were established from the 1870s, with Robben Island established from 1846. Although, as Harriet Deacon argues, many white insane were cared for by families or in other privately arranged situations, the insane population continued to grow. Most inmates were men, and many had come into contact with the law as criminals. The ethnic composition of the population of the insane in Robben Island was highly diverse and included Africans, Dutch, refugees and ex-slaves.[22] Other asylums in the Cape Colony are examined by Sally Swartz. She contends that gender and race shaped the meanings of asylum confinement for the black insane in the colonial period to 1920. Studies of African colonies, including Zimbabwe, French North Africa and Nigeria, focus on much later historical periods. The strict definition of 'colonial psychiatry' is highly pertinent to these places where Europeans ruled predominantly non-white populations; postcolonial scholarship has also focused more attention to these sites, given their struggles for independence after World War II.[23]

In Canada, the separate provinces maintained large psychiatric institutions with predominantly European patient populations.[24] The problem of racial difference again indicated the practices of colonial institutions; the white population more closely resembled that of the

Australasian colonies.[25] The families of the insane have been the subject of some Canadian scholarship.[26] Mary-Ellen Kelm demonstrates that families entered into a negotiation with asylum authorities in British Columbia, and that their continued involvement with institutions significantly influenced outcomes for some patients. However, institutions did not always appreciate the interventions families made into hospital life, including visiting hospital inmates and corresponding with doctors.[27]

Historians of psychiatry have revealed similar patterns in the management of asylums in different colonies. For instance, in most places the administrative practices of colonial institutions including official reporting and data collection served to highlight the efficacy of the asylum.[28] Deacon shows how the patient population of the South African psychiatric institution on Robben Island was 'made' through its annual reports, that is to say, produced discursively through reporting techniques.[29] Different historians have sought to read epidemiological meanings from asylum population data.[30] India's census reports might be interpreted as 'early attempts at developing an epidemiology of psychiatry', as Sanjeev Jain argues; the reports reflected the desire by colonial administrators to establish the real extent of mental breakdown so that institutional support could be provided.[31] Jain refers to the collection of information about the causes of mental disease, and geographical, religious and cultural differences within asylum populations. Asylums in India, as in other parts of the world, often sought to place this information within a wider context, comparing colonial asylums and their populations with those in England, Scotland, Ireland and Wales. Similar comparisons are found in the reporting techniques of official asylum inspectors in South Africa, Australia and New Zealand.

The 1863 report about colonial asylums by the British Colonial Office relied upon information about asylums collected from colonial governments, who responded to a series of questions. Their answers were then collated to form the basis of the report. The colonial governance of insanity in public institutions puzzled the British authorities. In their own British context, as the preamble to the report pointed out, institutions had sprung from the 'bounty and philanthropy of private persons' while in the colonies, institutions were almost totally supported by public funds and thus relied upon legislative authorities for their continued existence. By their very nature, colonial asylums were of and for the people, intricately bound up with forms of government and social order. But the report's preamble commented that it was perhaps because of this circumstance that colonial institutions failed,

from a British perspective, in their endeavours in specific ways. Some colonial institutions were perceived as inhumane, and resembled earlier forms of British standards of care. Many, including those surveyed in the Australian colony of Victoria, were seen as inferior to hospitals and 'regarded too much as means of relief from a troublesome class'.[32] Furthermore, the statistics gathered and reported by colonial authorities had omitted required details, suggesting that their administration was poor. The report, then, was designed to monitor the colonial institutions and to suggest improvement. The empire of provisions for insanity was a paper fiction, but one with discursive consequences for local authorities in colonial jurisdictions.[33]

Dr Manning was commissioned by the British Colonial Secretary to write the 'Report on Lunatic Asylums', which was presented to the New South Wales Parliament, and printed in Sydney in 1868. The report provided a detailed account of asylum administration, patient care, buildings and plans, and different perceptions of insanity and the insane in their social and cultural contexts including Britain, Europe and America. Tellingly, this report sought to define colonial asylums in New South Wales, or 'what asylums should be', against their 'imperial' or existing, older models, or 'what asylums are' in 'Europe and America'.[34] At the same time, the report created meanings around the 'colonial asylum' in Australasia that were echoed in asylum inspectors' reports thereafter, therefore forming a colonial norm. For instance, Manning argued that a boarding-out system would be destined to fail in new settler colonies: and despite various efforts to establish private care for insane individuals, this view was largely borne out in practice.[35]

In his report, Manning took care to emphasise the different issues that defined colonial institutions. Along with extensive travel around parts of Britain, America and Europe, he also visited Auckland Asylum in New Zealand. His concerns were with space, buildings, populations of the insane, and the very language used to define insanity, which would take on different meanings in the colonies. The presence of convicts in New South Wales, for instance, coloured people's perceptions of asylum inmates; it was Manning's view that their clothing should signal their difference from prisoner populations. But his major reflection was around families and colonial family structures. Having examined provisions for private care of patients in Belgium, he commented that any similar attempt would 'necessarily fail in a new Country, Colony or State', at least in the 1860s. His view was that over time, with a growing colonial population, more people would be available to constitute the type of 'community' required to provide such forms of care. It was

preferable to construct colonial asylums that could house 500 or so inmates, and to locate these near population centres to assist and maintain any existing family connections.[36]

Institutions in each of the four colonies examined in the present study, New South Wales, Victoria, Queensland and New Zealand, reproduced these reporting practices from the 1860s. The Australian colonies became states after 1901, but the effects of colonialism lingered. From around this time, the asylum inspectors throughout the Australasian colonies presented the dry, numerical and descriptive data of the asylum system and its patient populations to the local legislature. The different tables were accompanied by interpretative comments about the combined patient populations of various institutions, admissions and discharges, transfers, deaths, escapes and accidents; and often, more detailed data about the causes of admission and patient occupations. These provided some insight into the social worlds of the asylum population. Asylum statistics were also mobilised to highlight the potential of the asylum for governments, keen to see how their funds were spent. In addition, the annual reports were occasionally referred to in newspapers, particularly if a question about an increase in the insane asylum patient population caused public debate or concern. Early official reports tended to position the colonial asylums in relation to England, or to Britain more widely. For example, the Report on the Yarra Bend Lunatic Asylum for 1860 included tables comparing the asylum population at the Yarra Bend with those of 'English asylums' for 1859.[37] Later reports placed colonial institutional populations in their local context and occasionally also their international context, sometimes providing the numbers of patients inside institutions in countries of Europe and Asia; this was part of a wider trend in the presentation of statistical information in social reports.[38]

**New colonies and provisions for the insane, 1788–1860s**

Historians agree that psychiatric treatment as it developed in Australia and New Zealand was largely based on British practices and was part of a wider set of developments in the western or Anglo-American world.[39] Yet, as the Introduction to this book noted, unlike Britain and America, there was never a strong presence of private institutions for the insane in any of the four colonies.[40] Contemporaries noticed the distinction. In 1879, the Sydney newspaper the *Daily Telegraph* published a letter from Dr Manning which commented that there were 'in our public asylums patients belonging to the professional classes, clergymen, doctors, clerks, members of the civil service who are penniless

and friendless'.[41] Some of these patients would, in the old countries, be housed in private establishments. The colonies were relatively slow to adopt the major reforms of psychiatry in the old world, although the discourse of 'moral therapy' crept into asylum practices, and was present in the organisation of spaces, the social and cultural life of the institutions, and the prevailing discourses of treatment including work therapy and religious worship.[42]

Writing about the shared histories of psychiatry in Australia and New Zealand, historians have found both parallels and sharp distinctions.[43] New South Wales was settled using male convict labour in 1788. An uneasy relationship with local aboriginal peoples was established, and European diseases including smallpox ravaged their population. As the colonists pushed northwards and into the west, frontier violence and conflict raged over subsequent decades, destroying most of the indigenous peoples' links to their lands. By 1840, when New Zealand's first settlers established rights over land, forming a treaty with Maori, there had already been around five decades of a serious European presence in this region of the southern hemisphere, with fledgling colonies growing up around Port Philip (Victoria after 1852), South Australia, Queensland (1859) and Van Diemen's Land (Tasmania after 1855).

These new societies, though different in many ways, shared a collection of approaches to the establishment of colonial law and order. Until 1851 and 1859 respectively, the new colonies of Victoria and Queensland were legally and administratively part of New South Wales, which had been settled in the late eighteenth century. New Zealand was settled after British sovereignty in the 1840s, and was a European colony at several places in both islands, with Auckland and adjacent areas of the North Island becoming established over that decade. All four colonies established patterns of European governance over the local indigenous peoples who suffered losses of population through disease and conflict. One aspect of this governance involved deploying legal and medical models derived from Britain, with gaols, courthouses and hospitals established in each place from very early in the colonisation process. The problems of insanity and the confinement of the insane were approached through legislation. Until separate and distinct colonial acts came into force, the 1843 Dangerous Lunatics Act in New South Wales (based upon 1828 legislation in England) was in operation in all places, though modified in New Zealand in 1846 as the Lunatics Ordinance. Both pieces of legislation emphasised the safe custody of the 'dangerously insane', and the committal process was outlined as both a legal and medical one.[44] Subsequent legislation set in place

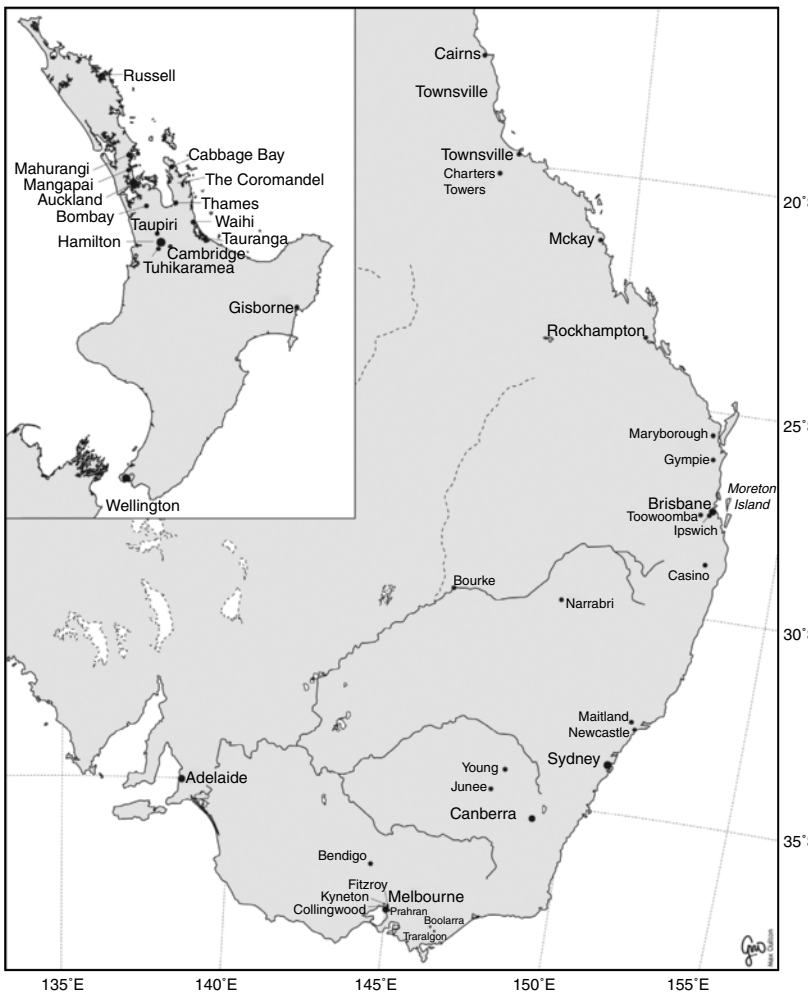
more detailed policy about asylum management, committal and discharge, maintenance payments and lunatic estates, trial absences and boarding-out, which was utilised to varying degrees in the colonies. The major acts were the 1867 Lunacy Statute in Victoria, the 1868 Lunacy Amendment Act in New South Wales (adopted by Queensland after separation in 1859), an 1868 Lunatics Act in New Zealand, and the 1884 Insanity Act, Queensland. Further amendments to acts in all colonies, with the exception of Queensland, were made in the latter decades of the nineteenth century.[45] By 1889, Dr Manning claimed that the laws were 'satisfactory, sufficient, and well abreast of the time' and even in advance of legislative provisions elsewhere in the world.[46]

Institutions including gaols for the confinement of the insane were initially makeshift and custodial, but provided basic accommodation before purpose-built spaces became the dominant response of colonists to the problem of insanity. In New South Wales, an asylum at Castle Hill was established in 1811 by Governor Lachlan Macquarie. It was praised by the contemporary press. Macquarie's instructions for the superintendent appointed in 1814 emphasised 'mildness, kindness and humanity' in keeping with the debates around the treatment of lunatics in England following a series of abuses at Bethlem Hospital. Tarban Creek Asylum (later Gladesville) operated from 1838, housing both convict and free settlers as inmates, and taking lunatics from Port Philip until the first asylum was opened there near the Yarra River in the 1850s. The custodial character of asylums throughout Australian settlements arguably owed something to Australia's origins as a penal colony.[47] However, this custodial element was also a characteristic of other colonial settlements: in New Zealand, where the white colony had not been a penal colony, lunatics were housed at Wellington Gaol, Dunedin Gaol and Auckland Hospital before the first purpose-built lunatic asylum was established in 1854 at Karori near Wellington.[48]

## A system of asylums and the spread of psychiatric knowledge, 1860s–1900

By the mid-1860s, as Henry Burdett's survey also noted in the early 1890s, asylums throughout the colonies were part of a network of institutions answerable to colonial asylum inspectors and colonial governments. When commenting on the growth of the asylum system in the colonies, Alan Atkinson observes that '[e]very well settled national population was supposed to contain a fixed proportion of madness'.[49] Arguably, colonial institutions became sites 'for the shaping of colonial identities in medicine' with gender, class and 'race' to an extent

fixing the discourse, if not the practice, around patient classification.[50] In addition, from the beginning, patients in psychiatric institutions in the Australian colonies and New Zealand reflected the diverse population created by migration to the colonies. The four public asylums or hospitals for the insane explored in this study shared certain characteristics. Each was located near a centre of population but also drew upon a




*Map 1.1* Map of the Australian and New Zealand colonies featuring main centres and areas mentioned in the text

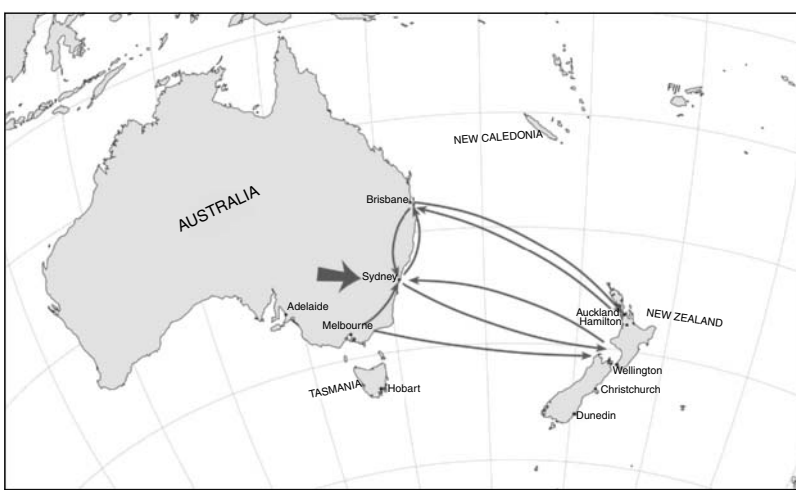
wide catchment area for its inmates, as Map 1.1 suggests. The sample for this study shows that patients came from large geographical areas.. For instance, Goodna patients were from far north Queensland, and townships all along the coastline north of Brisbane; and patients at Gladesville came from Brisbane, Melbourne, Newcastle (north of Sydney) and from many smaller townships in New South Wales. Distance was important in determining the role families could play in institutional confinement and underlines the significance of correspondence between families and institutions, as later chapters of the book argue.

All four institutions were established or operating by the 1860s.The first Australasian colony to establish an institution for the insane was New South Wales. Leaving aside Castle Hill, which operated from 1811 until 1926 to relieve the colony's gaols of the insane, Tarban Creek Lunatic Asylum was the first purpose-built asylum. It was later known as 'Gladesville', and officially known as the Gladesville Hospital for the Insane between 1869 and 1914.[51] The institution was located west of Sydney near the Parramatta River. The colony of New South Wales supported other institutions for the confinement of the insane: Parramatta Hospital for the Insane, first opened in 1849; Callan Park Hospital for the Insane (1878); several other rural institutions including Kenmore, at Goulburn in southern New South Wales, and a private asylum known as Bay View House at Tempe from 1865.The colony of Victoria gained autonomy from New South Wales in 1851. From the 1840s, Port Philip 'lunatics' were still sent to New South Wales, but the first buildings comprising Yarra Bend Asylum were established by the 1850s, and patients transferred from the gaol to the new site. By the 1860s the earliest asylums were located near, but not too close to, the metropolitan centre: Yarra Bend Asylum and Kew Metropolitan Asylum were both established in 1871. Two asylums were built in rural settings before 1900: Ararat Asylum and Beechworth Asylum were both established in 1867.

In Queensland, which separated from NSW in 1859, Woogaroo Lunatic Asylum's first buildings were constructed near Woogaroo Creek and the Brisbane River in 1865. Located halfway between Brisbane and Ipswich, the institution housed just fewer than 500 patients by 1879.[52] It was renamed Goodna Asylum by the 1880s (perhaps to dissociate it from public inquiries in the 1860s) and by 1898, the institution was known as Goodna Hospital for the Insane. Other institutions were built at Ipswich including Sandy Gallop (1878) and Toowoomba (1890), but Reception Houses at Brisbane, Townsville, Rockhampton and Maryborough ensured that potential patients were assessed before committal, an important practice, given the long travelling distances between places in the colony.[53]

New Zealand's asylums were spread through the two islands, located in both urban and rural parts of the colony. Auckland Lunatic Asylum, or 'The Whau', named after a local creek and based in the North Island of the colony, was one of several institutions in the colony of New Zealand by 1910. It was established in 1853 in the grounds of Auckland Hospital, later moving to new buildings at Pt Chevalier in 1876. From 1854, the asylum was administered by the Auckland Provincial Government, and by 1876, the asylum came under the control of the central government of New Zealand.[54] Also from the 1850s, other institutions were located in Wellington, and in the South Island. These included Karori in Wellington (1854), Sunnyside near Christchurch in Canterbury (1863), and Seacliff, near Dunedin in the Otago region (1872).

As Map 1.2 illustrates, I have positioned New South Wales as the hub of intellectual exchanges around insanity, its treatment, and its institutions, in Australasia. Manning himself described New South Wales as the 'mother Colony' at the Intercolonial Medical Congress of Australasia in 1889, where, selected as its President, he gave an overview of mental health in the Australasian colonies, as this chapter later describes.[55] New South Wales was the oldest of the colonies, and in some respects, at least in the Australian colonial context, retained its authority over the younger colonies; the medical profession was well-entrenched and




*Map 1.2* Map of the Australian and New Zealand colonies depicting the exchange of knowledge between places

integrated into social structures. Manning steered mental health in New South Wales, as his biography attests, to a position of preeminence and experience, although other individuals and mental health authorities also contributed to a robust set of colonial practices around institutional confinement. More importantly, I argue that the exchanges of knowledge which took place between these sites suggest a transcolonial framework for understanding the history of psychiatry.[56]

## Colonial asylum environments

In 1870, a party of official government visitors from England approached Gladesville Asylum by water on a 'cheerless' and rainy day. Despite the gloomy May weather, the beauty of the site was not lost on the group; they 'passed between fine parterres, gay with chrysanthemums and other showy winter flowers, to the principal entrance gate'. The place was alive with vegetation, with one of the visitors noting

> Passion and other vines already clothe a large portion of the boundary wall, erected on each side of the road, and between the walls and the flower borders there are several young orange trees, which have made fine growth, and which, in a few years, will form a grove of luxuriant beauty.[57]

Gladesville patients and staff also tended a vegetable and fruit garden which supported the diets of those at the institution. In the grounds of the hospital at the head of the inlet were salt water baths, and a boat house was to be built.[58] The wonderful garden was significant not only for its beauty, but also because it signalled the establishment of a place for the insane that might offer a curative environment, especially in the context of ideas about moral therapy that were circulating among British-trained colonial physicians. Images of the grounds of Gladesville sometimes featured kangaroos in the foreground of the lush garden setting, and the institution's physical culture was reputedly more 'nationalistic' than the Sydney institution at Callan Park [see Figure 1.1].[59] Like Gladesville, other asylum sites emphasized the beauty of their surroundings to visitors, as well as their relative accessibility to metropolitan spaces, even while they were removed some distance from intensely populated areas.[60] The Yarra Bend Asylum was often depicted in newspaper reports, and illustrations of the institution and its surroundings reflected views about its therapeutic purpose, as Figure 1.2 shows.[61]


*Figure 1.1* The garden, Hospital for the Insane, Gladesville, W. H. Broadhurst Postcard, c. 1900. Reproduced with the permission of the Mitchell Library, State Library of New South Wales, Australia.

The first official report of the Yarra Bend asylum in 1856 described the site as 'beautiful, quiet, and secluded', but too melancholic, without a 'prospect'. However, it was easily reached from nearby Studley Park.[62] After her second visit to the Yarra Bend Asylum in 1864, Annie Dawbin, a prolific diarist and observer of colonial life, walked to the asylum on the banks of the Yarra River, and crossed the water in a boat, later writing 'the river looked so beautifully calm, and I felt thoughtful'.[63] Patients at Goodna Asylum in the mid-1860s were not so fortunate with their physical environment, which revealed, far more tellingly, the limitations of the colonial institution. The promised gardens had not yet been planted, and inmates were cooped up in detention-like yards with high fences.[64] Goodna Asylum was also accessible by water, since it was located on the Brisbane River. As floods took their toll and the patient population increased at Goodna, more buildings were removed to higher ground.[65] The Brisbane River was used for patient therapies including a 'floating bath' for patients in the summer.[66] Mark Finnane suggests that the asylum was dogged by the inherent problem of its location, far away from many remote and inaccessible parts of Queensland.[67]

The architecture, landscapes and settings of colonial institutions shared common traits in design. They also created ideas about their function

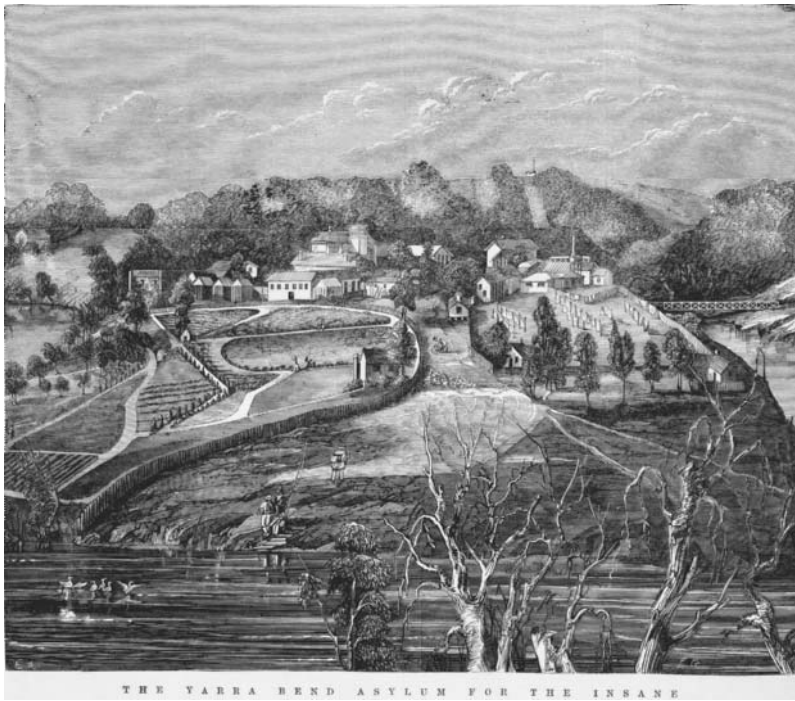



*Figure 1.2* The Yarra Bend Asylum for the Insane, *Illustrated Australian News,* 23 May 1868, p. 12. Reproduced with the permission of the Pictures Collection, State Library of Victoria, Australia.

which were visibly different from institutions beyond Australasia, even while they drew upon imperial models for buildings and locations.[68] The asylum buildings at Gladesville were constructed from around 1836, and the asylum quadrangle was designed by the colonial architect Mortimer Lewis in his first official job in the colony. Sandstone walls and buildings were added in the 1880s.[69] At the Yarra Bend, the original building was stone and was 'commodious, lofty, [and] well-ventilated'. Additional wooden structures were built to extend the size of the asylum following the early 1850s.[70]

Auckland's new asylum at Pt Chevalier was described as a 'modern' building in the official annual report of 1870. Located about three miles from the centre of the Auckland urban area on 22 acres of ground, much of which was taken up by a garden and farm, it included two large airing-yards surrounded by tall brick walls. The institution


*Figure 1.3* Avondale Asylum, Auckland, erected 1878, circa early twentieth century. Reproduced with the permission of the Alexander Turnbull Library, Wellington, New Zealand.

separated male and female patients into distinct yards. A church that could accommodate 250 people, spacious dining rooms, a kitchen, a bakehouse, cellars as well as dormitory spaces all defined the lives of patients and staff. It was crucial for authorities that the institution avoided having a 'prison-like aspect'.[71] Mrs S Russell Hendre, an official visitor to the Whau between 1897 to about 1904, visited patients at least monthly. In April of 1898 she noted that some 'quiet and industrious' women patients preferred to stay in, but considered that 'a small plot of ground, as an old fashioned flower garden' could be laid out for cultivation by female patients who would otherwise either remain inside, or pace up and down the dull courtyard.[72] A year later, Hendre noted with 'satisfaction' that her suggestion for a garden was to become a reality: the ground was being broken up in preparation.[73]

Inside institutions, patients and staff worked in settings which were increasingly modelled on the domestic spaces of home interiors. Photographs of the interior spaces of asylums in England in the late nineteenth and early twentieth century, as Mary Guyatt suggests, show


*Figure 1.4* Interior of women's ward, Goodna 1913. Reproduced courtesy of the State Library of Queensland, Australia, image no APE-045–0001-0029.

that the asylum was a place of 'comparative comfort' and that notions of 'homeliness' were highly important.[74] The world of the domestic family was invoked in these images which were used to promote and commend the institutions to the public.[75] There are few photographs of these furnished internal spaces in colonial institutions, but the annual reports often commented on wards, furniture and other aspects of these places. Figure 1.4 is a photograph of a female ward taken at Goodna in 1913 and illustrates the ways that hospitals for the insane strived to locate patients in situations like the middle-class home. As Marjorie Levine-Clark comments about pauper patients in West Riding Asylum in England, home comforts and the familial environment were designed to help patients 'reintegrate' into society, even though many of the patients were unfamiliar with such furnishings and spaces in their own homes.[76]

## The medical superintendents

Warwick Anderson writes that tracking the movements of doctors, as their medical careers took them to different parts of the British Empire,

might lead to a better understanding of the mobility of medicine itself. Most medical practitioners in the colonies had been trained in Britain.[77] Yet as Diana Dyason points out, far from being preoccupied with imperial medical models and practices, the professional interests of these men were focused on their colonial setting; local medical societies and journals were quickly produced.[78] In addition, tracking movements might involve more than investigating the imperial-colonial medical migrations of empire, and could include investigations of intellectual travels undertaken by nineteenth-century physicians. Akira Hashimoto argues that the transfer of medical ideas through the visits to Gheel in Belgium of professional medical personnel, some of whom were from Australasia, shows that travel can be interpreted as critical to the circulation of psychiatric knowledge in this period.[79] Significantly, then, the flow of ideas was not all one way between metropole and colony. Ideas about insanity and its management were also generated in the colonies and disseminated to the colonial audience.

As in Britain, the profession of psychiatry in the settler colonies, largely expressed through institutional management, was gaining in respect among the general population by the end of the nineteenth century. Mark Finnane states that these institutions were increasingly perceived as effective by the populace and attracted more families to make use of them.[80] The professional status of doctors and medical superintendents was partly responsible for this acceptance. In 1889, members of the Intercolonial Medical Congress met at the University of Melbourne, where they were welcomed by the Governor of the colony of Victoria and two colonial premiers. This was the second session of the congress. Delegates from Australia and New Zealand were treated to talks by learned colleagues, demonstrations of medical museum collections, concerts, dinners and a garden party. The importance of this event for the profession of medicine in the colonies should not be underestimated. It was here that issues of medical policy regarding infectious disease and sanitation, tropical medicine, surgery, public hygiene, pharmacology and psychology were debated and determined.[81]

The 'Section of Psychology' was introduced by its president, Dr Frederic Norton Manning, who was then Inspector General of the Insane in New South Wales and taught psychological medicine at the University of Sydney. Manning provided the group with an erudite survey of the state of psychological medicine in the colonies, or rather, the state of colonists' mental health.[82] Colleagues followed with more specific research papers on topics including legislation, nurse training, asylum economics, and significantly, race and insanity.

Frederic Norton Manning was born into a farming family in England and went on to study at St George's Hospital in London and at the University of St Andrews in Scotland where he gained his MD in 1862. Little is known about his early life, but much has been written about Manning's personal qualities and his considerable achievements in the field of mental health. Like other medical men trained in Britain, Manning sought experience as a physician in the colonies. Carrying letters of introduction to important colonists, he arrived in New South Wales in 1864. Appointed by the Attorney General, Henry Parkes, as the Medical Superintendent of Tarban Creek Lunatic Asylum (later Gladesville Asylum) in 1867, Manning's oversight of the state of asylums for the insane continued after 1879 when he was appointed Inspector General of the Insane in the colony of New South Wales, having spent time as an official asylum inspector for three years. His tenure as Inspector General lasted until 1898. He played a significant part in official inquiries into three institutions in different colonies of Australia, and carried out several roles in medical administration.

Manning not only introduced reforms in asylums, including more efficient admission and discharge procedures, and agitated for better public funding of institutions; he also introduced the training of asylum attendants and nurses, and his status and the respect he earned helped to ensure that public debate around issues of mental health was open and progressive.[83] Manning's achievements included his role as honorary secretary to the Prince Alfred Hospital, his presidency of the New South Wales Board of Health, and his contribution as medical adviser to the colonial government, in particular his role as the health and emigration officer 1889–92. He was also examiner in psychological medicine at the University of Sydney in the late 1880s. Involved in inquiries in other colonies including Queensland, Manning also had influence in the colonial world beyond Australasia.[84]

Late in his career, and until his death, he worked as a consultant in mental health from private rooms in Phillip Street, Sydney. Manning's medical career was illustrious, but never removed from the experiences of the sick and insane. After his death from stomach ulcer in 1903, more than one obituary commented upon the way his life was 'given to the amelioration of a class of suffering which needs special sympathy and insight'. As a mark of his sympathy towards the sick and insane, he was buried, at his own request, in the Gladesville Hospital cemetery.[85]

There were other individuals who shared Manning's enthusiasm for this project of colonial asylum management, and several men also played key roles in the management and reform of insanity in the period.[86]

Their careers and lives, as far as it is possible to describe these, should be viewed in a collective context, a group of professional men who were all largely trained outside the colonies, though some had been born in Australia or New Zealand. Their work was significant because the field of asylum medicine or asylum management was still under-developed and emerging. Some of these men forged careers as medical administrators; many progressed from roles as asylum superintendents to asylum inspectors. All had some experience of the world of insanity inside institutions beyond the colonial context. The superintendents were masters of their domains; their paternalistic roles were underscored by the concept of the familial space of the curative institution.[87]

Asylum superintendents were either English- or Scottish-born men like Manning, and/or British and Scottish trained, including Richard Scholes, born in Armidale, New South Wales, and James Hogg in Brisbane, who both took medical degrees from Edinburgh.[88] In Queensland, Scholes was superintendent of the Hospital for the Insane at Goodna; he died aged 45 after a short but important career in Queensland.[89] An obituary for Scholes expressed 'painful surprise and deep regret' at his death and remarked on his eminence and popularity, and his close work over time with Manning.[90] Scholes' role at Goodna was taken up by Hogg, who was also Inspector of Asylums in Queensland before his death in 1908. The thin, dark-haired Hogg gained a reputation as a 'careful administrator'.[91]

Edward Paley was born and educated in England. Prior to his roles as Asylum Superintendent at the Yarra Bend in Victoria in the 1860s, and then a twenty-year appointment as Inspector of Asylums for the colony of Victoria until 1883, he had been a resident surgeon in two English asylums.[92] Like Manning, Paley was also commissioned to conduct investigations into the colonial asylum system. In the 1870s, he travelled across the Tasman Sea to New Zealand to tour different several institutional locations, visiting asylums and report to the government there about the possibilities of centralisation. Paley's experience of institutional management and inspection in the 1860s in Victoria, the same period during which Manning raises concerns about family networks, framed his view of New Zealand institutions and their sometimes even more inaccessible locations. Paley's tour took him to Wellington and Auckland in the North Island, and to Nelson, Dunedin and Christchurch in the South Island. His observations about distances between places, and the problems this occasioned for families, were noted in his covering letter to the Colonial Secretary in November of 1873. Long, dangerous journeys, sometimes by sea, involved risks to

patients and those who cared for them. Paley's key recommendations were few, but he drew upon his knowledge of existing legislative models in the colony of Victoria when he stated that New Zealand needed not centrally located sites, but a far better organized central administration for lunacy in the colony.

Medical superintendents of asylums were also involved in educating and training new generations of psychiatrists. Dr William Beattie Smith, whose portrait gazed magisterially from the pages of the 1904 *Cyclopedia of Victoria*, was superintendent at three institutions in Victoria, and instructed medical students in knowledge of mental diseases after 1899, leaving a lecture series at the University of Melbourne's Medical School as his major legacy.[93] In addition, these men engaged with medical writings in journals and participated in regular medical society meetings and congresses. Their contributions to the discourses around insanity in the colonies were instrumental in shaping lay, public understandings of mental disease.

In New Zealand, institutions for the insane were independent of hospitals, and formed an asylum system across both islands of the country, with 'socially responsible citizens' involved in their management.[94] Although the 'needs of the physically ill often seemed more comprehensible and urgent' to colonists, increasingly, medically trained asylum doctors showed that 'insanity was a physical disease' that could be addressed within the space of a medical institution.[95] Robert Beattie, Assistant Medical Officer and later Medical Superintendent at Auckland Lunatic Asylum in the 1890s, was born in Melbourne, educated at the medical school at the University of Otago in the South Island of New Zealand, and completed his training at Edinburgh. Gray Hassell worked at a number of New Zealand asylums including Auckland. Born in Oamaru, New Zealand, he too studied in the United Kingdom and returned to work in New Zealand.[96]

In New Zealand, Duncan MacGregor became the Inspector General of Lunatic Asylums, Hospitals and Charitable Institutions in 1886, a role previously held briefly by Frederick Skae. Like his predecessor, MacGregor made frequent calls for increased government expenditure on mental health.[97] Both MacGregor and Skae were among the many Scottish-trained physicians who arrived in New Zealand as medical migrants. Skae was appointed to the role of Inspector of Asylums in 1876 and brought his family to live in Wellington, where New Zealand's government was based. He voiced strong criticism of New Zealand institutions in his pursuit to improve psychiatric care and psychiatric medicine, but his career was cut short after public controversy

in the early 1880s.[98] MacGregor, who arrived in New Zealand from Scotland as professor of mental science to lecture at the University of Otago in 1870, was known as a 'tall, immensely built man' with a 'commanding presence'.[99] He held strong views on social policy and during his lengthy career in New Zealand he occupied roles as an inspector of asylums and a medical officer at Dunedin in the South Island of the colony. In his work as Inspector General from 1886 he advocated that mental hospitals be run along 'scientific lines', encouraging hard work among inmates and better patient classification.[100] These views were echoed by other practitioners and medical administrators around the four colonies.

Psychiatry was, then, still a young field of practice and expertise in the middle of the nineteenth century, but its professional status was on the rise. The mental hygiene movement emerged in the early 1900s, yet its impact in Australasia was not felt until the 1920s.[101] Manning was succeeded as Inspector General of the Insane by Eric Sinclair in 1898.[102] In New Zealand, Frank Hay took over the role when MacGregor died in 1906. By the early twentieth century and prior to World War I, Eric Sinclair, Frank Hay, and other psychiatrists campaigned to have issues of mental health seen within a 'scientific' framework in the colonies.

## Patient populations

As Dr Manning noted at the Intercolonial Medical Congress in 1889, in the period between the 1860s and 1887, the colonists had become a population with a defined percentage of the committed insane. They were, in the words of historian Raymond Evans, 'hidden colonists' in that they were defined through their deviancy.[103] There were already, by 1887, around eight and a half thousand registered insane persons across the Australian colonies, in a total colonial (European) population of almost three million persons, making one in every 349 persons insane.[104] The ratio in New Zealand was slightly lower, with one in every 380 persons insane. Manning suggested that these colonial statistics compared well with those for Great Britain and Ireland, with fewer insane per head of population. He went on to explore the contemporary preoccupation with the nationality of the insane, showing that the greater number of asylum inmates had not been born in the colonies.[105] The 'hybrid' heritage of asylum inmates attracted attention from other speakers at the 1889 Congress, as I explore later.

Like other colonies in this study, the wider asylum patient population in New South Wales must be considered as the context for the

study of one institution's records (see Tables 1.1 and 1.2). By 1905, Gladesville catered for around one-third of all new admissions in New South Wales. The Yarra Bend in Victoria also took around one-third of all new admissions to insane asylums by 1905 (see Tables 1.1 and 1.2). Similarly, Auckland took just under one-third of all new admissions and readmissions to asylums in the colony.[106] However, unlike the three other institutions in this study, Goodna Hospital dealt with the majority of patients in the colony, as also shown in Tables 1.1 and 1.2; 85 per cent of all new admissions and readmissions in the colony of Queensland were to Goodna by 1905, because of the way the

*Table 1.1* Admissions and readmissions to all asylums in each colony, c. 1905*

| | NZ | NSW | VIC | Qld |
|---|---|---|---|---|
| Admissions | 577 | 826 | 664 | 279 |
| Readmissions | 102 | 183 | 84 | 56 |
| Total | 679 | 1009 | 748 | 335 |

*Note*: *Men outnumbered women in all categories except readmissions to institutions in Victoria, where 43 women and 41 men were readmitted in the period.
*Source*: Official figures from annual Asylum Inspectors reports, Parliamentary Papers (Australian colonies) and *Appendices to the Journal of the House of Representatives* (New Zealand), 1904–1905. The Australian colonies became states after Federation in 1901, but the concept of 'colony' is retained here to explore the lingering meanings of colonialism.

*Table 1.2* Admissions and readmissions for each of the four public asylums, c.1905

| | Auckland | Gladesville | Yarra Bend | Goodna |
|---|---|---|---|---|
| Admissions | 171 | 223 | 244 | 235 |
| Readmissions | 29 | 74 | na* | 50 |
| Total | 200 | 306 | 244 | 285 |

*Note*: *No figures were supplied for the Yarra Bend
*Source*: Official figures from annual Asylum Inspectors reports, Parliamentary Papers (Australian colonies) and *Appendices to the Journal of the House of Representatives* (New Zealand), 1904–1905.

population was sparse in the north of the state, meaning that few other large institutions existed.

The Australian and New Zealand asylums drew upon the population that had grown up in the flux of colonial life. Class, gender, and ethnicity shaped the institutional worlds of the insane, just as they characterised the colonies more widely. The public asylums housed people from all walks of life, but both reflected and reproduced the prevailing rhetoric around class, as attempts to shape the internal worlds of asylums reveal. The vast majority of institutionalised people were from poor, working-class families, with many from rural locations.

More men than women were committed to asylums in the colonies.[107] Yet the way that prescriptions for gender continued to define insanity paid scant regard to the realities of asylum statistics, with theories about the female propensity towards insanity entrenched in asylum discourse.[108] Men were more vulnerable to the phenomenon of sunstroke, highlighting the way that white bodies occupied the physical spaces of the colonies. During the 1870s, for instance, white male patients at the Yarra Bend admitted following so-called sunstroke reached as high as 16 per cent of the total male asylum population.[109] Irish-born John H was admitted to Goodna in 1878. A letter from his brother-in-law in 1885 queried his health, telling the doctors that he first 'took bad' when he arrived in the colony and worked on a farm in the heat; falling asleep under a tree, his hat was blown off by the wind and the 'sun harmed his head'. Afterwards his mother 'could see a great change in the poor fellow, and some of her friends advised her to speak to authorities on the subject'.[110]

Indigenous inmates are rarely noticeable in the patient records, perhaps due to their removal and dispersal throughout Australia by the 1860s and 1870s, the effect of colonial policies and practices of segregation from the 1830s. Unlike the situation in nineteenth-century Fiji, colonial India and parts of Southern Africa, the indigenous and non-white populations of the insane in New Zealand were not separated from the white Europeans inside the various hospitals for the insane around the colony. In colonies where the white population was a minority, the tendency to enforce segregation through institutional separation was more common than in the white settler colonies of New Zealand, Australia and Canada.[111]

The asylum system in New Zealand similarly drew upon a colonial population formed through immigration, with some people drawn to gold rushes in the South Island, and the local indigenous peoples. Maori were more noticeable in asylum patient case records and official

reported statistics than aboriginal people were in either New South Wales or Victoria, and also Queensland, particularly by the end of the nineteenth century. According to the official reports, fifteen 'Aboriginals' remained in Queensland asylums at the end of 1901, with just three admitted in that year.

According to the annual Asylum Inspector's Report for 1900, there were 21 Maori patients admitted to asylums in New Zealand that year, making the total population one Maori in every 303 persons.[111] By 1911, there were more Maori insane per head of Maori population, with rates of committal reaching 14 in every 10,000 women, and 23 in every 10,000 men.[112] Yet it is likely that in all colonies, more indigenous patients were inmates than official admission registers show; in New Zealand, more Maori patients than reported in the annual reports have been located at Auckland before 1900 through a close examination of patient casebooks.[113]

At the 1889 Congress, Dr Manning presented a research paper about aborigines and insanity based on observations of thirty-two cases from Queensland, provided by his friend and colleague Richard Scholes, and New South Wales. He drew upon early colonial writings, and knew about the missionary Reverend George Taplin's medical notes on the Narranjeri peoples around the Lower Murray which included rare cases of insanity.[114] Manning's account of insanity among aboriginal peoples should be viewed with care because, as Joy Damousi points out, it reflected contemporary stereotypes about racial groups.[115] Yet Manning's attempt to make sense of aboriginal cases of insanity in New South Wales and Queensland asylums is significant because it was the first time specific attention was paid to indigenous mental health in the colonies by a professional in the medical sphere, and it also made a synthesis of the available data about aboriginal people. It became an influential account, as Caitlin Murray argues, and 'blazed a trail' through international literature on the subject of insanity and race.[116] Manning noted that with greater contact between aboriginal peoples and Europeans, and the introduction of the 'vices and the cares of civilisation', there were 'more frequent notices of mental disease'.[117] Although Manning might have suggested a limited view of aboriginal intellectual abilities, he also highlighted the very real impact of colonialism upon indigenous peoples.[118] According to Manning, aboriginal modes of dealing with 'insanity' allowed the strong to encourage the weak to die or decline without interference, which sometime resulted in the mad person becoming revered or regarded as an 'inspired being'.[119] From 1868, in the period surveyed by Manning, only fourteen aborigines had been admitted to Queensland asylums, and only eighteen to asylums in New South Wales.

Like his contemporaries, Manning grossly underestimated the numbers of indigenous peoples before European contact, but in his recognition of their 'miserable' numbers in both colonies he showed an awareness of their fate at the hands of settlers and the ravages of disease. The majority of the aboriginal patients in Australian asylums were male, and many of them spoke English, leading Manning to speculate that they had worked as trackers or troopers.[120] Most likely they became patients following the loss of contact with their tribes, and their closer proximity to European modes of social control, including police, through the effects of legislation 'protecting' aboriginal people and separating them from whites in designated mission stations.

Similarly, in New Zealand, early European accounts of insanity among the Maori noted only a few cases during the colonial contact period. Evidence suggests that Maori viewed some forms of insanity as the result of a spell or incantation, declaring it makutu (bewitching), and sick individuals were sometimes banished from whanau (family) groups.[121] During the 1860s, and specifically at Auckland Lunatic Asylum, Maori began to appear in small numbers. There were consistent levels of Maori committals to this institution over the course of the nineteenth century, with more male Maori insane than female, once again suggesting that contact with European employers or police could result in Maori asylum committal.[122] This also marks the period of sustained military conflict between Europeans and Maori in parts of the North Island. Official asylum inspectors' reports in New Zealand made little comment about Maori patients during the nineteenth century, suggesting, as historians have argued, that their presence in the institution was viewed as one aspect of their inevitable decline and disappearance of indigenous peoples in the colonies, a view shared by colonial Australian contemporaries. Bronwyn Labrum suggests that Maori patients were committed to mental hospitals more frequently in the twentieth century, arguing that 'explanations of committal in terms of colonial rule only begin to have salience in the early twentieth century' possibly because Maori began to move away from rural areas into towns and cities which were centres of European population.[123]

The presence of Chinese asylum inmates attracted more official comment than did the presence of indigenous peoples in asylums as early as the 1870s. Their visibility on the goldfields in both Victoria and New Zealand led to concerns about racial difference in the colonies. By 1881, immigration restriction legislation to limit Asian immigration was introduced in Victoria, and similar legislation was later enacted in other colonies. Despite their relatively small numbers in asylums,

official inspectors' reports commented on the Chinese asylum population from the 1870s in both Victoria and New Zealand.[124] In both colonies the possibility that 'mixing' between the physically and mentally diseased Chinese and European inmates was possibly 'injurious' to Europeans caused great anxiety.[125]

At the Medical Congress of 1889, more than one colonial physician displayed a preoccupation with the question of 'race' and ethnicity of the insane in the colonies. As well as Dr Manning's observations of aboriginal patients, the ethnicity and heritage of patients in hospitals for the insane proved to be a significant area of interest for Chisholm Ross, Medical Officer at Gladesville. Ross examined the patient registers at Gladesville between 1878 and 1887 to determine whether any particular patient nationalities dominated the admissions. He was puzzled by the identities of the colonial born, suggesting they were 'of no special race'.[126] Their 'marked hybridity' confused Ross, who wanted to apportion the incidence of insanity to racial categories. Given the structure of the population (more colonial born were young people, but asylum admissions tended to be older people) any quest to define insanity through 'race' was bound to be complex. He did find that more Irish were confined, comparatively speaking, than others from Britain. He had suspicions that more Chinese mad existed than asylum admissions revealed, because they were 'harboured by their countrymen'.[127] His conclusions included that the hybridity of 'Australasians' possibly protected them from insanity, along with their environment, their diets, their conditions of life, and their lack of worry also shaped their responses to mental challenges. He listed 'self-reliance' and 'self-confidence' as two of the colonial attributes that held madness at bay.[128]

These ideas had some currency among contemporary medical professionals. In his report on the colony's populations of the insane for 1905, Dr Frank Hay pondered the relatively low incidence of insanity among the New Zealand born. He suggested that 'the conditions of colonial life' might 'awaken the prepotencies of the race and assist the environment to triumph over evil heredity'. This was newsworthy enough for its later distribution, in 1908, in the British publication *Journal of Mental Science*.[129] Yet the colonial life was not without difficulties, as the following chapters describe.

## Conclusions

This chapter has explored how the Australasian colonial world of insanity and psychiatry might be located within the larger context of the

British Empire to 1914, but more importantly, it has suggested that the colonial world itself deserves special attention, with investigations of the transcolonial elements of the practices of psychiatry placed centre stage. The Australasian colonial world lends itself to the transcolonial approach. The colonies were not 'national' entities until after the turn of the twentieth century, and even then, lingering influences of empire saw the mass participation of colonial troops in World War I. Colonists, indigenous peoples, new migrants, transient miners and the native-born whites all mingled in these new democracies and fashioned ideas about their own governance, including the meanings of the family and its role in supporting the sick and infirm. Although the term 'colonial psychiatry' has been used to refer, most often, to practices of psychiatry where the colonised were made subject to the coloniser, it might also refer to a web of ideas about white patients in settler colonies whose very precarious mental health worried colonial governments. Indigenous inmates were present in colonial institutions but were not separated from European patients. Anxieties about racial differences in the institutional populations were highlighted through debates about the presence of Chinese inmates, reflecting social debate around immigration policies in the nineteenth century. Concerns around ethnicity and 'race' in asylum populations were directed towards the construction of a 'white' identity for institutional populations.

Ascribing meanings to the colonial psychiatry of settler colonies, where populations of the insane were largely 'white', raised different issues to those in other colonies. Among these were questions about the nature of settler communities, the experiences of immigrant populations and their families, and family structures and networks: these are outlined in the following chapter. The web of institutional management extended from Sydney to Brisbane, Melbourne and Auckland and around the south-eastern colonies within the context of a colonial world of psychiatry creating its own particular culture.

# 2
# Families and the Colonial Hospital System, 1860–1910

The experiences of those who suffered from insanity over the second half of the nineteenth century were increasingly defined through the context of the development of a system of colonial hospitals for the insane. During this period, the professional arena of the psychiatric institution and its specialists took hold in Australia and New Zealand, as elsewhere. White families were made part of hegemonic asylum discourse in two major ways: first, through the concept of the dangers of the atomised family in the colonies; and second, through the concepts of heredity and degeneration, particularly after the 1860s.[1]

This chapter explores the specific meanings of colonialism in white settler colonies through an examination of mental health policies and practices. In these colonies, the articulation of colonial psychiatry was bound up with ideas about 'race', families and heredity.[2] In particular, the chapter investigates the relationships between families and asylums in Australia and New Zealand through official and medical concepts of institutional and medical care, arguing that over time, the colonial system of hospitals for the insane began to situate the family within the emerging discursive framework of mental hygiene. Writing about Canada, Cheryl Krasnick Warsh claims that nineteenth-century alienists, later psychiatrists, 'recognized the influence family life had on physical and mental health and termed it heredity'.[3] I argue by contrast that understandings of heredity were more complex and had some basis in the empirical observations of the insane and their families, as medical research conducted by Dr Manning shows. The histories of migrants and settlers, so often shaped by the very anxieties of settling, provide a background to the fears expressed by institutional personnel, who were concerned with the unsettling effects of colonial life.

In colonial society, the presence of those who had gone 'off the rails' defied the progress made in establishing new settlements with purpose, meaning and direction, as Alan Atkinson intimates; the management of insanity 'involved a tangle of moral problems symptomatic of the time'.[4] Among these was the management of colonial families. Finally, the institutional populations and patterns of committal in the colonies also show that some indigenous inmates received attention within debates about colonial families and mental health, although they were not the focus of colonial asylum administrators.

## Insanity and colonial society

In the 1860s, mirroring the industrialising world, colonial societies underwent rapid transformation. Following the gold rushes of the 1850s in Victoria, and the 1860s in Otago, New Zealand, colonists had begun to spread out around the various geographical regions of the colonies, and were no longer concentrated around ports and immediate hinterlands, but lived in both urban areas in the major cities, and in rural towns and villages. Urbanisation was rapid and distinctive in both Australia and New Zealand. The larger cities of Sydney, Melbourne and Auckland supported significant populations by the 1890s, with more than two thirds of the colonial population of Australia living in town and cities by 1891, and most of them in the large cities of Sydney and Melbourne.[5] Though the New Zealand population was smaller than Australia's, Auckland city and province was home to over 20 per cent of New Zealand's population in 1896.[6]

The traces of families, with their bonds of blood, marriage, obligation and need, are evident in written histories of the colonies. As this chapter argues, the 'family' was often invoked by institutional authorities both to explain insanity, and also to find solutions to it. From the 1870s, asylum inspectors lamented the problem of colonial insanity, at times arguing that it was more prevalent in the colonies due to what one doctor characterised in 1871 as 'the limited range of sympathy which the isolation of individuals and families in this country gives rise to'.[7] Institutionalisation of the insane could compound problems of isolation and geographical distance. Not only did the removal of patients to sometimes distant institutions create distress for patients; it also increased 'the sorrow of their friends'.[8]

From the 1830s, many young and single migrants, and newly married couples, arrived in Australia from different parts of Britain.[9] The largest proportion came from England and Wales, with Irish migration

to Australia peaking in the 1870s. Scots were the smallest group of migrants from Britain.[10] This contrasted with New Zealand, where Scots-born made up 24 per cent of the European population by the middle of the nineteenth century.[11] Families were fractured by the processes of migration. Migration to the colonies after the 1870s was horizontal, and reflected British patterns of familial structure in the wake of industrialisation. By then, assisted migration involved relatives bringing members of families to the colonies, and many families did travel together. These relationships are reflected in the asylum's record during this period. As families became 'inclusive and permeable', a wide range of relationships characterised new world societies.[12] In general, a mixture of old and new patterns of family formation existed in the colonies across the nineteenth century.[13]

By the 1880s, families had begun to develop networks of kin across the colonies. In the late-nineteenth century, historians have argued, 'pioneer middle-class families ... were awash with relatives', partly due to their greater geographical stability. However, class differences also shaped families in the wake of migration and settlement. Poorer families, members of which had to travel and separate for seasonal, rural employment, or mining, were more likely to be fractured and geographically distant.[14] Simple nuclear families were 'the norm' and only a small percentage of families included elderly parents and therefore could be considered as 'extended' families over three generations, unlike other parts of the western world.[15]

There were, then, 'rapid changes in the colonial family' in the period under examination, partly influenced by migration patterns and economic conditions, and also characterised by shifting expectations of family life.[16] Historians agree that the conjugal family co-existed with the more loose family affiliations described above, with an increasing emphasis on romantic love between the 1840s and 1900.[17] Penny Russell has shown that middle-class families used the concept of marriage to redefine the emotional relationships of those who were party to it; marriage became the space in which physical and emotional experiences took centre stage.[18] Erik Olssen suggests for New Zealand that this private, 'affective' family was more common in urbanised areas.[19]

Despite an emerging rhetoric about an 'egalitarian' society in both Australian colonies and New Zealand by the 1890s, class differences in the colonies were no less important than they were in Britain.[20] Stephen Garton also comments that 'the family' was embedded within social structures of power, with the new 'norms' about families, behaviour and gender being created within the psychiatric institution reinforcing

these power relations.[21] As mentioned earlier, the public asylums in this study catered to all classes, but mostly housed the poorer class of colonial cities and towns. In the final decades of the nineteenth century the asylum became more popular, gaining in acceptance; physicians associated with asylums, like the profession as a whole, began to occupy social positions of some prominence. This period marked a shift from earlier decades when asylums were perhaps regarded with more suspicion by colonial families.[22] Some scholars have shown similar patterns in other countries, arguing that broader definitions of insanity may account for the greater use of institutions by families and communities, as Chapter 3 explores in more depth.[23]

Medical superintendents appointed to manage asylums often showed signs of compassion and sympathy towards the inmates and their families. Yet they also held the authority to release patients, and some family letters to the asylum indicate a deep sense of deference towards their authority. Other families adopted a more critical stance towards institutions but nonetheless used them at times of crisis.[24] The complex and drawn-out negotiations with asylum authorities launched by some families also show that they exercised agency, often motivated by economic concerns, such as the cost of asylum maintenance or failing household economies, but also by the often distressing emotions surrounding mental breakdown, as Chapter 4 demonstrates.

Household formation reacted to external forces including economic factors and the changing interventions of the colonial state.[25] Family historians have shown that industrialisation in Britain meant that families were more likely to cohabit with others due to pressures upon housing, but in the colonial context this was not always the case, and historians have demonstrated that land selection legislation discouraged joint family cohabitation. As in some parts of Britain, close residence of family members rather than co-residence was more common. Colonial provisions for the poor and needy were different from those in Britain. Until the late-nineteenth century, the only fragmentary support that was available came from the colonial churches and religious charities.[26] In the absence of state welfare assistance, and perhaps to avoid resorting to benevolent or destitute asylums, nineteenth-century kin helped each other at times of death, bereavement and illness. Scholars have shown that in New Zealand families became the locus of 'mutual aid', acting as a 'surrogate society'.[27]

As asylum authorities noted, and as New Zealand historians have argued, colonial societies, in particular 'frontiers', were places marked by loneliness and transience for many people.[28] There were, of course,

always people without families reliant upon friends or acquaintances; as the asylum sources sometimes reveal, these people were also sometimes at the mercy of complete strangers. Contemporary accounts of the colonial family from official inspectors of the asylum reinforce this point. Asylum superintendents were aware, too, that patients in each of the asylums discussed here came from all over the area of the colony, some travelling vast distances. Patients were committed while they were working and living far beyond their place of origin in separate colonies, as Map 1.1 indicates in Chapter 1. As colonial populations dispersed and engaged in what Atkinson calls 'democratic settlement', many colonists succumbed to the difficulties and pressures of life.[29] In 1868, Manning wrote that assistance for patients released from the asylum was needed 'more urgently in a colony than in an older country. The patient is not infrequently a stranger in the land; kindred and home are far away; the few ties of friendship which he has formed have been swept away by the dire malady which has prostrated his intellect and ruined his fortunes'.[30] This position changed over time, and was modified in subsequent years in asylum inspectors' reports, but the idea that colonies were places where families were fractured, dispersed, and distant, remained. It was partly supported by asylum statistics, which showed, for instance, that half of all inmates in New South Wales in the 1880s had no relatives in the colony.[31]

Loneliness, isolation and dislocation shaped experiences for both wealthy settlers and poor immigrants to the colonies.[32] Loneliness could make the experience of anxiety (a word used frequently in letters and diaries of the period) intense and painful. Many women and some men wrote about sickness, death and grief. Frequently far from extended family they were forced to cope with the deaths of children or illness of spouses, particularly when wives grew ill and could not manage the family or the home, or husbands were out of work. Medical and advice books and medical experts in the nineteenth century acknowledged homesickness, or 'nostalgia', as a condition experienced by some people. As more people moved around the world and migrated to its different parts, painful articulations of homesickness apparently increased. Susan J Matt asserts that as this phenomenon was explored by the medical profession homesickness came to denote a 'psychological problem'. The effects of place, light, and the peculiar characteristics of 'race' were all said to play a part in determining one's predisposition to homesickness. Settlers could consult books of domestic medicine and find the cause of their own feelings of displacement.[33] Knowledge about the condition, a form of 'mental worry', also helped to sell supposedly

ameliorative products, such as Mother Seigel's Curative Syrup, advertised in newspapers in the Australian colonies and in New Zealand.[34]

In the 1850s, John Brooke, who left England and became a publican in Victoria, wrote to his sister that some might think going to the colonies was itself 'madness', but there was money in it.[35] Like others, Brooke expressed his positive feelings about going to Australia to try his hand at a new life. Similar hopes and dreams held by other new arrivals faded over time. The 'uncanny' bush and, for Europeans, its spooky emptiness, haunted some of their correspondence. Likewise, the initial rush of enthusiasm for the city, for some writers, gave way to desperation about changing fortunes and circumstances.

Letters were an important mode of communication between the colonies and Britain, as well as between different parts of the colonial world: the despatch and receipt of correspondence also became the subject of much commentary in letters and diaries.[36] In the 1850s, Edward Wilson, a new arrival who boarded with Dr Watkins of the Yarra Bend Asylum, described the concern about slow sorting of mail from the old country after the docking of ships in Port Philip Bay, Victoria, and the imminent opening of a new Post Office. He mentioned one newspaper report which suggested that the existing postal service was 'full of letters not delivered and ... some of them ha[d] been there for many months, neglected'.[37] Isaac Macandrew, who arrived in Adelaide, South Australia, in 1877, sent letters home the day he arrived, and was sorry none were waiting for him. He wrote lengthy descriptions of the arrival of the mail. As soon as the ships arrived, the mail bags were brought on shore by a steam launch, and then 'whirled away to the general Post Office':

> The great hall is thronged with people, some eagerly opening letters just received, standing about in everyone's way, others clamouring and shouting out their names to the bewildered officials and others (poor things I pitied them) looking so disconsolate and silent as no letter appeared for them.[38]

This sense of isolation experienced by those who received no letters is a common refrain. Arthur Ball, who left Kentish Town in England for Sydney in 1885, fretted over whether letters he had written were reaching his family in England some years later, in 1891.[39] Another, Charles Holmes, investigated the postal arrangements and advised his parents where to write to him as he moved about the colonies in the 1880s.[40] Atkinson argues that letters and the postal service enabled 'intimacy' among colonists who depended upon such communications for their sense of well-being.[41]

Much evidence also points to the success of postal communications in the period, with systems of overland mail in place by the 1850s. Despite such provisions, family relationships still grew strained across vast distances.[42] A sense of the dislocation experienced by some families is demonstrated by the letters of Susannah Watson, writing from Braidwood, New South Wales, in August 1867, to her daughter near Nottingham in England. Poor weather and floods prevented the mail for a time between Braidwood and Sydney, she reported, so it was with great happiness that Susannah received a letter from her daughter for the first time in ten years, and replied. She asked for news of her daughter's grandfather, Edward Watson, if he was still alive, or 'if dead, when he died' and whether she had heard from her brother Samuel, 'whether he is dead or alive', and she enclosed a photograph of herself. 'Perhaps you will be able to recognise your poor old mother', she wrote, 'who is now in her seventy-third year'.[43] Susannah also lived some distance from her son Charles who left Braidwood for work in Shoalhaven on the south coast of New South Wales; she described this as a 'great loss' but could not join him due to recurrent flooding. Such examples of what might be termed 'dislocation' show that the intimacy of families was often eroded by patterns of migration and colonial life.[44]

The loneliness of distance and family separations were sometimes amplified by the strangeness of the surroundings. Noting that new arrivals were themselves 'strangers' to the country in the 1850s, Edward Wilson felt that the 'stillness' of the bush was quite different from the stillness and quiet of England. '[H]ere, at midday, or any other time', he wrote, 'the stillness is strange, it is oppressive'; it made his 'very flesh creep'.[45] In the 1870s, Isaac Macandrew described the bush beyond Adelaide as 'lovely' but also lonely and isolated. On a journey back to town in a coach he witnessed a 'dark picture' of a landscape ravaged by bush fires, writing that there was 'something very dismal and melancholy in driving through the dead silence and gaunt, black, spectre-like shapes the charred stumps presented'.[46] Bushfires not only created strange and desolate landscapes; they also signalled loss. Edmund White's diary recorded the great fears of farmers in the heat of summer, when 'the sight of a match will set a place on fire'; the farmer would get no compensation, he wrote, 'except sorrow from his friends'. Other diarists noted similar worry over bushfires, as did regular newspaper reports.[47]

Atkinson reads similar accounts of the bush, with their 'strange atmospherics', as gendered narratives of place which might provide insight into spiritual understandings of the new country.[48] These men writing about

the loneliness of the bush were also contrasting it to the cities they had experienced, where a European-style of bustling life was evident. The sense of loneliness they both felt to be a tangible effect of the land was also reinforced by their status as migrants, travellers, people living at the edge of the world.[49] Their narratives became emblems of a new form of male identity, enshrined in poetry and song in the Australian colonies, but also hinting at darker aspects of colonial masculinity.[50] Moreover, the bush, in both the Australian colonies and in New Zealand, might, in the imagination, harbour wild natives, poised to attack, as a number of European diarists in both places suggest. Gender, class, and social status all shaped the colonists' worlds and experiences of homesickness.[51] In New Zealand, living near Christchurch, Sarah Courage spent her first Christmas in hot weather. In the evening she felt 'melancholy'. She and her husband 'thought and talked of Home, relations, and friends' and they wondered whether they would ever see them again. She wrote that they led a 'lonely life'.[52] Homesickness is also evident in Jane Oates' letters from New Zealand to her sister Margaret in the 1860s. Jane was living on the Wairarapa plains in the North Island in a 'whare [house] of split slabs and bark nailed onto the nicks to keep the wind out'. She was cold and ill in the winter; her husband had sold the 'clothes off his back to the natives for wheat'. It was eight years since she had seen her sister in England.[53]

By the 1860s, Edward Wilson was beginning to experience homesickness that was compounded by his apprehension of a long ship journey back to England. He wrote to his sister:

> You will say I am as unstable as the wind – first talking of coming Home then proposing to buy some land and live in the country – to tell you the real truth *I am tired of Melbourne very* – so I am unsettled and that's why I cannot fix myself – the voyage home is too long to be pleasant – and you see the difficulty I should have in settling in the country – I hope you will write to me and I trust I shall have more time on my hands now and if so I will try to improve it by writing better letters home.[54] (emphasis in the original)

Later communications repeat this fear of the journey back: he commented to his sister that the very thought of it rather 'frightened' him. Fear of the voyage home, as well as its prohibitive cost to many, was a common motif in contemporary writing.[55]

The challenges of colonial life were described well by Charles Holmes, who wrote a series of letters to his family in Cambridge, England,

between 1881 and 1884. Charles began his series from Rockhampton, Queensland, with great enthusiasm and hope for life in the new colonies. He was able to find employment as a wardsman in a hospital, and he commented that work for fellow emigrants seemed plentiful. He tried to persuade his sister Polly to come out to the colonies. Charles wrote more than once about the possibilities in the colonies if only the immigrant would allow him or herself to be open to them, but it was vital to remain 'steady', as he remarked in October of 1881: 'those who are steady are bound to do well, those who are not had better stay where they are'. Other 'new chums' expressed similar ideas about needing to stay strong in the face of challenges. Arthur Ball found the locals intimidating in Sydney in 1886. Looking for work with the other men at the ports near the emigrant ships was unnerving, as 'some of them spoke to me as if they could have swallowed me up knowing that I was a new arrival through my talk as the Colonials have a different way of speaking to the English'.[56]

By the 1890s, the economic downturn in the colonies was apparent everywhere. Sickness accompanied hard work and bouts of unemployment for some men like Thomas Dobeson in Sydney in the 1880s and 1890s. 'Thoroughly disheartened', Dobeson expressed his hatred of the 'cruel and selfish' people he met. He fell sick but could not afford a doctor. 'This seems to me a useless aimless sort of a life', he wrote, 'it is a life not worth having'. Little wonder that he reported the high rate of suicides in 1889 for its intrinsic curiosity value.[57] Like Dobeson, James Cox, who migrated to New Zealand from England in 1880, experienced colonial life as uncertain and, at times, depressing. Cox lived in the south-east of the North Island in the Wairarapa region where he worked as a casual labourer and eventually died a pauper.[58] Cox was reluctant to seek help for medical conditions, living in a 'regimen of self-denial', and experienced long periods of unemployment and idleness.[59] Both men, one in urban Sydney, the other among small towns in New Zealand, lived through difficult economic periods and struggled to maintain mental equilibrium.[60] Both expressed distrust of other people and found colonial life lonely. These examples suggest a world of experiences which can shed light on the way asylums functioned to alleviate social stress for families and for individuals.

## Families 'scattered about the colonies'

While some historical evidence shows that family networks across the colonies increased by the end of the nineteenth century, not all individuals

and families enjoyed harmonious relationships.[61] 'Isolation' could trigger mental breakdown, as Dr Manning suggested in Sydney in 1880. Although this was not confined to colonial life, he argued that mental breakdown was more pronounced in the colonies. 'Restlessness' seemed to be a feature of colonial life; itinerant workers, women and children left alone by men seeking work, and the lack of a 'system of family' all played their parts. There was, he thought, a marked tendency towards introspection, suspicion, distrust and selfishness among colonists who could not fall back on support from associates and family. Among men, mostly, this lonely life triggered the use of alcohol, and other abuses. Women, too, could experience quite 'terrible isolation' surrounded by both real and imagined dangers in out of the way places.[62] At Goodna in the 1880s, Maria S was 'dull', cried frequently and refused her food. Her husband suggested that isolation and loneliness had triggered her illness. He wrote to Dr Scholes in May 1885 from Brisbane explaining that she had lived a 'solitary life' while he was away from home seeking work: 'I had to leave home and was absent for weeks and months at a time that is the only way I can account for as being the cause of her complaint'.[63]

Dr Manning's interpretation of the problem of family dispersal and colonial isolation came as roughly two decades of asylum system management in the Australasian colonies was being assessed. However, these concerns were not new in 1880. Anxieties about the effects of colonial life had been expressed before. Amid fears about families as highly fractured entities in the colonies, asylum doctors also held the view that families might be a site of future recuperation for the insane, once patients had been released from its care. For instance, in 1873, Edward Paley, then Inspector of Lunatic Asylums for Victoria, wrote to the Colonial Secretary in London about his inspection of New Zealand lunatic asylums. Commenting on the possible construction of 'one or more Central asylums' in New Zealand, Paley argued that due to the distances between separate parts of the colony, it would not be entirely desirable. He wrote that

> The separation of patients from relations, friends, home and local interest, deprives them of a very powerful and important means of restoration to sound reason. The first approach of many insane persons to convalescence is indicated by a re-awakened anxiety about their homes and their belongings; and nothing so much tends to help their progress towards recovery as the presence and personal sympathy of relations or friends in whom they can have confidence and trust.[64]

The insane could be treated more effectively if families or friends were nearby. These comments reinforce Roy Porter's view that before the twentieth century the asylum aimed to support the family as the 'hegemonic' and 'paramount ... normalising agent'. '[E]mergent psychiatry', Porter argues, 'was designed to buttress the family unit'.[65] As later chapters of this book demonstrate, many letters between family members and the colonial institutions examined here indicate that families and the asylum shared ideas about the importance of 'the family' as a site for convalescence and recuperation. In the 1890s, to mitigate against some of these problems, Kenmore Hospital at Goulburn was built and opened for patients in the southern parts of New South Wales.[66]

However, it was not simply the presence of friends and family that mattered if the 'family' itself was to be an appropriate site for a patient's recovery. Family or home situations needed to be comfortable, and not in 'straitened circumstances' as Dr William Beattie Smith declared in 1903. By the early-twentieth century, the more careful articulation of the types of situation that would be most acceptable for home-based care revealed a stronger thesis about the constitution of families and forms of mental illness. In his Presidential address to a Victorian branch of the British Medical Association, Beattie Smith set out different ideas about institutional versus familial care. He suggested this in order to reinforce his call for changes to legislation in Victoria about private institutions and the housing of the insane more generally, but his observations signal the various tensions between families and institutions in the care of the insane.[67]

According to Beattie Smith, melancholic patients, particularly those suffering from prolonged depression, were best treated inside a hospital setting. Although forms of restraint were no longer in vogue, or recommended, the use of subtle restraint was necessary in such cases; here, Beattie Smith addressed concerns over suicidal impulses. The deluded also required 'asylum control', as he put it, because their delusions could harm families willing to care for them. Those suffering from alternate states of mania and depression were the most miserable, and lived between institutions and home; they were the original 'revolving-door' population of the insane. For those senile aged persons currently in the asylum, family-based care was recommended: but not if there was 'poverty and inconvenience, however dutiful the relatives'. Women diagnosed with puerperal insanity could remain at home, which was very desirable if possible. In some of these cases, the 'restoration to home surroundings shakes up the machinery', since the cause of this form of illness was seen as largely physiological. Interestingly, the need to

avoid a type of asylum state of mind was paramount for women in this category.[68]

Much of this evidence suggests that in the Australian colonies, as in other white settler colonies, institutions were increasingly seen as the appropriate places for the treatment of the mentally ill. Although families occupied an important role in the recovery of some patients, in many cases, which were more carefully delineated in the latter part of the period under investigation, institutions were more likely to be effective. In addition, some families failed, as Beattie Smith hinted, to provide a stable environment for the mentally ill through poverty or other perceived social weaknesses. These became the focus of parallel discussions in the late-nineteenth century, as the following section of the chapter explains.

## Heredity and degeneration

Jan Goldstein writes about the 'reconfiguration' of psychiatric thought in the mid-nineteenth century whereby psychiatrists began to theorise insanity as 'a product of degeneration' caused by a poor environment and nutrition, by alcohol abuse, and through heredity.[69] In the Australian context, Garton argues that theories about heredity and environmental influences shared common discursive threads from the late-nineteenth century, and that, therefore, later eugenics and mental hygiene movements must be seen in tandem.[70] In New Zealand, discourses of eugenics entered lay circles through debates about maternal and infant health in the early twentieth century. Frederick Truby King worried about 'physical degeneration' in the colony in the early years of the twentieth century. Maternal health was of special importance; women in cities, he suggested, needed fresh air and exercise, and their health determined their fitness to reproduce strong children.[71]

The story told about Lissie in the Introduction to this book, and other stories like it, also raised questions about heredity in families. White settler colonies faced a new challenge: how to protect the European population from mental deterioration in a new environment. In this context, health conditions in the colonies played a role in the perception of rates of insanity.[72] The same fears were articulated elsewhere, as Kelm shows for British Columbia; 'home life could be dangerous', the family a 'contaminated pool' of disease and possibly, vice.[73] Such fears were felt and expressed most keenly towards the end of the nineteenth century. In his lecture to delegates at the Melbourne Intercolonial Medical Congress in 1889, Dr John Springthorpe lingered over the concept of inheritance.

He argued that 'the new race' in colonial Victoria was descended from a healthy parentage, sound in bodily terms, but entirely 'neurotic' as evidenced by the prevalence of lunacy, epilepsy and diabetes.[74]

The major concern over racial health, and the preservation of the fitness of the predominantly white European population, was heredity and what was sometimes called weakness of mind. In 1885, Manning published an essay on heredity that presented data from the Hospital for the Insane at Newcastle, north of Sydney.[75] Manning selected eighty-two patients from twenty-one families among the population of those young imbecile and idiot children, where those parents and families were traceable and about whom some information could be collated. He expressed dismay that the twenty-one families he found all exhibited histories of 'insane relations' and that some continued to 'increase', meaning that more children of these reputedly unhealthy unions were being produced. As he sought information from the families involved, he found that only some could reflect on the possible causes of these conditions; some reasons offered by parents for their child's impairment, such as a mother falling from a horse during pregnancy, were dismissed as 'fanciful' by Manning, but at the same time indicate kinds of popular understanding about mental health and disability.[76]

Institutional committal papers for patients in all of the institutions in this study regularly recorded information about previous 'attacks' of mental breakdown and whether insanity ran in the family. Family visitors to the institutionalised were sometimes quietly observed: in Manning's opinion, they also frequently exhibited their own forms of neuroses.[77] In most cases, family members were quizzed about family health histories and provided details about insanity among extended family members. Although this information was difficult to verify, as Manning noted in 1885, and as Inspector of Asylums Frederick Skae had recognised in New Zealand in 1881, two themes are of special interest to the historian: the fact that it was sought, and the forms in which it came.[78]

Among the cases sampled for this study, several fell into Manning's categories of imbecile or idiot. David Wright points out in his study of intellectual disability in Britain that 'idiocy' was viewed as a chronic condition, and many persons labeled as idiots had been cared for at home for some time before committal.79 Patient case notes for chronic cases were often extremely sparse, suggesting that they were viewed nside the institutions as long-term and not worthy of careful observation. Particularly in the 1860s, cases of imbecile or idiot inmates at the Yarra Bend typically included fewer than two or three lines of

commentary over several years, as in Jane R's file: 'dirty habits ... in very delicate health: an imbecile, has to be fed'.80 Similarly, at Gladesville in 1889, 24-year-old John R was described as a congenital imbecile with a 'simple expression of face'. No other notes were made about his case.[81] The case of an 'idiot boy', William B at the Yarra Bend, presumably frustrated authorities. Aged 21, William had been a ward of the state under the Neglected and Criminal Children's Act (1864) and 'nothing was known about his antecedents' in 1896.[82]

These inmates were not always forgotten inside institutions. Catherine B, a young woman confined at Auckland in the 1890s, and described in her case record as a 'congenital idiot', received very little attention from medical observers. Like other patients labelled as 'imbecile' or 'idiot' in this period, her case was perhaps regarded as hopeless. She was the daughter of a farmer at Mahurangi, some distance north of Auckland, and their surname indicates that they were continental European immigrants. Her sister stated that she had been 'an idiot all her life'.[83] Her case record reveals very little about her family's interest in her. However, her father made significant attempts to contact the asylum. In September of 1892, he visited the asylum with details of his financial situation, to refute police accusations that he would 'not worry himself to get money' to cover the cost of her maintenance.[84] He pledged to make regular payments.[85] On the same occasion he met his daughter, referring to her in the Visitors' Book as 'Kitty'. He visited the asylum again later that year.[86] Kitty's case shows that the negative view of institutions towards these cases of patients with chronic and incurable conditions was not always accepted by the families who had cared for them prior to asylum committal.

In each of the institutions examined here, only a handful of patients suffering from what was most likely a psychiatric disorder was designated as hereditary mental illness, but more were noted in passing as possessing family histories of insanity. Inherited insanity could be triggered by other problems: one woman was admitted to the Yarra Bend in 1898 suffering from delusions and melancholy, which was identified as being related to family bereavements, but there was also a note that her mother had spent time at the same institution.[87] As the next chapter demonstrates, clinical case records drew heavily upon family observations of the insane at the time of committal, and some correspondence between families and institutions shows that the gathering of information about patients was continued over the time of hospialization. Two stories illustrate some of the practices and frustrations experienced in the collection of family data at Gladesville. In the case of

John R,admitted to Gladesville in 1879, casenotes and committal papers indicate that he had been an inmate at Gladesville ten years earlier. He was known to have had two attacks of insanity labelled 'mania' in 1879. Described as a thin man, of medium height, and with brown hair and a beard, he was brought in 'gesticulating wildly', 'unsteady', and in the opinion of the notetaker, 'utterly lost mentally'. His illness was pronounced hereditary: 'He has been in this institution before, and in similar places (eg at Woogaroo) and there is a history of insanity in the family, his father committed suicide'. John made steps towards recovery and was discharged in 1880.[88]

While John's case was relatively straightforward, a second illustrates the difficulties of gathering family information. Young Edith C, aged 21, was taken to Gladesville in 1882. Diagnosed as melancholic, Edith spoke quietly and rationally, but was a mystery to police and to the asylum authorities. In one story, she had run away from her friends, and could not explain her identity. In another, she had become lost in Sydney while living with an uncle, and was twice picked up by police. In their efforts to find her family, staff at Gladesville noted that Edith's grandfather was insane. But it emerged later that the name she gave was most likely false; the hospital placed an advertisement in the press and 'Edith' was identified by a member of the public as 'Annie'. After her discharge, the young woman married a former inmate. The notes read: 'it will be interesting to watch the progeny (if any) of this marriage'.[89] In his essay, Manning's foreshadowed later eugenic discourse when he commented on the peculiar way in which neurotic and insane people were drawn to each other and often married. Their 'peculiar sympathy' was not as morally offensive as consanguineous marriage, but it tended to increase the likelihood of 'tainted' offspring.[90]

At Auckland, patient casebooks set aside a space for a statement of 'history', which was usually taken from a family member. Annie E was 32 when she was admitted to Auckland Mental Hospital in 1908. Her melancholia had been haunting her for only a week, but since two other family members had been intitutionalised, and she had had a previous episode of hospitalisation, meant that her family acted swiftly to have her institutionalised. Her father's statement summarised her life: she was born in Greymouth, New Zealand, she had originally been 'fairly clever' and in possession of a good memory. She had no vices, and was not of either strong or weak will. While her life had not been solitary, she was troubled by bad legs, and had been 'operated on' in the past. In her twenties she had been hospitalised in Wellington for a similar attack. Her sister noted that two

family members, including her brother, had also been inside mental institutions.[91]

Families of the insane were also interested to locate the causes of insanity and breakdown, often entering into a dialogue with institutional authorities about heredity. Geoffrey Reaume asserts that in Canada, families made links between insanity and heredity, and he and other scholars emphasise the guilt and shame families associated with these forms of insanity.[92] However, some of the evidence from the institutional records suggests that families cooperated with medical authorities when questions about heredity were posed. James G's wife Annie wrote to Goodna in 1867 explaining that her husband's father had been four times in an asylum in England. She thought he had died in an institution in 1865.[93] At the Yarra Bend, one patient's wife confessed in her letter that her own family had experienced brain disease and illness, but she could not comment on her husband's family.[94] Letters to the Auckland Mental Hospital from one family in the early twentieth century made an attempt to negotiate the release of John A, a man who was said to be mentally 'naturally weak' from birth, but a 'manly chap' in physical terms, and capable of working. The letters indicate that family members had ongoing conversations with different medical personnel about his 'family weakness'; there was a shared understanding of his condition, but disagreement about where John could be best cared for. 'He won't never be any better than he is', wrote John's brother-in-law, 'because he was always funny, and madness must run in the family on the Maori side. ... It troubles me a lot but it cant be helped I suppose. It is a funny thing that madness runs in familys' (sic).[95] The reference to the 'Maori side' of the family opens up another theme in the discussion around heredity that is further explored later in this chapter, but here, the knowledge of a family inheritance is critical; mental weakness in families worried medical personnel and colonists alike, to the extent that, as Skae claimed, 'hereditary taint' was denied by some families.[96]

Being 'strong and sound' were seen as guaranteed prerequisites for success in colonial life. The epithets were commonly used, as the following example shows. Henry G, who died at Goodna in October 1890, was the subject of a discussion between his sister and Dr Scholes in April that year. She wrote anxiously from Townsville:

> You no doubt will remember his poor mother Sarah Jane G. She acted in the same way and my brother's actions were simply those of his mother's repeated even to the smallest detail. This is what causes us

> all so much uneasiness fearing that it is hereditary and I would like you to give me your candid opinions on the case.[97]

Henry's death was caused by 'congestion of the brain', and it is likely that he and his mother shared a form of hereditary brain disease marked by a rapid deterioration and death. The institution noted that his delusions involved his belief that he came from 'the strongest and soundest family in Queensland'.[98]

What frustrated Manning and his contemporaries was the relative youth of the colonial 'family tree'. It was not yet fully grown, and it depended upon the oldest inhabitants of a society and their recollections.[99] This was a familiar refrain from Manning, who had argued five years earlier that it was far easier to study patterns of heredity in England, Scotland, Ireland, and parts of Europe.[100] The darker meanings in Manning's writings, like those of his contemporaries, hinted at the possible future necessity of population controls and the segregation of the mentally unfit.[101] In New Zealand, institutional authorities held suspicions about the rates of heredity among the population of the mentally ill; medical superintendents thought it was likely that more patients had hereditary causes for mental disease than the institutions had been able to determine in the 1880s.[102]

Arguments about mental deficiency and mental hygiene intersected with other public health measures from the late-nineteenth century. In New Zealand, legislation passed in 1911 formed a new approach to issues of the care and control of those deemed 'mentally deficient'.[103] The Mental Defectives Act (1911) highlighted 'newly discovered categories of deficiency' being used inside the institutions, and reinforced anxieties about heredity for families who had struggled to care for 'defective' members at home.[104] Little research exists to show how the legislation worked in practice. However, the new language of classification was refined over time by medical practitioners, and relationships between families and institutions also changed, as a study of patients at Tokanui Mental Hospital in New Zealand's North Island between 1912 and 1935 explains.[105]

## Families and hospitals for the insane

As later chapters of this book demonstrate, families took a range of forms, and so did their relationships with colonial institutions. They made use of institutions for manifold reasons, and with a number of different outcomes. Families may also have been useful in containing

'madness' or preventing institutionalisation. Garton's study of New South Wales shows that those committed to asylums were often single, without many family connections, and therefore vulnerable to police arrest.[106] Certainly, institutional records reveal many inmates without families, or inmates whose families disowned them, pointing to what Garton argues is evidence that colonial families were not marked by strong ties. The halting letter of Minnie H regarding her 23-year-old son James, confined at Goodna, explains that she 'only reared him', she had no contact with his father, and that she had no money for his support. She ended her letter 'I am very sorry that he is there but I can't help him'.[107] In the case of heredity, asylum doctors were sometimes making guesses about patterns of insanity in families that could equally have been ascribed to social conditions and difficult life experiences in the colony. Margaret D, an Irish servant aged 36 and unmarried, very plausibly claimed 'brutal ill treatment' by other people in 1883 when admitted, but was described as having suffered from 'marked delusional melancholia apparently of long standing', and to make matters worse, had a sister who was insane and housed in Parramatta asylum.[108] There was little chance of a reinterpretation of her condition and she was transferred to another institution in 1902.

Yet married patients, adult children and those with extended family did appear in asylums. In many instances, families became unable to continue to care for very sick relatives over longer periods of time, either through economic pressures, or because they feared violent or very disturbing behaviours.[109] Although I am reading patient cases and other institutional sources for their accounts of family relationships, it is useful to provide a broad indication of the patterns across the cases I have located. Specifically, the cases of patients and their families sampled for this research highlight some relevant general demographic aspects of the colonial institutions.[110] The majority of patients in the sample were born in the colonies. Asylum statistics reveal that institutions confined larger numbers of colonial-born in the later decades of the period under investigation, with the exception of Queensland and New Zealand.[111] Numbers of men and women in the sample are roughly equal, with more men committed to Auckland and Goodna than to Gladesville and the Yarra Bend. Among the patients sampled from all the institutions, more women patients were married and widowed, while more men were single. These overall characteristics accord with the findings of asylum inspectors in their annual reports, although historians have correctly emphasised that colonial asylums tended to house more single men due to population imbalances throughout the nineteenth century.[112] Most

had their religious affiliation noted as Church of England with the next largest group of patients named as Roman Catholics. Most were aged between 20 and 40, and most were suffering from mania and/or melancholia. The vast majority of patients were white Europeans. Most people were brought to institutions by relatives or police, and where the police were involved, it was sometimes following a request by the family or other persons close to the patient.

**Indigenous inmates and families**

This chapter has thus far focused on the anxieties of white colonists in the settler societies of the Australian colonies and New Zealand, largely because, as Chapter 1 explained, the major populations of the insane were Europeans. The 'family', too, as the institutions and medical experts imagined it, was a European concept. However, the stories and lives of indigenous patients and families in settler societies, and the types of behaviours noticed in indigenous community contexts, are also important aspects of the discussion. For the most part, these histories remain hidden from view. Newspaper reports that mention aboriginal people in relation to the asylum are rare. In a 'very unusual occurrence', as the Victorian *Argus* newspaper remarked, an aboriginal woman of the 'Mount Emu Tribe' suffering from lunacy was examined by two police at Smythesdale in Victoria in 1874. Rather than following the advice that she be committed to an asylum, a man who knew of her people decided it would be better for her to be sent to Corranderk Station 'where she would be well taken care of'.[113] In New Zealand, cases of Maori insanity reported in newspapers show that Maori reportedly recognized signs of 'mental aberration' in their own societies; one man hanged himself in his whare (house) at Russell in 1883, while another man set fire to his whare at Te Puke in the North Island and was arrested by police and taken to Auckland for medical examination.[114]

As Chapter 1 suggested, the cases of aboriginal patients at Gladesville presented by Manning in 1889 reveal little about indigenous families, except to suggest that by this stage of the colonising process, contemporaries noted that aboriginal peoples came to the institutions after contact with the colonisers, indicating separation from traditional family groups. In the small number of cases where patients recovered and could be discharged, their release was postponed due to the difficulty of finding them a home.[115] Later studies of the aboriginal insane, conducted in the 1920s, show that their presence inside psychiatric institutions was still a relative oddity. Medical cases and writings focused on their racial characteristics and tendencies, refracted through a European

lens. Cases reported to the Australasian Medical Congress in 1889 and later published in the *Medical Journal of Australia* also reveal that indigenous Australians came into contact with medical and legal authorities as damaged peoples, both physically and mentally sick, and in extreme states of poverty. Psychiatrist John Bostock sees this as an opportunity to explore evolutionary psychiatry, and writes that 'contact with civilisation, phthisis and other diseases, mixed breeding and general racial decay' produced the sad cases witnessed by the medical profession.[116]

In New Zealand, at Auckland, Maori patients' experiences reveal that many Maori reacted poorly to the asylum as a European institution and place of confinement. Lorelle Burke shows how confined Maori displayed evidence of 'cultural displacement', including their physical dislocation and also formal alienation from land, and had little contact with family or tribal groups. Most of the seventy-two Maori who were committed to Auckland Mental Hospital between 1860 and 1900 were identified as suffering from mania, but the 'exciting cause', information usually provided by a family member, was rarely recorded. Only two of the patients had their tribal affiliation mentioned, suggesting not only that Maori families were rarely involved in committal, but also that European authorities had a poor grasp of the crucial meanings of these collective identities for Maori themselves.[117] Cases of Maori inmates at Auckland illustrate these points.

The stories of three Maori inmates, all of advanced age, highlight the changed conditions for Maori following colonisation and white settlement. Mereana H was admitted to Auckland aged 76 in 1898 from Maketu, west of Tauranga, in the Bay of Plenty. Mrs Emily Way, a European woman, provided information about Mereana's insanity, telling the doctors that her family had known the patient for fifty years.[118] In 1908, a male Maori named 'K', said to be aged 70, was committed with the help of police, but members of his own community reported he had been frightening women 'by shaking a stick at them'. It is possible that K was causing tensions within his tribal setting. He had once been a great orator, as his committal papers noted. Yet he had also been accused of 'witchcraft' by other Maori. K seemed to have crossed the boundaries of acceptability in some fashion, causing alarm and distress to his own people.[119] This was also the year of the enactment of the Tohunga Suppression Act (1907) which called for all Tohunga (experts) to be prosecuted for practising illegal forms of medicine.[120] European anxiety about 'quackery' and superstition among Maori, and among some Europeans, including medical 'quacks', drove the measures to control the Tohunga; but unsurprisingly, the circulation of political ideas

about Maori sometimes also found expression through the Tohunga in their communities, making the Tohunga a political threat to colonists.

In a similar vein, the political meanings of some Maori behaviours possibly attracted the attentions of white settlers and police, as well as posing a threat to the equilibrium of tribal groups under pressure as a result of colonisation. Hakina H was a Maori Chief and a professed Catholic who troubled the settlers by 'sleeping in outhouses, pulling up turnips' and wandering about, unable to be contained by his relatives. Some of his thoughts, said to be delusions, displayed open political resistance to settlers; not entirely wrong, he believed the land belonged to him and that it was being held by Europeans.[121]

## Conclusions

Dr Manning was optimistic about admission rates in the early 1880s. His role in the development of lunacy legislation in the late 1870s and 1880s led to new practices regarding the certification of the insane, which had eased the pressure on asylum committals. When considered in relation to the growing population of New South Wales, overall insanity admissions were decreasing, pointing to what Manning saw as both a decline in the incidence of insanity in the population and the increased efficacy of asylum treatments.[122] At Auckland, rates of committal per head of population also slowed between 1871 and 1911.[123] Yet the patient populations in both places rose by the 1890s. In Sydney and New South Wales, asylum population increases gave both Manning and his successor reason to worry that mental health problems were increasing in the population rather than being conquered.[124] At Auckland, the population increased from 163 in 1876, to 770 by 1910, a rise which mirrored the growth in the national asylum population over the same period.[125]

Manning was interested in mental health epidemiology. He wanted to protect the colonial population's mental health, and his constant attention was on the 'prevention' of insanity. In addition, the asylum's intervention into the health of the population through its reporting signalled a contribution to the governing of colonial society. Despite views that colonial society, a less 'civilised' version of society in the old countries, might be more disposed to problems like insanity, there were also widely held views about the potential for colonial society to escape such problems. These ideas were contradicted in the early-twentieth century, as Garton suggests, when the asylum population in New South Wales continued to grow. Asylum inspectors tracked the asylum population

and its diseases, seeking ever more precise classifications for an asylum epidemiology. In doing so, this structural separation between families and the asylum, through the institution's ordering of categories, effected meanings for colonial families.

The chapter has described the investigations by colonial administrators and medical personnel into the patients they saw filling the wards of hospitals for the insane. Authorities perceived the roles of families in relation to mental breakdown as both limited and instrumental to the causes and treatments of hospital inmates. The complex arguments made by institutional authorities at different points about families and their roles show that the 'colonial family' was itself being defined over time and in relation to new ideas about insanity and its cures. Some families remained elusive and problematic to define, including the families of poor and indigenous inmates, and those with apparent biological flaws. In the following chapter, the processes through which a range of families came into contact with colonial institutions, and engaged in dialogue with institutional personnel, further explains the evolution of the relationship between the families of the insane and their doctors.

# 3
# Families and the Language of Insanity

In January of 1894, Gippsland settler and farmer Catherine Currie wrote in her diary:

> Oh I am so disappointed in my children. I thought they could not help loving their Mother, but I have never had their respect since their Father shut me up in a Lunatic Assylum (sic). That was a Dreadful misfortune but it was not his fault as he only did as he was advised by the Stupid people I had here. I remember it all *so well so well* that morning. They took me away Saturday morning 17 Sept 1881. I only begged to be put in a nice clean bed, I was better if they could have seen it. I had been ill, they nursed me (*two* nights) then took me off to a Lunatic Assylum tied up in an old corn sack, is it any wonder that I raved. O I shall write it all some day when I have time.[1] (emphasis in the original)

Although Catherine was never able to write a full account of her periods of institutionalisation at the Yarra Bend Asylum in Melbourne, Victoria, her commentary remains an important and rare personal account of mental breakdown in the period. While she claims in the diary entry above to have been badly treated, the evidence suggests that Catherine's family looked out for her; she suffered at least two major episodes of mental illness, the first in the early 1880s. She wrote about that first experience just as the second episode was about to hit her, and she was again hospitalised in 1895. The memory of being transported in the 'old corn sack' was no exaggeration. In Figure 3.1, a sketch in the *Police News* depicts a 'wife' being taken to the asylum in the 1870s in just such a sack, being tied in by police, who were often asked to assist in such cases. The woman in the newspaper sketch was


*Figure 3.1* 'Sacking' a Wife at Cape Schanck, *Police News*, 23 June 1877, Reproduced with the permission of the Rare Books Collection, State Library of Victoria, Australia.

later proved to be 'sane', but Catherine was not. Her breakdowns were precipitated by the death by drowning of one child, which had followed the earlier death of her first daughter; and later, her feelings of anxiety about family, farm life in Gippsland, and probably feelings of depression and worthlessness which began when she realised she had been so difficult. These feelings transformed into anger over time. Catherine's family had made an attempt to care for her, as many other families, faced with the challenges posed by mental distress, also did. Her husband and children called upon local doctors who would have been aware of the work of doctors at the Yarra Bend and at other colonial asylums. In 1895, Catherine was taken to a local hotel at Drouin and examined by two doctors who followed the legal procedures and took accounts of her illness from family members; the paperwork was complete, and on the same day, Catherine was taken to Melbourne and committed.[2]

Catherine's story reminds us of the value of a personal account of madness. Despite the suggestions of international historians in the field, including Nancy Tomes, who maintains that to compare personal responses to 'painful experiences such as illness and death over time' might enable historians to 'detect important shifts in the language and symbols ... used to discuss emotional experiences', few scholars have

attempted to write about mental health in this period using autobiographical sources, perhaps because scholarship in this area has focused to a very large extent on archival sources produced by institutions.[3] In addition, as my research indicates, few personal accounts of mental breakdown exist or have survived in public archival collections. Moreover, public asylums or hospitals for the insane did in fact create populations of the 'mad' and took over the management of a language of mental illness by the late nineteenth century. Therefore, asylum patient case records, as this chapter explores, remain an important source of information about mental breakdown or distress before hospital committal. In particular, the chapter seeks to add to and extend existing studies of lay attitudes to madness, still important to determining the reception of professional ideas about mental illness in the nineteenth century, as Wright argues.[4] As well as this, the chapter highlights Tomes' salient points about the very function of psychiatric institutions in this period; patient case notes and committal documents tell historians a great deal about how families responded to insanity, and how they interacted with and perceived the institutions which contained it.[5] Implicitly, responses differed across class and gender lines, as the chapter describes.

This chapter discusses the interplay between 'lay' and institutional accounts of mental breakdown or insanity, and the way knowledge of mental breakdown and a language surrounding it was present among the families of the insane at the time of asylum committal, as medical experts themselves suggested. Ideas about what constituted 'madness', and how to describe it, circulated among colonists from the earliest years of colonial settlement. Knowledge or suspicion of mental illness was present in the general community, along with both empathy and anxiety about such conditions. On rare occasions, some people who were neither medical practitioners nor journalists ventured inside institutions and witnessed the insane firsthand.[6] Charles Rosenberg asserts that historians need to consider two interrelated problems: 'the process of disease definitions' and their consequences in the lives of individuals and in the structuring of medical care.[7] Rosenberg reminds historians of the role played by laypersons 'in shaping the total experience of sickness' and also that the diagnosis is itself a 'key event' in that experience.[8] Roy Porter, too, establishes a crucial research agenda for historians interested in patients, suggesting that in the past, people were engaged in 'positive health' and 'routine health maintenance'; in addition, historians ought not to 'underestimate the role of the family in sickness care'.[9]

At the time of legal committal or certification, persons suspected as insane were described by those close to them; most often, family members, but sometimes, employers or neighbours. These descriptions were noted in committal papers and later transferred to patient case notes in many instances. Such observations provide rich evidence of the ways that insanity was understood by a lay population. There is a complex relationship between these 'indications of insanity', usually described outside the asylum but filtered to the asylum via the medical certificate, and the medical diagnosis made inside asylum case papers. Nancy Theriot posits that 'the medical discourse elaborating the theory contained a chorus of professional, patient, and patient-advocate voices, with the professionals taking the other two perspectives as the raw material, the empirical basis of diagnosis'.[10] Theriot's perceptive work has been extended in a range of contexts, and especially by historians of psychiatry. Historians including James Moran make sense of similar descriptions in their specific contexts.[11] For instance, drawing upon legal records produced in a slightly earlier period in New Jersey, Moran plots an epidemiology of the asylum using lay indications by examining the large number of cases involving delusions. He is also interested in the number of cases where 'incoherence of speech' is cited as the major sign of insanity.[12] Others privilege the way that institutional practices were changing in the nineteenth century. Cheryl Krasnick Warsh suggests that at the Canadian Homewood Retreat, by the early twentieth century, 'innovations in diagnosis' allowed physicians to refine their classifications of insanity; interviews with patients 'supplanted vague judgements based upon third-hand information'.[13] However, Warsh does not examine the way that lay language intruded into the clinical diagnoses made by asylum physicians. The present chapter takes up this question. It explores the language used by family members about individuals suffering mental disorders and the way their understandings were incorporated into clinical case notes by medical professionals.

Colonial institutional records support these historical interpretations of the way that families, medical personnel and patients all interacted to produce diagnoses in other contexts. This chapter also asserts, then, that like their British, American and Canadian counterparts, colonial institutions were also involved in the work of making a language about insanity. Dr Manning reported in 1881 that insanity was not necessarily on the increase in New South Wales; instead, people were becoming more aware of asylums as 'fit homes for the perturbed or weak in intellect'. At the same time, he suggested, there had been a broadening of standards of behavioural change; people were more inclined to notice

the behaviour of others.[14] Yet as this chapter will show, Manning also cautioned against accepting every family's version of events or their judgements of 'odd' behaviour, and he worried that some agencies of the law, too, were prone to 'exaggeration' in the identification of mental distress or disorder. After all, he said, not all marriages were happy, but not all those squabbling were mad.[15] His reluctance to accept all intimate views of prospective patients suggests that a subtle shift was taking place in the period; medical experts with experience in observing the insane were beginning to command the art of diagnosis inside the institutions. Akihito Suzuki argues that at Bethlem Hospital in London, under the regime of one medical superintendent in the 1850s, this transition was evident in the practice of obtaining testimonies from patients themselves.[16] In any case, as we saw in Chapter 2, the practical difficulty in collecting background histories of patients from families in the colonies remained. This chapter investigates these issues of lay and clinical diagnosis by first looking at the different places for the dissemination of a language of mental disorder, beginning with public discussion in newspapers, medical reports and domestic medical books. It then moves into the institutional records themselves, to show how popular understandings of insanity intersected with professional language used in the institutions of the period.

## Popular and expert understandings of madness

Newspapers played a role in creating common understandings of colonial cultures of health and well-being. Newspapers peddled sometimes lurid accounts of mental disorder, all of which helped to circulate a language of illness which seeped into private correspondence and journal writing.[17] These included reports of persons suffering from 'weak intellect' and 'despondency', women 'coolly' being left at the door of the hospital for asylum committal, accounts of 'unpleasantness at home' which led to a wife being brought up on a lunacy charge, in a drawn-out court case involving marital neglect, institutional committal and claims of wrongful confinement. Violent public derangement was also reported.[18] Therefore, just as private accounts of the problems of colonial life, such as that expressed in Catherine Currie's family diary, circulated a language of mental instability, so too did public newspaper accounts contribute to wider understandings of insanity. If newspapers were 'significant forces in achieving social cohesion and a distinctive "countrymindedness" ', they also promoted the anxieties about and dangers of social dislocation and fractured families.[19] The colourful

reports from city courts perhaps also underlined the fears of individuals who devoured news and also sent it home, although some readers were more cynical, for instance, Edward Wilson, who wrote in a letter in 1853 that finding the 'truth' in newspapers was 'like looking for a needle', describing the two Melbourne dailies, the *Argus* and the *Morning Herald*, as 'trash'.[20]

Charles Holmes' belief that 'steadiness' was vital to survival in the colonies was undoubtedly a view shared by a number of men, struggling to stay afloat and maintain their masculinity through work and family responsibilities.[21] It was no good being weak-minded. Young men who arrived 'without colonial experience and without sufficient sense', as the *Argus* reported in 1873, could get into scrapes, and were sometimes foolish and eccentric. Similar reports of new arrivals suffering from lunacy being let loose on unsuspecting cities were almost as worrying as concerns over infectious disease.[22] The term 'epidemic' was used in relation to reported cases of insanity in the *Auckland Weekly News* in 1883.[23] The *New Zealand Herald*, too, ran advice columns about insanity, advising readers as to its causes, which ranged from heredity and 'abuse of alcoholic excess' to 'prolonged anxiety'.[24]

The newspapers also reported on topics of interest to the community, such as the ordinary monthly meeting of the Medical Society of Victoria in 1873, where Dr Patrick Smith, then Resident Medical Officer at the Yarra Bend, spoke about the symptoms of insanity. The *Argus* noted that Smith's paper was 'exceedingly comprehensive and carefully written' and that it advocated that insanity was 'curable'.[25] This report may have stimulated some readers to seek out the transcript of Smith's paper in the *Australian Medical Journal* at Victoria's Public Library in the same month. Smith was concerned to show that insanity was an illness with symptoms, much like other illnesses, and that sufferers, and their families, could possibly discern it by knowing about its indications: among these, sleeplessness, changes in mood, headaches and strange sensations.

Like Dr Manning and other physicians, Smith advocated early diagnosis and treatment of insanity to attain the best outcomes for patients and their families. Insanity, he argued, did not usually strike someone overnight, but rather announced itself through a series of 'premonitory symptoms'. Based on a study of patients admitted to the Yarra Bend, Smith found that family members had often noticed the changed behaviours of persons who were later found to be insane, and had seen these changes emerge over long periods, up to a year in some instances. The key to 'recovery', Smith suggested, was treatment at an early stage of the mental disease.[26]

Health books also contained information about the signs and symptoms of insanity. In Australia and New Zealand, archival research shows that many settlers used Letts diaries published by Cassell's which contained lists of useful publications for colonists including a selection of health books, among them, Cassell's *The Book of Health*.[27] We can reasonably assume that among those who could afford them, and could read, these books were consumed and consulted. Their contents were wide-ranging. For example, *Brett's Colonists' Guide and Cyclopedia of Useful Knowledge*, published in Auckland in 1883. *Brett's* covered farming and horticulture, livestock, wine making and climate, and contained a section titled 'The Family Doctor' and another called 'Maori Pharmacopoeia'.[28] Although *Brett's Colonists' Guide* did not deal specifically with insanity, it included sections on 'hysterics' and sleeplessness. George Fullerton's *The Family Medical Guide,* first published in Sydney in 1870, was into its eighth edition in 1889 and contained several pages about insanity, including definitions of mania and monomania. The guide cautioned that the insane sometimes had great 'cunning' and could disguise their feelings, making the diagnosis of 'insanity' difficult.[29] Fullerton was a Brisbane doctor who understood the challenges which faced colonists who lived in remote locations, or in towns yet to produce sufficient networks of family support.[30] Another work especially designed for the 'Australian and colonial settlers', and published in both London and Sydney, was *Everybody's Medical Adviser.* This work, which discussed insanity over six pages and used and explained medical terms, included legal advice about institutional committals based on the British legal model, but contained enough legal similarities to be useful beyond Britain.[31]

Settlers developed a 'vocabulary' of health in the Australian colonies and in New Zealand, as both Judith Raftery and Barbara Brookes argue.[32] Many people were what Roy Porter might call 'articulate' sufferers, and some had lay knowledge of medical techniques and contemporary treatments, as well as harbouring their own theories and giving their own meanings to illness experiences. The spread of this language over the period sheds some light on the range of colloquial expressions used to describe insanity. In 1836, Anne Wilson, living near Thames in New Zealand, found her Maori nursemaid, Totoia, 'gone mad'; she was 'quite wild'.[33] Ada the Cambridge, the wife of a clergyman in Victoria, described the fate of the wife of another 'Bush clergyman' in the 1870s: the woman was 'run down and worn out' and taken to an asylum after going 'mad upon the spot'.[34] Newspapers used terms such as 'driven insane', 'suffering lunacy', 'deranged', 'suffers from mania', 'unsound

mind', 'insane condition', 'judged insane', 'becomes mad', 'religious fanatic', 'demented state' and 'mental aberration', among other terms.[35]

Catherine Currie's illness was reported in the local newspaper in more compassionate terms than most similar reports, but was probably no less shameful for the family. The *Warragul Guardian* reminded readers that Currie's child had died several months before, thus attributing her 'acute mania' and 'mental anguish' to bereavement and loss. The report also described her embarrassment at losing a signed cheque, and at not being able to stop it at the bank, speculating that the 'prospect of having to tell her husband that she had been careless enough to lose the cheque troubled her so much that her mind became deranged'. The *Guardian* was hopeful of her recovery.[36] That Currie was hospitalised was newsworthy; the public sympathy for her case was both unusual and remarkable for its openness.[37] This chapter interrogates the way that patient case notes also reveal the presence of a popular language of insanity, even while this language was being performed in a medical context.

**Legal processes**

In each of the four colonies dealt with in the present study, committal to a hospital for the insane was governed by legislation requiring medical certification by two medical practitioners and a Justice of the Peace. Requests for certification could be made by the relatives and friends of patients, or by the police. These laws were deemed by colonial medical practitioners to be appropriate and 'well abreast of the time'.[38] Doctors who conducted examinations and signed certificates were required to be 'independent and unassociated persons', meaning that families could not abuse the system by contacting doctors who were relatives. 'Imperfect certificates' were rejected, and patients could not be detained if a further medical report remained unwritten in the early period of confinement.[39] Medical practitioners were reminded of their roles and duties with respect to lunacy certification in official publications such as the *Australian Medical Journal* and the official medical directory for Australasia, which included New Zealand and the Pacific. For example, Patrick Smith designed his 'Hints on the Giving of Certificates of Lunacy' for medical practitioners, which was published over three issues of the medical journal in 1873–74.[40] *The Australasian Medical Directory* appended a 'Remembrancer for the Signing of Certificates in Lunacy' which covered all the colonies explored here, also highlighting differences between places, showing the extent of the awareness about trans-colonial insanity provisions.[41]

Nonetheless, professional anxieties about practices of legal certification occasionally arose among medical personnel in the colonies. Smith's 'Hints' provided examples of specific situations and legal precedents to aid physicians who were confused or worried about certification. He suggested that doctors use common sense in determining the effects and outcomes of certification in some cases, showing that families did often care for long-term chronic insane at home if they were able. Smith's advice also included commentary on common diagnoses such as melancholia, mania and dementia.[42] In 1883, Manning claimed that medical practitioners were well-informed about medical certificates of insanity.[43] In New Zealand, similar concerns meant that case book entries were careful to mention patients whose committal processes had been unusual, as in the case of Margaret C, whose certificate was too 'informal' to accept, so she was taken before a judge in 1891.[44]

The case of one man who claimed he had been wrongly confined in Victoria, as reported in the *Australasian Medical Gazette* in 1882, raised fears about legislation, medical practice and the very facts of insanity.[45] William Smith was certified as insane by Dr Iffla who interviewed the patient, his family and neighbours. Smith's wife was alarmed at her husband's jealousy of her, and specifically his claim that she was acting improperly with the butcher, Mr Strugnell, so she called upon Dr Iffla to examine her husband. Without the legal case taken against Dr Iffla which followed, the detailed testimony of witnesses would most likely have never been recorded. Smith's neighbour Rachel Appleby testified that Smith 'used to walk up and down before her place like a caged tiger, stamping his stick and rolling his eyes, this continuing week after week'. Another neighbour, George Potts, 'stated that Smith came to him in a terribly excited state, saying that Strugnell was not fit to live'.[46] Medical personnel also gave evidence about the facts of insanity for both the plaintiff and the defence cases before a jury, which eventually awarded in favour of the plaintiff. The *Gazette* worried that because the case and the indications of insanity themselves were put before a jury to decide the professional judgement of the doctor had been undermined.

By 1903, when Dr William Beattie Smith gave his Presidential Address to a Victorian branch of the British Medical Association, 'deciding ... what patients should be sent to asylums, and what patients should not' was still vitally important to the profession.[47] The knowledge required for diagnosis had become more complex over time, and institutions had also changed, having been placed under pressure to relieve overcrowding during the nineteenth century as the purpose-built structures creaked with the strain of population increases.

## Marginal notes: family observations in patient case notes

George, a clerk from Lane Cove, was admitted to Gladesville, probably by his mother with the co-operation of police, in November of 1885. His mother supplied some observations about his condition: he had been 'depressed in spirits believed his mother had treated him badly and threatened to kill her and that people wanted to kill him and that his father's spirit haunted him'. From this brief set of observations, his behaviour on admission, and, in his case, an earlier admission to the asylum, the psychopathological label 'Mania' was applied to him and he stayed in the asylum for almost a year. He made comments about his own experiences soon after admission which were also recorded in the case papers; it appeared he was aware he had been 'ill using' his mother (which probably means he had been physically violent towards her), he had done so 'because he had not anything better to do and because the people in his neighbourhood disliked him'. In fact, he came to prefer the asylum to being at home.[48]

This short history of George and his experiences is intriguing for a range of reasons. Here, the focus is on the marginal notes, taken from the medical certificate, which appear in different forms in the asylum patient case notes. These notes constitute a set of observations of the patient from the families' or friends' points of view. George, we learn, was 'depressed in spirits'. But how usual was the lay description 'depressed in spirits' at this time? More importantly, what do such descriptions tell us about the way that medical diagnoses incorporated 'familial definitions' of insanity, and what do they tell us about the 'interplay between medicine and society'?[49]

During the nineteenth century, the asylum became the dominant site of theorizing about the causes and cures of insanity. It was here that doctors 'could observe the insane, note their symptoms, record successful remedies and theorise about causes'.[50] Stephen Garton writes that in the mid-nineteenth century in New South Wales the causes of insanity were far from fixed, and that accepted causes, including alcohol abuse, grief, over work, poverty, urban life and heredity, were reinterpreted and extended in the colonial context. By the 1870s, colonial causes of insanity in Australian colonies included 'anxiety', 'isolation' and 'sunstroke'.[51] The main diagnostic labels for forms of 'mental disorder' applied in institutions in New South Wales (as in other colonies in the period) fell into four categories: Congenital or Infantile Mental Deficiency; Mania; Melancholia; and Dementia. There were degrees of each, for instance, Mania Acute, Melancholic Mania, Senile Dementia.[52]

What historian of psychiatry German Berrios calls the 'common language of description' of mental disorders was developed by professionals over the course of the nineteenth century.[53] Berrios sees the nineteenth century as the period in which a 'descriptive psychopathology' became evident in patient case notes. It was this period that marked a crucial moment in the development of a diagnostic language. Moreover, the subjective experiences of sufferers became part of the diagnosis.[54] James Moran prefers to read lay observations of the alleged insane as 'indications' of insanity rather than 'symptoms'. As Moran says, there is a problem using the term 'symptom' for these 'indications' or descriptions; he says they are not 'diagnostic' in the medical sense, and that they do not contribute to what Berrios calls the 'common language of description' of mental disorders.[55] Family members did not routinely use the language of 'descriptive psychopathology', although Moran comments that his sources sometimes reveal that language families used to describe what they saw was influenced by medical terminology.[56] As Berrios has shown, this 'descriptive psychopathology' was a professional language used to signal the treatment and prognosis of a patient. Berrios can tell us a great deal about this system of language and how it developed over time in his comprehensive study aimed at clinicians, but he does not tell us about either the language used by families, or about the perceived 'causes' that were seen to underpin and shape the diagnosis. However, Berrios does state that this language is based on a 'conceptual network meshing observer, patient and symptoms together'.[57]

There is now an extensive literature around the use of case notes, including a detailed discussion by Hilary Marland about the history of puerperal insanity in Victorian Britain.[58] Marland's description of case notes at the Royal Edinburgh Asylum in the mid-nineteenth century supports my findings about case notes in the colonies. 'Case histories', she writes, 'were largely reliant on details given by those closest to the patient – family, friends and neighbours'.[59] Similar patterns of recording patient case notes can be identified in each colony and its institutions for the insane. Gladesville case papers are striking for their marginal notes, largely family observations drawn from medical certificates, often repeating information gathered by two different doctors at the time of committal. While the patient case notes taken at Goodna are similar to Gladesville notes, the observations of family and friends were incorporated into the general case notes rather than highlighted in the margins, and arguably assume less importance. The case notes taken at the Yarra Bend similarly incorporate, rather than emphasise, family observations. In Auckland, particularly by the 1880s, case notes

recorded separate, formal information about family history, also mediated by two doctors and conveyed in their notes at committal.[60] Overall, despite their subtle differences, the striking feature of all case notes examined here is that they incorporate the behaviours of the 'mad' as noted by lay people at the point of committal, and sometimes during their periods of asylum confinement. Family, friends, employers and neighbours also made contact with the asylum at different times, either in response to the institution's queries, or in their efforts to trace and communicate with relatives and contacts; such correspondence is discussed in the following chapter in greater detail.

## Lay descriptions of insanity

Edmund, a 39-year-old carpenter from Sydney, was admitted to Gladesville in 1893. The medical certificate, summarized in marginal notes in the case papers, indicated that his family had noticed he was highly suspicious 'of all around him' and that he spoke in a 'quick jilty style'. He was also suffering from delusions, including the belief that he was to inherit a large sum of money. It is unclear, though unlikely, whether any family members used the word 'delusion' but they certainly described the delusional state to those authorities involved in admitting Edmund, and the word was subsequently used in the patient case profile.[61]

An unusual degree of suspicion, disturbed, highly agitated speech patterns and strange ideas: these descriptions certainly accord with a list of 'symptoms' published in the *Australian Medical Journal* in the 1870s by Dr Patrick Smith.[62] Such descriptions were then grouped by medical staff using interpretative categories. The 'chorus' of professional and familial voices noted by Nancy Theriot is evident in the cases described here. Before making a diagnosis, doctors were dependent upon families or those close to the patient as they sought details about the causes of insanity, which were deemed either 'Moral' or 'Physical' in New South Wales, Victoria and Queensland. The distinction was implicit but not explicit in New Zealand, as official reports show.[63] Therefore the testimony of families and patient subjects was invaluable, though mediated by medical officers, as official reports indicate.[64] Medical officers determined how the indications of the moral and physical 'causes' of insanity would be classified using key descriptors: 'domestic trouble', 'mental anxiety or worry', or 'isolation', just three of the official moral causes of insanity in the late nineteenth century.[65] Despite this mediation, relatives communicated their concerns in a language derived

from everyday life, and arguably, as this chapter suggests, these also shaped asylum discourse.

In both the following examples from Gladesville Hospital, patients' families assisted the asylum in providing possible 'physical' causes of insanity. Like Edmund, several patients were delusional. Their delusions made them violent and dangerous towards other people, or likely to harm themselves. Family members sometimes struggled to find a 'cause' for this behaviour. It was easy when a patient had a relative who had suffered from a bout of insanity sometime in the past, and a number of the case papers show that the asylum's theories about heredity circulated among its clientele. John R, a single man described as a hairdresser, threatened his sister-in-law. His brother told the asylum there was a 'history of insanity in the family'; their father had committed suicide.[66] In other cases, delusions and violence were brought on by drink. John M had a 'constant craving' for alcohol and in 1883 his wife could endure no more. He threw a kettle of boiling water at her because she refused to buy him alcohol. Here, the cause was clear and the case papers simply note 'drink' in the relevant place, also noting John's slurred speech, his droop and loss of memory.[67]

'Moral' causes were more complicated and could also be present in cases where physical causes were noted. Ellen G was a 'poorly nourished woman' who believed her daughter had contracted syphilis from a 'clerk at the store' and then spread it among the male members of the family, although it appeared no syphilis was present. Ellen's 'melancholia delusional' was said to be caused by 'domestic trouble'.[68] In one of the most extensively recorded cases, 30-year-old Alexa C, described by her nurse and companion Miss Armitage as having said 'her inside [was] dead to all feeling' and suicidal, puzzled the asylum doctors. They conducted an investigation (most probably with the assistance of Miss Armitage) and found that Alexa had been engaged to be married to a medical man who had 'seduced' her and then broken off the engagement; she was then horribly ashamed when the news made its way into family circles.[69]

'Domestic trouble' was a euphemism, or a catch-all phrase, for a range of household problems that hint at dominant expectations of gender roles. As Labrum shows for Auckland, such 'trouble' was caused by women in the setting of the home, and their failure to perform household duties or inability to assume maternal roles were two warning signs of possible mental instability.[70] Sometimes such failures were serious, with threats of violence made towards children a more extreme signal of distress. In 1888, Emma P's husband told the authorities at Goodna Hospital that

his wife threatened her children, 'left home at night [and] neglected her duties'.[71] But men, too, caused 'domestic crises', as Labrum notes.[72] These might be relatively minor. The wife of Thomas F explained in 1908 that although he had been 'originally clever,' with a 'good memory', her husband had been involved in 'family disputes' and 'off and on ... mentally depressed' for at least two years prior to committal.[73] Stephen H caused a greater disturbance. His wife told the medical officer at Auckland that he began drinking heavily eighteen months earlier, and then gave up his work, perhaps because he 'was afraid to be seen outside'. He was always 'brooding and worrying' and was also inconsiderate: he took 'no notice of what goes on in the house'.[74]

**A lay symptomatology?**

It should be clear from these examples that the moral and physical causes of insanity, as reported by those close to patients, were described in everyday language: 'drink', 'domestic trouble'; 'history of insanity in the family'. These causes were not symptoms, but were used in the case papers to illustrate the indications or descriptions of insanity also provided, as for instance, in the phrase used by Miss Armitage about her charge, Alexa: 'her inside is dead to all feeling'. I want to return now to the indications themselves, and the more difficult questions raised by these, to make sense of a 'lay symptomatology' which informed the medical diagnosis.

What Barbara Brookes calls a vocabulary of health, writing about ordinary people and their health and hygiene practices in the New Zealand context, is relevant to this discussion.[75] Bodily sickness and insanity were very different problems, even in the mentalities of the late nineteenth century, yet the language used to describe both sometimes overlapped. Mary H wrote to her husband from Gladesville referring to her 'state of health'; and Jane H placed her faith in the asylum doctors and the 'hospital'. But there was also an emerging and consistent vocabulary being used to describe the specific 'feelings' that mental breakdown produced. Mary H was 'low spirited'; and John R's brother wrote to the asylum asking for help with John, who seemed 'very low'.[76] Auckland case notes also demonstrate that doctors assisting families in the certification process provided some, though by no means all, of the possible language that could define the problems they witnessed.

Violence, delusions (including hallucinations) and incoherence of speech dominate among the cases in my different samples. Some others were suicidal; a number were deemed indecent, going naked and behaving in overtly sexual ways; many neglected their household duties. A few were dazed, confused and wandered without purpose. Several were

simply miserable and morose. Some families simply thought the patient 'strange'. It is clear that at the stage of committal the patient's behaviour had worsened over a period of time. Without categorizing or 'counting' these different behaviours, since my interest is not in determining their frequency, it is possible to represent the wide range of changes noticed by family and friends prior to a person's committal (see Appendix).

The language of lay observers itself needs a closer examination. These observers repeatedly used particular phrases, drawing attention to evidence of mental deterioration, either through changed speech patterns, facial expressions, mood swings, or unusual behaviours. In 1879, Trevor L from Brisbane was reportedly 'rambling in his statements ... restless in manner ... forgetful'. In his case, family members thought he had been well twelve months earlier, but he 'began to fail mentally'. It is likely that they saw Trevor deteriorate. When he suddenly stated he had been to New Zealand, which was untrue, and booked a passage to Sydney without telling anyone, his brother-in-law became concerned.[77] Emily B was overly excited, too talkative, even to the point of raving and she became abusive.[78] Charlotte R was 'incoherent and constantly muttering to herself'. She was unhappy and believed her husband was trying to poison her children. But her 'melancholy' gave way to 'fits of ungovernable temper' and her husband was forced to send her to Gladesville.[79] Thomas O had a 'wild, dazed expression of face' and talked nonsense.[80] Ellen T aged 17 was 'strange and vacant in manner' in 1896.[81] Arthur S was 'strange and morose' while Florence M neglected her household duties and spent money on 'useless and nonsensical articles'.[82] John A was very restless and laughed immoderately for no reason. His wife noted a 'marked restlessness of the eyes'.[83] Elizabeth C was 'depressed and miserable' in 1906 and took very little interest in her surroundings.[84]

This term 'depressed' appears increasingly in the patient records, and in some letters penned by family members, by the latter decades of the nineteenth century. By 1860, the term 'depression' appeared in medical dictionaries. A paper on hydrotherapy appeared in the *Intercolonial Medical Journal* in 1901, with hydrotherapy prescribed as a treatment for cases of mental depression deemed effective.[85] Janet Oppenheim's discussion of the diagnosis suggests that in the nineteenth century a 'more picturesque vocabulary' was used to describe the condition of depression.[86] Berrios tells us that the term 'depressed' was used to extend the meaning of 'melancholia' by the middle of the nineteenth century.[87] Several terms, including melancholy, were used regularly. Other terms (listed in the Appendix) also conjured the condition of depression, including 'low in spirits' and 'dejected'. Case notes reflect

the use of the term depression by the later decades of the nineteenth century and it appears more often after 1900, and it applied to both men and women.[88] Henry G's sister wrote to Dr Scholes at Goodna from Townsville, North Queensland, in 1890, to inquire after him and to comment on his condition. She gave a now familiar description of 'depression', also using the word: 'in the first place [he] took a depressed and melancholy mood we could not get him out of the house even for a stroll in the evening sitting about in a listless way pretending to read but never making progress with his book'.[89] At the Yarra Bend, Elizabeth P from the Melbourne inner city suburb of Collingwood was admitted to the asylum suffering from 'melancholia delusional' in 1904. Her notes comment on her 'marked depression', and after a period of probationary leave, Elizabeth returned to the institution saying that 'she has been very depressed'.[90] Another woman confined at the Yarra Bend, Hannah J, was, like Elizabeth, sober and industrious and middle aged. She was admitted in August of 1905 after a three-week period of depression. The day after her arrival at the asylum her notes remarked: 'Patient is much depressed mentally and physically ... Asked about herself says to all questions "I don't know".'[91] George B at Goodna was said by his family to be 'depressed, silent, refus[ing] food' in 1911.[92] 'Depression' increasingly evoked a physiological explanation for the condition; a 'sinking' of spirits; 'weakened' conditions of the nervous system.

By the late nineteenth century there was a greater general knowledge about mental breakdown circulating among colonial towns and growing cities. Medical and pharmaceutical advertising, occasional cartoons, news reports and family knowledge combined to help produce a shared language. Garton notes that a 'popular literature on nerve and brain complaints flourished' in the early twentieth century in New South Wales.[93] There was, perhaps, a 'suburban' language about mental illness developing around people's experiences, with the names of institutions becoming euphemisms for insanity.[94] In New Zealand, satirical cartoons about asylum confinement appeared in the *New Zealand Observer and Free Lance* in the 1890s.[95] Figure 3.2 depicts a conversation between the Medical Superintendent and an attendant at Auckland, who discuss a visit from one patient's wife. Commenting that she wanted to take him out of the institution, the men remark that his desire to stay showed he was not 'crazy' at all, suggesting that preferring married life was a sign of insanity. In the background, 'typical' figures of madness, such as those represented in famous illustrations of the madhouse, are sketched in to depict institutional life. This cartoon, and others like it, also demonstrate that family visits to the institution were not unusual, as Chapter 6 explores.


*Figure 3.2* Proof of His Sanity, cartoon by William Blomfield, published in the *New Zealand Observer and Free Lance,* 8 October 1898, p.3. Reproduced courtesy of the Alexander Turnbull Library Wellington, New Zealand.

## Expert knowledge

Family members sometimes grappled with 'expert' knowledge: puzzled about what happened to their relatives inside the institution, they pursued explanations. Ethel P entered Auckland asylum in 1908, aged 18.[96] She was 'originally clever' with a 'good memory', a 'strong will' and had 'no vices'; her breakdown was attributed to the death of her younger brother. Discharged 'recovered' in 1909, her family having agitated for release, and following a probationary period applied for by her mother, Ethel was readmitted in 1910 by police. The case files include correspondence between Ethel's mother and the asylum's medical officer Dr Beattie. Ethel's mother was worried about her daughter, writing in 1911 that she herself was 'lonely at home', since another daughter had died. The mother struggled financially, twice writing to the institution to change arrangements for day release for Ethel because she had to work, and did not want to lose her job, 'as it is only day work'. The case files were then silent, until 1913, when in January, Ethel's sister Helen wrote to the institution from Wellington, in an effort to find out what had happened to her. Helen wrote, 'we were all very shocked to hear about her death', and questioned the stated official cause which had been noted as phthisis, or wasting disease which was often tubercular:

> There must have been considerable signs of wasting away you have said in nearly all of your reports that her general health was good so of course I thought she was all right physically. Was she up and outside until the last because it seems cruel to us if she was, as she must have been very weak ... did you ever discover what caused the brain disorder?

The reply came two days later from Dr Beattie:

> You probably do not know that Phthisis in those mentally afflicted is frequently 'masked' that is to say that the disease may have progressed considerably without the patient showing any indications of the disease.

Perhaps on the defensive, Beattie continued:

> She never spoke to anyone here, and she remained resistive to the very last [making a physical examination impossible] ... I could not have recommended her going home excepting her home had been in proximity to a Mental Hospital.

In Ethel's case, it seems likely that one member of a family was assigned the task of finding out more from the institution; in similar cases, it appears that this person, the advocate, had sought medical advice from a friend or local doctor before writing.

Families attempted to ask questions, to obtain knowledge about illness and to make sense of insanity, disease and in Ethel's case, causes of death. A letter written by one man on behalf of his sister, whose husband was confined at Gladesville, suggests that families might have contested medical decisions. She was, as he wrote to Dr Manning, 'very much grieved by your opinion' of her husband's state, which she believed to be only temporary.[97] In May 1907, the wife of Thomas W wrote to Dr Hogg at Goodna hospital. She began with questions, asking if there was any hope of her husband's recovery. She continued with comments about his poor state of health over a number of years, and included a list of medicines that her husband had been prescribed for the past six years. She did not know that he was confined with General Paralysis of the Insane (GPI), the tertiary stage of syphilis, and was also infected with gonorrhoea, or that he had tried to cut off his testicles with a metal collar stud; her letter indicates she thought he had other disorders including sciatica and a 'buzzing' in the ears. Her letter shows that some people consulted many doctors, tried many potions and entertained many theories about symptoms and cures. Her observations of her husband over time included that 'he used to fret terrible, and would not eat much, and fell away something awful, and went a nasty sallow colour, and got terrible nervous'.[98] But despite evidence that a 'lay tradition based on self-care and neighbourly co-operation' existed in colonial life,[99] family members often deferred to doctors, too: as this sad wife also wrote, referring to her husband's many medications, 'Doctor I thought I would tell you all he has taken, because I thought you would know better how to treat him'.[100]

Dr Manning had published papers about both phthisis and GPI some years earlier, in 1880. Reflecting on the causes of asylum deaths, Manning noted that two organic diseases, phthisis pulmonalis and GPI or paresis, had particularly awful consequences for sufferers. In the case of phthisis, just as Beattie had explained to Ethel's family, the 'lingering' disease was physical and mental in nature; the insanity that accompanied the condition was 'characterised by delusions of suspicion and fear' and patients were often irritable and violent. GPI was a relatively new disease label in the middle of the nineteenth century and had been difficult to diagnose until the 1880s. It was, as Manning reported, an 'insidious' disease, and featured a 'strange mixture of sanity with moral

aberration'. Sufferers tended to conceal their erratic behavior, making the observations of family and physicians alike somewhat fraught. The disease ended in a descent into a calm and gentle dementia or mental weakness.[101] In both cases, lay opinions were likely to be made less meaningful by the very nature of these diseases and their progression.

## First-hand accounts of mental breakdown

Sometimes patients themselves described their own conditions. Walter Lindesay Richardson, the father of well-known Australian writer Henry Handel Richardson, died in 1879 from GPI. He spent time in both the private institution Cremorne, in Richmond, Melbourne, and then the Yarra Bend Asylum, on the advice of his friend Dr George Graham who was Superintendent at Cremorne in the 1880s. Walter's final letters to his wife Mary, whom he called 'Marie', were written from a period of convalescence on the coast near Geelong. These letters are interesting for their first-hand account of mental deterioration. It was with both a dim awareness of his condition and prescience when Walter wrote in February 1877 that he did not think he would ever be an old man, and that he felt himself getting feeble. It was worry and anxiety that made him feel 'wretched *about the future*' (emphasis in the original). In subsequent letters he was 'low spirited', and on one occasion he went to post a letter and found himself 'unable to articulate': 'I could not say what I wanted, I am very uneasy about myself I lay down – I said I thought it was a faint & said I had been out in the sun – I am afraid it is something worse'.

In his next letter, Walter told Marie that he supposed his attack was 'mental depression & the intense and protracted heat', and he felt a little better, but the attack was followed by bouts of 'giddiness' and his reeling 'like a drunken man'. 'There must be something wrong inside my head' he wrote, 'You know I have complained of head ache for some years ever since that sun stroke at Ballarat'. By September he was unwell again after some apparent respite from his illness, and complaining once more of giddiness and his 'poor head', and of being 'broken down'. By September of 1878, Walter was admitted to Cremorne, and two months later, was a patient at the Yarra Bend. Sent out on leave from the asylum in February 1879, he died at home with his family in August that year aged 53.[102]

Some other cases of patients' own descriptions can be located inside institutional records themselves. For instance, Alexa's comment, reported by her nurse, that 'her inside is dead to all feeling'.[103] Herbert B,

who was said to be in a 'state of great tension', also identified his own illness: Herbert knew he had to control the voices in his head, and struggled to maintain this control so that he would not harm anyone.[104] John W wrote to a relative in England named Jack from Goodna around 1908: 'I must have gone a bit wrong or I would not be here. I feel alright now'.[105] Sarah L was confined in the asylum in 1884 but accused her husband of being the one with the problem; she said he had suffered from sunstroke and 'his brain was wrong, his mind astray'. Her husband had taken to sleeping in the shed, he was so afraid of Sarah; but she was adamant that he had pawned their things, drank heavily and was mad.[106] Elizabeth T stated her own 'case [was] hopeless' in 1896.[107]

Dr Patrick Smith also interviewed individual patients about their symptoms and these rare, first-person accounts were published as case studies in his paper of 1873. Smith encouraged patient 'J A' to narrate his own case. This man had a business on the goldfields and a family to support, and the possibility of earning a good amount of money in a short time drove him to work 12 to 14 hours a day. 'How I could hold out used to surprise everyone', said J A, 'But I never felt ache nor pain, nor did I ever feel tired'. Gradually his time for sleep reduced so much that J A became 'restless and excitable'; he noted that 'while in this state a very serious calamity overtook me, and completely upset me. I must have acted strangely, though I cannot remember having done so'. He then found himself at the Yarra Bend recovering slowly from 'delusional insanity'. Smith used the case of J A to illustrate the symptom of sleeplessness. In another case, a former seaman told of his own premonitory symptom of headache which resulted from a fright caused when he was on board a ship in danger of sinking.[108] Such cases suggest that the practice of taking personal case histories from patients was becoming more common inside the institutions for the insane. These histories were amplified through the observations made by families, used to enrich these family accounts, and sometimes, in certain cases, given more credence than family observations.

Despite the extensive evidence that family and friends found ways to present their concerns about others to medical staff, there were times when they were simply unable to find the vocabulary or language for what they knew to be unusual behavior in the person close to them. Lay language, then, could not always capture the essence of the problem. For example, at Auckland Lunatic Asylum in 1895, the casebook entry for a male patient in October reads: 'Patient's wife came to see him yesterday. She says his memory is failing … she notices something else wrong but can't say what it is'.[109] This inability to express the change in

those close to patients had implications for the increasing influence of medical or clinical language by the twentieth century.

## Conclusions: family strategies

Perhaps asking why family members, friends, employers and others supplied the asylum with these 'lay diagnoses' or indications of insanity can shed light on the language they used. Why did families and friends so readily describe oddities, eccentricities, hereditary illnesses and mental disorder? In other contexts, as historians have shown, families were asked to provide information by particular doctors, including Thomas Kirkbride in nineteenth-century Pennsylvania, who maintained a detailed correspondence with families of the insane.[110] Since the process of medical certification required 'evidence' of insanity, Tomes asserts that lay accounts of this evidence might constitute a kind of 'casting about' for the symptoms, a re-reading of events, to justify committal.[111] In the Australasian context, similarly zealous medical superintendents over the nineteenth century, including Manning, had established relationships with the wider community beyond the asylum. Manning did this because he saw the need for communication between institutions and the public. Reporting on the supposed causes of insanity in 1880, he remarked that the causes assigned and forwarded with patients to institutions were 'often conjectural, and sometimes absurd' and that these were 'supplemented by inquiries from relatives and from the patients themselves, and corrected by the light thrown on the cases by their subsequent history and progress'.[112] In 1881, Frederick Skae, then Inspector of Asylums in New Zealand, commented on similar frustrations and argued that contradictory reports about patients from friends rendered asylum statistics 'useless'.[113] Like Manning, Skae believed that speaking kindly to patients and families was important in order to make sense of their particular mental health problems.

But the evidence suggests something else, as Dr Patrick Smith also claimed in the 1870s: that sometimes families had cared for the insane person at home for short or extended periods of time, perhaps avoiding institutionalisation, until they simply could not ignore the behaviour they witnessed or became fearful. Examples of extreme violence and threats abound in the records. Less extreme indications of insanity were also troubling, sometimes because they threatened the household economy or became frustrating to family members. Therefore, as David Wright suggests, families also played a role in the identification of 'madness'; they did not merely respond to it.[114] Some of the letters,

in particular, reveal that people sought help from the asylum, and in doing so, they ventured to make lay assessments of the mental states of people close to them. The very literate foster son of Marion H worried that his foster mother was hopelessly addicted to alcohol, to the extent that he could not control her or help her. He wrote that 'she flies into a passion and defies me' and broke her promises; he said: 'I cannot afford a nurse and doctor, nor can I afford [her] continual drinking – let alone the harm mentally and physically it is doing her'.[115]

Lay diagnoses or indications of insanity, together with the few descriptions of mental disorder made by the insane themselves, also provide us with numerous insights into families. We might say that, as Marjorie Levine-Clark suggests, 'case histories construct a spectrum of domestic relationships'.[116] From the servant who supported her employer's committal of her prominent husband, a former Chief Justice, commenting that she had seen a 'very great change in him ... he will not speak', also reporting she had found a pistol under his pillow;[117] to the husband fearful of his wife's visions of 'wild beasts and men' roaming the house at night,[118] the many different situations affecting households reveal the range of family relationships, formed through expectations of class and gender, that were present in colonial settings. As Akihito Suzuki notes about the Victorian family in England, insanity could threaten the boundaries between the private and public worlds of the family, and the sometimes dramatic eruption of insanity within families also exposed it to controlling forces beyond its walls.[119] The following chapter explores these relationships and the emotional lives of families facing mental breakdown.

# 4
# Writing to and from the Asylum

In 1899, Abigail M was committed to the Yarra Bend Asylum. Abigail, aged 49, was a widowed hotel keeper in a rural town in Victoria. She was brought to the institution in Melbourne by a friend who cited 'worry' as the cause of Abigail's 'alteration in character' and sleeplessness. In the first few days her bodily health was assessed and she slept and ate well, though she was 'mildly resistive' to the institutional routines in place. Early the following year she was deemed well-enough to be transferred into a cottage, one of the newer buildings on the site for more capable and independent inmates. This lasted for only two days; her emotional 'relapse', as the casebook called it, meant that she was returned to the wards 'dull and listless', and was thereafter increasingly 'melancholic and apathetic', doing no work.[1] It took a further two years for Abigail to be considered for trial leave and, finally, discharge into her son's care, at the end of 1902.[2]

The 'want of harmony' experienced by Abigail M at the Yarra Bend in 1899, and sudden changes in her 'emotional state', characterised the family and medical descriptions of many other committed patients during the period.[3] Medical casebooks are a rich record of the range of emotions deemed inappropriate or troublesome in everyday life: grief or loss; melancholy, worry and despair; excessive laughter or exuberance; and regularly, fear and fright. Extreme expressions of emotion were one indication of mental instability; another was the lack of emotion, which indicates that control over the emotions was considered both desirable and possible in nineteenth-century life. Historians of insanity and the psychiatric institution have not, with some exceptions, chosen to explore more closely and specifically the worlds of emotions in the cases they sample and study. However, David Wright perceptively notes that the scholarly debate about the ability of families to care for

the mentally unwell, and their very emotional agency in relation to institutions, parallels the rise in histories of the 'affective' family, a literature which informs this study in several ways.[4] This chapter explores the expression of emotions through both patient cases and patient and family correspondence. In this way, it builds on the previous chapter, because the privacy of the 'home' or household was one site where insanity disrupted and threatened order and highlighted the emotional worlds of families. In particular, the chapter aims to extend the scholarly discussion about families and asylums, and the roles played by families and their reasons for institutional committal, by examining the different emotional relationships to asylum confinement experienced by both patients and families.

In her study of puerperal insanity, which draws upon a wide range of case note materials from English and Scottish institutions, Hilary Marland explores family relationships in some depth, and she also provides insights into the emotional lives of families, noting that case histories contain 'factors harder to pin down' than physical weariness, including 'disappointment, gloom, and desolation'.[5] Other historians interested in families and insanity have also hinted at the emotional worlds of their subjects, finding evidence of 'familial closeness' and 'happy private lives in loving families', as well as grief and conflict.[6] Studies of families and asylums in colonial contexts, including work by Mary-Ellen Kelm and Geoffrey Reaume in Canada, demonstrate that the emotional worlds of colonial families are highly relevant to the broader inquiry about families and asylums.[7] That institutions were, as Finnane contends, playing specific roles in the management of 'social crisis' suggests that an account of the emotions around such crises for families is highly relevant to understanding how institutions intervened and enacted these roles.[8] Nineteenth-century asylum inspectors and superintendents might have agreed with Patricia Grimshaw's modern assessment that Australasian families were sites of both strong affection and the 'deepest misery'.[9] This chapter also examines the official reports produced by inspectors and shows that these seemingly dry documents might also hold clues to understanding the range of emotions inside institutional spaces in this period.

There is evidence that in middle-class families in the Australian colonies and in New Zealand, as elsewhere, a 'high valuation' was placed on family life. Penny Russell argues that in colonial Melbourne, 'emotional attachments, affection, desire, grief and mirth were all intrinsic to the ideal conception of family life'.[10] This ideal of family life was enhanced by what historians have termed the 'cult of domesticity', or

a growing emphasis on the role of women in the home, in both a 'sentimental' sense, incorporating religious ideology and gender prescriptions, and in a 'scientific' sense, with household management prized by contemporaries, underscored the increasing emphasis on marriage and childrearing.[11] In addition, as Erik Olssen has argued for New Zealand, young married couples in the 1880s expected more from marriage than their parents had; the importance of companionship was noted by contemporaries.[12]

Certainly the 'ideal' of the middle-class family and its emphasis on strong affection, which was just as important as a model of morality and stability for working-class families, is only one side of the story of families and emotions. Patient cases reveal that deep misery also characterised family life, and in particular, the lives of those families fractured across multiple lines by economic and educational paucity and by a lack of networks of extended kin for support.[13] Women in some occupations, such as domestic service or governess work, were more vulnerable to physical and mental breakdown.[14] Stephen Garton remarks for New South Wales that the records of the asylum also reveal colonial families of the past as being characterised 'by high levels of violence, conflict, tension, anxiety and depression'.[15] Sometimes these became visible as family shame, such as asylum committal, was exposed, illustrating the claim that the affective family sheltered and grew not only intimacy but also secrecy and silences.[16] One patient at Gladesville wrote to her husband in 1880 to express her worry at the 'ill luck' that dogged their wedding, blaming this for her illness.[17] There were asylum patients whose kin disputed their relationships, perhaps to avoid paying maintenance fees, as Chapter 5 explores. In 1886, the two brothers of Auckland Asylum inmate John D, named in a record book of maintenance investigations, claimed he was illegitimate; it was also noted they were in 'poor circumstances'.[18] A housekeeper who was 'thrown out' of her employer's house in Albion, Queensland, was angry with the 'doctor at the Goodna Asylum' because the family claimed to have had no idea their wife and mother, Emma P, was to be discharged.[19] Since Emma had threatened neighbours, 'neglected her duties' and disappeared from home at night before her committal, it seems likely her return home would cause her family further distress.[20] Minnie G complained to a friend that it was strange in all the time she had been confined at Goodna, several months at the time of writing in 1899, she had never received a parcel from her husband.[21] Edmund H's wife wrote to Gladesville in 1893 explaining that her husband's mental deterioration was due to loss of work and income; his 'poor circumstances ... preyed

on his mind'.[22] Many other cases like these indicate that family 'misery' was widespread.

Perhaps more than any other theme explored in the field of the history of psychiatry, this focus on families has the potential to open up a discussion about past emotional cultures based on material generated by records associated with mental illness and the asylum. Peter Stearns insists that 'aspects of emotional experience are legitimate subjects for historical inquiry' and has formulated a framework for this approach.[23] Historians of the family have been obvious in their engagement with the history of emotions, with much of the scholarly terrain occupied by investigations into the meanings of familial love, obligation, marriage and divorce. While some social historians of the family have viewed the nineteenth-century family as a 'repository of private affection and emotional bonds', others preferred to emphasise the family as an institution characterised by economic ties.[24] Thus Nancy Christie very convincingly reads female begging letters in nineteenth-century Canada as evidence of an 'economy of obligation', interpreting the 'language of affection or "sensibility"' in female correspondence as a language, or even a genre, 'of deference and subordination' designed to elicit aid.[25] Furthermore, disagreements between historians who have insisted that emotions are the invention of modernity, and those who have sought to describe emotional worlds in pre-modern pasts, have led to what Rainer Beck describes as 'a horrifying distance' between 'us' and the people of the past: they were 'people who knew hardly any "feelings" at all'.[26]

The question underpinning this chapter is not 'did emotions exist', but how might we access these and give meaning to their expression? It explores the emotional expressions made by the 'mad' themselves, and those made by families of the 'mad', also evaluating the range of emotional states, and the different attitudes of medical personnel towards them. The chapter also draws upon extensive collections of family and patient letters. With some exceptions, historians of the asylum have mostly privileged institutional records, often because other source materials have not always been extant. To examine the family's relationship with the asylum, and the different experiences of negotiating with asylums, it is necessary to explore the value of correspondence. Letters potentially provide a deeper reading of the emotions surrounding asylum committal, confinement and discharge. Correspondence to and from the institution, in which families negotiated and communicated with asylum officials in sometimes very lengthy letters, affords us a glimpse of the emotional responses to managing mental breakdown. Letters were used in medical practice, as Louise Wannell outlines for the

York Retreat in the late nineteenth century, and as the previous chapter also described.[27] As Ellen Dwyer shows for state asylums in New York, the correspondence of relatives of patients indicates that families often imagined the institution as a site for the care and custody of those who could no longer be contained in ordinary domestic situations.[28]

Correspondence also offers insights into the cultural practice of writing itself, and into the lives of families who negotiated the problems and possibilities of colonial spaces.[29] Through letters, the asylum also became a site for the discussion and performance of 'emotion'. Given the vast distances between families and some sites of institutional confinement, such as the Goodna Hospital in Queensland, letters served the vital purpose of a means of contact and intimacy.[30] However, letters between patients and those outside the institution were regularly inspected and sometimes destroyed, a situation that was paralleled in British institutions in the same period.[31] In the colonies, legislation determined that patients' letters be reviewed by the asylum inspector and destroyed if they contained questionable content. Letters were in fact often held by the asylum and attached to case papers. The extensive archival holdings of some institutions indicate that letters, as Finnane reminds us, were sometimes deemed by asylum authorities as too incoherent or disturbing to send.[32] Official criteria for the disposal of letters were not outlined but the archive shows that this content might include hostile communications to family members, or incomprehensible letters that showed the sad evidence of mental deterioration. Official reports regularly described this process. In his report on Gladesville for 1880, Dr Manning noted that he had 'looked over with some care all the patients' letters detained by the Superintendent, and ordered their destruction, considering their detention reasonable and right'.[33] At issue here was the risk of an improper treatment of patients' letters. Family correspondence did reach patients, but was also reviewed. It seems likely that the contents of some letters were also checked for their potential impact on patients. Just as the presence of visitors in the ground of the hospital was depicted positively, as further evidence of the harmonious and peaceful surroundings which welcomed all inside its walls (see Figure 4.1), so too did letters from family members play a role in public relations between authorities and the society beyond the institution. It was difficult for patients to write letters from the asylum, since obtaining paper and writing instruments was not straightforward. On 30 November 1904, John M wrote from Parramatta Lunatic Asylum to his wife: 'Dear Wife, Please excuse the smudges, it is such a task to do a bit of writing here


*Figure 4.1* Hospital for the Insane, Gladesville, W. H. Broadhurst Postcard, c. 1900. Reproduced with the permission of the Mitchell Library, State Library of New South Wales, Australia.

sometimes'.[34] However, patients did find ways to write letters. Many wrote to a range of people to advocate for their release; some wrote to complain about conditions; others wrote to family quite resigned about their mental conditions, including Herbert F, who announced to his family in 1910 that he was 'alive and well ... still an inmate in the Lunatic Asylum making songs and prophecies etc with no signs of getting out to come home'.[35]

The chapter reflects both upon the emotional struggles experienced by families, so far as it is possible to discern in fragmentary sources, and also on the way emotions were framed in both medical and lay language. The expressions of emotion around asylum committal and discharge are read here as an index to contemporary emotional cultures, given the reasonable assumption that 'emotions cannot exist apart from the society that shapes them'.[36] For example, Marland's study of emotions and puerperal insanity shows that emotions have been gendered at key historical junctures.[37] In addition the chapter reveals some new historical actors through its inquiry. The emotional lives of middle-class families have received more attention than the emotional lives of the poor, largely because more individuals among the middle-classes left behind written records of their inner worlds. Yet this chapter demonstrates that

some of the correspondence between families and asylums, from people of all economic and educational backgrounds, highlights that collections of private diaries and letters between family members are not our only means of accessing these; we might also explore the records of institutions. In the following section I explore patient case notes for traces of emotion, and explore the emotional lives of families, before turning to family, patient and institutional correspondence to find out more about the emotional cultures of the wider societies within which they were embedded.

## Traces of emotion in patient case records

Mental breakdown revealed itself through a disturbance of emotions in most individuals committed to institutions. The extreme disturbances of emotional balance witnessed in some cases, often accompanied by violent behaviour, could frighten observers and families.[38] Charlotte R was admitted to Gladesville in 1884, and her case notes remark that she experienced both 'melancholy' and 'fits of ungovernable temper'. Her husband could not cope with these 'fits' and her accusations that he was poisoning their children.[39]

Rab Houston suggests that 'grief' and love sickness were common causes of insanity according to eighteenth-century patient case notes.[40] In the case notes of colonial asylums, grief and loss of love also appear as accepted causes of insanity. Margaret C, at Auckland between 1891 and 1899 until her death, was believed to be suffering from extreme grief at the loss of her husband and child, and sat 'with her eyes closed' refusing to answer questions; her emotional state like that of 'an imbecile'.[41] The committal papers of Ida D at Auckland speculated that grief led to the strange delusion that she saw her son 'of about 6 years (who died some months ago) flying about in the sky'.[42] Robert W's wife noticed his 'disposition' was 'entirely changed' in 1901, and his father-in-law commented that his 'manner' had completely altered, but his stay at the Yarra Bend was relatively short; he left within a few months.[43] Maria F, sent from Brisbane Hospital to Goodna in 1885, cried 'without cause' and 'moped' around the hospital, taking no interest in anything or in herself.[44] Like excessive crying, 'immoderate laughter' coupled with some odd behaviours caused John A's family to worry in 1904.[45] Distress over failed love affairs was most often cited as the reason for breakdown among younger women whose economic circumstances were otherwise robust.

Such cases hint not only at emotional disappointment, but also at secrecy around sexual behaviour and at sexual experiences which

caused fear and anxiety. These were largely 'untold stories', as the authors of *The Family Story* suggest, and can be read as evidence of family silences and repression.[46] Alexa C, who, as the previous chapter discussed, described herself as 'dead to all feelings', had possibly been abused by her fiancé. In 1896 she was admitted to Gladesville with delusions about her gross immorality. From a comfortable home in Sydney, and normally articulate and attractive, Alexa had been engaged to a medical man who broke off their relationship when he found she was prone to melancholy. Alexa claimed she had been 'seduced', and not only by her fiancé, but also by the family doctor.[47] Although the claims were denied by the men involved, questions about this case and others remain. Women could be vulnerable to others in settings where the imbalance of power in gender relationships was commonplace.

The asylum aimed to restore inmates to the appropriate state of emotional balance. As illustrated by Abigail M's case, described at the outset of this chapter, sudden changes in 'emotional states' confounded and dismayed those around her. The institution hoped that through a regime of rest, diet, work therapy and other treatments, this type of emotional disruption could be brought under control. The pattern evident in this one example is repeated over and over again in cases from each of the institutions explored here. John W, at Goodna in 1907, steadily became 'more cheerful' until his discharge.[48] Cecilia L, admitted to Auckland in 1900, changed from being 'distraught' to commenting that she did not 'believe in worrying as it [had] brought her here'.[49] John O was 'much brighter in manner and talk' after a two-month stay at Goodna, which led to a trial release; in his case, the pattern of improvement was let down by his failure to live well outside the institution: his wife could not manage him in 1890 and he was returned, only to become 'anxious to be allowed another chance of leave'.[50]

The use of the words 'emotion' and 'emotional' occurs in only a few of those cases sampled for this study. According to his case notes, John B became 'very emotional' when questioned about his wife, and could 'scarcely keep from bursting into tears'.[51] Abigail M's committal papers mention her 'sudden change of emotional states'.[52] Admitted to Auckland in 1889, Eleanor L was 'very emotional and cries or laughs without much reason' and some years later sat 'for most of the day' in one chair.[53] The elderly Maori Chief, K, confined at Auckland in 1908 suffering from acute melancholia, was referred to in similar terms: 'Patient is very changeable, at one time he is depressed and emotional and bursts into tears ... at another time he becomes angry and excited'.[54] This man had become alienated from his tribal community, frightening

others and causing conflict. Other Maori patients in the asylum were similarly confined as a result of their conflict with Europeans, either police or employers, who noticed their unusual behaviour. Patient case notes suggest that Maori patients often became emotionally withdrawn following their institutionalisation.[55]

Despite the infrequent use of the specific terms 'emotion' or 'emotional', regarded as 'modern' words in 1905, the primary sources used throughout this discussion show that many different descriptions of specific emotional states do appear in these case records.[56] In addition, by the latter decades of the nineteenth century, the case notes at Auckland set aside a specific space for the individual's history, including their emotional history or temperament, as seen from the family or friends' points of view. The wife of Thomas F, admitted to Auckland in 1908, commented that he was 'passionate, affectionate', but had 'no vices' until his recent bout of alcoholism triggered by a family dispute.[57] Minnie F was not passionate, but known to be 'placid', making her 'erratic speech' and obsessive religious behaviour even more unusual.[58] What were the meanings of these personality types, 'passionate' and 'placid', in the context of nineteenth-century colonial society? Used in the descriptions taken at Auckland, it seemed to connote a life lived well, but at other times, displays of 'passion' were considered inappropriate. Marion H 'flew into a passion', or had a tantrum, when denied alcohol and 'defied' her foster son, who explained to staff at Gladesville that no one was 'more anxious' than he to assist her: 'I really am at my wit's end'.[59] These differing meanings of behaviours – of language itself – suggest the importance of historically specific explanations of emotion and personality. Thomas Dixon has explored the language of emotions relevant within medical discourse, especially as it has changed over time. 'Passions' and 'affections' were more meaningful within medical discourse until the late-nineteenth century, when the term 'emotions' began to take hold, in part due to the rise of the new field of psychology.[60] Early definitions of moral insanity, as Joan Busfield argues, contained a loose collection of 'emotions and behaviours' including feelings, affections, temper, impulses and dispositions.[61] In addition, historians have argued that young colonials were seen as possessing more freedom of self-expression than their counterparts in Britain, meaning that new varieties of emotional language also became current in this period.[62]

In their observations of patients, medical staff scrutinised the physical manifestations of emotions in their facial expressions and other actions. I have been focusing on language, but as Rosenwein reminds us, 'emotions are always mediated by words and *gestures*' (my emphasis).[63] Reading

the gestures noted in the case books can also be productive for researchers. Isabella M, confined at Goodna in 1889, was 'very low spirited and tearful, silent and solitary in her habits, unwilling to occupy herself in any way'.[64] George B looked 'fixedly at [the] ground during examination' and had a 'miserable' expression.[65] These and other descriptions, as Dixon suggests, have been interpreted using contemporary theories about melancholia and other diagnostic categories, but we might also find out about the emotional experiences of patients by re-examining such materials.

Patient cases also provide insights into the emotional worlds of families. Annie W threatened her husband and four children with 'a tomahawk and other weapons'. Her violence and 'eccentricity' – she was taciturn and sometimes burst into tears when people spoke to her – caused her husband to despair; he returned her after each trial leave with comments about her inability to control her emotional states. While this could be read as his intolerance of her behaviour, other evidence shows that he was delighted when she returned home. He wrote to the superintendent at Goodna in 1885: 'I am glad to say she holds quite as well as when you saw her last and she is a little livelier in her manner, in a general way she seems contented. ... I think she is getting a little better of her nervousness.'[66] This family and others struggled with the strangeness and unpredictability of mental change.

In cases of serious threat to the patient's life, this struggle was stark and highly distressing. Amelia E's sister was a nurse, and noted Amelia's behaviour as especially worrying in 1904: she had 'attempted to swallow a box of matches – to set fire to herself – also to cut her throat with a razor'.[67] In the sad case of Jane H, a young married woman with two children, eventual suicide was not averted. Taken to the asylum at Gladesville in 1886 because she had cut her wrists, thrown herself from a balcony, and refused to eat, Jane repeatedly tried to commit suicide while inside the institution. Despite these attempts, she was granted leave of absence, during which time her husband expressed himself unable to cope with her 'self-destruction'. Finally, Jane was discharged in 1887.[68] She was found dead in her bath at home shortly afterwards, and a newspaper cutting reporting her death was kept with her case notes. It perhaps functioned as a reminder to asylum staff to take more care with suicidal subjects. Chapter 6 explains that cases from the institutions suggest that families wishing to remove suicidal patients and take them home were asked to sign an agreement that they were aware of the need for vigilance.[69] We can only speculate about the emotional impact of these events on families and asylum staff. Contemporaries reported reactions only sporadically. The death of William R, a former

inmate of Gladesville who committed suicide using a pocket knife while on a trial absence from the hospital, 'cast quite a gloom over the district' since he left behind a widow and four children, according to another newspaper report, attached to his case record.[70]

**Locating emotions**

Finding evidence of emotion in patient casebooks is one way we might enrich our understanding of family relationships, but it remains surprisingly limited. Turning to other sources beyond the institution helps to situate the glimpses of these emotional worlds of colonists. After all, people who had not come into contact with institutions for the insane also expressed emotion. After the death of a child in her employer's family in Victoria in the 1860s, governess Louisa Geoghegan wrote to a friend: 'Her death has cast a great gloom on everything'.[71] Perhaps this 'gloom', a mood that pervades diary entries and letters by many colonial women and men, is a clue to understanding the emotional lives of families in this period. Chapter 2 described the way that colonists attempted to maintain intimacy across vast distances and during periods of separation. A colonial doctor's wife living in New South Wales, Nina Spasshatt, described the closeness generated through letters as the ability to imagine home and family being physically near. In a letter to her brother-in-law, Joshua, in 1863, she claimed, 'I could quite enter into your feelings'.[72] Nina's loneliness then, before her husband Percy died in the 1870s, was not only the product of the bush life, which she felt had 'spoiled' her, but was exacerbated by Percy's absences as he tended to the local sick. Percy was a doctor and his work took the family from Tumut to Armidale in New England, northern New South Wales. 'Percy is much away', she said.

> It is very sad when he is away, and somehow I don't get accustomed to it – but then when he does come every thing is forgotten in the joy of that coming home. I know of nothing more trying than to see a patient following in at the open gate, and know that I must retire until that somebody's wants are attended to.[73]

Percy's death only a few years later was a shock that caused her much 'agony'. Her letters were sad accounts of his last moments in sickness and her terrible grief.

Grief could, as the *Book of Health* warned readers, 'knock down' any person with its heavy blow: 'It stuns, and we reel – are prostrated by the loss of a friend, or a fortune, or hopes'.[74] Many of the family papers examined for this study – indeed, most of these, where they contained

correspondence – included mourning notepaper and remembrance notes and cards. In her cultural history *Australian Ways of Death: A Social and Cultural History 1840–1918,* Pat Jalland draws upon manuscripts, published works, and newspaper reports, among other materials, to analyse the various representations and expressions of grief, practices around death. Her work also plots a particularly Australian articulation of dying and its rituals.[75] The example of grief provides a useful theme to pursue in institutional records because death was a commonplace of colonial life, but not everyone succumbed to the anxieties around death and dying, and grief triggered mental breakdown in only some members of the population. For those who did experience grief as a terrible blow, and one from which recovery was difficult, institutional care provided one possible solution.

As well as looking outside the institutions for hints of everyday emotions, we might return to the bureaucratic and official reports for discussions of causes of insanity. Official asylum inspectors' reports included tables of the causes of insanity, compiled from patient casebooks, in each colony over the decades examined here. These are also interesting sources of information about attitudes to emotion, especially differences between women and men. For example, reports collated supposed reasons for mental distress including household stress, (labelled 'domestic trouble'); mental anxiety and worry caused by business or financial problems; love affairs and seduction; fright and shock; and isolation and nostalgia. These were all 'moral' causes, and as such could be said to have been produced by social circumstances.[76] As the previous chapter showed, 'moral' and 'physical' causes were provided to asylum doctors by family, or determined by the asylum at committal. 'Moral' causes included 'domestic trouble', a category most often applied in cases of women. Houston has argued that 'emotional causes of insanity, notably bereavement, were more likely to be cited as an explanation of a female's descent into madness'.[77] At the same time, the case descriptions of some conditions, including melancholia and mania, also tended to be more detailed, especially when compared with cases of those defined as 'imbecile', meaning that more language of emotion was produced around some subjects.

## Family and patient correspondence

The traces of emotion found in patient case histories are a moving, disturbing and yet ultimately limited set of reminders of the calamity of insanity. Extant letters to and from family members of the insane, patients themselves, and medical authorities, offer the possibility of a deeper reading of

the emotions surrounding asylum confinement. Family members often wrote to the institution to express concern about the emotional changes they had witnessed in the person close to them prior to committal. They also wrote to offer family histories and theories about illness, or to ask for advice. They wrote expressing worry, anxiety, fear and doubt. They also sometimes wrote to thank asylum superintendents for their care of ill relatives. Patients wrote to family members to keep in contact, request advocacy or affirm their recoveries. They sometimes wrote to asylum authorities and others to petition for their release. Here, I focus on how we might read this range of letters for their emotional content.

Asylum committal made a strong impact on the lives of families. Ada B's husband was required to sign a note stating that his wife needed extra care for her epilepsy when he took her out of the Yarra Bend in 1899. This was something of a victory, since he had written a lengthy letter pleading 'earnestly' with the medical superintendent Watkins to allow her to come home. He was only 'a poor man ... yet ... able to take care of her', and he 'beg[ged] most earnestly that you will allow me to take her home as soon as possible'. He explained in a postscript: 'I will guarantee to look after her well. I don't wish [to] break up my home if I thought you would allow me [to] take her away.'[78] If there was any chance of her release, he would grasp it, like others in the same position. The family of 70-year-old John B, confined at Goodna in 1900, petitioned with a letter signed by several members of the family, saying they were 'very glad ... to see [him] out and looking so well ... we sincerely wish to keep him out and shall be most anxious for him to be at liberty'.[79]

Although Christina G had 'violently assaulted her mother-in-law' and her children were visibly malnourished, she was nevertheless needed at home.[80] Her mother wrote to Gladesville in 1893 to ask how her daughter was 'getting on' and if she would 'ever get better':

> I must let you know that her poor husband is Dead he died in the Walgett hospital on the 14th of July I got a wire from Narabrie telling me of his Death so thire are four Children over thire some where we cannot find out where they are ... before he Died he never spoke a word to tell where he left the Children so you see that I am a heart-broken mother with my Daughter in Gladesville and her husband dead and her Children ... some where oh I hope and trust in God that she will soon be all right again.[81]

This heartbreak echoes through other cases in different ways, also appearing as worry or anxiety. The brother-in-law of John H wrote

in 1885 to find out how John was getting on at Goodna, 'anxious' about the 'poor fellow' and theorizing that 'the sun harmed his head'.[82] Josephine B's mother wrote more tartly to Gladesville inquiring about an operation that her daughter was told might assist with her insanity, said to be caused by puberty: 'Let me know if something could be done where she is. I would like something to be done, it is time she was released from Gladesville. I am very unhappy about her and I wish you to relieve her sufferings and mine by doing as I mentioned for her.'[83]

Some family members became upset at the thought of having their insane relative released. John O's wife was adamant that he caused her trouble when he went home on trial leave: 'Saturday, when I sent the telegram, he was dreadful. I am losing my trade through him, yesterday he came in drunk and threatened me with a knife.'[84] Another John, also confined at Goodna, drove his wife to declare in a letter:

> Hearing that my son William is trying to get his father home I Mrs P wife of John P do strongly object to him coming out as he only a nuisance to me. Every time he has been out he comes and torments the life out of me.[85]

But families and patients also expressed their gratitude to asylum superintendents. There are several examples from Goodna, perhaps suggesting an institutional emphasis on maintaining contact with families and patients following discharge. In 1906, former patient John M wrote to Dr Hogg: 'Dear Sir, I am influenced by a grateful remembrance of your many acts of kindness to me at Goodna'.[86] Reminding us of the existence of a trans-Tasman world of asylum management, a woman who took her sister the long distance from Goodna in Queensland to New Zealand by ship wrote in 1889 to thank Dr Scholes for his kindness: 'My sister tells everyone how kind you were to her that you were the only friend she had there'.[87]

Patients also communicated their anger and frustration at their relatives and the institution through letters. In a letter of 1886 that was both comical and caustic, 21-year-old George wrote to his mother from Gladesville. It is useful to present this letter in its entirety because George's own emotions are expressed within the form of an ordinary letter which mimics pleasantries:

> My dear Mother
>
> What on earth is the use of your writing such nonsense to me as your last. I intend to keep it in order to get you into Callan Park

> on the first opportunity. In fact your silence makes me think you are there now. However I fear there is no such luck. I suppose you are only too glad to have your fling with your friends Mrs Cooke Mrs Mackle the Porter. You hideous beast you would do anything for them while I was starving well you wretch I write this to tell you that I want some money if you aren't in gaol or somewhere else I expect to see you on Monday
>
> Yours truly
>
> Please let me know Harry J's address. I want to write to him.[88]

As the previous chapter explained, George was a clerk from Lane Cove, and was probably committed to Gladesville by his mother with the cooperation of police in November of 1885.[89] In the letter above he accuses his mother of being mad, or even a criminal; he expresses a deep distrust of her and yet asks her for money. Other letters like this one indicate that patients were not always able to perform sanity or adjust their emotions as authorities expected. As the chapter has explained, these letters did not reach intended recipients, and their emotional expressions were therefore constrained by institutional regulations.

## The asylum as a 'theatre of emotions' for families

Writing about middle-class colonial families, Russell suggests that 'family relationships ... were suspended between the public and private worlds'. The 'private' family became a 'theatre' for the public display of affections and the performance of gender roles.[90] Hilary Marland examines the idea that emotions, when displayed incorrectly within the space of the family, might threaten to destabilise it.[91] Suzuki also explores the public performances of insanity in the spaces of the courtroom, arguing that lunatics were 'on stage' and performing their identities to audiences in emotional narratives.[92] With the disruptive individual removed from the household, did the asylum also become a site for the expression of family emotion? Was it a 'theatre of emotions' for families, with the emotions performed through correspondence?

The private correspondence of some families hints at these possible readings of communications with the institution. Thomas W's wife, who, as the previous chapter described, was unaware of his syphilis when she wrote to Dr Hogg at Goodna hospital about her husband, began with questions, asking if there was any hope of her his recovery. This

woman appeared to care very deeply about her husband. She pleaded with Hogg:

> Please Doctor would you let me know if myself and the children could come up and see him, as I would dearly love to see him, but if I thought it would upset him, I would not ask to come, so please Doctor hoping I am not giving you too much trouble, and thanking you for your kindness to me.[93]

These querulous notes in her letter, and her emotional plea – 'I would dearly love to see him' – constitute a type of emotional performance. Like the female begging letters investigated by Christie, this type of communication with the asylum doctors could be considered as possessing certain tropes: she professed her knowledge of her husband's health (without knowing its actual state, presumably protected from this by the institution); she commented on the strength of her desire to see him, but deferred to the doctor's opinion and expressed her gratitude to him. In all this, a very private and emotional matter, her husband's committal and confinement as an insane person was laid bare and discussed with a stranger.

Despite the fact that the asylum was a public institution, regularly inspected and reported upon, it was able, to an extent, to protect families from the scrutiny of 'the public' because it offered the confinement of visibly difficult and emotionally unstable family members. And yet communities knew when someone had been taken away; neighbours and police were often involved in the identification of insanity and/or the committal of allegedly insane persons. There was certainly some secrecy around asylum committal. The doctors – medical superintendents – lived on site, as Figure 4.2 shows; they were part of the institutional world which confined the insane. The doctors, then, had a privileged relationship with persons who were once close to their families and loved ones. This placed them in a special relationship with some writers, eager to treat them as confidantes and experts. As the discussion of Thomas W above illustrates, correspondence between families and the institution might also indicate that some individuals and family groups felt the need to detail their private emotional responses to the institution to willing listeners.[94] How did people externalise and perform their emotional selves in this context?

In 1892, a woman wrote to Eric Sinclair, the medical superintendent at Gladesville, from Adelaide in South Australia. Her son John was confined at the Sydney asylum and in her letter she expressed her

*Figure 4.2* Superintendent's residence, Goodna. Reproduced courtesy of the State Library of Queensland, Australia, image no 177592.

great unhappiness at the distance between them. 'I am very anxious to know how my son is keeping', she wrote. It then emerges that she wished to know if her husband had ever made contact with her son, 'as he is not living at home or the last year and nine months'. She explains:

> And he thought he could live better by having all his money to himself. I wish my Poor Son was in the Adelaide Asylum where I could see him. Dear Sir I am sending 2 stamps. Sorry my means are very Humble. My bad Husband has brought me to Great Poverty. I have been so Distressed in mind about my Poor Son I wasn't able to get this written for such a long time. Dear Sir Please Write Soon. I remain yours respectfully Servant [name].[95]

Her son had been at Gladesville since 1889. He was 24, single, and while well-nourished he appeared to have a 'congenital mental deficiency'. In 1895, three years after his mother's letter, he was transferred to Kenmore Hospital, an institution at Goulburn, south of Sydney.[96] The purpose of

her letter shifts from an inquiry about her 'poor son' to a greater curiosity about whether she might find her husband, who had deserted her leaving her without any income. She was perhaps responding to an inquiry about maintenance payments, though this is not certain from the letter. She performs her emotional responses to her son's confinement, her abandonment and poverty, and her own mental distress in turns in this letter. The asylum was, for a moment in time, listening to her. This raises the possibility that members of the wider community found asylum superintendents to be benevolent as well as authoritative about social and mental misery. As Louise Wannell has suggested, doctors could become 'mediators' and 'confidants' in such situations.[97]

Emotional expressions were also 'scripted', just as the identities of lunatics conformed to social and cultural scripts in the legal spaces of the courtrooms explored by Suzuki.[98] Patients also knew to 'perform' their recoveries. George B wrote letters to Goodna hospital authorities in 1903 claiming that he was a 'very quiet and inoffensive man', but that he had been threatened inside the institution. He stated he had 'recovered' his 'senses' and demanded discharge. Apparently he was unconvincing, because he was transferred to Toowoomba Hospital for the Insane in 1904.[99] In a more successful performance, Christian F, a 19-year-old woman from Maryborough in Queensland was admitted to Goodna in November of 1907, and discharged in February 1908. She wrote to her mother while in Goodna:

> I am glad to tell you I am well. I feel as well now as ever I was ... you'll get a surprise when you see me I am not the half-dead sort like I was there [in Maryborough]. I have got strong and my memory has come back to me. ... I hope they don't keep me too long down here for I'd like to go home. I am not all the time as though I was drunk now. ... I'll take fine care I'll never get in that state again.[100]

She signed the letter 'your loving daughter', another indication she was 'restored' to her right senses, and had the appropriate relationship with her mother. A number of letters written by patients at Goodna examined in this study are styled using similar modes of communication: John W, mentioned earlier as a patient who changed during his confinement, wrote to a family member in England around 1907 stating he 'felt alright now' and remarking very positively that the institution looked after its inmates: there are 'good sized gardens ... we go out for exercise, some of us go outside to do a little work, it helps to keep the mind occupied. I go to church very often'.[101]

## Conclusions

This chapter has assessed a range of source material to find out about families and patients and emotions surrounding asylum committal. In particular, it has also introduced correspondence, not always foregrounded by historians in this field, and has argued that letters might be read more carefully for the family's emotional response to mental breakdown through acts of writing. Writing alone was not always adequate, as one letter writer knew, telling the asylum superintendent that he 'might on a personal interview with you explain matters more satisfactorily' than he could do in his letter.[102] Yet these letters tell us that some nineteenth-century individuals used writing to explore the expression of emotion not possible in other ways either due to physical distance, especially in the settings of colonial Australia and New Zealand, or cultural conventions.

By delving further into patient case records and family correspondence with the asylum, we might now find new ways of assessing the emotional lives of families facing the stress of mental breakdown, and gain a fresh understanding the role of large, public institutions for the confinement of the insane. Extending the range of possibilities for historical readings of the family's agency and motivations must also take account of the emotional impact of asylum committal in different contexts. By examining the family's relationship with hospitals for the insane, this study shows that families were inventive in their use of the asylum, often negotiating with asylum authorities. In many cases, the family was deeply involved with the asylum, suggesting significant levels of emotional and practical engagement. The following chapters explore the practical ways in which families and individuals coped with the financial pressures of institutional confinement in the colonies, and their successes and failures in negotiating patients' transitions between the asylum and the worlds of family and employment.

# 5
# Tracing Families for Maintenance Payments

In 1889, at the Intercolonial Medical Congress held in Melbourne, Dr W L Cleland, Resident Medical Officer at Adelaide's Parkside Asylum, made extensive comments about the economic management of Australian asylums for the insane. He asked why it was that asylums had failed to collect more in aid of maintenance from patients' friends and relations. 'Considering the well-to-do character of the Australian labouring classes', he said, 'It surely ought to be one of our Australian features, that the relatives or friends of nearly every patient should be able to contribute something'.[1] Cleland's many suggestions and schemes for colonial institutions were roundly described as 'too idealistic' by the medical gathering. That same year, the brother of a woman committed to the Auckland Asylum some years earlier, declared himself 'unwilling and unable' to contribute the cost of her care. He had a family of his own; the woman's husband was working in Sydney, and her father-in-law had also left the colony for New South Wales.[2] This family story echoes many others found in the archives of the four public institutions examined in this work. Throughout the late nineteenth century and into the twentieth, while the collection of maintenance payments was improved, public asylum attempts to elicit full payments from families and friends consistently failed.

As the Introduction to this book suggested, the problem of maintenance payments remains an aspect of the colonial mental hospital that differs from similar hospitals in parts of Britain and America, where pauper and private institutions were distinct.[3] Yet despite its potential as a window onto the lives of colonial families, the subject of maintenance payments to public mental hospitals has attracted relatively little attention among historians of the psychiatric institution, either

in Australia and New Zealand, or even beyond.[4] This chapter examines the questions surrounding maintenance payments to public hospitals for the insane in to shed light on colonial family behaviours at the time of asylum committal. I explore how and why colonial institutional authorities sought families of the insane for maintenance payments, and in doing so, I examine what trace of these encounters remains in the archival record. I first want to sketch out the debates that took place in the colonies about maintenance payments to suggest that these were part of a wider attempt to define family responsibility in colonial society.

Perceptible changes in thinking about the obligations of the state towards the sick, elderly and needy, evidenced by the introduction of the Old Age Pension in New Zealand (1898), New South Wales (1900), Victoria (1901) and the Australian Commonwealth (1908), and various kinds of medical relief and assistance to the sick poor, have been subject to robust debate among historians keen to examine the changing boundaries between notions of private responsibility and the provision of state welfare.[5] To extend these discussions, I argue that cooperation and resistance to maintenance payments by families of the institutionalised, partly engendered by loose legal prescriptions around the certification of insanity, coexisted during the period. In particular, as the chapter demonstrates, resistance took different forms and evoked a range of responses from institutions and the public. To explore why this might have been the case, I examine three themes that emerge from the sources: families in poverty; families who were involved in what the asylum authorities assumed to be deception to avoid making payments; and finally, family economies, both fiscal and emotional, using evidence of contestation and dispute over money and family relationships.

Different practices of maintenance collection and record keeping across the colonies are reflected in the archival sources. For instance, at Auckland, the Record Book of Maintenance Investigations 1890–1899, which is a companion to the Maintenance Payment Ledger 1885–1910, provides extensive detail about some families and patients, while the schedule of maintenance bonds at the Yarra Bend and the records of the collection of payments at Gladesville are less descriptive. A further point of interest is that the maintenance bonds at the Yarra Bend include both records of persons released on bond to the care of families, and payments of maintenance bonds for asylum confinement.[6] Evidence of maintenance payments at Goodna is drawn from patient and hospital correspondence.

## Asylum patient maintenance costs in the colonies, 1860s–1900s

In each of the four colonies, asylums, along with public hospitals and later, industrial schools and primary education, were considered the responsibility of the state.[7] In the Australian colonies and in New Zealand, early laws put in place the expectation that asylums should be supported by government. Margaret Tennant interprets this as evidence of early involvement in state welfare.[8] The New Zealand Lunatics Ordinance (1846) arguably marked a shift in the social and legal meanings of family responsibility in relation to the mentally ill, contrasting with related legislation which stated that families and relatives were liable for the support of the destitute.[9] Although subsequent legislation in all the colonies further defined the meanings of the 'public' insane asylum the role of the family remained ambiguous. While the different pieces of legislation all made provision for institutions to seek maintenance costs no payment was required before asylum admission.[10] The legislative powers which enabled the hospitals for the insane to draw on the state's regulatory bodies and functions, including police, to recover their costs were also open to interpretation by families. The conversations among medical superintendents in official reports demonstrate some of their frustration with the ambiguous nature of the laws, as the chapter shows.

Christina Twomey points out that the poor sought 'assistance and welfare services from specifically state institutions' in the nineteenth century.[11] Other historians including Stephen Garton, Brian Dickey, and Margaret Tennant all argue, as Twomey's work about deserted wives also shows, that the reality of colonial attitudes to the poor was more complex, with systems of outdoor and indoor relief, including benevolent asylums, in place in the nineteenth century.[12] Warwick Brunton has described New Zealand asylums as *de facto* poor houses.[13] Although, as Tennant points out, there were no pauper asylums in the colony, the Whau at Auckland was sometimes described as a 'pauper asylum', because of poor conditions, including a lack of space.[14] Asylums for the insane were also sometimes sites of charity. At the 1877 Royal Commission into Woogaro Lunatic Asylum (later Goodna Hospital), it was noted in evidence that when destitute patients were discharged, asylum staff would take up collections of clothing and blankets to offer them; they were also given one free rail pass or steamer passage.[15] In 1913, an editorial in the *Sydney Morning Herald* described mental hospitals as charitable institutions, showing that this sense of their role lingered for some time.[16]

Although some health and welfare institutions were either partly or entirely supported by public funds, including hospitals, there was no poor law in any of the colonies.[17] Stephen Garton argues that Australian colonists were 'wary and contemptuous' of such a law, a view generally shared by other historians of welfare.[18] Illustrating this point, Michael Horsburgh suggests that some colonists felt uncomfortable about the charitable associations of hospital care in the nineteenth century, and that this view stimulated debate about the introduction of a class of 'paying patients' by the 1890s; between 1892 and 1910 the percentage of hospital income derived from paying patients in New South Wales grew to 15 per cent.[19]

The idea that a public fund would lead to 'pauperism, an upsurge in idleness, and a general decay in the moral standards of society' was shared by middle-class colonists, and their view extended to the asylum.[20] Nor was there an established class of wealthy benefactors, as in the British or American context; there was no social elite either willing or able to support either public institutions for the insane or private ones for the wealthy insane. Although the middle-classes remained sceptical of asylums, Gladesville Hospital regularly received an odd assortment of donations including fruit, plants, illustrated monthly papers and magazines, cash, and one year, mountain ducks, a rosella parrot and three deer, suggesting that some in the middle-class population supported its endeavours, or perhaps that Manning's public reputation encouraged this class to contribute.[21] Public newspaper notices in other colonies, such as the short notice of thanks published in the *Auckland Weekly News* in January of 1891, acknowledged some support for patients in the form of illustrated papers and parcels of sweetmeats.[22]

From the 1860s, asylums reported to colonial governments annually, making detailed assessments of their expenditure and costs recovered from families, and other forms of revenue. Asylum inspectors were at pains to remind governments that their institutions were not like other medical institutions, either in the colonies or beyond: for instance, asylums in Victoria, unlike hospitals, were 'entirely supported by Government funds', as the widely circulated 1864 report on colonial hospitals and asylums around the world reminded colonial readers. Early debates about the cost of supporting patients in New South Wales and Victoria demonstrate that this had a long history. In 1856, the cost of maintaining inmates at the Yarra Bend was reported as 'considerable', perhaps because the colony of Victoria was newly established, and not yet supporting a population a large enough to sustain its requirements for food and other items.[23] Patients and attendants needed to be

well fed, as the dietary scale demonstrates, with requirements for meat, bread, tea, sugar, milk and vegetables. Staff had to be paid sufficient to recruit and retain attendants.[24] In later years, asylum farms produced ample food and were proudly tabled in reports as helping to keep costs down; patient labour was touted as one important benefit to the public purse; as Dr Manning commented, 'patients supported at the expense of the State can be fairly expected to work for its benefit'.[25]

In Manning's expansive report on the world's asylums published in 1868, he deliberated on the possibility of the building of new asylums in New South Wales. He reminded the government that some years earlier, following a Commission of Inquiry into asylums in the colony, the Catholic Bishop Dr Willson of Hobart had been vocal on the issue of maintenance payments. In 1863, Willson had argued that a large Sydney asylum could contain 'three classes' of patient: those who were from 'humble' ranks, supported by public funds; those of the middle-classes, who could pay up to twenty or thirty shillings a week; and a 'third class paying according to the comforts they received'.[26] Willson disapproved of private institutions for the insane, believing that a mixed public establishment could effect cures more successfully. Manning reiterated these ideas as he presented his view that the colony's main approach to the support and provision of the insane should run along these lines, a point he reiterated in 1869. The friends of patients, he recommended, 'should be charged with their maintenance in accordance with their ability to pay'. In special cases, this would be a very low fee, of around five shillings per week. In other cases, the amount should exceed the usual payment of just over two shillings per day, especially considering some patients did no work because they were deemed to be 'paying patients'.[27]

Despite these recommendations, Manning wrote somewhat irritably about maintenance payments in his Inspector's Report for Gladesville in 1876. While the total amount gathered for the previous year was the best effort yet – almost £1080 – it involved, said Manning, 'a wearisome amount of correspondence, and the frequent assistance of the Crown Solicitor'. He continued: 'The tricks and subterfuges which are resorted to, to throw the cost of maintenance upon the Government, are not calculated to raise one's opinion of the standard entertained of personal responsibility'.[28]

Manning's complaint is important, because it is echoed around the different colonies and in the various inspectors' reports over the following decades. In Victoria, Dr Edward Paley wrote in 1879 that the relatives of patients might be asked to provide a declaration of wealth,

their 'position and means of payment'.[29] Perhaps because Manning was a zealous asylum superintendent, and later played an active role in the reform of lunacy legislation and nursing training in New South Wales, the reports for that colony were always more expansive on the subject of maintenance payments than were the reports for other colonies. Manning also had a great deal of rapport with families and empathised with their plight, as institutional and family correspondence reveals. But his views about the 'personal responsibilities' of colonists not living up to expectations help us understand his frustration in 1876. Another common explanation for the low recovery of maintenance payments around this time was that patients had few family connections. Again, in Victoria, Paley commented that while most colonists were 'better off' than their counterparts in Scotland, it was more difficult to obtain information about families in the colonies; 'it is well known', he wrote, 'that many of our asylum inmates are without either friends or relatives'.[30]

There were similar concerns elsewhere. In New Zealand, Frederick Skae's official report as Inspector of Hospitals and Charitable Institutions for 1880 noted that the lack of parish funds, and the relaxed nature of laws surrounding maintenance, meant that 'insanity' became an 'elastic' term, applied to many who could, in his opinion, be better placed in other forms of care.[31] Very few patients at Auckland had families covering the cost of their maintenance: the official inspector noted that only 27 of the 235 patients present in the asylum had made any payments towards costs for that year, and in only two cases were the entire costs met. In some cases, 'the sums contributed [were] got with difficulty, and hardly worth collecting'. The view of the relieving officer collecting the sums was that many could afford to pay more. Some amounts were recovered from family estates by the Public Trustee.[32]

In New South Wales, maintenance collections increased between 1876 and 1885. In addition, costs were still being recovered from the Imperial Treasury at Parramatta Asylum for the support of convict inmates, and sales of fat and old stores also helped to balance the books. While the actual cost of patient maintenance fluctuated, it had generally fallen over time. The pattern of falling costs and rising collections was sustained into the twentieth century, and by 1916 was attributed to the strong economy and established asylum farms. In Victoria in the 1870s, the Yarra Bend was more expensive than other asylums in the colony and recovered little from families.[33] Ten years later, the New South Wales reports made comparisons between the four colonies examined here, showing that the average weekly cost of maintenance was

around the same for each colony, at just over twelve shillings in the 1880s.[34] By the early twentieth century, all four colonies showed yearly costs per patient hovering around the twenty pound mark, with New South Wales and Queensland asylums marginally more expensive than Victorian and New Zealand institutions.[35]

At the Intercolonial Medical Congress in 1889, Dr William Beattie Smith, then superintendent at the Hospital for the Insane at Ararat in Victoria, championed the concept of the boarding-out of the insane. He commented that asylum inmates were essentially 'wards of the State, and housed by the various governments almost regardless of social distinction, the friends of each patient paying as much as they can be got to'.[36] In the 1860s, Manning had argued that insanity was different from other forms of illness because it was difficult to treat at home, and because it exposed patients 'to ill-treatment from the careless, the greedy, and the cruel', and because it had the effect of 'pauperizing' both patients and their families and friends.[37] This observation was a stark reminder of the reality of the colonial system for the management of the insane. In the following section of this chapter I comment on this theme, also touching on what institutional sources can tell us about social experiences in the colonies.

## Poverty, families and institutions

In 1893, the wife of a patient at Gladesville told the medical superintendent that her husband had been promised a job working on the roads, but that when the offer did not materialise, 'he found it very hard to obtain work of any kind, and he gradually got into very poor circumstances which preyed on his mind'.[38] One of the most common triggers for asylum committal was noted as 'poor circumstances'. There was steady, and in some cases, rapid economic growth in the south-eastern Australian colonies between 1860 and 1890. The population was increasing, manufacturing and construction expanded, and factories employed 17 per cent of the workforce by 1890. Unemployment was low, and the average male wage was between seven and eleven shillings per day, with similar average rates of pay in New Zealand. Women's official participation in the workforce was around 37 per cent by the early 1880s.[39] However, as institutional records indicate, even before the formal economic depression of the 1890s, people fell upon hard times. In rural towns in all of the colonies, work was seasonal and casual, and often disrupted by weather patterns and calamities such as drought. In 1869, many families could not afford to pay a one-pound bond for

the discharge of their relative to the asylum in New South Wales, and it was recommended that this be removed.[40]

An urban culture of poverty was apparent in the large cities of Australasia from the 1850s. Families were particularly susceptible to the deleterious effects of rapid change in colonial life. They were 'broken up' as one historian put it, and especially vulnerable to rough conditions and cycles of economic bust and boom.[41] Finnane has written that in working-class families, the ongoing economic and social stresses of life were common and well-known, suggesting that 'sudden signs of failure to cope' could surprise and upset families.[42] Children were identified as one vulnerable population by colonists. Some attention to the housing and education of destitute children was expressed though state-run institutions from the late 1850s in New South Wales.[43] For families and individuals, the experience of poverty both followed and compounded the problem of insanity. Margaret Tennant finds that sickness was an official cause of poverty in 1890s New Zealand, with the insanity of a breadwinner also appearing in the statistics compiled by government.[44] At Auckland, the record book of maintenance investigations for the 1890s, which includes some cases from earlier years, is the most detailed source of information on this subject. Over half of the 60 patients sampled for the study appeared in the record of maintenance investigations. 'Unable to contribute' was a common phrase, repeated in a number of the cases recorded here. The inspection of family incomes and habits of life was routine, and gendered assumptions about family-relationships-shaped decisions about them that were made by asylum authorities and by police. For instance, female family members were usually assumed to be doing their best, and were not vigorously pursued for payments by police, especially if they were seen to be 'industrious and respectable'.[45] The institution was obliged to find out as much as it could, often also looking to extended family and therefore even seeking people who lived beyond the colony, as cases discussed later in this chapter show. The information gathered about families and their finances in this process often paints a fairly desperate picture of life for many people.

In New South Wales, maintenance ledgers for Gladesville were not detailed about family circumstances. The records indicate payments made, but not attempts to seek payment. Of the sixty patients sampled from the Gladesville casebooks, only nineteen could be located in the maintenance books. Some of these patients were supported for short periods by family members; notes indicate that payments fluctuated, probably at times when finances were tight. The husband of Emily B,

who lived in Newcastle, contributed £2.3.4 per month from 1880, but this was reduced to £1.12.6 in February of 1881, until Emily's discharge in September that year. Louisa S was supported by her husband Frederick in the early 1890s, until in 1893 he could no longer sustain monthly payments; in 1894, only one payment was recorded, for £5, and the account was finally written off and closed in 1896. Louisa remained 'incoherent and odd' and was finally transferred from Gladesville to an unnamed institution in 1902.[46]

As the hospital authorities sought relatives for maintenance payments, they sometimes uncovered fractured families. In Victoria in the 1860s, some women fell victim to the hazards of peripatetic lifestyles: Annie O was an Irish woman living on the gold diggings in 1863 when she was admitted suffering from mania to the Yarra Bend by her husband. However, Annie's husband apparently paid for her keep.[47] Young single men who travelled the colonies looking for work were more vulnerable to institutional committal. In 1905, the mother of a 23-year-old labourer explained to the Goodna Hospital in Queensland: 'I have no mone (sic) or property and I can't afford to pay for him I only reared him I don't know where his father is. I never heard from him this 20 years. I am very sorry that he is there but I can't help him'.[48]

Although poverty and poor circumstances defined the experiences of many asylum inmates and their families, some were more fortunate, at least in financial terms. The case of Alexa C, discussed in Chapter 4, a young woman from a wealthy Sydney family who was admitted to Gladesville broken-hearted, delusional, suicidal, with the observation made by her nurse and companion that she had been 'seduced' by two unscrupulous men known to the family, raises questions about how the well-to-do handled such family matters. Alexa was in Gladesville for only a month and her maintenance was paid for in cash, an amount that totalled £3.0.9. In other cases, it is possible that the problem of the stigma associated with institutional confinement was a reason for the relatively poor rates of maintenance fee recovery, as Garton has suggested.[49] However, cases recorded for both Gladesville and Auckland also show the regular maintenance payments made to support inmates by a range of relatives and friends. In one case, Sarah R's husband made payments of £1.1.8 each month during the late 1870s and early 1880s, that is, over several years, with larger payments to cover a period of suspended payments in 1882.[50]

The perception that many people abused the system, articulated throughout the nineteenth century in official reports and newspapers, drove legislative change such as the Insanity Act in Queensland

in 1884.[51] Despite perceptible changes in social thinking about the obligations of the state towards the sick, elderly and needy, little seems to have changed for the administrators of the hospitals for the insane by the early decades of the twentieth century.[52] In New South Wales, as the *Sydney Morning Herald* noted in 1913, there was still a 'tendency' exhibited by some people to 'lean entirely upon the good arm of the State in the matter of the treatment of those suffering from mental disease'. However, the editorial argued that the law should be applied with discretion to allow those without the means to pay to be supported.[53] In practice, pursuing families for payment made busy work for the police, as archival records demonstrate. Shirking responsibility and avoiding payments to institutions was also often hard work for those accused of it.

## 'Tricks and subterfuges': deceiving authorities?

Whether motivated by the stigma of contact with the hospital for the insane, or simply unwilling to support family members, as Manning suggested in the 1870s, some relatives and friends did indeed go to considerable lengths to explain why they were unable to support their committed relatives. Prominent legal cases profiled in colonial newspapers, such as the case of Matilda King reported in the *Argus* over the month of July 1872, raised public attention to institutional confinement and maintenance payments. Matilda King was taken to the Yarra Bend in 1865, and her brief case notes reveal that the institution had determined that Matilda's husband Bernard had been 'living with another woman' but that he had means to pay for her support: he earned a good wage at the Hall of Commerce and had owned property.[54] He was summoned to court because he had not paid maintenance even though he had deserted his wife. Yet the case was complicated: King defended his honour, saying that his wife was actually still an inmate of the asylum and only out 'under the charge of bondsmen'. While she was confined, he said, he had paid the costs of her maintenance as a lunatic asylum inmate. Further reports showed that he had, in fact, paid more than seven shillings per week to the institution. However, Matilda showed the court that she had been deserted by her husband prior to her committal, and that she was now released; the issue was that she was entitled to past and current alimony payments. The court awarded in her favour.[55] Readers may have gained insight into the workings of asylum committal by following the case.

Letters to the institution from family members revealed that some relatives were dishonest or unwilling to take responsibility for the

problem of mental breakdown. In 1885, the wife of one patient wrote to Dr Scholes at Goodna to explain that she had only pretended to be dead to 'shock' her husband from his state:

> It was merely to try the effect of a shock on my unfortunate husband, that I begged Mrs Allen to write news of my death, as a confidential friend had told me of a case of that kind that had proved successful. The above address will always find me if required. Enclosed is a one pound note as a Christmas present to my husband.[56]

This woman's husband had been committed five years earlier, and he died in 1895. It seems fair to assume that this tactic failed to work since the institution sought confirmation of his wife's death.

One husband was threatened with arrest when he defaulted on payments to support his wife in the Auckland asylum. Elizabeth A was admitted in 1889 suffering from brain disease which left her demented and destructive. She was released, then readmitted in the early 1890s. Her husband was a bushman working in the Coromandel district; he supported their three children and his own parents. However, it was assumed he had the means to pay for her support; his land was freehold and he earned a tidy sum each week, about which the police were suspicious: they advised that 'no leniency should be shown'. He was difficult to track down and the police lost patience after issuing an order for payment; the entries in the Record Book of Maintenance Investigations show him disappearing into the bush, with the man working in a road party or working remotely in 1895 and 1896.[57] Other men went missing in similar circumstances, 'up country in NSW', or on gum diggings in the Northland region of New Zealand.[58]

In 1886, the two brothers of inmate John D contacted by the Auckland asylum claimed to be in 'poor circumstances' and also disputed the claim for maintenance, 'on account of John's illegitimacy'.[59] In a different case, the two sisters of Catherine F who were contacted in 1889 professed themselves 'unable to pay because of having to support an aged mother', but they directed the authorities to their brother William who owned a large farm and was 'well able to contribute'. The police traced William, and assessed his property, a 'perfect wilderness of furze and scrub', but were still trying to get him to pay in 1898. By then he had sold the land, and was keeping a boarding house with his wife.[60] Those who lived in remote areas were still sought by the authorities, who were not deterred by distance, however frustrating the cases may have been.

Sometimes people who raised suspicion could surprise. The father of one young female patient diagnosed as a 'congenital idiot' was farming unsuitable land at Mahurangi, most of which was swamp, and was 'burdened' by a large mortgage in 1892. Police declared that they would find it 'difficult to get any [payment] from him', also assessing the income of his brother who worked as a labourer. However, this man visited his daughter Catherine, whom he called 'Kitty', on more than one occasion at Auckland asylum, as Chapter 2 noted, and on one of these he left an account of a land sale made especially for the purpose of supporting his daughter. Although the records of payment appear to trail off in the archive, this story indicates that families sometimes experienced hardship and sacrifice in their efforts to support the institutionalised. Kitty died at Auckland in 1909.[61]

The views of the police are scattered throughout the record of maintenance investigations for Auckland, and sometimes appear in the casebooks in the records of other asylums referred to in this study. After extensive work to recover maintenance payments for one female patient in the late 1880s, police became exasperated. Her husband had the children, and his own mother to support. Two of her brothers were employed and single, while a third had a family to support. An order was made to her husband to pay five shillings a week, but this was quickly in arrears. But the police were suspicious and in 1895, commented again that 'no leniency should be shown' towards him.[62] Police in New Zealand were also sometimes involved in tracing individuals who had skipped the colony and disappeared into remote areas of Queensland or New South Wales, or who had made plans to go: police traced Alice, the wife of Alfred T, confined at Auckland in the 1890. He had been the manager of a cheese factory in the Waikato district. The police investigation in 1895 uncovered a bank account with several hundred pounds, and Alice's plans to leave for Australia. Similarly, Victorian cases show that some Victorian colonials escaped to New Zealand.

In New Zealand, police also made attempts to ascertain the ownership of land in the late nineteenth century in relation to maintenance payments for Maori patients and their relatives. Maori were, perhaps, patients whose cultural circumstances were at odds with the normative expectations of the institution. Patient Winiata W had been in and out of Auckland asylum and no maintenance had ever been paid. Police discovered that he was 'said to live with the tribe at a Pah (sic) in Mongonui and has an interest along with some others in some land but no deposit'. Mereana H, admitted to Auckland in 1898, had no relatives to support her because she had been supported, probably through

employment, by a European family for most of her life; but she, too, was still possibly linked to 'an interest in some land' through her tribe. The record of the investigation noted that an application to the Native Land Office could assist in finding this out.[63] It was not uncommon for land and its value in general, owned by both Maori and Pakeha, to be of interest in these police investigations. However, the Pakeha scrutiny of Maori land ownership has a different historical resonance. While it is outside the scope of this discussion, land alienation was a significant theme in the institutional records for the Maori patients located at Auckland. The Record Book of Maintenance Investigations lists the details of eighteen Maori patients, most of whom had relatives with an interest in land.[64]

## Family economies: money and emotions

Taking the example of Sydney, Shirley Fisher notes that colonial urban economies, with their reliance on pastoral and construction industries and casual, mobile labour, placed 'extreme stress on the formation and maintenance of families'.[65] Family economies, then, might be understood as both fiscal and emotional. Cases from Auckland illustrate this theme well. In the 1880s, one patient's maintenance was paid out of her parents' estate which her brother claimed had been whittled away by the cost of their funerals. Another brother and two sisters were then traced, and named, and the Public Trustee made inquiries into the status of the estate, a quest which continued for ten years until the trail went cold.[66] In another case, the four brothers of Frederick M were located after investigations by police. All four brothers were employed, two as bank managers, one as a solicitor, and the fourth as a surveyor. Their incomes were assessed and are listed in the records. Police deemed three of them, in particular the solicitor, to be 'hard up' and unable to make payments. The wealthiest brother was hit with legal proceedings, but suddenly left his position due to ill health. The other three brothers were then spurred into action, and came up with another solution, offering to pay small amounts each week towards the cost of maintenance. Legal proceedings were dropped. The Maintenance Payments Ledger records the way the brothers shared the responsibility among themselves.[67] The ledger provides other glimpses into family economic life: cheques that were dishonoured; families who kept up regular payments over many months; families who, as in the case of Frederick M, juggled the costs between siblings and other relatives. In some cases, debts were 'written off' by the Inspector General of Asylums.

Patients and families sometimes used the institution as an adjudicator in family disputes. The New Zealand relatives of Isabella M were outraged in1888 when they heard that authorities at Goodna in Queensland were seeking family contacts to assist Isabella in the event of her discharge. They wrote, 'hoping you will find her husband and make him pay for her keep and not send her here a burden to those who have more than enough of their own'.[68] Isabella died the following year at Goodna. In a different case, Catherine M, while on a trial release from Goodna, wrote to Dr Scholes asking for money: 'I get no money no mater (sic) what I do ... I want the money you recovered from my husband'.[69] There was a perception that maintenance payments collected by institutions could be returned to patients once safely released and recovered, and although this was not the case, there were occasions when the asylum was obliged to pay a discharged patient or his or her family any monies owed, as a letter to the Auckland Asylum from the Public Trust Office in Wellington noted about patient John L in 1898.[70]

Other ideas about the ways in which maintenance costs were used to determine discharge were common among families. One patient's brother-in-law wrote to the Auckland Mental Hospital in 1913 about his wife's brother John, telling the Superintendent that friends told the family that unless maintenance was paid, release was unlikely. 'If they will only let my brother-in-law out', he wrote, 'I will sign any agreement to pay for every day that he has been cared for in the mental hospital'. Notes about this patient suggest that institutional confinement was not unknown in the extended family; knowledge about different asylum practices therefore circulated among its members, even across colonial borders.[71] This brief discussion suggests that historians might revisit both the experiences of mental breakdown, and the relationships between families and institutions in this period, by examining the meanings of 'family' for the friends and relatives of those who were institutionalised.

## Conclusions

Margaret Tennant comments on the 'persistent ideal' of 'family responsibility' which shaped some public responses to the needy in colonial life.[72] This ideal was never realised in the matter of asylum committal, but arguably underpinned many of the public narratives around asylum committal into the early twentieth century. While it is possible to show that some families sought help from institutions, others were

highly disadvantaged in their encounters with authorities, including members of indigenous communities in both Australia and New Zealand. As Chapter 2 argued, colonists placed more emphasis on the mental health of Europeans; it was the white colonial family that was firmly positioned in the centre of changing institutional discourses of insanity and its management between the 1860s and 1914.

Debates about the management of institutions continued into the early twentieth century. Despite the relatively slim gains made in the collection of maintenance fees, the vast majority of asylum patients were still largely supported by the state.[73] While the problems of overcrowded hospital spaces and ongoing costs drove leading professional figures in the colonial world of psychiatry to express concern over the poor rate of maintenance payments in medical meetings, newspaper articles and medical publications, their frustration over institutional finances and maintenance collection was linked to demands for legislative change around private institutions, and related discussions about patients and leave-of-absence or trial leave, and the boarding-out of the insane, a practice which never took a firm hold in Australasia, as the following chapter shows.

# 6

# Porous Boundaries: Families, Patients and Practices of Extra-Institutional Care

In 1873, a note from the Yarra Bend Asylum recorded that Margaret C, admitted to the care of the institution in September, was allowed to go home in the care of her husband but only under the condition that he was aware of her suicidal impulses. Margaret's husband was told about his wife's melancholia and suicidal tendencies because her health was to be his responsibility once she was placed in his custody. The Recognizance for Safe Custody of a Lunatic outlined that he would be liable to pay a sum of £50 if he failed in his care of Margaret. But how would this work in practice? While no further details survive in Margaret's case, her situation, as a mother of five children, suggests that she would be returned to everyday life where she would either survive, or experience a relapse of her poor mental health.[1]

More information exists for other patients who were released on trial for short periods of time. William R was granted a leave of absence from Gladesville Hospital in January of 1889. He had made what the institution considered to be good progress following his initial diagnosis at admission in August 1888. William had suffered from delusions and hallucinations, he heard voices, and was deemed unable to take care of himself. But by the end of that year, he seemed 'almost well'. Sadly, while out on leave, William went into the bush in the early hours of the morning, sharpened a knife, and slit his own throat. He left behind a wife and four children. A newspaper report was pasted into his case file.[2]

This chapter takes up David Wright's question about the 'primacy of the mental hospital' by investigating how families and communities coped with insanity back inside the space of the private household, and how patients themselves may have coped with this transition.[3] It therefore examines the interplay between institutions and the outside

world, and the spaces between institutionalisation. Debates across the period about methods of extra-institutional care, including trial leave and boarding-out, show that the institution's walls were not impermeable. In the nineteenth century, the European and Scottish systems of boarding-out of the insane were frequently cited by contemporaries around the world, including by colonial and other asylum administrators, as examples of what might be achieved, especially by the 1880s and 1890s. The Scottish scheme was created in the middle of the nineteenth century and has been described by Harriet Sturdy and William Parry-Jones as a 'pioneering policy'.[4] Sturdy and Parry-Jones suggest that in Scotland, the history of the boarding-out system demonstrates a 'gradual acceptance of the insane'.[5] The 'remarkable insane colony of Gheel', as Henry Burdett described the Belgian boarding-out system in his study of the world's asylums published in the 1890s, also became a model for those seeking new forms of extra-institutional care, especially after the 1860s.[6] Perhaps surprisingly neither Australasian historians of welfare or psychiatry have turned their attention to colonial practices of the 'boarding-out' of the insane, although parallels with other forms of boarding-out might be found. Studies of social policy in Australia indicate that the term boarding-out was used in cases of destitute children who were placed into care.[7]

Recalling Akihito Suzuki's notion that mental breakdown was potentially threatening to families from the inside, this chapter outlines the way that families and private households nevertheless became sites for the negotiation of the control over insanity in some instances.[8] Nancy Tomes also argues that as families came increasingly to find institutionalisation one solution to family domestic problems caused by the stress of mental breakdown, the asylum, too 'inevitably became the focus of familial conflicts'.[9] I argue that some of these might be witnessed through the mechanisms discussed in this chapter. Provisions, however limited, existed in all the colonies for the 'safe custody' of the insane. This chapter describes these provisions by drawing upon trial leave and leave-of-absence registers and statistics, official reports, legislation, correspondence and patient case notes. These histories of families and their negotiations with institutions are among the hardest to identify in institutional archival sources, as Geoffrey Reaume writes in his study of Toronto Hospital for the Insane in Canada between 1870 and 1940. Indeed, the 'limited documentation' of discharge and forms of release, noted by Reaume for Toronto, is replicated in the colonial Australasian institutional contexts.[10] Yet by piecing together fragmentary pieces of evidence, this chapter argues that public institutional sources can reveal

much about families' own abilities to care for the insane at home, and even more about their often complex responses to mental breakdown. These reactions also highlight the roles of the hospitals for the insane in their efforts to further define the roles of families and institutions in colonial society.

The chapter first examines the different practices of trial leave across the colonies, also exploring the rhetoric against family and patient experiences. The transitions between the asylum and home could be tense, fraught with anxiety and often end badly. There was a relationship between trial leave and eventual discharge, but also between repeat discharge and readmission. How families fared in their efforts to prevent calamity is one focus of the discussion. Public commentary and reportage about 'lunatics at large' added to the atmosphere of uncertainty about the way that these practices functioned. The chapter also examines colonial attempts to institute boarding-out schemes. The relative success of trial leave for colonial institutions and families meant that boarding-out was ultimately a failure in the colonial environment. Finally, the chapter provides an account of one colonial organisation devoted to assisting patients (and by extension, their families) following discharge from a hospital for the insane. The After Care Association of New South Wales was established in 1907 and realised its dreams to facilitate community rehabilitation for some of the mentally ill.[11]

## Trial leave and leave of absence: institutional practices across the colonies

The concept of being out on a 'trial' conveys the intention of asylum authorities, who expected patients and their families to remain in contact with them. Some institutions required a regular meeting while a patient was on a trial leave, or, if travelling long distances presented difficulties, a form of contact such as a letter from a local doctor could sometimes suffice. The name given to this practice differed from place to place following separate legislation. It was known variously as 'Absent on trial' (Auckland); 'Leave of absence' and 'Trial leave' (Victoria); 'Leave of absence' or trial (New South Wales); and 'Leave of absence' (Queensland). Auckland Mental hospital kept a register of patients absent on trial from 1878. This was most likely a bureaucratic practice begun in response to criticism of the institution by the Inspector of Lunatic Asylums who noted that the hospital had inadequate systems in place to record patients on probation.[12] The register perfunctorily records names, dates and places of residence.[13] In Victoria, applications

could be made on behalf of patients seeking leave of absence from the asylum.[14] Each application had to be signed by the person who was responsible for the patient while they were on leave, and the Medical Superintendent, and approved by the Inspector General. Applications recorded the relationships between the patient and the person responsible for them while on leave; the place where the patient would reside while on leave; and the dates of leave.

By the early decades of the twentieth century, these practices of trial leave were regarded as very successful. Perhaps because of the relatively high numbers of patients out on leave from institutions in each colony over the course of a year, the official view on patients' leave was that it was a practice more common to the colonies than elsewhere, and well-suited to that context. Dr Eric Sinclair, in his Presidential Address to the Australasian Medical Congress for 1908, described the 'power to give leave of absence' as being of 'inestimable value':

> Not only may convalescent patients be discharged earlier than would be justified without it, or doubtful cases tried outside, but unrecovered patients may be permitted to go to their homes for short periods, and those liable to renewed attacks may spend the intervals with their friends. Again, by permitting a patient to be absent on leave to himself, as it is called, many cases can be allowed to leave the hospital who have not sufficient confidence in their own stability to be discharged. They are aware that they still belong to the institution, and can return at any time they desire, and thus the nervousness they would otherwise feel is allayed.[15]

Sinclair's comments show a growing awareness of the way that mental health patients were dogged by sometimes unpredictable illness trajectories, which also formed a pattern of care. The notion that patients would still 'belong' to the asylum is also important. As Cheryl Krasnick Warsh points out, families' input into institutional care did not end with discharge, because individuals continued to be in a relationship with the institution and the wider community which had been shaped by their status as patients.[16] This is illustrated in the cases of patients reported beyond the institutional confines, sometimes when they were out on leave, supposedly enjoying the freedoms of life as recovering patients. A one-time official visitor to hospitals for the insane, Mr F G Ewington, gave an interview to the *New Zealand Herald* in 1896. He told the reporter that the treatment of insanity had changed to the extent that sufferers were more often released and able to resume 'normal' life. Cure was an

aim of the institution. 'Frequently', he said, 'I meet people in the streets of Auckland whom I have seen in the Asylum. I always make a point of not noticing them unless they notice me first; otherwise, I might suggest painful associations'.[17] Short periods of leave when well could allow families to adjust to individual sufferers in the domestic environment, even temporarily, also relieving the institutions of pressures on space. However, as the chapter indicates, not all such temporary absences were positive for patients and their families or friends.

Families knew enough about these practices to want to use them, as Sinclair also noted.[18] Institutions were regularly petitioned by family members. At the Yarra Bend, a register of applications for patients' leave of absence made by family and friends reveals that while caution was exercised, institutional authorities did hope for 'cures' beyond the hospital. In 1899, Margaret K's mother Honora made a formal request for her daughter to leave the asylum at Yarra Bend, stating 'I am desirous of removing the patient ... although Dr Watkins informs me that she will require special observation for some time; and I agree to provide such attention'.[19] Margaret, a farmer's widow who cared for her five young children, had been admitted two years earlier suffering from delusional melancholia. The removal request was approved, and later that year Margaret was finally discharged. Others made similar undertakings, often writing to the institution to explain their circumstances, in the hope that the Inspector of Lunatic Asylums would look kindly on their plight.

In New South Wales, the system of leave of absence was introduced by Dr Manning in 1880 and was designed for those patients 'on the borderline of recovery'.[20] The legislative adjustment in New South Wales took some years to trickle down and effect change; by 1885, as the report of the Inspector General showed, eighty-eight people from five institutions in the colony were granted leave during the year, with thirty-one remaining on leave from Gladesville at the end of the year. The report noted that these numbers were an increase on previous years.[21] Leave was both useful for determining the possibility of discharge, as Stephen Garton states, and also functioned to relieve overcrowding. The rates of leave increased in later decades when the system was managed by Eric Sinclair.[22] Leave of absence from the institution often preceded discharge, as this chapter later explores.[23] Periods of leave could be granted to patients who may have seemed at risk after their release on trial. From time to time, patients did not survive the stressed induced by leave at home. The reasons for leave were complex and often related to family roles and responsibilities. When, in 1894, Frances K claimed

to have 'sold herself to the devil', she was taken to Gladesville where she stayed for around a year. Pronounced a 'melancholic', she set about writing to her Aunt Annie. 'Will you come and see me', she asked, 'now the month is up I want to know about my children'. She was worried she had neglected them: 'I do not know one moment's peace my life is a living death.' Sometime later, she was granted a leave-of-absence from the institution before her eventual discharge in 1895.[24]

The Insanity Act (1884) provided for an extended Leave of Absence for patients in Queensland institutions. In his Report of the Inspector of Hospitals for the Insane for 1905 the inspector Dr James Hogg noted that this provision was used widely to great advantage, and gave patients 'an opportunity of enjoying home life during their quieter periods, and enabling friends to see how patients get on under ordinary circumstances'.[25] It was also an opportunity for families to test their capacity to relate to and cope with the patient at home. Despite the apprehension some families must have felt, they still wrote to asylum authorities to request and even plead for their sick loved ones to be allowed home on leave. Sometimes, this leave proved to be positive, but not for all family members. John B's two daughters and son-in-law all signed a letter to Goodna in 1899 saying that they were glad to see John out on leave, 'looking so well', and hoped that they could 'keep him out ... most anxious for him to be at liberty'. However, his wife was 'afraid to live with him', showing that families were not always united or harmonious in their responses to patients and their release.[26]

The importance of a clear understanding of medical certification, discussed in Chapter 3, was also relevant to the process of trial leave. Dr Patrick Smith's 'Hints on the Giving of Lunacy Certificates' published in the *Australian Medical Journal* in 1874 also outlined the role of doctors in providing medical certificates. Smith reminded the readers of his 'Hints' that patients who went out on leave had usually been 'for a considerable time in an asylum, and their dispositions ascertained to be thoroughly harmless'.[27] These patients were allowed out so that medical superintendents could decide whether they were fit to leave the institution for good; whether the 'change of air and scene' and time spent with family and friends was beneficial, or still prone to risks to the patient or those around him or her.[28] He explained that the process was called 'probation' or 'trial', and during this period, a patient could, through his relatives and friends, make an application to a single medical practitioner for a certificate, which could be sent to the superintendent to hasten discharge, unless a patient resided in the same neighbourhood as the institution. In that case, a patient might present in person to the

asylum to show his or her fitness for release. Families made attempts to interpret the regulations for themselves. The family of elderly George B, who escaped while on trial leave from the Yarra Bend, made a special request for his irregular release, suggesting that such a certificate was too difficult to obtain since they lived more than 17 miles from a doctor. Their request was referred to the Master in Lunacy.[29] In 1900, the father of 19-year-old Mary M wrote to the Yarra Bend to explain that it was inconvenient to find a doctor, because they lived 30 miles from the nearest medical practitioner; besides that, Mary was well, and the family did not 'notice anything wrong with her'.[30] However, it was only a few days later when her father wrote once more, stating: 'since then she has been a deal worse she is very queer this five days ... we cannot get her to eat any food can I send her back to [the] Asylum'.[31]

Dr Smith agreed with his contemporaries that some medical practitioners were uneasy about having to exercise their medical judgement in such cases. The responsibility was perhaps 'too great', as Smith predicted in his 'Hints', for these doctors. George B was admitted to Goodna Hospital in 1907, and in 1908, he was allowed out on leave several times. Originally from Ipswich, George was back working there when he took himself to the doctor to procure a certificate of good health. The doctor wrote to Goodna to explain:

> He stated he was in regular work and did not want to lose work. Not knowing the man I did not want to give a certificate, but said I would write and that he could present himself shortly. As far as I could ascertain in the surgery, his mental condition is sound at present and he is a fit and proper person to be at large.[32]

Being in regular work was crucial to George, who first found himself unemployed after an injury made him too weak to work as a fireman; he became depressed and miserable. The casebook notes show that his period of leave in 1908 did not lead directly to discharge, though he was released in 1911.

Although official reports reveal that practices of leave of absence played an important role in the work of institutions, especially by the end of the period being examined, relatively few patients sampled for this study were granted trial leave or leave of absence. For example, only a quarter of New South Wales patients in my sample, or sixteen of sixty individuals, were ever granted periods of leave, according to the records I have located, and even smaller numbers of patients in both Auckland (ten of sixty patients) and Goodna (eight of thirty-five patients) hospitals

were allowed out on trial. The patients sampled for the Yarra Bend were drawn in part from registers of patients on maintenance bonds and their cases provide evidence of the specific practices at work in Victoria, which had developed around the concept of boarding-out. The following examples drawn from the archival research illustrate the sometimes difficult nature of the transitions between institutions and 'home'. As the Inspector General of Asylums, Duncan MacGregor noted in New Zealand in 1905, the 'technical phrase' of leave of absence 'on trial' embodied the possibility of failure, the fear of which shadowed patients and their families alike.[33]

**Transitions**

For the families, relatives and friends of inmates who offered support to those on trial leave from institutions, the transition was sometimes difficult. Patients were often expected to return to their normal household duties, but also regularly failed to perform them adequately, or were distracting and unpredictable at home. Annie W, an eccentric woman, conducted her housework well, but then followed her husband jealously and excitedly as he went about his daily business. Yet Annie's husband wrote very positively to Goodna to provide an account of his wife while she was on leave, suggesting that he could bear her eccentricities if she was 'getting a little better of her nervousness'.[34] In other cases, patients released were unable to conform to family and institutional expectations of good behaviour. In November 1890, John O, formerly a lighthouse keeper, was released from Goodna into his wife's care around three months after his admission. However, the case notes record that 'his wife could not manage him he borrowed money from the neighbour and went and got drunk on it', and a Goodna attendant was sent to collect him from his home on Moreton Island and take him back to the hospital.[35] His wife wrote to Dr Scholes to apologise, confessing that she should never have taken him out. He was 'dreadful', she said; 'I am losing my trade through him, yesterday he came in drunk and threatened me with a knife'.[36] Nonetheless, John was discharged several more times over a period of two years, each time agitating for his own release. The wife of David P, released from Gladesville in 1907, had to cope with her husband doing no work, and leaping 'about the streets all day ... restless and talkative'.[37]

Families in 'poor circumstances' were less able to take care of economically unproductive patients released on trial periods of leave. They often needed a domestic worker or breadwinner back home to support the household economy. As Jennifer Robertson has argued, families

committing adult men to institutions sometimes lost a valuable wage; those committing adult women lost household members who had, at least when well, functioned as domestic organisers and caregivers, cooking, cleaning, preserving fruit and meat, making butter and soap, and selling eggs.[38] These factors shaped discharge statistics. Bronwyn Labrum argues that adult women were discharged from the Auckland Mental Hospital more frequently than men, in part because of their important domestic roles in the home.[39] Although these economic concerns could drive family decisions about bringing patients home, emotional attachments also played a role in arrangements for trial leave. Henry, the husband of Ada B who was admitted to the Yarra Bend in 1899, was desperate to have his wife home, as Chapter 4 described. Her role as housewife was one factor, but Henry was adamant that despite his work on the wharves, he could take care of her. He explained that she was not dangerous, nor was she addicted to drink; he could handle the episodes of fitting which characterised her illness. He ended his letter with a plea to allow his home to be made whole again.[40]

Despite the advice offered to medical practitioners by Dr Smith in his 'Hints', patient behaviours while on leave and outside the asylum walls were not always benign. Charles M, a young man 'deficient in intelligence and memory', and judged a congenital idiot, was released on several periods of leave from the Yarra Bend in the late 1890s having performed asylum work, behaved well, and was clean and tidy in his habits. His father wrote to Dr Watkins in 1900, perturbed by his son's self-abuse and worse, his habit of exposing himself to women. He went to some lengths to prevent police from intervening in the case. It was heartbreaking for his father to admit that, as neighbours had commented, he was 'not fit to be at large'. Watkins telegrammed to say that 'under the circumstances' he had better return Charles to the institution 'at once'.[41] Other patients went home and were violent towards family members and others in their communities. The fair-skinned, blue-eyed Alice D was returned to Gladesville in 1895 following her 'erratic conduct', and her violence and abuse towards her brother's wife.[42]

Visits home sometimes ended prematurely. Sarah Ann R made several visits home to her husband in Sydney in 1884, but each of these ended early, which contributed to the delay in her eventual discharge by ten years.[43] Her illness was compounded by what her husband supposed was secret drinking, as he suggested to the institution when she was committed in 1879.[44] Another woman, 17-year-old Ellen T, was admitted to Gladesville in December of 1896 after showing unusual behaviours including following her mother everywhere, suspicion, and a vacant

manner. One of the family's theories was that Ellen had been injected with cocaine by a dentist three months earlier causing her to become 'rather stupid'.[45] She continued to be nervous and frightened in the hospital for several weeks, but was allowed out on leave in January of 1897. She was returned to Gladesville before the end of her leave, described as 'unmanageable at home and said by her mother to be doing outrageous things'.[46] She swore at her mother, refused to be controlled, kicked and hit her, and threatened to put poison in her tea. One family solution was to send her to stay with another family, but here Ellen stole money and was rough with the small children in the household. After two further months at Gladesville, and indications that Ellen could be polite, cheerful, and conduct herself well through work, she was discharged.

The line between a trial leave and formal discharge could be blurred by some families keen to secure a patient's release from hospital, as institutional authorities themselves recognised. Charles M was assumed discharged from Gladesville in 1900 when he had merely been granted leave. Although not, seemingly, particularly unwell, he resumed institutional life and played cricket for the Gladesville team until 1903.[47] If a patient did not return to the hospital as planned, as pointed out by Dr Sinclair in 1908, he or she could be recaptured as an escaped patient, again reinforcing the belief that patients on leave still belonged to institutions in law.[48] The copious correspondence which remains in the files for Emily R, who was institutionalised at Auckland in 1900, shows that family members became attuned to the rhythms of illness, hospitalisation, leave and discharge. Following at least four admissions, Emily and her family knew by 1915 that a medical certificate was required if she was on probationary leave and at home for specified periods of time. They wrote frequently during her periods of leave to request extensions of time, writing convincingly of Emily's good health.[49]

**Discharge**

Most of the patients sampled for this study were eventually discharged. One-third of Auckland's patients and over half of the patients sampled for Gladesville, the Yarra Bend and Goodna were released. The length of their official institutional stays varied, and some patients were discharged and readmitted more than once, but the vast majority of patients stayed in institutions for several months. Many patients were then released. After their release, their stories often end abruptly and cannot be traced much further. However, aspects of the discharge process itself also sheds some light on family processes of coping with mental breakdown and its aftermath.

Repeat admissions, such as the case of Mary J at Auckland, who was admitted eight times between 1894 and 1911, tell us much about the dynamics of family and institutional care. Mary's nine children found it increasingly difficult to cope with her alcohol abuse and violent, alcohol-fuelled outbursts, even though they assisted her when she was discharged and released.[50] A remark in Mary's case notes for November 1900 sums up the family's dilemma: 'Begins to look forward to being discharged early tho her people – it is said – are always glad when she is in the asylum – as when away from a well-ordered life she becomes troublesome to her neighbours ... [and] gets lazy'.[51] The family of Mary Ann U faced similar challenges. She had been admitted to Goodna seven times since 1879 for reasonably short periods of time, around three to six months. Admitted again in 1896, 'thinner and worse for wear' and seeming glad to be back, by the early 1900s, she was able to go out again on short periods of leave. On these occasions she stayed with her daughter in Brisbane. In March 1902, Mary Ann wrote to Dr Hogg at Goodna:

> Dr Hogg, Sir, I now take the pleasure of writing these few lines to you just to let you know how I am getting on I am keeping very well thank God and I hope to continue so the same when I come up next week you will give me my discharge.[52]

However, only a few days later, Mary Ann's daughter had an operation in hospital and was forced to return her mother to Goodna, and she faced several more transitions between family and the institution that year until she was discharged in 1909. Her daughter was possibly worried about the limitations of the care she could provide, telling the asylum after one visit home that her mother had 'been behaving very well, but that she was worried over some fainting attacks which she had had'.[53]

Patients were also faced with the demands and problems posed by negotiating life outside the institutions, but the extant evidence rarely tells the story from their point of view. Patients' own correspondence to asylum doctors survives in a few instances. Thomas L, whose delusions had included the idea that he was 'Chief Engineer of the World' in 1885, left Goodna in 1886. He was on his way home to Maryborough in Queensland when he stopped at a hotel and had half a pint of beer, as he confessed to Dr Scholes, to keep his 'courage up and also to strengthen the inner man' before his wife and daughters met him at the wharf.[54] He repeated the asylum's own dictum when he remarked that the 'old saying still holds true that if ever so Humble there is no

Place like Home in the Bosom of one's own Family', and conveyed his gratitude to the medical staff at Goodna.[55] Henry C wrote to Dr Hogg requesting a formal letter of discharge, and unlike Thomas reported that he was 'keeping away from the drink'.[56] Other Goodna patient letters also survive, a fact which perhaps demonstrates a significant level of trust between patients and doctors at the institution. In her letter to Dr Hogg in January of 1896, Eliza W described herself as 'feeling so well' that she did not want to lose the chance to leave the hospital, find work and re-establish a home for herself.[57] While Eliza's strategy seemed to work, and led to her discharge from Goodna, another patient who wrote to Dr Scholes ten years earlier claiming he had 'done good for this establishment' was forced to effect his own escape in 1885.[58] Perhaps less fortunate was George B, who wrote demanding his discharge from Goodna in 1903, explaining that he was a 'very quiet and inoffensive man' but that he had already appealed to visiting medical men for his release.[59] But George was not released, because his fate was to be transferred to an institution at Toowoomba in 1904.

These patients and others had been able to advocate for themselves, albeit to a limited extent in some instances. Keen to speak on their behalf, families also occasionally made their way inside the asylum walls in person.[60] Many of the letters examined in this study reveal that families not only wrote about leave arrangements and discharge, but also often wanted to visit institutions, and would write for special permission to do so. Patients also wrote, asking, and pleading, for family contact and advocacy. Both patient case notes and family letters show that family members often physically encountered institutions at the point of committal, and also at the point of discharge, both highly emotional moments in the lives of patients and their families.[61] A family visit could make the prospect of a trial leave more likely, as it did for Ellen G in 1895, who 'improved so much after a visit from her husband that she was allowed absence on trial', followed by discharge in April 1896.[62]

Some archival sources tell us more about these processes for patients and families. The Visitors' Book at Auckland records hundreds of visits made to patients at Auckland over the period 1891–1911.[63] When visitors signed in, they were obliged to note their name and address, the name of the patient being visited and their relationship to that person. Some patients were visited regularly by the same person, others by different family members. Some addresses indicate that visitors came from distances of over 100 miles.[64] This source also tells us more about processes of leave and discharge. For example, for some patients,

asylum committal, trial absence and discharge became a pattern, with family support an important factor in their experiences. This is illustrated by the many visits over time to Stephen H at Auckland. Aged 41, Stephen was a tinsmith who had been 'acting strangely' for some time, drinking too much, and who had become melancholic and withdrawn at the time of his committal in May 1900. His wife gave copious information about his state, including that he 'became timid and was frightened to go out of the house imagining people were watching him'.[65] He was admitted and discharged several times over the next two years. In 1900, he was visited several times by his wife and his father until his discharge in September. The following year he was visited at the asylum again, this time by his wife and daughter, by his sons together, then by a son with his daughter, his father, and so on, with a shifting pattern of family responsibility over many months suggested by the range of arrangements. Stephen's family lived in Auckland's inner city, making their visiting more possible, since the asylum was accessible to them. Their visiting also suggests an understanding of the importance of its therapeutic value, with evidence that his initial committal was only a short stay in the asylum. At committal in 1900, he had been concerned about 'disgracing his family'.[66] These visits show a distinct determination on the part of family to ensure his eventual complete recovery.

In other cases, different factors, including ethnicity, ensured that institutional committal was tantamount to a death sentence. Very few Maori patients were discharged from Auckland when compared to European patients. Maori were also more likely to remain in the care of the state, either through confinement in prisons or in homes for the elderly. Of the total number of Maori committed to Auckland between 1860 and 1900, more than half died in the institution.[67] Winiata was a 28-year-old Maori male who was admitted to Auckland for the fourth time in 1885. 'Noisy, independent and quarrelsome' in the asylum, Winiata's behaviour outside the asylum also attracted the attention of the newspapers.[68] 'A few days ago', reported the *Auckland Weekly News* in October of 1883, 'the Maoris came down the river with a man named Winiata, whom they had bound hand and foot and clothed in a straight waistcoat'. Describing him as 'very violent', the Maori handed Winiata to Constable Scott.[69] Some years later the man was again in the news after burning down his mother's house.[70] The repeated admissions and returns to his whanau (family) show that Winiata was not shunned by his own people, who struggled to care for him and made use of the institution when his mania returned.

**Escapes, suicide and death**

Newspaper reports such as these, which focused on the dangerous 'lunatic' at large, did not encourage confidence in the asylum system in the colonies. Garton writes that Dr Manning was cautious about the leave scheme in the early 1880s, especially given the public anxiety about the insane in public in the 1870s.[71] Manning and other doctors were called to account for their decisions on some occasions.[72] Newspaper reports explored questions of family responsibility. Nora Downs, who had a history of insanity and hospitalisation, but was now living with family near Colac in Victoria, left her brother's home taking money and a travel-bag in 1870. She was missing for several weeks until she was found dead in the bush on a remote track. The *Argus* commented that the inquest into her death blamed her brother's negligence in not keeping a closer watch over her movements.[73] The dark-haired, swarthy Catherine Beveridge, lately of Kew Lunatic Asylum near Melbourne, was missing in 1879, identifiable by her black and red shawl and her black straw hat.[74] An asylum escapee was reported captured in the *Auckland Weekly News* in 1891.[75] 'LUNATIC AT LARGE' was used more than once in the *Auckland Weekly News*. The repeated escapes and captures of David Hartwell warranted the use of the headline in 1905.[76] Hundreds of short reports filled the columns of colonial newspapers in the period investigated in this study.

Patients walked free from institutions, and became escapees, when they were deemed well enough to be in the grounds without supervision, such as George J, who made more than one daytime wander beyond Gladesville in the 1880s.[77] Gladesville may have gained a reputation for being insecure: two other patients escaped, one slipping away from the attendants while in a walking party, and the other while working in the garden.[78] One man who was said to have 'escaped' from the Yarra Bend took up his own defense with the institution, writing that he had been on leave from the asylum for over three months, therefore he could not be 'recaptured'.[79] He also took over the communication between the asylum and his wife. He wrote that 'neither she nor I consider it necessary to seek further medical examination'.[80] Knowing the legal processes was, for Frederick E, one way of assuming control over his health, and he was able to orchestrate his own release. Patients who had experienced serious episodes of mental breakdown were generally viewed as unlikely candidates for trial leave. This chapter and Chapter 4 have already mentioned cases of suicide as examples of the probable emotional impact of mental illness on families, such as William R who slit his own throat while out from Gladesville on leave of absence, and

*Table 6.1* Discharge, removal and death from all asylums in each colony, c. 1905

| | NZ | NSW | VIC | Qld |
|---|---|---|---|---|
| Discharge/removal | 391 | 586 | 343 | 144 |
| Deaths | 214 | 342 | 331 | 131 |
| Total | 605 | 928 | 674 | 275 |

*Source*: Official figures from annual Asylum Inspectors reports, Parliamentary Papers (Australian colonies) and *Appendices to the Journal of the House of Representatives* (New Zealand), 1904–1905.

*Table 6.2* Discharge, removal and death for each of the four public asylums, c. 1905

| | Auckland | Gladesville | Yarra Bend | Goodna |
|---|---|---|---|---|
| Discharge/removal | 88 | 234 | 89 | 110 |
| Deaths | 64 | 53 | 75 | 88 |
| Total | 152 | 287 | 164 | 198 |

*Source*: Official figures from annual Asylum Inspectors reports, Parliamentary Papers (Australian colonies) and *Appendices to the Journal of the House of Representatives* (New Zealand), 1904–1905.

Jane H whose shocking suicide after her leave from the same institution highlighted the risks in a rather dramatic fashion.[81] Both William and Jane wrote lengthy, confessional and strange letters to family members which were held by the hospital as evidence of their poor states of mind. Jane had made three suicide attempts while inside Gladesville, but was still granted leave.

Although most patients sampled for this study were eventually discharged, there were some whose lives ended in the institution. Mary J, whose family cared for her in Auckland between her repeated episodes of mental breakdown, died in the institution in 1915. One of her daughters, Ada, explained by letter that she had worried about the fact she had not been able to visit her at the hospital; she had twice been ready to go but stopped by bad weather, and because 'my baby is just at that funny age', she wrote, 'when you can't leave him with strangers'.[82] She wondered if her mother had left any kind of message when she died. The

short, typed reply was dated over a week later and probably provided little comfort to the family. 'She was going about in the ordinary way and appeared somewhat suddenly to become extremely depressed and ill-looking', it read; 'She was put to bed at once and very soon became helpless and then unconscious and died from heart failure'.[83] Many other families would receive no letter of explanation.

## Boarding-out

In his presidential address to the Intercolonial Medical Congress in 1889, Dr Manning reported that psychiatric institutions were largely supported by the State and its funds. In addition, there was 'no established system of payment to relatives, or "boarding-out" '.[84] He compared the situation to Britain and America, noting that different systems of governance prevailed in each place. Yet it would be fortunate, he argued, if colonial institutions were supplemented by further support from private persons. From his position as Medical Superintendent of the Hospital for the Insane at Ararat in 1889, Dr William Beattie Smith addressed the Intercolonial Medical Congress about the housing of the insane in Victoria. He advocated that public asylums were the most appropriate institutions for the management of insanity, but that they required better state funding and support. Patient classification was the answer to problems of overcrowding. However, the chronic and harmless insane should be housed with their own relatives, or with persons of the same religion and social class, under strict supervision. The colony needed efficient receiving houses for short-term diagnosis and treatment, and the entire system of mental health was in need of reform.[85] Beattie Smith was still advocating reforms in 1908, and his ideas were reported widely through the medical congresses and the *Journal of Mental Science*.[86] By 1908, Eric Sinclair was reporting that two systems operated in the Australian colonies: a boarding-out system, used in New South Wales, Victoria and Western Australia, to varying degrees of success; and boarding-out to relatives, used in New South Wales, Western Australia and Queensland far more effectively.[87]

Victoria was one colony where the concept of formal 'boarding-out' to guardians was seriously entertained for a short period in the late nineteenth century, though information about the practice is difficult to locate. Charles Brothers' administrative history of the care of the mentally ill in Victoria to 1905 provides a brief account of boarding-out and asylum farms. He notes the influences of the lengthy Royal Commission into the hospitals for the insane held in the 1880s and

known as the Zox Commission after its chairman, Ephraim Zox.[88] Considered an 'effective means of dealing with the harmless class of insane', boarding-out would possibly ameliorate the perceived problems of large institutions.[89] However, the commissioners were not entirely convinced that system of boarding-out would succeed. One fear was that persons in the community might be motivated by self-interest to care for a patient at home, which was obviously fraught with dangers. Perhaps colonial populations were not geared to provide for their fellow citizens in this way, as they were in Europe, as Frederick Allman wrote to the *Sydney Morning Herald* in 1907. Other correspondence to colonial newspapers echoed these sentiments. A 'sympathiser' responded to Allman's letter, also writing to the *Sydney Morning Herald* in 1907 to remark that although 'Australians' were 'a large-hearted, generous people', the matter of insanity usually meant they were 'inclined to "pass by the other side" '.[90]

However, in 1889, an amendment to the lunacy legislation in Victoria meant that boarding-out was possible. This followed earlier practices in that colony of allowing home-based care for some patients with the permission of authorities. At the Yarra Bend, any relative or friend could apply to the Inspector General of the Insane for the care and control of a patient held in an asylum through a Maintenance Bond from the 1850s.[91] The Inspector could deliver a patient over to the care of that person upon the execution of a Maintenance Bond to the sum of fifty pounds by the friend or relative. This contracted an individual to successfully care for the lunatic patient or a penalty would have to be paid. The patient was deemed to be out on 'probation'.[92] By 1890, when boarding-out took effect in Victoria, there were 54 patients out on probation from the Yarra Bend, and around 150 patients out from other institutions in Victoria.[93] A similar system operated in New Zealand, and effectively functioned as a mode of discharge from the institution, as one contemporary noted in 1889.[94] By the late 1880s in Victoria when the boarding-out system proper was legally sanctioned, it met with resistance and difficulties, as Brothers notes. Some patients did not want to leave the institution to live with strangers, and in some cases, their families also protested. Guardians needed to be given special guidance, in addition to their payment, which ranged from six to twelve shillings per week.[95] The system was first operated from 1890. It was viewed as an 'extension of liberty' to some patients who qualified, and asylum officers were charged with the task of finding suitable guardians, notifying the rules through newspapers. The scheme, in its first year of operation, was seen by some contemporaries to have failed.[96]

Between 1890 and the early years of the twentieth century, an average of thirty patients per year were boarded out, though some of those were quickly returned to public institutions, presumably because the care arrangement had failed.[97]

## The After Care Association, New South Wales, 1907

Commenting on the lack of support for patients discharged from medical care in New Zealand, Duncan MacGregor called for philanthropic organisations to establish 'After-care for Hospital patients' in every centre in 1905.[98] MacGregor cited five cases of recently released patients to make his point. One man had confided that he 'dreaded leaving the institution and re-entering friendless upon the old life', aware that he struggled to exist, and had few to help him. Another patient's family had been contacted five times about her imminent discharge but had ignored all correspondence, and the asylum authorities felt it was important to situate her in an appropriate home but to prosecute the family for her continued maintenance. Another man was at risk, even though he would be discharged; his relatives would 'not have anything to do with him'. These stories illustrated the need, as MacGregor argued, for interim, half-way care that could act as a bridge between institutional life and the world outside.[99]

Despite the evidence that this type of care was needed urgently in New Zealand, the first Australasian organisation devoted to community advocacy for sufferers of mental illness was established in New South Wales in 1907.[100] The After Care Association of NSW was founded by Emily Paterson, who was a cousin to the famous Australian poet, 'Banjo' Paterson. Emily Paterson was born in 1864, and lived at the house 'Rockend' with her grandparents for most of her childhood years. Rockend was located near Gladesville. Judith Godden has commented that Paterson was afflicted with poor eyesight, later blindness, and, she speculates, depression; Godden suggests that Paterson began to visit Gladesville patients in the 1900s as a 'form of mutual therapy'.[101] These visits to patients raised Paterson's awareness of mental illness. She was especially keen to help to ameliorate the problems facing patients following their discharge, and reasoned that similar organisations existed in other parts of the world. Her scheme was championed by medical superintendent at Gladesville, Dr Herbert McDouall, and Dr Oliver Latham. Latham became a well-known neuropathologist and also worked voluntarily in psychiatric hospitals during his career.[102] Although Manning died in 1903, the founders of the Association saw this as a continuation of his aim for the care of the mentally ill. As Chapter 2 described, Manning

had advocated from 1868 that relief for discharged patients was particularly urgent in the colonies because families were dispersed, but he also stressed the problem of the stigmatisation of mental illness.[103] Paterson's own death was reported by the Association in its annual report for 1917; she was known as a 'generous friend'.[104]

The founding resolutions of the Association were simple: to assist convalescent patients discharged from mental hospitals and psychiatric clinics to adjust to the world beyond the institution, and to find employment; and to continue to see support and funds for this cause. It was also hoped that in time, a halfway home might be established to provide such persons with temporary shelter. One of the problems Paterson had identified in speaking with patients at Gladesville was that upon their release, returning to their family home or usual circumstances was often impossible or difficult; some patients were released with no money and very little family support, while others were worried about going back to environments that reminded them of their past breakdowns or were likely to create conflict.[105]

The After Care Association was, then, designed to provide patients with a rehabilitative space between the institution and future home; it was implicitly providing the families of former patients with support, though its focus was upon the support and advocacy of patients themselves. The Annual Reports of the Association reminded its subscribers of the various cases it supported during the year. In particular, those without families seemed most likely to receive financial and practical assistance. In other cases, the Association acted as a bridge between institutional release and return to the family. Eight case studies were described in the Annual Report for 1910. Three of the cases were widows, including one young widow. Aged 22, she

> [had] no friends in Sydney, has been very ill mentally and was nearly a year in Gladesville before recovering. Temporary lodging and board and clothing supplied by the Association. Situation as general servant obtained for her which she retained until she had earned sufficient to enable her to return to her relatives in the country. A letter received from her at Christmas time states she is well and happy.[106]

Support for the individuals listed ranged over financial support, temporary accommodation and advocacy; the reports suggest that discharged patients had to apply to the Association for funds or assistance.

The case studies were brief but conveyed the work being done by the Association. One young woman received a railway pass to allow

a restorative trip to country New South Wales. Another widow was given a weekly payment of five shillings for one month, in addition to advocacy to gain access to government assistance from the State Children's Relief Department, and she was granted clothing, boots and a new sewing machine to help her earn her own money. A young man received food, clothing, furniture and some money to support his family. One 'girl', without any friends in Sydney, was directed to a position as a housemaid and gradually repaid her small debt to the Association, which was not required. In one case, an elderly woman discharged from Gladesville found work, and three months later was set to live with her daughter. Her daughter returned her to the institution, where she was 'quite as well mentally as when out on probation', until the Association obtained another position for her.[107]

The Association was, perhaps, like the institutions themselves, driven by the need to maintain sanity in the lives of those patients well enough to be discharged, but early successes outlined in the annual reports gave way to some instances of relapse and recommittal. Mental illness posed difficulties in that sufferers did not always fully recover their health. In 1912, the Annual Report was proud to state that of twenty-nine cases dealt with, employment was found for twenty-three persons. Employers, it noted, were 'showing greater kindness and consideration towards ex-patients'. In 1913, one employer was congratulated for offering a 'second trial' to a 'recurrent case'.[108] The Association also felt that it was helping to 'dispel prejudice' among members of the public. A further six patients were returned to relatives or friends. A perceptibly moralistic language pervaded the reports in the years following 1910. 'Our most unsatisfactory cases are alcoholics', noted the report in 1915.[109] Yet at this stage, a greater awareness of the deep problems facing those persons whom the Association aimed to assist was also more apparent: 'This obviously slow process ... cannot be computed in hard cash', as it explained to its subscribers.[110]

Assessing the public response to the Association over time is more difficult. One detailed newspaper report in the *Sydney Morning Herald* in 1911, written to report on the Association seeking some government assistance, was complimentary, describing its work as 'unobstrusive but entirely praiseworthy'. It was a 'lacuna in the chain of charity that encircles society' that no organisation or fund existed before After Care to support these unfortunate cases. The views expressed towards mental illness in this article were highly sympathetic.[111] An appeal for funds to continue the work of the After Care Association was launched in 1927. By then, the Association had helped around a thousand people.

The hostel for community-based care was opened in 1923 at Pendle Hill, and included a farm, realising the early dreams of the founding committee for a small 'Home of Industry' where the cultivation of vegetables, domestic tasks and the farming of poultry would help to fund the ongoing assistance of former inmates of mental hospitals.[112]

## Conclusions

This chapter has argued that by investigating the experiences and meanings of trial leave and forms of extra-institutional family care in the four colonies explored in this study we might come closer to understanding the role played by institutionalisation in the lives of colonial families across the period. Policies of trial leave or leave of absence from institutions appear to have been more widespread in the colonies this study has chosen to privilege than in Britain or Europe, where boarding-out was more successful. However, trial leave or leave of absence were not without risks to patients, their families, and the general public, as suggested by various examples from both patient notes and newspapers. Despite the fragmentary and incomplete nature of the historical records of patients living outside the hospitals for the insane, I have suggested that many of our assumptions about their lives following institutionalisation – if they were indeed released discharged – might be tested further through deeper investigation of both official institutional records, and other sources. In the following concluding chapter, to reflect on how historians might proceed, and on what we can ever know about families, the insane and their histories, I interrogate archival practices, collections and their interpretation.

# 7
# Conclusion: Families, Insanity and the Archive

The family was certainly closely engaged with the asylum, as a number of historians have already convincingly argued. Cheryl Krasnick Warsh claims that using institutional records 'opens a window' to the lives of nineteenth-century families.[1] Using a similar metaphor, Ellen Dwyer writes that asylum records provide a lens through which to view families.[2] But despite their work, some puzzles remain. The authors of *The Family Story* write that in history, 'the family is everywhere and the family is nowhere'.[3] While 'some aspects of family life ... have been largely ignored by historians', and this has 'produced silences and absences' in the story of the family, families themselves 'have been active agents in the formation of family stories and ... in the creation of silences within those stories'.[4] This book demonstrates that the family was indeed 'inside' the asylum, even while it was also excluded from that space. Families and their observations of the insane crept into official asylum documents, including patient case notes, sometimes as marginalia, and at other times in more overt ways. Re-reading these clinical notes reveals that the boundaries between the asylum and the outside world were highly porous, and it also suggests that archival materials and their provenance might be an important additional aspect of the historical analysis of institutional records. The archive is, as Antoinette Burton comments, both a repository and a site for the cultural construction of knowledge.[5]

This book has engaged with two interrelated problems: first, it has argued that to make sense of the histories of families and insanity in the Australasian colonies, historians need to contest the formation of histories of psychiatry as local and national histories, and to look instead at transcolonial entanglements. Second, to achieve this aim, it has located these histories through an exploration of four different

official archival repositories, also looking beyond these four repositories at other archival productions. Tony Ballantyne argues that investigating multiple archives as 'nodes' in the web of empire is a vital aspect of writing histories which destabilise national narratives.[6] In this concluding chapter, I want to perform a self-reflexive examination of my own praxis and show how it relates to recent theorisations of 'the archive'. Archives house not just 'found histories', but histories which are themselves shaped by their files and boxes, by the very administration of paper, as Thomas Richards might argue.[7] Indeed, much of the recent scholarship about the archive has focused on colonialism and the archive, and the way that the archive is 'both the product of the uneven dialogics of the colonial encounter, and a space where the schema of colonialism was worked out', as Ballantyne suggests.[8] The nineteenth-century 'asylum archive' is no exception; this period saw the dramatic rise of the institution in the West, and its export to colonial settings, as the significant work now being produced by historians in the broad field of the history of psychiatry in colonial settings attests.

As the Introduction to this book argued, historians of the asylum have often privileged a quantitative research mode. Others have found ways to represent the lives of patients, and sometimes their families, through closer readings of voluminous case materials. In both types of history, the temptation to see this archive as complete, full of useful facts about institutions, the regimes and practices operating within them, and those committed to the institutions, is overwhelming. Of course, patient case material has been subjected to interrogation and critique before now. This book has not suggested that problematising patient cases is new for historians. For example, exploring patient cases with a critical eye has allowed historians to show how these were representations, how cases created certain identities for patients, and how they were gendered, raced and classed in different and varied locations.[9]

However, the institutional archive often fails to uncover its own practices. The archive of materials produced by colonial asylums is like other, similar official archives in that it reproduces the power relations of the past.[10] Although now a fairly commonplace idea, this is an important point, given the reliance by historians in this field on these records, but their only too rare admission that these clinical notes have a peculiar status being observations of persons who were relatively powerless.

Separate chapters in this book have suggested that we can also find several new and sometimes surprising angles by unpicking institutional records and their meanings. There are two more dimensions to

my study: first, when I bring the families of patients into the analytical framework, I have found that the archive does become a 'contact zone', as Burton and Florencia Mallon have indicated for other kinds of archival records, with the collisions between the researcher, patients' families and institutional authorities revealing much about archival and psychiatric institutional practices and about the practices of the researcher.[11] Second, the transcolonial and transarchival dimension of the work has encouraged me to seek fresh ways of explaining the archival production of knowledge, because each archival site throws light on the processes of the others.

## Exploring the archives

David Wright argues for a closer examination of forms of admission certification in different places, suggesting also that broader record linkage in histories of psychiatry would enable researchers to find a deeper appreciation of the extent of institutional worlds and families.[12] In other words, Wright has also been concerned about the way that historians have tended to write histories of psychiatry by exhausting the official institutional records without recourse to other source materials. This is an important point. My study has not fully undertaken this task because it has been focused on what the official archives themselves offer historians in the field of the history of the colonial family. For historians, accessing the lives of asylum inmates and their families has been difficult, but certainly not impossible. The fleeting appearances of families in the 'asylum archive' show that colonial societies were engaged, in different ways, with how to protect and care for people whose minds and lives had become crowded with the delusional thinking produced by their conditions, such as the many inmates who became violent towards family members. The possibilities here rest on my assertion that historians' quest to discover 'agency' within official records, or how families defined their roles in relation to the asylum, is not the only aspect of a re-reading of asylum source materials. The different archives utilised in this study also represent and produce 'the family' in distinct ways. Navigating the different archival systems used in each place, including state archives, Public Records, and, in New Zealand's case, National Archives, has involved a very useful scrutiny of asylum record-keeping practices, and, in essence, scrutiny of the attitudes held by the chosen public institutions towards 'the family' itself.

In Sydney, I chose Gladesville Asylum. At the State Records of New South Wales archives in Western Sydney, two letter files, 'Letters from

patients, 1864–1924' and 'Letters concerning patients, 1863–1914', were used to select individuals for tracing. This was a random selection, but many of the individual cases in the sample are drawn from the 1890s and later, because the letter files themselves provide more examples from these decades. The New South Wales sample therefore provides extremely rich letter material.

In Victoria, I chose the Yarra Bend Asylum in Melbourne. At the Public Record Office I selected sixty cases by choosing individuals mentioned in Maintenance Bonds (1851–1884) and in Applications for Leave of Absence (1899–1923). This sample includes less letter material, and as with other institutions, cases of patients admitted in the 1860s are very sparse; in some cases, no patient case note detail at all was retrievable.

In Queensland, I chose to look at the records of Goodna Hospital, known later as Wolston Park. At the Queensland State Archives I used patient casebooks to locate thirty-five patients and their families, because letters were contained inside casebooks at the front of each book, and not separated out as with other archival records in this study. At Goodna, the availability of adjunct asylum records, such as registers of patient maintenance payments, for searching was limited.

In New Zealand, I chose to examine patients and families at the Auckland Lunatic Asylum. Here, the National Archives branch at Auckland houses a similar range of asylum archival materials to those already mentioned. However, there are some gaps in the run of casebooks in the period. The loose patient case files have been separated from the patient casebooks. There was not an obvious separate cache of letters, and no discharge or leave register could act as the basis of my selection (patients selected from these initially yielded no case notes or files). Instead, I used the 'Record Book of Maintenance Investigations, c. 1890–99' which contains references to patients committed in an earlier period. Aside from its useful material about families, friends and employers of women and men admitted to the asylum, and the tracing of payments by them to the institution, it also provided a series of references to individual patient cases.

Despite the apparent unevenness in the individual samples, my findings about patients are all consistent with the overall patterns of the asylum's patient population. While patient cases from the later period in the study are over-represented in my samples, these offer us rich detail about the workings of institutions, and about the negotiations of families with these institutions, in the latter decades of the nineteenth century. This study has also highlighted the different effects of colonialism through the relative populations of, for instance, indigenous

inmates inside institutions in the Australian colonies compared to those in New Zealand. Chapter 1 suggested that psychiatry in the colonies was enmeshed in a world of the shared experiences of colonialism; the common ground of colonies (later states in Australia) as both colonial possessions, and separate self-governing sites, ensured the complexity of their manifold approaches to social and cultural problems.

**Families inside the asylum**

Grappling with the question of lay 'diagnosis', historians have explored the intersections between family and clinical descriptions of mental breakdown. My study has contributed to these debates. Lay descriptions of insanity, especially the use asylums made of family observations of inmates prior to and at the point of committal are at the centre of this book. At Auckland, patient casebooks from the 1880s show that a specific section of the notes on the patient was set aside to record family observations collated from the committal documents, as well as separate notes on the family history. The sister-in-law of May H said that she had 'always been of a melancholy morbid disposition', according to the record made by the institution in 1909. May's brother's comments were set out in the asylum's style, showing he had responded to questions at her committal. May had been born in Auckland, and spent all her life in New Zealand. She was, according to her brother, 'originally dull', had a 'good memory' and a 'strong will', but was 'placid, not affectionate nor energetic'. She had 'no vices' and 'no cause for grief' but she had been 'absent minded for six months'. Her brother speculated the cause of her illness as 'solitary life'.[13] In Sydney, Gladesville cases gathered similar details from family members, employers and friends. However, unlike the Auckland cases, these details were transferred from separate committal papers and copied into patient case files as marginal notes, some more substantial than others.

As I have argued, the gathering of family data suggests two things. First, institutions needed to reply upon accounts of mental breakdown offered by those close to patients because patients themselves were often 'incoherent' at the time of admission. Records show that where possible, patients were 'interviewed' about their own states of mind, although this practice was haphazard and not routine; the same records may be read for evidence of the patient's own 'voice'. Second, institutions were increasingly concerned to uncover patterns in instances of family insanity so that the data about heredity could be explained; this became more critical with the rise of discourses around mental hygiene in the latter part of the nineteenth century, as Chapter 2 explored.

The content of patient cases reflected the type of observations made by those seeking medical advice about committal. In addition, these family observations sometimes also reflected the social context of committal, as historians have shown. Women, it was sometimes noted on committal, neglected their household duties; men were often threatening towards wives and children.[14] John A's wife described his behaviour in 1904: 'he suddenly jumps out of bed in the night and runs round the house in search of imaginary enemies armed with an axe or crowbar and says he will make a clean sweep of the whole of them if they do not let him alone'. She also said that he laughed 'immoderately' for half an hour at a time for no reason.[15] Maori patients were often brought to the Auckland asylum only after contact with Europeans, and were more likely to have been physically unwell and suffering from the shock of cultural contact with colonists in an institutional setting.[16] Many other Maori without family were observed in public or by their neighbours or employers.

The asylum incorporated these observations in casenotes and, later, official statistics (for instance, in tabulations of the different causes of mental breakdown). Lay language which appears in the case records is therefore significant as we uncover more about institutional practices and the possibility of contemporaries disturbing these through their interactions with institutions. This language, as Chapter 3 suggested, made sense of what seemed to be insane behaviour, and families themselves invented ways of describing what they identified as 'strange'.[17] Yet the overall effect of the information supplied is one of unevenness and gappiness, as if the struggle to define mental breakdown itself broke down under the pressure of its collection. These patient case records are, as Sally Swartz reminds us, 'a complex discursive site'.[18] They can tell us a great deal about individuals who, paradoxically, despite the circumscribed nature of their lives through their hospitalisation, have relatively well-documented lives in the historical record. Nevertheless, the evidence is highly constructed and mediated through the asylum's own language. What remains, as Foucault writes of the records of madness in the past, is 'the speech of the excluded,' but disembodied from the speakers themselves.[19]

Yet Lissie's story, introduced earlier in this study, shows that families did make their way inside the asylum through letters and other fragments of their communications with institutional authorities. Lissie's father wrote a story of heartbreak about his daughter's hospitalisation, also providing doctors with important diagnostic information as he relayed her history. In fact, far more information about Lissie

is contained in his letter than in her patient case entry, which ends abruptly in 1906.[20] Such interventions tell us a great deal about how families used the institution. Sometimes families with more than one experience of the institution were relatively familiar with its operations. Robert R wrote to the asylum in 1879, specifically to Dr Manning, to seek help for his brother John. He explained that he had assisted his brother financially through difficult times, but that recently his brother had become violent, threatening Robert's wife, and that he had begun talking strangely – he claimed to be 'King of Queensland'. Robert confided that he himself had recently spent time in Gladesville, and that insanity ran in the family. He wrote: 'I shall never be able to repay you for your kindness to me I am only sorry that I did not come before ... I thank God that I have a sound mind and my suffering is not so much'.[21] Letters like this one show that for many families the asylum was a place that might offer a solution to the problem of insanity.

Patients also wrote letters to family and friends outside the institution. Although these letters were not always sent, following institutional practices, it is clear that their contents were frequently communicated to family members and used in the processes of discharge and patient appraisal. Sometimes patients were able to convince asylum authorities of their fitness for discharge, as the examples in Chapter 4 demonstrated. The chapter also suggested that emotional responses to asylum confinement are rarely investigated by historians, but should be considered alongside the mechanics and statistics of committal and discharge, especially by historians interested in family dynamics, or in the affective family and the asylum, as suggested by David Wright.[22]

Chapter 5 argued that interpreting maintenance payments and their collection also sheds light on familial relationships and attitudes towards asylum confinement. The patchy records of payments made by families to the different institutions in this study reveal that despite official anxiety about the low returns, and institutions' own attempts to retrieve monies owed, many families were simply unable to meet payments over longer periods of time. However limited, the source material from the asylum archives affords historians insights into poverty and wealth and the myriad reactions to asylum confinement, including avoidance of responsibility and family struggles over responsibility. It also tells us about the interactions between different agencies, including the role of police in the matter of institutional committal.

In Chapter 6, the fragmentary nature of the archival evidence is revealing. We only find out about patients and their families through their presence in the institutional record. When their lives were no

longer defined through institutional protocols, or when patients and their families sought to evade these, the historical trail goes cold. Our knowledge about what happened to individuals who had been struggling to stay well during periods of trial leave is limited, and highly mediated by the sources.

## Locating families

My approach has highlighted two seemingly contradictory matters about families and psychiatric institutions: first, that historians can find out about families and their dealings with institutions, which were considerable in many cases; and second, that in many respects, we also find that we are no more generally certain about families and their interactions with authorities at all. Looking across the archival sites, other issues arise. At Auckland, the records of maintenance payments are more detailed than elsewhere, and provide descriptions of families and police pursuit of money owed. Here, I found many stories of families not readily found in casebooks that would have remained invisible had I not used the maintenance books to trace families, and instead relied only on a random sample of patients from casebooks. However, while there is rich content for Auckland, in other archives, similar maintenance books are either non-existent, or are ledgers which provide lists rather than commentaries.

In the Public Record Office of Victoria, the records of maintenance bonds provide me with a different view of families, in part due to the practices at the Yarra Bend in the period. Any relative or friend of the committed person could apply to the Inspector General of the Insane for care and control of a patient held at an asylum. As Chapter 6 explained, carers could be contracted through the payment to authorities of a fifty-pound bond and would need to remain in contact with the institution about the bonded person. Records of maintenance bonds include the case of Theresa C, whose sister wrote to the institution from the Melbourne Coffee Palace in Bourke Street in 1899 pleading for her probation, saying 'she has got a chance now'. Theresa's sister offered her own theories about building up her sister's strength and health.[23]

As mentioned earlier, the collection of patient and family letters at Gladesville Hospital provides an especially rich source of information about family dynamics; letters I located for Goodna patients and their families were similarly useful. Yet letters, although they can tell us a great deal about family relationships, as well as interactions with authorities and the impact of institutionalisation, also present different

problems. Patient letters from all the institutions were never sent, in accordance with the laws of the time. Letters sent to patients were not always read by them, but evidence suggests their content was more often communicated than not, and such letters were also used in decision making by the institution. The sizeable cache of letters suggests a great deal of 'interaction' that was largely symbolic.[24]

## Grappling with archival records: some conclusions

Historians have found that accessing the lives of asylum inmates and their families has been difficult, but not impossible. Emma Spooner explores the way families appeared and disappeared in the records of the Auckland Asylum between 1870 and 1911. Families were dislocated, she shows, not only geographically and emotionally, but also through the later archival practices of separating their letters from patient casebooks. These dislocations are not problems for historians to ignore, or smooth over, in their attempts to construct narratives about families and institutions, however tempting this might be.[25] Despite evidence that families did engage with institutions, past institutional and archival practices can also obscure these histories.[26] More excitingly, as Ann Laura Stoler argues, is the proposition that archives, no longer entirely viewed as stable sites of historical knowledge, might instead be viewed as embodying 'discrepant accounts, dissenting voices', thereby unmaking institutional power.[27]

For example, the impact of the shaping of Gladesville cases, with marginal notes forming part of the clinical record, provides an interesting point of comparison with the notes collected at Auckland. In the Gladesville cases, the family seeps into asylum practices and becomes part of the clinical observation, both intruding into it and also occupying a role in it, performing what historians have described as a dialogue between families, patients and institutional authorities.[28] Letters are sometimes separated from patient cases in archival collections, such as those for Gladesville. At other archives, letters are stored inside patient casebooks but protected from deterioration by clear plastic, such as those in the Queensland records of Goodna Hospital. In both places, these archival interventions manage to create the effect of a hidden and incomplete world of communications beyond the researcher's grasp. Such 'fleeting registers in the colonial record', as Tracey Banivanua-Mar argues in a different context, hint at stories 'with no ending or conclusion'.[29]

Archival materials should be re-examined as rich sources of information about families, households and most importantly, the language

used by ordinary people to describe mental states. The traces of emotion found in patient case histories are a moving, disturbing and yet inconsistent set of reminders of the calamity of insanity. Letters to and from family members of the insane, patients themselves, and medical authorities offer the possibility of a deeper reading of the emotions surrounding psychiatric confinement. We can also explore the porous boundaries of the asylum through the themes of leave-of-absence and maintenance payments, and discover that families had many and multiple interactions with colonial institutions in this period.[30] Debates across the period about methods of extra-institutional care, including boarding-out and trial leave, show that the institution's walls were not impermeable. The outcomes for patients who were able to navigate the spaces between the asylum and the community, including discharge, are an important reminder, in our present, of the institution's past function and meanings.

By looking across colonies and the archival sites created in their wake, I have opened up a transcolonial and transarchival inquiry which suggests that the archive, too, must be problematised beyond national borders. In addition, by examining the families of patients, I have indicated that the institutional collisions between patients, families and authorities become more apparent, and produce more complexities, than patient studies alone. Finally, utilising available theoretical models and teasing out the way that archives operate to obscure as well as produce histories of the insane, I have shown that histories are indeed not 'found', but very much 'made'.

Historians insistent upon reviving debates around family agency in the matter of committals and discharges to the asylum are working with the same evidence they have always had, but are interpreting it in new ways. They are beginning to explore the ways in which evidence emanating from the institutions shows us that families were in fact present at committal, discharge, and during patients' stays in the institution. However, I have argued that revisiting asylum sources equipped with the theoretical tools to discover patient and family 'agency' in institutional committals may not by itself be enough to reshape either histories of the colonial family, or histories of insanity. Following theorists of language and textual representations, and acknowledging the problematic of the power/knowledge relationship, enables historians to examine their research archives using self-reflexive methodological and theoretical frameworks. What we can ever 'know' about mental breakdown in the past is contingent upon the way the archival sources have been collated, what is extant, and how we read these materials.

The 'family', both 'real' and discursive, is positioned in critical ways by the asylum archive. If the family is both present and absent from the record, does this mean that it was both present and absent in the past? Is it our readings of the archival materials that bring this category of 'the family' into view? These questions and many others will continue to extend our readings of families, 'madness' and the asylum for years to come.

# Appendix: Indications of Insanity Noted by Family and Friends of Inmate Prior to Committal

## Changed speech

Answers in whispers
Boastful
Foul language
Rambling in statements, incoherent
Singing
Speaking quickly
Talkative, raving
Talks nonsense
Will not speak unless pressed

## Changed mental state

Anxious and depressed
Dejected
Delusional
Depressed
Depressed in spirits
Excited
Failing mentally
Fits of temper
Foolish
Forgetful, absent minded, bad memory
Great state of tension
Hallucinations of sight and hearing
Inside is dead to all feeling*
Irrational
Listless
Low spirited
Melancholic
Mind unhinged
Miserable
Peculiar and eccentric
Religious delusions
Strange conduct, morose
Strange in his head
Suicidal
Suspicious
Unable to give account of self
Unfounded fears
Vacant manner
Very queer
Want of harmony
Wild expressions of face

## Changed behaviour

Abandonment or neglect of children/ family and/or household duties
Aimless and despondent
Cannot be trusted
Childishness
Claims ill treatment
Craving for drink
Crying
Dancing
Destructive
Dirty in habits
Does not behave like a sensible person
Eating like an animal
Erratic conduct, strange, irregular manner
Exalted opinions of self
Fumbling

Goes naked, indecent manner
Has become negligent of self
Holding hands in front of face
Lustful/raving about sexual functions
Masturbation
No appetite
Noisy
Not working
Refusing food
Restless in manner
Self-abuse
Singing hymns
Tears hair
Tendency to continual sleeping
Uncontrollable
Unexplained laughter
Unnatural
Violent and dangerous with threats to others
Wandering
Wears a man's hat (a woman)
Wrings hands

*Note*: *This statement was made by the patient.
Some of these are direct quotations but behaviours may apply more widely; much of this language used was used by lay observers or 'translated' by doctors.
*Source*: These observations were all made by the family or friends of patients at the time of committal, and taken from the case notes and case papers of Gladesville Hospital for the Insane, Goodna Hospital for the Insane, the Yarra Bend Hospital for the Insane and Auckland Mental Hospital, c. 1860s–1910.

# Notes

## Introduction

1. State Records New South Wales (SRNSW), Gladesville Hospital, CGS 5034, Letters concerning patients, 4/8207, Letter 110.
2. SRNSW, CGS 5031, 1857–1925, Medical casebooks, Folio 56. This patient was named Marion but known as 'Lissie' in her father's letter.
3. I am using the term 'family' to describe the broad array of relationships and associations asylum inmates had with blood relatives. It is primarily a European derived definition.
4. This work is also inspired by the research agendas established by scholars including Roy Porter, Charles Rosenberg and Nancy Tomes. See for instance Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society* 14 (1985), pp. 175–98; Charles E. Rosenberg, 'Framing Disease: Illness, Society and History', in *Framing Disease: Studies in Cultural History,* edited by Rosenberg and Janet Golden (New Brunswick, New Jersey: Rutgers University Press, 1992); Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840–1883* (Cambridge UK and New York: Cambridge University Press, 1984).
5. Nancy Tomes, 'The Anglo-American Asylum in Historical Perspective', in *Location and Stigma: Contemporary Perspectives on Mental health and Mental Health Care*, edited by Christopher Smith and John A. Giggs (Boston: Unwin Hyman, 1988), pp. 14; 19. In revising her earlier work for a paperback edition, Tomes comments that she was 'forcibly struck' by the roles of families; see Nancy Tomes, *The Art of Asylum Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia: University of Pennsylvania Press, 1994), p. xix.
6. Mark Finnane, 'Asylums, Families, and the State', *History Workshop* 20 (1985), p. 135.
7. David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* 10:1 (1997), pp. 137–55.
8. Finnane, 'Asylums, Families, and the State', p. 143.
9. Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880–1940* (Kensington: UNSW Press, 1988), p. 189.
10. See Mary-Ellen Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905–1915', *Journal of Family History* 19: 2 (1994), pp. 177–93; Patricia Prestwich, 'Female Alcoholism in Paris, 1870–1920: The Response of Psychiatrists and of Families', *History of Psychiatry* 14: 3 (2003), pp. 321–36; and Marjorie Levine-Clark, 'Dysfunctional Domesticity: Female Insanity and Family Relationships among the West Riding Poor in the Mid-Nineteenth Century', *Journal of Family History* 25: 3 (2000), pp. 341–61.
11. Ellen Dwyer, *Homes for the Mad: Life inside Two Nineteenth-Century Asylums* (New Brunswick and London: Rutgers University Press, 1987), p. 87; Cheryl

Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883–1923* (Montreal and Kingston, London and Buffalo: McGill-Queen's University Press, 1989), p. 91.

12. Akihito Suzuki, 'Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century', in *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective*, edited by Joseph Melling and Bill Forsythe (London and New York: Routledge, 1999), pp. 115–36.
13. James Moran, 'The Signal and the Noise: The Historical Epidemiology of Insanity in Ant-Bellum New Jersey', *History of Psychiatry* 14: 3 (2003), pp. 281–301; David Wright, 'Delusions of Gender? Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam and New York: Rodopi, Clio Medica 73, 2004), pp. 149–76.
14. Akihito Suzuki, *Madness at Home: The Psychiatrist, The Patient, and the Family in England, 1820–1860* (Berkeley, Los Angeles, London: University of California Press, 2006), p. 24.
15. Suzuki, *Madness at Home,* p. 150.
16. Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Basingstoke, Hampshire and London, Palgrave Macmillan, 2004).
17. All of these institutions were called 'asylums' before 1914, but name changes occurred at different points over the period of this study; therefore the proper names used here alternate between 'asylum' and 'hospital for the insane'.
18. Frederick Norton Manning, *Address Delivered on Resigning Charge as Medical Superintendent of the Hospitals for the Insane at Gladesville and Callan Park* (Sydney: Government Printer, 1879). D. I. MacDonald papers, National Library of Australia, Manuscripts Collection, MS 5147.
19. Finnane, 'Asylums, Families and the State', pp. 145–6. Tomes argues that in the United States, the distinctions between private and public asylums were more blurred than in Britain at the same time; see 'The Anglo-American Asylum', p. 9.
20. For a brief comment on Australian private institutions, see Garton, *Medicine and Madness,* p. 109. On private institutions in New Zealand, see Alan Somerville, 'Ashburn Hall, 1882–1904', in *'Unfortunate Folk': Essays on Mental Health Treatment 1863–1882,* edited by Barbara Brookes and Jane Thomson (Dunedin: Otago University Press, 2001), pp. 83–103. On private institutions in Britain, see Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792–1917* (London and New York: Routledge, 1992).
21. Finnane, 'Asylums, Families and the State', p. 145. Melling and Forsythe argue that English asylums also took a broader cross-section of society than previously supposed; see Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (Routledge: London and New York, 2006), p. 173. On Callan Park, see Garton, *Medicine and Madness*, p. 109; and on Kew, see a report in the *Australasian Medical Gazette*, October 1892, p. 394.

22. Tomes, 'The Anglo-American Asylum', p. 12.
23. For Australian welfare histories focused on the nineteenth century, see Brian Dickey, *No Charity There: A Short History of Social Welfare in Australia* (Sydney: Allen & Unwin, 1987); Stephen Garton, 'Rights and Duties: Arguing Charity and Welfare 1880–1920', in *Welfare and Social Policy in Australia: The Distribution of Social Advantage,* edited by Michael Wearing and Rosemary Bereen (Sydney and London: Harcourt Brace, 1994), pp. 23–38. For New Zealand, see Margaret Tennant, *Paupers and Providers: Charitable Aid in New Zealand* (Wellington: Allen & Unwin and Historical Branch, 1990); David Thomson, *A World Without Welfare: New Zealand's Colonial Experiment* (Auckland: Auckland University Press with Bridget Williams Books, 1998).
24. International histories of the family include Leonore Davidoff, Megan Doolittle, Janet Fink and Katherine Holden, *The Family Story: Blood, Contract and Intimacy, 1830–1960* (London and New York: Longman, 1999). For discussion of the nature of the colonial family, see Michael Gilding, *The Making and Breaking of the Australian Family* (Sydney: Allen & Unwin, 1991) and *Families in Colonial Australia*, edited by Patricia Grimshaw, Chris McConville and Ellen McEwen (Sydney: Allen & Unwin, 1985); for specific comment about family economies in Australia, see Shirley Fisher, 'The Family and the Sydney Economy in the Late Nineteenth Century', in *Families in Colonial Australia*, pp. 153–62. On the changing relationship between the state and families in the matter of child welfare, see Robert van Krieken, 'Children and the State: Child Welfare in New South Wales, 1890–1915', *Labour History* 51 (1986), pp. 33–53.
25. See for instance Davidoff et al., *The Family Story*; Rosemary O'Day, *The Family and Family Relationships, 1500–1900: England, France and the United States of America* (Houndmills, Basingstoke and London: Macmillan, 1994); *Family History Revisited,* edited by Richard Wall, Tamara K. Hareven and Josef Ehmer (Newark: University of Delaware Press, 2001); Michael Anderson, *Approaches to the History of the Western Family 1500–1914* (Cambridge UK: Cambridge University Press, 1980); and *A History of the Family: Volume Two, The Impact of Modernity,* edited by Andrė Burguière et al., translated by Sarah Hanbury Tenison (Polity Press, 1996).
26. See for instance separate contributions on these themes in *Families in Colonial Australia*, edited by Patricia Grimshaw et al.; Patricia Grimshaw, 'Marriages and Families', in *Australians 1888*, edited by Graeme Davison, J. W. McCarty and Ailsa McLeary (Broadway, Sydney: Fairfax, Syme & Weldon, 1987), p. 318; and Gilding, *The making and breaking of the Australian family*. On New Zealand, see Erik Olssen and Andree Levesque, 'Towards a History of the European Family in New Zealand', in *Families in New Zealand Society*, edited by Peggy Koopman-Boyden (Wellington: Methuen, 1978); Erik Olssen, 'Families and the Gendering of European New Zealand in the Colonial Period, 1840–1880', in *The Gendered Kiwi*, edited by Caroline Daley and Deborah Montgomerie (Auckland: Auckland University Press, 1999), pp. 37–62.
27. Nancy Christie, 'Interrogating the Conjugal Family', in *Mapping the Margins: The Family and Social Discipline in Canada, 1700–1975,* edited by Nancy Christie and Michael Gauvreau (Montreal and Kingston: McGill-Queen's University Press, 2004).

28. Exceptions include Pat Jalland's histories of death and grief in Australia; see *Australian Ways of Death: A Social and Cultural History 1840–1918* (Oxford, New York and Melbourne: Oxford University Press, 2002).
29. Penny Kane, *Victorian Families in Fact and Fiction* (New York: St Martin's Press, 1995), p. 11.
30. Bronwyn Labrum, Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum 1870–1910, Unpublished Masters Thesis in History, Massey University, 1992; Catharine Coleborne, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848–1880s* (Perth, Western Australia: Australian Public Intellectual Network, 2007). For old world sites, see Marjorie Levine-Clark, '"Embarrassed Circumstances": Gender, Poverty, and Insanity in the West Riding of England in the Early Victorian Years', *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, edited by Jonathan Andrews and Anne Digby (Amsterdam and New York: Rodopi, 2004), pp. 123–48; and Wright, 'Delusions of Gender?', pp. 149–76.
31. Tomes, 'The Anglo-American Asylum', p. 3; Wright, 'Getting Out of the Asylum', p. 155.
32. David Wright, 'Family Strategies and the Institutional Confinement of "Idiot" Children in Victorian England', *Journal of Family History,* 23: 2 (April 1998), p. 191.
33. Finnane, 'Asylums, Families and the State', pp. 146; 137.
34. For the term 'transcolonial', see *Decentring Empire: Britain, India and the Transcolonial World*, edited by Durba Ghosh and Dane Kennedy (Hyderabad, India: Orient Longman, 2006).
35. See for instance Ann Curthoys, 'Does Australian History Have a Future?', *Australian Historical Studies* Special Issue, 'Challenging Histories', 33: 118 (2002), pp. 140–52; Philippa Mein Smith, 'New Zealand Federation Commissioners in Australia: One Past, Two Historiographies', *Australian Historical Studies*, 34: 122 (2003), pp. 305–25; Peter Gibbons, 'The Far Side of the Search for Identity: Reconsidering New Zealand History', *New Zealand Journal of History*, 37: 1 (2003), pp. 38–49.
36. See also Philippa Mein Smith, Peter Hempenstall and Shaun Goldfinch, *Remaking the Tasman World* (Christchurch: University of Canterbury Press, 2008).
37. Jürgen Kocka, 'Comparison and Beyond', *History and Theory,* 42 (2003), pp. 39–44; Michael Werner and Benedicte Zimmerman, 'Beyond Comparison: Histoire Croisée and the Challenge of Reflexivity', *History and Theory,* 45 (2006), pp. 30–50.
38. *Messy Beginnings: Postcoloniality and Early American Studies,* edited by Malini Johar Schueller and Edward Watts (New Brunswick New Jersey: Rutgers University Press, 2003), p. 5.
39. Tony Ballantyne, *Orientalism and Race: Aryanism in the British Empire* (Houndmills, Basingstoke, Hampshire and New York: Palgrave, 2002), p. 3.
40. 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* (Manchester: Manchester University Press, 2001), p. 108.

41. Philippa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire* (London and New York: Routledge, 2003).
42. Ballantyne, *Orientalism and Race*, p. 3.
43. Warwick Anderson, 'Postcolonial Histories of Medicine', in *Locating Medical History: The Stories and Their Meanings*, edited by Frank Huisman and John Harley Warner (Baltimore and London: Johns Hopkins University Press, 2004), pp. 299–300. See also David Wade Chambers and Richard Gillespie, 'Locality in the History of Science: Colonial Science, Technoscience, and Indigenous Knowledge', *Osiris* 15 (2001), pp. 221–40.
44. James Moran, David Wright and Mat Savelli, 'The Lunatic Fringe: Families, Madness and Institutional Confinement in Victorian Ontario', in *Mapping the Margins: The Family and Social Discipline in Canada, 1700–1975*, edited by Nancy Christie and Michael Gauvreau (Montreal and Kingston, London, Ithaca: McGill-Queen's University Press, 2004), p. 297.
45. See Sally Swartz, 'Lost Lives: Gender, History and Mental Illness in the Cape, 1891–1910', *Feminism and Psychology* 9:2 (1999), pp. 152–8; Coleborne, *Reading 'Madness'*.
46. See for instance Tony Ballantyne, 'Archives, Empires and Histories of Colonialism', *Archifacts* (April 2004), pp. 21–36. Scholarship about the 'asylum archive' includes James Mills, *Madness, Cannabis and Colonialism: the 'Native Only' lunatic asylums of British India, 1857–1900* (Basingstoke: Macmillan, 2000); Emma Spooner, Digging For the Families of the 'Mad': Locating the Family in the Auckland Asylum Archives, Unpublished Masters thesis in History, University of Waikato, 2006).
47. I selected sixty cases from the three institutions in New South Wales, Victoria and New Zealand, and thirty-five from Queensland to reflect the relative population balances in each colony.
48. However, some historians might argue that the psychiatric institutions in the South Island of New Zealand provide better examples of the intellectual development of psychiatric thought and practice; see, for example, the contributions to Brookes and Thomson, *'Unfortunate Folk'*.
49. Garton, *Medicine and Madness*, pp. 75; 79.
50. Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago and London: University of Chicago Press, 2007), p. 13.

## 1 Colonial Psychiatry in the Australasian World

1. See, for example, the report tabled to colonial parliaments in 1864: 'Hospitals and Lunatic Asylums', dispatched to colonial governments by the Secretary of State and presented to Parliament, *Victoria Parliamentary Papers* (*VPP*) vol 3, 1864–1865, which was a review of colonial institutions commissioned in England. It did not examine New South Wales institutions, instead focusing on Victoria, Western Australia and Tasmania. However, it too shows a distinct discourse around colonial institutions that was growing and being disseminated in this period.
2. F. N. Manning, *Report on Lunatic Asylums* (Sydney: Government Printer, 1868).
3. Henry C Burdett, *Hospitals and Asylums of the World: Their Origin, History, Construction, Administration, Management and Legislation* (London: Churchill,

1891–1893) in 4 volumes. The first two volumes focus on asylums, the third on hospitals, and the fourth includes the plans of a number of institutions. Indeed, Fiji could productively be brought into this study. Henry Burdett was the Founder of the English Hospitals Association. Jacqueline Leckie has shown that the St Giles Asylum was established later than asylums in the colonies under discussion here, in 1884; see Leckie, 'Modernity and the Management of Madness in Colonial Fiji', *Paideuma,* 50 (2004), pp. 251–74; and 'Unsettled Minds: Gender and Settling Madness in Fiji', in *Psychiatry and Empire*, edited by Sloan Mahone and Megan Vaughan (Houndmills, Basingstoke and New York: Palgrave Macmillan, 2007), pp. 99–123.

4. Nancy Tomes, 'The Anglo-American Asylum, p. 6.
5. Mark Finnane suggests that institutions formed a 'new regime' for managing social crisis; see Finanne, 'Asylums, Families and the State', p. 141.
6. Diana Dyason, 'The Medical Profession in Colonial Victoria, 1834–1901', in *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, edited by Roy and Milton Lewis Macleod (London and New York: Routledge, 1988), p. 194.
7. Joy Damousi, *Freud in the Antipodes: A Cultural History of Psychoanalysis in Australia* (Sydney: UNSW Press, 2005), p. 15.
8. Patterns of committal are discussed separately in Chapter 2.
9. Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870–1940* (Cambridge, Melbourne and New York: Cambridge University Press, 1996), p. 3; Alison Bashford, 'Medicine, Gender, and Empire', in *Gender and Empire,* edited by Philippa Levine (Oxford UK: Oxford University Press, 2004), pp. 112–33; U. Kapalgam, 'The Colonial State and Statistical Knowledge', *History of the Human Sciences* 13:2 (2000), pp. 37–55. See also Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in an Age of Risk* (London: Sage, 1996), Chapter 2.
10. Finnane, 'Asylums, Families and the State', p. 141.
11. See for instance, Anne Marcovich, 'French Colonial Medicine and Colonial Rule: Algeria and Indochina', in *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, edited by Roy Macleod and Milton Lewis (London and New York: Routledge, 1988).
12. David Arnold, 'Medicine and Colonialism', in *Companion Encyclopedia of the History of Medicine*, edited by W. F. Bynum and Roy Porter (London and New York: Routledge, 1997 [1993]), pp. 1393–416; Bashford, 'Medicine, Gender and Empire'.
13. See *Psychiatry and Empire*, edited by Mahone and Vaughan; see also Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*, (Stanford CA.: Stanford University Press, 1991); James H. Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857–1900,* (London and New York: Macmillan/St Martins, 2000); Waltraud Ernst, 'Idioms of Madness and Colonial Boundaries: the Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', *Comparative Studies in Society and History,* 39:1 (1997), pp. 153–81; Harriet Deacon, 'Racial Categories and Psychiatry in Africa: The Asylum on Robben Island in the Nineteenth Century', in *Race, Science and Medicine*, edited by Waltraud Ernst and Bernard Harris (London and New York: Routledge, 2000).

14. His emphasis; see Roy Porter, 'Introduction', in *The Confinement of the Insane: International Perspectives, 1800–1965,* edited by Roy Porter & David Wright (Cambridge and New York: Cambridge University Press, 2003), p. 17.
15. Richard Keller, 'Madness and Colonialism: Psychiatry in the British and French Empires, 1800–1962, *Journal of Social History* 35:2 (Winter 2001) pp. 295–326. See also Leckie, 'Modernity and the Management of Madness in Colonial Fiji', pp. 251–74.
16. Waltraud Ernst, 'Idioms of Madness and Colonial Boundaries', p. 153.
17. Mrinalini Sinha, *Colonial Masculinity: Historical Writing on Gender and Citizenship* (Manchester, UK: Manchester UP, 1995); Ernst, 'Idioms of Madness and Colonial Boundaries', p. 168; James Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857–1900* (Basingstoke: Macmillan, 2000).
18. Mills, *Madness, Cannabis and Colonialism;* Sally Swartz has also made arguments about the black insane in South Africa; see 'The Black Insane in the Cape 1891–1920', *Journal of Southern African Studies*, 21:3 (1995), pp. 399–415.
19. Waltraud Ernst, 'Out of Sight and Out of Mind: Insanity in early Nineteenth-Century British India', in *Insanity, Institutions and Society, 1800–1914*: *A Social History of Madness in Comparative Perspective* edited by Joseph Melling and Bill Forsythe (London and New York: Routledge, 1999), p. 252.
20. Waltraud Ernst, 'European Madness and Gender in Nineteenth-century British India', *Social History of Medicine,* 9:3 (1996), p. 371.
21. *Psychiatry and Empire*, edited by Mahone and Vaughan, p. 3.
22. Harriet Deacon, 'Insanity, Institutions and Society: The Case of the Robben Island Lunatic Asylum, 1846–1910', in *The Confinement of the Insane*, pp. 20–3.
23. Sally Swartz, 'The Black Insane in the Cape, 1891–1920', *Journal of Southern African Studies*, 21: 3 (1995), pp. 399–415. For other studies of Africa, see Jock McCulloch, *Colonial Psychiatry and the 'African Mind'* (Cambridge UK and Melbourne: Cambridge University Press, 1995); Lynette A. Jackson, *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe* (Ithaca and London: Cornell University Press, 2005); Keller, *Colonial Madness*; and Jonathan Sadowsky, 'Confinement and Colonialism in Nigeria', in *The Confinement of the Insane*, pp. 199–314.
24. On Canada, see James E. Moran and David Wright (eds) *Mental Health and Canadian Society: Historical Perspectives* (Montreal and Kingston: McGill-Queen's University Press, 2006); David Wright, James Moran and Sean Gouglas, 'The Confinement of the Insane in Victorian Canada: The Hamilton and Toronto Asylums, 1861–1891', in *The Confinement of the Insane*, pp. 100–28.
25. On aboriginal patients, see Robert Menzies and Ted Palys, 'Turbulent Spirits: Aborginal Patients in the British Columbia Psychiatric System, 1879–1950', in *Mental Health and Canadian Society: Historical Perspectives*, edited by James E Moran and David Wright (Montreal and Kingston, London and Ithaca: McGill-Queen's University Press, 2006), pp. 149–75.
26. See also Wendy Mitchinson, 'Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum: The Case of Toronto', in *Essays in the*

*History of Canadian Medicine*, edited by Wendy Mitchinson and Janice Dickin McGinnis (Toronto: McClelland and Stewart, 1988); Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870–1940* (Don Mills and Oxford; Oxford University Press, 2000); Warsh, *Moments of Unreason*.

27. Kelm, 'Women, Families and the Provincial Hospital', pp. 177–93. Geoffrey Reaume has shown similar details for the Toronto Hospital for the Insane; see Reaume, *Remembrance of Patients Past*.
28. Ernst, 'Out of Sight and Out of Mind', p. 262. Ernst writes that despite the fact that numbers of insane were not extraordinarily high in the early nineteenth century in Britain, and that professional psychiatric medicine was yet to take hold, the 'interest and imagination of medical professionals and the wider public alike' was captured by asylum and its techniques, p. 245. A similar process was at work throughout India before the middle of the nineteenth century. Elsewhere, I have argued that official textual representations 'produced' the asylum population discursively, in turn producing meanings of 'madness'. See Coleborne, *Reading 'Madness'*.
29. Deacon, 'Insanity, Institutions and Society', p. 21.
30. We might examine the new 'public health' practices of the colonies, using this term broadly, as Alison Bashford has used it, to describe 'the ordering of categories of clean and unclean, normal and pathological, healthy and unhealthy'. See Alison Bashford and Claire Hooker (eds) *Contagion*: *Contagion*: *historical and cultural studies* (London: Routledge, 2001), p. 39.
31. Sanjeev Jain, 'Psychiatry and Confinement in India', in *The Confinement of the Insane,* pp. 285–6.
32. 'Hospitals and Lunatic Asylums', *Victoria Parliamentary Papers* (*VPP*), vol 3 (1864) p. 13.
33. Information was sought from asylums in the West Indies, Hong Kong, British Columbia and Vancouver, Southern Africa, Australia and New Zealand, among other places, and at the time of its release not all of these dominions had responded.
34. Manning, *Report on Lunatic Asylums*, p. i.
35. Manning, *Report on Lunatic Asylums*, p. 115
36. Manning, *Report on Lunatic Asylums,* p. 115.
37. 'Report on the Yarra Bend Lunatic Asylum for 1860', *VPP* (Melbourne: John Ferres, Govenment Printer, 1860–1861), Appendix.
38. 'Report of the Inspector-General of the Insane 1890', *Journal of the Legislative Council New South Wales*, p. 6.
39. Ken Kirkby, 'History of psychiatry in Australia, pre-1960' *History of Psychiatry* 10 (1999), p.198; Warwick 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*, edited by Warren Brookbanks (Wellington: Brookers, 1996), p. 4; Garton, *Medicine and Madness*.
40. Only one private institution for the insane operated in New Zealand, Ashburn Hall near Dunedin, and it has been the subject of several historical studies. See for instance, Somerville, 'Ashburn Hall', pp. 83–103. No full-length studies of private institutions in Australia exist. However, Dolly MacKinnon and Lee-Ann Monk are working on several articles for publication about private asylums in Australia c. 1850–1929, including a history

of the Harcourt Family's private asylums c. 1840s–1940s. A reception house operated at Darlinghurst as a temporary clearing station for those brought up on insanity charges from the late 1870s, and this practice was unusual in the colonies; however, the travelling distances experienced by Queenslanders ensured that more than one reception house operated there during the period.

41. Letter from F. Norton Manning to the *Daily Telegraph*, 2 September 1879, p. 3
42. Garton makes the point about the adoption of moral therapy in *Medicine and Madness*, p.17.
43. The histories of psychiatry in each country have captured the attention of successive generations of historians with work ranging from institutional and professional histories to social histories of insanity. However, few of these works attempt or achieve any sustained comparison between the sites. See Eric Cunningham Dax, 'Australia and New Zealand', *World History of Psychiatry*, edited by J. G. Howells (London, Bailliere Tindall, 1975), pp. 704–28; Coleborne, 'Making "Mad" Populations in Settler Colonies', p. 110; C. R. D. Brothers, *Early Victorian Psychiatry 1835–1905* (Melbourne: A. C Brookes, Government Printer, 1962); Garton, *Medicine and Madness*; Milton Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980* (Canberra: Australian Government Publishing Service Press, 1988); Catharine Coleborne and Dolly MacKinnon (eds), *'Madness' in Australia*: *Histories, Heritage and the Asylum* (St Lucia, Queensland, University of Queensland Press/API Network, 2003); Brookes and Thomson, *'Unfortunate Folk'*.
44. For a discussion of the links between the colonial laws and those in the imperial context, see Garton, *Medicine and Madness*, pp. 12–23; and Brunton, 'Colonies for the Mind', pp.4–6.
45. In Victoria, legislation included the Lunacy Act (1890) and Lunacy Act (1903); in New South Wales, amendments came in the form of the Lunacy Act (1878), Lunacy Act (1881) and the Lunacy Act (1898); in New Zealand, the Lunatics Act (1868) and Lunatics Act (1882) and in Queensland the 1884 legislation remained until its amendment in 1935.
46. Other Australian colonies enacted legislation at different times: Western Australia (1871); South Australia (1864); and Tasmania (1858) with an amendment in 1885. See also the comments by Frederick Norton Manning in his 'President's Address', *Intercolonial Medical Congress of Australasia* (1889), p. 820.
47. Kirkby, 'History of *psychiatry in Australia, pre-1960'* , p. 193; Lewis, *Managing Madness,* pp. 6–7.
48. Coleborne, 'Making "Mad" Populations in Settler Colonies', p. 110; Brunton, 'Colonies for the Mind, p. 7.
49. Alan Atkinson, *The Europeans in Australia: A History – Volume Two* (Melbourne, Oxford, New York: Oxford University Press, 2004), p. 283.
50. Coleborne, 'Making "Mad" Populations in Settler Colonies', p. 106.
51. On Castle Hill, see W. D. Neil, *The Lunatic Asylum at Castle Hill, Australia's First Psychiatric Hospital, 1811–1826* (Sydney: Dryas, 1992).
52. Mark Finnane, *Wolston Park Hospital 1865–2001: A Retrospect* (Brisbane, Queensland: Wolston Park Hospital, 2000), p. 24.

53. Ross Patrick, *A History of Health and Medicine in Queensland*, (St Lucia, London and New York: University of Queensland Press, 1987), p. 126.
54. The asylum appears to have been known informally as 'Avondale asylum' from about the 1870s or at least by the 1890s, as archival material reveals.
55. *Transactions of the Inter-Colonial Medical Congress of Australasia*, Second Session held in Melbourne, Victoria, Jan., 1889 (Melbourne, Sitwell & Co. London, 1889); see also Caitlin Murray, 'The "Colouring of the Psychosis": Interpreting Insanity in the Primitive Mind', *Health and History* 9:2 (2007), p. 10.
56. Future research could extend and interrogate this model through a more thorough assessment of mental health literature in the colonies, including that produced in New Zealand's South Island by prominent mental health practitioners and examine the interplay between individuals, medical journals and other professional organisations.
57. 'Gladesville Asylum', *Sydney Mail*, 28 May, 1870, p. 3.
58. 'Gladesville Asylum', *Sydney Mail*, 28 May, 1870, p. 3.
59. James Semple Kerr, *Out of Sight, Out of Mind: Australia's Places of Confinement, 1788–1988* (Sydney: S. H. Ervin Gallery and Australian Bicentennial Authority, 1988), p. 127.
60. James Beattie links the physical surroundings of institutions with their aim to 'cure'; see 'Colonial Geographies of Settlement: Vegetation, Towns, Disease and Well-Being in Aotearoa/New Zealand, 1830s–1930s', *Environment and History*, 14 (2008), p. 596.
61. For more information about newspaper accounts and debates about the Yarra Bend in this period see Coleborne, *Reading 'Madness'*.
62. 'Report on the Yarra Bend Lunatic Asylum 1856', *VPP*, p. 3.
63. *The Journal of Annie Baxter Dawbin,* 1858–1868, edited by Lucy Frost (St Lucia: University of Queensland Press, 1998), entries for June–July 1864, p. 425.
64. Ray Evans, 'The Hidden Colonists: Deviance and Social Control in Colonial Queensland', in *Social Policy in Australia: Some Perspectives*, edited by Jill Roe (Sydney and Melbourne: Cassell Australia Ltd, 1976), p. 82.
65. Mark Finnane, 'The Ruly and the Unruly: Isolation and Inclusion in the Management of the Insane', in *Isolation: Places and Practices of Exclusion* (London and New York: Routledge, 2003), edited by Carolyn Strange and Alison Bashford, p. 92. Ross Patrick also describes the terrible floods in 1890 and 1893; see Patrick, *A History of Health and Medicine in Queensland,* p. 127.
66. Patrick, *A History of Health and Medicine in Queensland,* p. 126.
67. Finnane, 'The Ruly and the Unruly', p. 92.
68. Colonial institutions lent their names and situations to a common and widely circulating language about insanity. By the twentieth century, dictionaries of slang included the term 'yarra' meaning 'stupid, eccentric or even crazy'. In his poem 'Nonsuited' which was published in 1925, Brunton Stephens listed 'Yarra-bend' and Woogaroo along with Bedlam and Colney Hatch. See Eric Partridge, *A Dictionary of Slang and Unconventional English* Volume II: The Supplement (London: Routledge and Kegan Paul Ltd, [1937] 1970), p. 1521; *The Australian National Dictionary*, edited by W. S. Ramson (Melbourne: Oxford University Press, 1988), p. 756;

*The Poetical Works of Brunton Stephens,* new edition (Sydney: Cornstalk Publishing Company, 1925), p. 109.

69. National Trust, New South Wales, *Gladesville Hospital, Sunday 14 August 1988* (Sydney: Bicentennial Activity Committee, National Trust NSW, 1988), n. p.; Morton Herman, 'Lewis, Mortimer William (1796–1879)', *Australian Dictionary of Biography*, vol 2, (Melbourne: Melbourne University Press, 1967), pp 112–13.
70. 'Report on the Yarra Bend Lunatic Asylum 1856', *VPP*, p. 3.
71. 'Report on Lunatic Asylums in New Zealand 1870', *Appendices to the Journal of the House of Representatives* (*AJHR*), D–29.
72. National Archives of New Zealand (NANZ), Auckland Asylum, YCAA 1049/1, 18 April and 28 May, 1898.
73. YCAA 1049/1, 1 April 1899.
74. Mary Guyatt, 'A Semblance of Home: Mental Asylum Interiors, 1880–1914', in *Interior Design and identity,* edited by Susie McKellar and Penny Sparke (Manchester and New York: Manchester University Press, 2004), p. 48.
75. Guyatt, 'A semblance of home', p.p. 51–3.
76. Levine-Clark, 'Dysfunctional Domesticity', p. 255. Margaret Tennant also writes about the way that ideas about 'home' pervaded welfare discourses in New Zealand through institutional settings; see 'The Decay of Home Life? The Home in early Welfare Discourses', in *At Home in New Zealand: History, Houses, People,* edited by Barbara Brookes (Wellington: Bridget Williams Books, 2000), pp. 24–40.
77. See for instance Dyason, 'The Medical Profession in Colonial Victoria'; and M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge UK: Cambridge University Press, 2007).
78. Dyason, 'The Medical Profession in Colonial Victoria', p. 194.
79. Akira Hashimoto, 'The Japanese Reception of Belgian Family Care through German Psychiatry. A Close Look into the Gheel Visitors' Register', Unpublished Conference Paper Delivered at 'Comparison, Transfer and Histoire Croisée in the History of Psychiatry', Southampton, England, 3–4 September 2005.
80. Finnane, 'Asylums, Families and the State', p. 144.
81. *Transactions of the Inter-Colonial Medical Congress of Australasia*, Second Session held in Melbourne, Victoria, Jan., 1889 (Melbourne, Sitwell & Co. London, 1889), p. 21.
82. Manning. 'President's Address', pp. 816–33.
83. His influence on relevant lunacy legislation such as the Lunacy Act (1878) and the Lunacy Amendment Act (1881) in New South Wales has been noted by historians including Garton, *Medicine and Madness*, p. 28.
84. Manning was called from Sydney to inspect Woogaroo and to speak at a select committee inquiry in 1869.
85. 'Death of Dr. Norton Manning', *The Town and Country Journal,* 24 June 1903, p. 37; D. I. McDonald, 'Frederic Norton Manning (1839–1903)', *Australian Dictionary of Biography* (Melbourne: Melbourne University Press, 1974), pp. 204–5; Catharine Coleborne, 'Manning, Frederick Norton', in *Dictionary of Medical Biography: Volume 4: M-R*, edited by W F Bynum and Helen Bynum (Westport CT: Greenwood Press, 2007), pp. 843–4.

86. I have focused on the medical figures who appear through the records of the institutions and families in this study. I have chosen not to depict any medical personnel through photographic portraits, because I am unable to depict any patients and their families; this evidence is either non-existent, or highly sensitive.
87. This point is well made by Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam and New York: Rodopi, 2008), pp. 69–70.
88. Patrick, *A History of Health and Medicine in Queensland,* p. 127.
89. Richard Scholes died in July 1898 at Goodna Hospital; see *The Brisbane Courier*, 9 July, 1898, p 6.
90. 'Sudden death of Dr Scholes', The *Toowoomba Chronicle*, 9 July 1898, p. 2. This obituary was also published in Brisbane's *Courier Mail* 9 July 1989, p. 6.
91. Obituary, *Australasian Medical Gazette*, 20 November 1908, p. 632.
92. For a detailed account of Paley's career, see Andrew Crowther, 'Administration and the Asylum in Victoria, 1860s–1880s', in '*Madness' in Australia,* edited by Coleborne and MacKinnon, pp. 85–95.
93. Eric Cunningham Dax, 'Smith, William Beattie (1854–1921)', *Australian Dictionary of Biography*, vol 11 (Melbourne: Melbourne University Press, 1988), pp. 664–5; K. F. Russell, *The Melbourne Medical School 1862–1962* (Melbourne: Melbourne University Press, 1977), p. 108. See the *Cyclopedia of Victoria*, vol 2 (Melbourne, 1904), p. 71.
94. Brunton, 'Colonies for the Mind', pp. 7–8.
95. Brookes and Thomson, *'Unfortunate Folk'*, pp. 10; 15.
96. R. E. Wright-St Clair, *Medical Practitioners in New Zealand from 1840 to 1930* (Hamilton: R.E. Wright-St Clair, 2003), p. 177. See also YCAA, 1083/5F, Historical Records Collection – Notes on History of Auckland Mental Hospital; *AJHR*, 1890–1911, H-7.
97. McDonald, 'Frederic Norton Manning (1839–1903)', pp. 204–5; Coleborne, 'Maning, Frederick Norton', pp. 843–4; M. A. Tennant, 'Macgregor, Duncan, 1843–1906', *The Dictionary of New Zealand Biography, Volume Two, 1870–1900* (Wellington: Bridget Williams Books and Department of Internal Affairs, 1993), pp.85–6; Rex Wright-St Clair, 'Skae, Frederick William Adolphus, 1842–1881', *Dictionary of New Zealand Biography* vol 2, 1870–1900 (Wellington: Bridget Williams Books and Ministry for Culture and Heritage, 1993), pp. 466–7. On asylum doctors in Victoria more generally, see Damousi, *Freud in the Antipodes*, pp. 12–21.
98. Wright-St Clair, 'Skae', p. 466.
99. Tennant, 'MacGregor', pp. 285–6.
100. See also 'Report on the Mental Hospitals of the Colony of New Zealand for 1906', *Journal of Mental Science* (January, 1908), p. 199.
101. Garton, *Medicine and Madness*, pp. 55–6; pp. 80–1
102. Stephen Garton, 'Sinclair, Eric (1860–1925)', *Australian Dictionary of Biography*, vol 11 (Melbourne: Melbourne University Press, 1988), pp. 614–15.
103. Evans, 'The Hidden Colonists'.

104. F. N. Manning, 'President's Address', *Transactions of the Inter-Colonial Medical Congress of Australasia*, Second Session held in Melbourne, Victoria, Jan., 1889 (Melbourne, Sitwell & Co. London, 1889), pp. 816–17.
105. Manning, 'President's Address', p. 818.
106. Very little scholarly work has been conducted on this institution, but the best work to date has considered the asylum as a gendered space and has examined the asylum population using the analytical tools of social and cultural history, such as Bronwyn Labrum's work. See Labrum, 'Looking beyond the Asylum: Gender and the Process of Committal in Auckland, 1870–1910', *New Zealand Journal of History*, 26: 2 (1992), pp. 125–44. See also Labrum, 'The Boundaries of Femininity: Madness and Gender in New Zealand, 1870–1910', in *Women, Madness and the Law: A Feminist Reader*, edited by Wendy Chan, Dorothy E. Chunn and Robert Menzies (London, Sydney and Portland, Oregon: Glasshouse Press, 2005), pp. 59–77.
107. Labrum, 'The Boundaries of Femininity', pp. 59–77; Garton, *Medicine and Madness*, pp. 32–3.
108. See Coleborne, *Reading 'Madness'*; Garton, *Medicine and Madness*, pp. 148–54.
109. Leigh Boucher, 'Masculinity Gone Mad: Settler Colonialism, Medical Discourse and the White Body in Late Nineteenth-Century Victoria', *Lilith* 13 (2004), pp. 56–7.
110. QSA, Wolston Park Hospital [formerly Goodna], A/45606, folio 126, Letter 2 October 1885.
111. Scholarship about aboriginal Australians and insanity includes Norman Megahey, 'More Than a Minor Nuisance: Insanity in Colonial Western Australia' in *Historical Refractions: Studies in Western Australian History,* edited by Charlie Fox, xiv (1993), pp. 42–59; Catharine Coleborne and Dolly MacKinnon, 'Psychiatry and its Institutions in Australia and New Zealand: An Overview', Special Issue of *International Review of Psychiatry* 18:4 (2006), pp. 371–80. See also Bain Attwood, 'Tarra Bobby, a Brataualung Man', *Aboriginal History* 11: 1–2 (1987), pp. 41–57.
112. 'Report on Lunatic Asylums for the Colony for 1900', *AJHR,* H-7, p. 15.
113. Labrum, 'The Boundaries of Femininity', p. 61.
114. 'Report of the Inspector of Hospitals for the Insane for 1901', *Queensland Parliamentary Papers* (*QPP*); 'Report on Lunatic Asylums of the Colony for 1900', Table VIII.
115. F. N. Manning, 'Insanity in Australian Aborigines, with a Brief Analysis of Thirty-Two Cases', *Transactions of the Intercolonial Medical Congress* (1889), pp. 857–60.
116. Damousi, *Freud in the Antipodes,* pp. 17–18.
117. Murray, 'The "Colouring of the Psychosis" ', p. 11.
118. Manning, 'Insanity in Australian Aborigines', p. 858.
119. Damousi reads this evidence critically, but it could also be interpreted as some awareness or recognition by contemporaries of the problems surrounding colonisation for colonised peoples; Damousi, *Freud in the Antipodes*, p. 18. Murray assesses Manning's account as both a critique of white European civilisation and a justification of it; see Murray, 'The "Colouring of the Psychosis" ', p. 14.
120. Manning, 'Insanity in Australian Aborigines', p. 858.

121. Manning, Insanity in Australian Aborigines', p. 859.
122. Brunton, 'Colonies for the Mind', p. 6; L. K. Gluckman, *Tangiwai*: A *Medical History of 19 century New Zealand* (Auckland: Whitcoulls Ltd, 1976), p. 131; p. 143.
123. Very little work has been conducted on the history of Maori insane in New Zealand using patient case records. The major exception Lorelle Burke, 'The Voices Caused Him to Become Porangi': Maori Patients in the Auckland Lunatic Asylum 1860–1900, Unpublished Masters Thesis in History, University of Waikato, 2006.
124. Labrum, 'Looking Beyond the Asylum', p. 128, and 'The Boundaries of Femininity', p. 61. Robert Menzies and Ted Palys comment on the relatively small numbers of indigenous peoples confined in psychiatric hospitals in British Columbia when compared to the numbers confined in criminal justice settings; see Menzies and Palys, 'Turbulent Spirits', p. 158.
125. Coleborne, 'Making "Mad" Populations in Settler Colonies', p. 115.
126. See the commentary in Jeremy H. Bloomfield, 'Dunedin Lunatic Asylum 1863–1876', in *'Unfortunate Folk': Essays on Mental Health Treatment 1863–1992*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), p. 27.
127. Chisholm Ross, 'Race and Insanity in New South Wales, 1878–1887' *Transactions of the Intercolonial Medical Congress of Australasia* (1889), p. 850.
128. Ross, 'Race and Insanity', p. 852.
129. Ross, 'Race and Insanity', pp. 852–3.
130. 'Report on the Mental Hospitals of the Colony of New Zealand for 1906', p. 200.

## 2 Families and the Colonial Hospital System, 1860–1910

1. Daniel Pick argues that 'degeneration' was not a fixed term in the nineteenth century but that it had a range of meanings applied in different political and social contexts. See Pick, *Faces of Degeneration: A European Disorder, c. 1848–1918* (Cambridge and New York: Cambridge University Press, 1989), p. 7.
2. Roy Porter suggested that it was critical to ask questions about the role played by psychiatry in imperial and quasi-imperial contexts; see Roy Porter and David Wright (eds) *The Confinement of the Insane*, p. 17.
3. Warsh, *Moments of Unreason*, p. 99.
4. Alan Atkinson, *The Europeans in Australia: A History*, vol 2 (Melbourne and Oxford: Oxford University Press, 2004), pp. 282; 279–86.
5. David Day, *Claiming a Continent: A New History of Australia* (Sydney: HarperCollins, 2001), pp. 122–3.
6. Erik Olssen, 'Towards a New Society', in *The Oxford History of New Zealand,* 2nd edition, edited by Geoffrey W. Rice (Auckland: Oxford University Press, 1992), p. 256; p. 258. See also Jeanine Graham, 'Settler Society', in *The Oxford History of New Zealand*, edited by Rice, p. 117.
7. 'Report of the Joint Committee on Lunatic Asylums 1871', *AJHR*, H-10, p. 10.
8. 'Report of the Joint Committee on Lunatic Asylums 1871', *AJHR*, H-10, p. 13.

9. I am leaving aside the question of convict transportation to Australia and focusing on new immigrants to the colonies.
10. Beverley Kingston, *The Oxford History of Australia*, vol 3, 1860–1900, 'Glad Confident Morning' (Melbourne and Oxford, UK: Oxford University Press, 1988), p. 124.
11. James Belich, *Making Peoples: A History of the New Zealanders* (Auckland: Penguin Books, 1996), p. 315.
12. Nancy Christie and Michael Gavreau (eds), *Mapping the Margins: The Family and Social Discipline in Canada, 1700–1975* (Montreal and Kingston, London and Ithaca: McGill-Queen's University Press, 2004), p. 11. See also Ellen McEwen, 'Family history in Australia: some observations', in *Families in Colonial Australia*, edited by Patricia Grimshaw, Chris McConville and Ellen McEwen (Sydney, London, and Boston: George Allen & Unwin, 1985), pp. 186–97. On migration patterns and family formation in New Zealand, see Ian Pool, Arunachalam Dharmalingam and Janet Sceats, *The New Zealand Family from 1840: A Demographic History* (Auckland: Auckland University Press, 2007), p. 55.
13. Kingston, *The Oxford History of Australia*, p. 141.
14. On the spasmodic and restricted nature of waged work in New Zealand, see Belich, *Making Peoples,* p. 379. See also Claire Toynbee, *Her Work and His: Family, Kin and Community in New Zealand 1900–1930* (Wellington: Victoria University Press, 1995).
15. McEwen, 'Family history in Australia: some observations', pp. 196; 193. However, this does not suggest a weak form of kinship in colonial Australia; rather, it indicates that demographic patterns are important in the assessment of family structures.
16. Olssen, 'Families and the Gendering of European New Zealand' , p. 54. See also Melanie Nolan, *Kin: A Collective Biography of a New Zealand Working-Class Family* (Christchuch: Canterbury University Press, 2005)
17. Olssen, 'Families and the Gendering of European New Zealand', p. 50.
18. Penny Russell (ed) *For Richer, for Poorer: Early Colonial Marriages* (Melbourne: Melbourne University Press, 1994), p. 10.
19. Olssen, 'Towards a New Society', p. 263.
20. James Belich refers to this myth in New Zealand as 'populism'; see Belich, *Making Peoples,* p. 322.
21. Garton, *Medicine and Madness,* p. 189.
22. See also Finnane, 'Asylums, Families and the State', pp.134–48.
23. Nancy Tomes, 'The Anglo-American Asylum', p. 13
24. See also Tomes, 'The Anglo-American Asylum', p. 3.
25. Gilding, *The Making and Breaking of the Australian Family,* p. 31.
26. Kingston, *The Oxford History of Australia*, p. 154.
27. Judith Raftery, 'Keeping Healthy in Nineteenth-Century Australia', *Health and History,* 1 (1999), pp. 274–97; Barbara Brookes, 'Hygiene, Health, and Bodily Knowledge, 1880–1940: A New Zealand Case-Study', *Journal of Family History,* 28: 2 (2003), pp. 297–313; McEwen, 'Family history in Australia: some observations', pp. 194–6. In addition, because 'institutional frameworks remained relatively weak well into the twentieth century', the family must be seen a 'primary locus for the social construction of marginality and deviancy' and as a site for the regu-

lation of behaviour, Christie and Gauvreau (eds), *Mapping the Margins,* p. 15.

28. Miles Fairburn, *Ideal Society and its Enemies: The Foundation of New Zealand Society 1850–1900* (Auckland: Auckland University Press, 1989), p. 195. A special issue of the *New Zealand Journal of History* was devoted to a discussion and critique of this work; see 25:2 (October 1991).
29. Atkinson, *The Europeans in Australia*.
30. Manning, *Report on Lunatic Asylums*, p. 161.
31. Finnane, 'Asylums, Families and the State', p. 137.
32. David Fitzpatrick renders the experiences of Irish immigrants to Australia through positive themes, but also finds instances of loneliness in the letters collected for his *Oceans of Consolation: Personal Accounts of Irish Migration to Australia* (New York: Cornell University Press, 1994; Melbourne, Melbourne University Press, 1995).
33. *The Book of Health*, edited by Malcolm Morris (London: Cassell, 1883), pp. 521–3; p. 978; F. Norton Manning, 'The Causation and prevention of Insanity', *Journal and Proceedings of the Royal Society of New South Wales* 14 (1880), pp. 2–3. See Susan J. Matt, 'You Can't Go Home Again: Homesickness and Nostalgia in U.S. History', *The Journal of American History*, 94:2 (September 2007), p. 470.
34. See 'One Woman's Nerves', *Auckland Weekly News,* 10 January 1891, p. 8; and 'Nostalgia', *Goulburn Herald*, Friday 7 November, 1902, p. 3.
35. Letter from John Brooke to his sister, 12 March 1853, Brooke Family papers, NLA MS 146.
36. Alan Atkinson, *The Commonwealth of Speech: An Argument about Australia's Past, Present and Future* (Melbourne: Australian Scholarly Publishing, 2002), pp. 4–5.
37. Edward Wilson Papers, October 1853, NLA MS 2126, Transcript of letters, p. 55. Newspapers regularly informed readers about postal services, usually on the front page.
38. Isaac MacAndrew Papers, Letter 01 March 1877, NLA MS 5521, Transcript, p. 41.
39. Arthur Ball Papers, letter to parents from Sydney in 1891, NLA MS 9455.
40. Charles Holmes Papers, Letter 11 October 1881, NLA Mfm M1860.
41. Atkinson, *The Commonwealth of Speech*, pp. 4–5.
42. On postal systems, see Atkinson, *The Commonwealth of Speech*, p. 5.
43. Susannah Watson, Letter 21 August 1867, Watson Family Papers, NLA MS 8886.
44. For another use of the word 'dislocation' see Matt, p. 474.
45. Edward Wilson Papers, October 1853, NLA MS 2126, Transcript of letters, p. 55.
46. Isaac MacAndrew Papers, Letter 01 March 1877, NLA MS 5521, Transcript, p. 35.
47. Edmund White Papers, Diary, 1888, NLA MS 5697. On Catherine Currie's reports of bushfires in Victoria in the 1880s see Catharine Coleborne, 'Hearing the Voices of the Excluded: Re-Examining "Madness" in history', in *History on the Couch: Essays in History and Psychoanalysis* edited by Joy Damousi and Robert Reynolds (Melbourne, Melbourne University Press, 2003), p. 23.

48. Atkinson, *The Commonwealth of Speech*, pp. 19–20. On European experiences of the Australian bush, see Richard Waterhouse, *The Vision Splendid: A Social and Cultural History of Rural Australia* (Perth, WA, Fremantle Arts Centre Press/Curtin University Books, 2005), p. 71.
49. Writing about white American men in the tropics of the Philippines, Warwick Anderson comments on the diagnosis of neurasthenia among nervous men, and the way it might be read as 'an ambivalence towards colonial expansion'; see Anderson, 'The Trespass Speaks: White Masculinity and Colonial Breakdown', *American Historical Review* 102: 5 (December 1997), p. 1348.
50. Garton, *Medicine and Madness,* p. 119.
51. Matt, 'You Can't Go Home Again', p. 474.
52. Sarah Courage, *'Lights and Shadows' of Colonial Life: Twenty-six years in Canterbury, New Zealand, by A Settler's Wife* (Christchurch, Wellington and Dunedin: Whitcombe and Tombs Ltd, [1896], 1976), p. 114.
53. Jane Oates, letter 3 March 1865, in *The Lives of Pioneer Women in New Zealand,* selected by Sarah Ell (Auckland: Gordon Ell, The Bush Press, 1992), p. 47
54. Edward Wilson Papers, letter fragments 1860s; letter to sister 24 March 1861, NLA MS 2126.
55. Edward Wilson Papers, letter fragments 1860s; letter to sister 24 March 1861, NLA MS 2126.
56. Charles Holmes Papers, Letter 11 October 1881, NLA Mfm M1860; Arthur Ball Papers, Letter to mother from Sydney, 16 March 1886, NLA MS 9455.
57. Thomas Dobeson, *Out of Work Again: The Autobiographical Narrative of Thomas Dobeson 1885–1891,* edited by Graeme Davison and Shirley Constantine, Monash Publications in History, 6 (Clayton: Monash University, 1990), pp. 24–5; p. 90.
58. Miles Fairburn, *Nearly Out of Heart and Hope: The Puzzle of a Colonial Labourer's Diary* (Auckland, Auckland University Press, 1995), p. 1.
59. Fairburn, *Nearly Out of Heart*, pp. 132–8. Nolan has also explored families and class in New Zealand; see *Kin*.
60. Fairburn goes as far as trying to determine whether Cox was suffering from a form of mental disorder, *Nearly Out of Heart*, pp. 187–91.
61. See the discussion about ethnicity and atomisation in Angela McCarthy, 'Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century Auckland, New Zealand', *Social History of Medicine* 1: 1 (April 2008), p. 57.
62. See Manning, 'The Causation and Prevention of Insanity', pp 5–7. Yet for women, too, some of the causes of insanity were organic and inescapable, such as women's tendency towards insanity following pregnancy and birth.
63. QSA, A/45611 folio 23.
64. E. Paley, 'General Report on Lunatic Asylums in New Zealand 1874', *AJHR*, H-1, p. 1.
65. Roy Porter, 'Madness and the Family before Freud: The View of the Mad-Doctors', *Journal of Family History* 23 (1998), p.169.
66. Lewis, *Managing Madness*, p. 16.
67. W. Beattie Smith, 'Insanity in Its Relations to the Practitioner, the Patient, and the State', *Intercolonial Medical Journal of Australasia*, viii: 2 (February 20, 1903), pp. 53–72.

68. Beattie Smith 'Insanity in Its Relations', pp. 55; 57; 58–9; 60; 62; 67–8.
69. Jan Goldstein, 'Psychiatry', in *Companion Encyclopedia to the History of Medicine* vol 2, edited by W.F. Bynum and Roy Porter (London and New York: Routledge, 1997 [1993]), p. 1363. Anne McClintock also argues that 'madness became increasingly drawn into a racial and a eugenics discourse'; see McClintock, *Double Crossings: Madness, Sexuality and Imperialism* (Vancouver: Ronsdale Press, 2001), p. 12.
70. Stephen Garton, 'Sound Minds and Healthy Bodies: Re-Considering Eugenics in Australia, 1914–1940', *Australian Historical Studies* 26:103 (October 1994), p. 181.
71. As reported in the *Evening Post*, 70:32 (7 August 1905), p. 4; 70:26 (3 July 1905), p. 2. My thanks to James Beattie for sharing these references.
72. Emma Spooner has shown how the bureaucratic gaze of colonial governments turned inwards and onto white New Zealanders as these issues became important; see Spooner, Digging for the Families of the 'Mad', p. 48.
73. Kelm, 'Women, Families and the Provincial Hospital', pp. 180–1; on Canada, see also Reaume, *Remembrance of Patients Past*, p. 182.
74. J.W. Springthorpe, 'Hygienic Conditions in Victoria', *Transactions of the Intercolonial Medical Congress* (Melbourne, 1889), p. 466. For more on Springthorpe, see Damousi, *Freud in the Antipodes*, pp. 11–12.
75. This was based on a talk to the Royal Society of New South Wales.
76. Manning, 'A Contribution to the Study of Heredity', *Australasian Medical Gazette*, 17 July 1885.
77. Manning, 'The Causation and Prevention of Insanity', p. 10.
78. 'For Skae's commentary, see 'Report on the Lunatic Asylums of New Zealand 1881', *AJHR*, H-13, p. 11.
79. David Wright, 'Family Strategies and the Institutional Confinement', p. 195. Parnel Wickham argues that the terms 'idiocy' and 'imbecility' were present in institutional records in the American context from the seventeenth century, but that by 1860, the more complex classification systems used inside asylums reflected a new language in medical practice and administration, a finding borne out by the records of Australian and New Zealand institutions. See Parnel Wickham, 'Idiocy in Virginia, 1616–1860', *Bulletin of the History of Medicine* 80 (2006) p. 699.
80. VPRS, 7400/P1, unit 1, folio 203.
81. SRNSW, 4/8177, 50, folio 233.
82. VPRS, 7399/P1, unit 11, folio 114, 23 October 1896. See Christina Twomey, 'Gender, Welfare and the Colonial State: Victoria's 1864 *Neglected and Criminal Children's Act', Labour History* 73 (November 1997), pp. 169–86; van Krieken, 'Children and the State', pp. 33–53.
83. YCAA, 1048/5, 13 February 1892, n.p.
84. YCAA, 1044/1, Record Book of Maintenance Investigations, folio 38.
85. YCAA, 1045/1, Maintenance Payment Ledger, 1885–1899, folio 133.
86. YCAA, 1075/1, 6 September 1892; 15 December 1892.
87. VPRS, 7400/P1, Unit 12, folio 154.
88. SRNSW, Gladesville Hospital 4/8165, casebook 38, folio 241.
89. SRNSW, Gladesville Hospital 4/8171, folio 210.
90. Manning, 'A Contribution to the Study of Heredity', p. 265.

91. YCAA, 1048/11, folio 9.
92. Reaume, *Remembrance of Patients Past*, p. 195; p. 208.
93. QSA, A/45600, folio 237.
94. VPRS, 7399/P1, unit 11, folio 340.
95. Letter to Dr Gray, 22 January 1913; and Letter to Dr Beattie, 15 November, 1912, YCAA, 1026/12, Patient case Files No. 4119–4141, case 4125.
96. See 'Report on the Lunatic Asylums of New Zealand 1881', *AJHR*, H-13, p. 11.
97. QSA, A/45619, folio 42.
98. See Note 97.
99. Manning, 'A Contribution to the Study of Heredity', p. 266.
100. Manning, 'The Causation and Prevention of Insanity', pp. 10–11.
101. Hospitals for the insane in other parts of the world also generated discussion about heredity. Colonial medical personnel no doubt read works such as the 1907 English publication of a Danish text, *Degeneration in Families: Observations from a Lunatic Asylum*, reviewed in the *Journal of Mental Science* in 1908.
102. 'Report on the Lunatic Asylums for New Zealand 1881', *AJHR*, H-13, p. 2
103. Just how far the new Mental Defectives Act influenced institutional practices for mental hospitals is difficult to determine and remains largely neglected in the scholarly debates. For one exception, see Adrienne Hoult, Institutional Responses to Mental Deficiency in New Zealand, 1911–1935: Tokanui Mental Hospital, Unpublished Masters Thesis in History, University of Waikato, 2007.
104. Hoult, Institutional Responses, pp. 4–5.
105. Hoult, Institutional Responses, p. 53.
106. Garton's study showed that there was a correlation between being 'single' and being admitted to the asylum in New South Wales; REF.
107. QSA, A/45643 folio 26, 25 October 1919.
108. SRNSW, CGS 5031, 4/8172, folio 80.
109. Bronwyn Labrum, 'Looking beyond the Asylum'; Jennifer Robertson, 'Unsettled, Excited and Quarrelsome': The Intersection of Violence, Families and Lunacy at the Auckland Asylum, 1890–1910 , Unpublished Masters Thesis in History, University of Waikato, 2006.
110. Minor differences between the institutions which appear in the sample of patients are not statistically significant because my sampling method was based on a qualitative mode of finding out about patients and their families, as the final chapter in this book explains. I have not included a table of my sampled patients for this reason.
111. By 1906, in NSW, 55 per cent of patients were born in the colonies, with the majority born in New South Wales; see 'Report of the Inspector-General of the Insane 1906', *NSW Parliamentary Papers* (1906), p. 12. In Victoria in 1904, slightly more of the entire institutional population was born in the colonies: 60 per cent, with by far the majority born in Victoria; 'Report of the Inspector of Lunatic Asylums 1904', *Victoria Parliamentary Papers*, p. 9. In Queensland by 1901, Australian and New Zealand born patients made up 22 per cent of the total institutional population; 'Report of the Inspector of Hospitals for the Insane for 1901', *Queensland Parliamentary Papers*, p. 797. In New Zealand, the population of the asylum at Auckland in 1877

was primarily foreign-born, with the majority of patients born in England, Ireland or Scotland; see 'Report on the Lunatic Asylums of New Zealand 1877', *AJHR*, H-10, p. 1. By 1900, New Zealand-born patients still only comprised 28 per cent of the Auckland population; see 'Report on the Mental Hospitals of the Dominion 1910', *AJHR*, H-7, p. 15. See also the salient points made by McCarthy in her study of migration, ethnicity and the asylum at Auckland in 'Ethnicity, Migration and the Lunatic Asylum', p. 49.

112. Finnane, 'Asylums, Families and the State', p. 135; Garton, *Medicine and Madness*, p. 118; Labrum, 'The Boundaries of Femininity'.
113. *Argus*, 29 December 1874, p. 6. Coranderrk was an aboriginal reserve territory created in Victoria in 1863 under the control of the Central Board for Aborigines, established in 1860; see Richard Broome, *Aboriginal Australians: Black responses to White Dominance 1788–1994,* 2nd edition (Sydney: Allen & Unwin, 1994), p. 71. Also living in Victoria, aboriginal man Tarra Bobby was treated differently. For a poignant account of his institutionalisation, see Attwood, 'Tarra Bobby, a Bataualung Man', pp. 41–57.
114. *Auckland Weekly News*, 27 October 1883, p. 13; *Auckland Weekly News*, 18 May 1905, p. 35. More cases of Maori insanity such as these were located through extensive newspaper research conducted for this project.
115. Manning, 'Insanity in Australian Aborigines', p. 860.
116. C. A. Hogg, 'Twelve Cases of Insanity in Australian Aboriginals with a Commentary', *Transactions of the Australasian Medical Congress*, published as a supplement to the *Medical Journal of Australia*, 21 June, 1924, pp. 455–6; 5 July, 1924, pp. 457–8. For John Bostock's commentary, see *Medical Journal of Australia,* 5 July, 1924, pp. 459–64. See also Murray, 'The "Colouring of the Psychosis" ', pp. 7–21.
117. Burke, Maori Patients in the Auckland Lunatic Asylum 1860–1900, p. 32, Table 2.1; p. 77 and Appendix 1, p. 78. Of the total of 72 Maori admitted, 43 were men and 29 were women.
118. YCAA, 1048/8, folio 73.
119. YCAA, 1048/11, folio 36. The full name is not used here as it is the only name given in the casebook to identify this patient. Labrum has also explored this theme in her work; see 'The boundaries of femininity'.
120. On the relevant legislation, see Derek Dow, ' "Pruned of its Dangers": The Tohunga Suppression Act 1907', *Health and History*, 3:1 (2001), pp. 41–64.
121. YCAA, 1048/9, folio 9.
122. Garton, *Medicine and Madness*, p. 41; see also Finnane, 'Asylums, Families and the State'. Yet only a decade or so earlier, 'madness' proved to be almost 'contagious' in colonial Victoria. High numbers of the insane in Victoria in the 1870s, explained by the 1880s as being produced by the large number of fairly helpless people without friends and families, caused official anxiety about the colony's mental health. These anxieties were communicated to asylum officials in New Zealand in asylum inspectors' reports there. In New Zealand, at the Seacliff Asylum in the South Island, Frederick Truby King also believed that specific forms of treatment had reformed the institution and produced more cures, but the figures do not support his claims; see Cheryl Caldwell, 'Truby King and the Seacliff Asylum', in *'Unfortunate Folk': Essays on Mental Health Treatment,* edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), p. 48.

123. In 1871, of the European population, 13 per 10,000 women and 22 per 10,000 men were committed; by 19 11, the figures were 8 and 12 respectively; see Labrum, 'The Boundaries of Femininity', p. 61.
124. Garton, *Medicine and Madness*, pp. 47–8.
125. 'Report on the Lunatic Asylums of New Zealand 1877', *AJHR*, H-8, p. 1; 'Report on the Mental Hospitals of the Dominion 1911', *AJHR*, H-7, p.2. See Spooner, Digging for the Families of the 'Mad', p. 30.

## 3 Families and the Language of Insanity

1. Ann (Catherine) Currie, 1845–1908, Farm Diaries 1873–1916, La Trobe Australian Manuscripts Collection, State Library of Victoria, MS 10886, MSB 623, 7 vols; 16 January 1894.
2. Elsewhere I have written about Catherine's diary and her patient case notes from the Yarra Bend. Her story is also well-told by Ailsa McLeary. See Coleborne, *Reading 'Madness'*, pp. 116–18, p. 195; Coleborne, 'Hearing the "speech of the excluded": re-examining "madness" in history', in *History on the Couch: Essays in History and Psychoanalysis* edited by Joy Damouis and Robert Reynolds (Melbourne, Melbourne University Press, 2003), pp. 17–25; Ailsa McLeary, with Tony Dingle, *Catherine: On Catherine Currie's Diary, 1873–1908* (Melbourne: Melbourne University Press, 1998), pp. 146–7.
3. Nancy Tomes, 'Historical Perspectives on Women and Mental Illness', in *Women, Health and Medicine in America: A Historical Handbook*, edited by Rima D. Apple (New York and London: Garland Publishing Inc., 1990), p. 171.
4. Wright, 'Getting out of the Asylum', p. 144.
5. Nancy Tomes, 'The Anglo-American Asylum, p. 114
6. Annie Baxter Dawbin was one such person; she accompanied Dr Barker to the Yarra Bend Asylum in the 1860s: see *The Journal of Annie Baxter Dawbin 1858–1868*, edited by Lucy Frost, (St Lucia: University of Queensland Press, 1998), June 1863, pp 332–4; June–July 1864, pp. 424–5.
7. Charles E. Rosenberg and Janet Golden (eds) *Framing Disease: Studies in Cultural History,* (New Brunswick and New Jersey: Rutgers University Press, 1992), p. xvi
8. Rosenberg and Golden, *Framing Disease*, p. xviii.
9. Roy Porter, 'The Patient's View', pp. 193–4. Feminist historians of medicine have also made major contributions to these debates in their work about women and childbirth, among other topics. These historians have also ensured that private lives of patients and their negotiations with medical authorities have been well documented, including a now extensive literature about childbirth and associated issues. See for instance *Women, Health and Medicine in America*, edited by Rima D. Apple (New Brunswick, NJ: Rutgers University Press, 1990).
10. Nancy Theriot, 'Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science', *Signs* 19, no. 1 (1993), p. 23.
11. Bronwyn Labrum, 'The boundaries of femininity: Madness and Gender in New Zealand, 1870–1910', in *Women, Madness and the Law: A Feminist Reader*, ed. by Wendy Chan, Dorothy E. Chun and Robert Menzies (London,

Sydney, Portland Oregon: Glasshouse Press, 2005); Moran, 'The Signal and the Noise', pp. 281–301; Tomes, *A Generous Confidence*. Both Labrum and Moran seek to map the frequency of different indications.

12. Moran, 'The Signal and the Noise', p. 290.
13. Warsh, *Moments of Unreason*, p. 38.
14. Manning, 'Is Insanity increasing?' *Journal and Proceedings of the Royal Society of New South Wales* 15 (1881), pp. 401–7.
15. F. N. Manning, 'Medical certificates of insanity', *Journal and Proceedings of the Royal Society of New South Wales* 17 (1883), p. 275.
16. Suzuki, 'Framing psychiatric subjectivity', pp. 115–36.
17. Public interest in legal cases involving criminal insanity, murder trials and similar cases is outside the scope of this argument but relevant to the discussion of a circulating knowledge about insanity.
18. Mary Duncan, *Argus*, 18 October 1870, p. 5; Letitia Beck, *Argus*, 1 May 1873, p. 5; 2 May 1873, p. 5; 3 May 1873, p. 5; *Argus*, 20 June 1873, p. 5.
19. Rod Kirkpatrick, 'House of Unelected Representatives: The Provincial Press 1825–1900', in *Journalism: Print, Politics and Popular Culture* edited by Ann Curthoys and Julianne Schultz (St Lucia, Queensland, Australian Public Intellectual Network, 1999), p. 35. On the potential for newspapers to create common cultures, see also Atkinson, *The Commonwealth of Speech*, pp. 5–6; and Atkinson, *The Europeans in Australia*, pp. 244–8.
20. Edward Wilson Papers, October 1853, NLA MS 2126, Transcript of letters, p. 46.
21. Annabel Cooper, 'Poor Men in the Land of Promises: Settler Masculinity and the Male Breadwinner Economy in Late Nineteenth-Century New Zealand' *Australian Historical Studies* 39 (2008), pp. 245–61.
22. *Argus* 6 February, 1873, p. 5; *Argus*, 3 May, 1871, p. 5.
23. *Auckland Weekly News*, 20 October 1883, p. 21
24. 'Insanity', *New Zealand Herald*, 6 January 1900, Supplement, p. 6.
25. *Argus*, 6 February, 1873, p. 5. Smith (also known as Peter), born in Scotland, later held the position as Medical Superintendent at Goodna (1877–1883); see Australian Medical Pioneers Index, http://www.medicalpioneers.com/cgi-bin/index, 2008.
26. Patrick Smith, 'On Premonitory Symptoms of Insanity: The Importance of Early Diagnosis and Treatment', *Australian Medical Journal* (February 1873), pp. 39–47.
27. For example, the Pierce Galliard Smith papers held by the National Library of Australia contain several Letts' Universal Diaries, Australasian editions, published in the 1890s. These contained advertising materials such as a small booklet promoting Cassell and Company publications in health. NLA MS 2656 Pierce Galliard Smith, Box 18. See also *The Book of Health*.
28. *Brett's Colonists' Guide and Cyclopaedia of Useful Knowledge,* edited by Thomson W. Leys (Auckland: H. Brett, 1883); 'The Family Doctor', pp. 447–64.
29. George Fullerton, *The Family Medical Guide* (Sydney: William Maddock, 1889), pp. 222–6.
30. Michael J. Thearle, 'Domestic Medicine in Colonial Queensland', in *New Perspectives on the History of Medicine,* edited by H. Attwood, R. Gillespie and M. Lewis (Melbourne: University of Melbourne and the Australian Society for the History of Medicine, 1990), p. 132.

31. *Everybody's Medical Adviser and Consulting Family Physician: A Practical Handbook of Health and Self-management*, edited by George Black (London and Sydney: Ward, Lock; and William Dobell, c. 1880s), pp. 631–7.
32. Raftery, 'Keeping Healthy', pp. 274–97; Brookes, 'Hygiene, health, and Bodily Knowledge', pp. 297–313; Barbara Brookes, 'The Risk to Life and Limb: Gender and Health', in *Sites of Gender: Women, Men and Modernity in Southern Dunedin, 1890–1939*, edited by Barbara Brookes, Annabel Cooper and Robin Law (Auckland: Auckland University Press, 2003).
33. Anne Wilson, Diary, 18 July, 1836, in Frances Porter and Charlotte Macdonald (eds) *My heart will write what my heart dictates: the unsettled lives of women in nineteenth-century New Zealand as revealed to sisters, family and friends* (Auckland: Auckland University Press, Bridget Williams Books, 1996), p. 265.
34. Document 4.6, 'A clergyman's wife describes their plight', *Freedom Bound: Documents on women in colonial Australia*, edited by Patricia Grimshaw, Susan Janson and Marian Quartly (Sydney: Allen & Unwin, 1995), p.146.
35. These findings rest on a comprehensive survey of terms used in the *Argus* between 1870 and 1879. Similar use of language and accounts of insanity appear in different newspapers in the other colonies. Medical journals were not immune from the worst excesses of perjorative language about insanity. 'Humorous' reports such as one published in the *Australian Medical Journal* in 1873 perpetuated the stereotypes of madness; in this case, a doctor ran away from a violent woman dubbed 'Mad Margaret' who was so difficult to contain that her own family were too afraid to 'get rid of her', 'Local Topics', *Australian Medical Journal* (February 1873), p. 63.
36. *Warragul Guardian*, 22 September, 1881, p. 2.
37. Bryan Gandevia has suggested that given their worries living in remote places, and high rates of child mortality in the early years of the colony on Victoria, it is no wonder that women in Australia became 'mental wrecks', Bryan Gandevia, 'Land, Labour and Gold: The Medical Problems of Australia in the Nineteenth Century', *Medical Journal of Australia* 1:20 (May 1960), p. 757.
38. The major pieces of legislation in each colony, all established between the 1860s and 1880s, as outlined in Chapter 1, varied in minor ways but processes of legal committal were identical. Manning noted that in South Australia and Tasmania, in cases of indigent patients admitted to institutions, one medical certificate would be accepted; 'President's Address', *Transactions of the Inter-Colonial Medical Congress of Australasia*, Second Session held in Melbourne, Victoria, Jan., 1889 (Melbourne, Sitwell & Co. London, 1889), p. 820. For a brief overview of different processes in France, America and England, see Wright, 'Getting out of the Asylum', pp. 147–8.
39. Manning, 'President's Address', p. 820.
40. Patrick Smith, 'Hints on the Giving of Certificates of Lunacy', *Australian Medical Journal* (December 1873), pp. 356–60; (January 1874), pp. 14–9; (February 1874), pp. 43–8.
41. *The Australasian Medical Directory and Hand Book,* edited by Ludwig Bruck, 5th edition (Sydney and London, Balliere, Tindall and Cox, 1900), pp. 222–4
42. Smith, 'Hints', (December 1873) p. 360; and 'Hints' (January 1874), pp. 18–9.

43. Manning 'Medical Certificates of Insanity', pp. 266–77.
44. YCAA, 104/5, folio 641.
45. 'Certificates of Lunacy – The Smith v. Iffla case', *Australasian Medical Gazette* (February 1882), pp. 65–6. Doctors received payments in some colonies for their medical certification of the alleged insane.
46. 'Certificates of Lunacy – The Smith v. Iffla case', p. 65.
47. Beattie Smith, 'Insanity in its Relations' , p. 54.
48. SRNSW, CGS 5031 Gladesville Hospital, Medical casebooks 1857–1925, 4/8175, folio 278, 23 November 1885.
49. Tomes, 'Historical Perspectives on Women and Mental Illness', p. 163; Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), p. 163.
50. Garton, *Medicine and Madness,* p. 55.
51. Garton, *Medicine and Madness*, p. 55.
52. The asylum dealt with bodily disease too, of some interest to me but outside the scope of this discussion.
53. German E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge UK: Cambridge University Press, 1996).
54. Berrios, *The History of Mental Symptoms*, p. 22.
55. James Moran, 'The Signal and the Noise', p. 285; Berrios, *The History of Mental Symptoms*.
56. Moran, 'The Signal and the Noise', p. 285.
57. Berrios, *The History of Mental Symptoms,* p. 1. For further discussion about disease interpretation see Mark S. Micale, *Approaching Hysteria: Disease and its Interpretations* (Princeton New Jersey, Princeton University Press, 1995).
58. See for instance John Harley Warner and Guenter Risse, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine* 5 (1992), pp. 183–205; Marland, *Dangerous Motherhood*, pp. 97–105.
59. Marland, *Dangerous Motherhood*, p. 101.
60. This followed 1882 legislation in the colony. In the separate case files, which are not always available, copies of medical certificates with two doctors' opinions noted are filed with other documents.
61. The word and terms 'delusion', 'religious delusions' seem to have been part of doctors' vocabularies, rather than in common use by lay observers. 'Hallucination' similarly became a 'translation' in the marginal notes in the case notes or case papers. See my Appendix.
62. 'Protracted sleeplessness'; 'persistent headache'; 'great depression or exaltation of spirits without sufficient cause'; 'alteration in the state of the nerves of special sense' (hearing and seeing things); 'lesions of motor power' (squint, droop); 'gradual emaciation'. Dr Smith, 'Hints' (December 1873) p. 360.
63. Official asylum inspectors' reports to parliament show that in New South Wales, these two categories were being used by the mid-1870s. Interestingly, in 1875–1876, it was noted that there were 'difficulties' in 'obtaining trustworthy information concerning patients on their admission'. See 'Report on the Hospital for the Insane, Gladesville 1875', *Journal of the Legislative Council of New South Wales* (Sydney: Thomas

Richards, Government Printer, 1876), p. 7. In Victoria, official inspectors' reports use these categories by the 1880s. In Queensland, moral and physical causes also applied, whereas in New Zealand, the causes of insanity were listed without being grouped in this manner. Garton argues that by the 1880s, 'moral' causes were cited far less frequently as medical knowledge about the physical causes of insanity gained influence and filtered through to the asylum's clientele; see Garton, *Medicine and Madness*, p. 99.

64. Around a decade later, it was noted in the same report that these 'causes' were 'verified or corrected by the Medical officers as far as possible', indicating that some language was more heavily mediated; see 'Report on the Hospital for the Insane, Gladesville 1885', *Journal of the Legislative Council of New South Wales,* p. 26.
65. Levine-Clark notes that 'moral' causes were more often attributed to cases of women experiencing problems in the home, 'Dysfunctional domesticity', p. 346.
66. SRNSW, CGS 5031, 4/8165, folio 241.
67. SRNSW, CGS 5031, 4/8172, folio 228
68. SRNSW, CGS 5031, 4/8183, folio 247.
69. SRNSW, CGS 5031, 4/8184, folio 69.
70. Labrum, 'The Boundaries of Femininity', pp. 70–4.
71. Queensland State Archives (QSA), Wolston Park Hospital (formerly Goodna), A/45616, folio 142.
72. Labrum, 'The Boundaries of Femininity', pp. 74–7.
73. YCAA, 1048/11, Medical Casebooks, folio 46.
74. YCAA, 1048/9, Medical Casebooks, folio 2.
75. Brookes, 'Hygiene, health, and bodily knowledge', pp. 297–313. See also Raftery, 'Keeping Healthy', pp 274–97.
76. SRNSW, CGS 5035, 4/8201, no 121; CGS 5035, 4/8201, no 96; CGS 5034, 4/8206, no 15.
77. SRNSW, CGS 5031, 4/8165, folio 272.
78. SRNSW, CGS 5031, 4/8168, folio 97.
79. SRNSW, CGS 5031, 4/8173, folio 179.
80. SRNSW, CGS 5031, 4/8182, folio 243.
81. SRNSW, CGS 5031, 4/8185, folio 219.
82. SRNSW, CGS 5031, 4/8186, folio 145; 4/8187, folio 150.
83. SRNSW, CGS 5031, 4/8191, folio 226.
84. SRNSW, CGS 5031, 4/8193, folio 296.
85. 'Cases of Mental Depression – Hydrotherapy Recovery', *Intercolonial Medical Journal* (February 1901), pp. 76–9.
86. Janet Oppenheim, *'Shattered Nerves': Doctors, Patients, and Depression in Victorian England* (New York and Oxford: Oxford University Press, 1991), p. 5.
87. Berrios, *The History of Mental Symptoms,* pp. 298–9.
88. In my sample of patients, more women than men were diagnosed with 'melancholia' in each institution, but the differences are not significant in numerical terms.
89. QSA, A/45619, folio 42.
90. VPRS, 7400/P1, Unit 1, folio 138.
91. VPRS, 7400 P1, Unit 14, Folio 203.

92. QSA, A/45648 folio 64.
93. Garton, *Medicine and Madness*, p. 67.
94. For instance, as the previous chapter also noted, the Victorian asylum named the Yarra Bend, excited a number of slang terms in the nineteenth century.
95. See for instance *New Zealand Observer and Free Lance*, 12 October 1895, p. 11; p. 8 October 1898, p. 3. Researcher Murray Frost located 9 cartoons about insanity and the asylum published in this paper between 1895 and 1911.
96. Patient case files, YCAA, 1026/12, no 4112; and YCAA, 1048/11, folio 10.
97. SRNSW, CGS 5034, 4/8206, no 16.
98. QSA, A/45648, folio 29.
99. Raftery, 'Keeping healthy', p. 285.
100. QSA, A/45648, folio 29. Patricia Prestwich found that in the French context, families were more reluctant to defer to medical expertise. See 'Family strategies and medical power: 'voluntary' committal in a Parisian asylum, 1876–1914', in *The Confinement of the Insane*, pp. 93–4.
101. F. N. Manning, 'Ten Years at Gladesville' (Sydney: Thomas Richards, Government Printer, 1880), pp. 4; 8; 10–12.
102. See a relevant discussion and the letters between Walter and Mary in *Marriage Lines: The Richardson Family Letters 1854–1877*, edited by Meg Probyn (Melbourne: Australian Scholarly Publishing, 2000), pp. 60–5; pp. 325–58. See also Axel Clark, *Henry Handel Richardson: Fiction in the Making* (Brookdale: Simon Schuster, 1990).
103. SRNSW, CGS5031, 4/8184, folio 69.
104. SRNSW, CGS 5031, 4/8184, folio 277.
105. QSA, A/45649, folio 54.
106. SRNSW, CGS 5031, 4/8174, folio 13.
107. SRNSW, CGS 5031, 4/8184, folio 157.
108. Smith, 'On Premonitory Symptoms of Insanity', pp. 40–1.
109. YCAA, 1048/6, folio 439.
110. Tomes, *A Generous Confidence*, 91.
111. Tomes, *A Generous Confidence,* 95.
112. F.N. Manning, 'The Causation and Prevention of Insanity' (Sydney: Government Printer, 1880), p. 1.
113. 'Report on the Lunatic Asylums of New Zealand 1881', *AJHR*, H-13, p. 11.
114. David Wright, James Moran and Sean Gouglas, 'The Confinement of the Insane in Victorian Canada: The Hamilton and Toronto Asylums, c.1861–1891', in *The Confinement of the Insane*, p.122.
115. SRNSW, CGS 5031, 4/8182, folio 20.
116. Levine-Clark, 'Dysfunctional Domesticity', p. 346.
117. YCAA, 1048/10, folio 53,
118. YCAA, 1026/12, Committed patient case files, December 1910.
119. Suzuki, *Madness at Home*, p. 121.

## 4 Writing to and from the Asylum

1. Public Record Office of Victoria (PROV), Yarra Bend Asylum (VA 2839), VPRS Victoria Public Record Series (VPRS), 7400/P1 Unit 12, 30 September 1899, folio 269.

2. VPRS, 7570/P1, Unit 1, File 1900/1870, Bundle 4.
3. VPRS, 7556/P1 Admission Warrants, Unit 29, 4359.
4. Wright, 'Getting Out of the Asylum', p. 153. For instance, see the work by Davidoff et al., *The Family Story*.
5. Hilary Marland, 'Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century', *History of Psychiatry,* 14:3 (2003), p. 307. See also Marland, *Dangerous Motherhood*.
6. Levine-Clark, 'Dysfunctional Domesticity', pp. 348; 347. Patricia Prestwich also hints at 'emotional' families in her comments that claims of violence may have been exaggerated by family members who had an 'emotional need to justify their actions', or the committal of relatives; see Prestwich, 'Family strategies and medical power: 'voluntary' committal in a Parisian asylum, 1876–1914', in *The Confinement of the Insane*, p. 91. See also Catharina Lis and Hugo Soly, *Disordered Lives: Eighteenth-Century Families and Their Unruly Relatives* (Cambridge UK, Oxford UK and Cambridge Mass.: Polity Press, 1996), p. 7.
7. Kelm, 'Women, Families and the Provincial Hospital', pp 177–93; Reaume, *Remembrance of Patients Past*.
8. Finnane, 'Asylums, Families and the State', p. 141.
9. Grimshaw, 'Marriages and Families', p. 318.
10. MacKenzie, *Psychiatry for the Rich*, p. 97; Penny Russell, *'A Wish of Distinction': Colonial Gentility and Femininity* (Melbourne: Melbourne University Press, 1994), p. 127.
11. Olssen and Levesque, 'Towards a History of the European Family', pp. 8–9.
12. Olssen, 'Towards a New Society', p. 264. See also Olssen, 'Families and the Gendering of European New Zealand', pp. 37–62.
13. Marjorie Levine-Clark has shown through her English case study of West Riding in the nineteenth century that poverty led to emotional distress; see Levine-Clark, ' "Embarrassed Circumstances" ', p. 133.
14. Davidoff et al., *The Family Story*, pp. 12–3.
15. Stephen Garton, *Medicine and Madness,* p. 189.
16. Davidoff et al., *The Family Story*, pp. 244–65.
17. SRNSW, CGS5035, 4/8201, letter 16 November 1880.
18. YCAA, 1044/1, Record Book of Maintenance Investigations, folio 22.
19. Queensland State Archives (QSA), Wolston Park Hospital, Medical casebooks, A/45616; letter 142, 28 May 1907.
20. QSA, A/45616, folio 142, admission notes 1888.
21. QSA , A/45633, October 1899, Letter 101.
22. SRNSW, CGS5034, 10 July 1893, Letter 49.
23. Peter Stearns and Carol Z. Stearns, 'Emotionology: Clarifying the History of Emotions and Emotional Standards', *American Historical Review* 90 (2001), p. 814. See also Jan Lewis and Peter Stearns (eds), *An Emotional History of the United States* (New York and London: New York University Press, 1998). In framing his approach to the history of emotions, Stearns has emphasised the importance of the discursive context for emotions in any period; the need to examine changing emotional expressions over time; and the tensions inherent in an examination of the mediation between emotional standards and peoples' experiences. The social history of medicine and health is no exception. Stearns mentions the history of health as one field that might benefit from such an

inquiry, p. 832. Together with Stearns, historians have attempted to classify 'emotives' using specific archives, such as William Reddy's exploration of French judicial archives of the 1820s. Barbara Rosenwein has explored 'emotional communities' and her work offers useful observations for this interpretation of the asylum as one site for the expression of emotion; see Rosenwein, 'Even the Devil (Sometimes) Has Feelings: Emotional Communities in the Early Middle Ages', *The Haskins Society Journal,* 14 (2003), pp. 1–14. See also *Medicine, Emotion and Disease, 1700–1950*, edited by Fay Bound Alberti (Houndmills, Basingstoke and New York: Palgrave Macmillan, 2006).

24. Christie and Gavreau (eds), *Mapping the Margins*, p. 14.
25. Nancy Christie, 'A "Painful Dependence": Female Begging Letters and the Familial Economy of Obligation', in *Mapping the Margins*, p. 71.
26. Rainer Beck 'Traces of Emotion? Marital Discord in Early Modern Bavaria', in *Family History Revisited*, edited by Richard Wall et al. (Newark and London, Delaware: University of Delaware Press, 2001), p. 137. Beck sought and found emotions in 'documentations of disorder', or petitions for divorce in seventeenth-century Church records. See also Davidoff et al. *The Family Story* for a succinct overview of these debates in the history of the family in their introductory chapters.
27. Louise Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875–1910', *Social History of Medicine* 20:2 (2007), pp. 297–313.
28. Dwyer, *Homes for the Mad*, pp. 85–7
29. Martyn Lyons, 'Love Letters and Writing Practices: On *Écritures Intimes* in the nineteenth century', *Journal of Family History* 24:2 (April 1999), p. 232; Greg Stott, 'The Persistence of Family: A Study of a Nineteenth-century Canadian Family and their Correspondence', *Journal of Family History* 31:2 (April 2006), pp. 190–207.
30. See Mark Finnane, 'The Ruly and the Unruly: Isolation and Inclusion in the Management of the Insane', in *Isolation: Places and Practices of Exclusion*, edited by Carolyn Strange and Alison Bashford (London and New York: Routledge, 2003).
31. In 1907, reports from the London County Council asylums detailed some anxiety about the suppression of patients' letters; see Reports from London County Council Asylums, *Journal of Mental Science*, Jan (1907), p. 204.
32. Finnane, 'Asylums, Families and the State', p. 138.
33. 'Report of the Inspector General of the Insane 1880', *Journal of the Legislative Council New South Wales,* p. 11.
34. SRNSW, CGS 5136 Parramatta Hospital, Letters from patients, c. 1897–1920, 4/8580, no 9.
35. SRNSW, CGS 5136, 4/8205, no 391.
36. Rosenwein, 'Even the devil has feelings', p. 4. While I do not examine the frequency of occurrence of particular emotions, it could be relevant to 'measure' emotional descriptions in this manner.
37. Hilary Marland, 'Languages and Landscapes of Emotion: Motherhood and Puerperal Insanity in the Nineteenth Century', in *Medicine, Emotion and Disease*, pp. 53–78.
38. On violence and the asylum in New Zealand see Robertson, 'Unsettled, Excited, and Quarrelsome'.

39. SRNSW, Medical Casebooks (5031), 4/8173, 7 January 1884, folio 179.
40. R. A. Houston 'Madness and Gender in the Long Eighteenth Century', *Social History,* 27:3 (2002), p. 320.
41. YCAA, 1048/5, entry for September 1891, folio 641. Houston, 'Madness and Gender in the Long Eighteenth Century', p. 320. The very acceptance of 'grief' as a cause of insanity suggests that the emotional bonds between spouses, parents and children and other family members were strong; see Levine-Clarke, 'Dysfunctional Domesticity', p. 347.
42. YCAA, 1026/12, Committed Patient Files, 3 December 1910
43. VPRS, 7399/ P1, Unit 13, 20 March 1901, folio 46.
44. QSA, A/45611, 21 February 1885, folio 23.
45. SRNSW, Medical Casebooks (5031), 4/8191, 10 February 1904, folio 226.
46. Davidoff et al., *The Family Story,* p. 244.
47. SRNSW, 4/8184, folio 69, 18 January 1896
48. QSA, A/45649, 11 November 1907, folio 54.
49. YCAA, 1048/9, 24 June 1900, folio 21.
50. QSA,A/45619, 3 September 1890, folio 134.
51. QSA, A/45633, 15 June 1899, folio 64.
52. VPRS, 7556 P1, Unit 29, no 4359.
53. YCAA, 1048/5, February 1891 note in case, folio 370.
54. YCAA, 1048/11, 27 August 1908, folio 11.
55. See Burke, Maori Patients in the Auckland Lunatic Asylum 1860–1900.
56. Thomas Dixon, 'Patients and Passions: Languages of Medicine and Emotion, 1789–1850', in *Medicine, Emotion and Disease, 1700–1950,* p. 27
57. YCAA, 1048/11, 21 October 1908, folio 46.
58. YCAA, 1048/10, 31 July 1904, folio 110.
59. SRNSW, 5034, 4/8206, 26 July 1894, letter 55.
60. Dixon, 'Patients and Passions', pp. 26–7
61. Joan Busfield, 'Class and Gender in Twentieth-Century British Psychiatry: Shell-Shock and Psychopathic Disorder', in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry,* edited by Jonathan Andrews and Anne Digby (Amsterdam and New York, Rodopi, 2004), p. 312.
62. See Phillips, *A Man's Country? The Image of the Pakeha Male – a History* (Auckland: Penguin, 1996).
63. Rosenwein, 'Even the devil has feelings', p. 6.
64. QSA, A/45611, 25 September 1885, folio 269.
65. QSA, A/45648, 19 June 1907, folio 64.
66. QSA, A/45611, 26 February 1885, folio 33; letter 33, 5 October 1885.
67. VPRS, 7556/P1, Admission warrants, Unit 39, no 4587.
68. SRNSW, 4/8176, 29 April 1886, folio 64.
69. VPRS, 7400/P1, Unit 5, folio 214; Unit 14, folio 163.
70. SRNSW, 4/8177, 23 August 1888, folio 149.
71. Louisa Geoghegan, in *The Governesses: Letters from the Colonies, 1862–1882* edited by Patricia Clarke (Sydney: Allen & Unwin, 1985), pp. 104–5.
72. Nina Spasshatt to Joshua Bay, 15 September 1863, in Alison Hyles Papers,1861–1973, NLA MS 5843, xerox copies of typescripts.
73. Nina Spasshatt to Joshua Bay, 15 September 1863, in Alison Hyles Papers, 1861–1973, NLA MS 5843, xerox copies of typescripts.

74. Bennett, *The Book of Health*, p. 523.
75. Jalland, *Australian Ways of Death*. Pat Jalland's work surveys a number of rich accounts of death and dying, arguing that expressions of grief in nineteenth-century Australia were governed by expectations of gender; women were expected to grieve openly and with emotion. Consequently, she suggests, 'the individual histories of men's experiences of grieving remain largely hidden from history' p. 143.
77. Houston, 'Madness and Gender in the Long Eighteenth Century', p. 320. Cases of women's emotions as causes of insanity are also cited in Houston's work 'Class, Gender and Madness in Eighteenth-Century Scotland', in *Sex and Seclusion, Class and Custody*, pp. 49–50.
78. VPRS, 7570 P1, Unit 1, F99/1789, Bundle 2, 2 July 1899.
79. QSA, A/45633, 15 June 1899, letter 64.
80. SRNSW, 4/8180, 16 August 1892, folio 159.
81. SRNSW, 5034 (Gladesville Hospital, Letters Concerning Patients) 4/8206, letter 46. Original spelling and punctuation have been replicated here.
82. QSA, A/45606, 12 October 1885, letter 126.
83. SRNSW, 5034, 4/8206, letter 47.
84. QSA, A/45619, 26 November 1890, letter 134.
85. QSA, A/45611, 10 March 1905, letter 39.
86. QSA , A/45643, n.d. 1906, letter 120.
87. QSA, A/45616, 23 January 1889, letter 146.
88. SRNSW, CGS 5035 Gladesville Hospital, Letters from patients 1864–1924, 4/8201, no 92, 4 February 1886.
89. SRNSW, CGS 5031 Gladesville Hospital, Medical casebooks 1857–1925, 4/8175, folio 278, 23 November 1885.
90. Russell, *'A Wish of Distinction'*, p. 127.
91. Marland, *Dangerous Motherhood*, pp. 65–94.
92. Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England 1820–1860* (Berkeley, Los Angeles, London: University of California Press, 2006), pp. 29–38.
93. QSA, A/45648, Letter 12 May 1907.
94. What Reddy called 'emotives' is interpreted by Rosenwein as being similar to 'performatives', Rosenwein, 'Even the devil has feelings', p. 6.
95. SRNSW, 5034, 4/8206, Letter 37, 5 January 1892.
96. SRNSW, 4/8177, folio 233. Admission 17 January 1889.
97. Wannell, 'Patients' Relatives and Psychiatric Doctors', p. 306.
98. Rosenwein, 'Even the devil has feelings', p. 6. Suzuki, *Madness at Home*, p. 33.
99. QSA, A/45639, 1 Dec, 1903, letter 97, folio 97.
100. QSA, A/45649, 11 November 1907, folio 49.
101. QSA, A/45649, 11 November 1907, folio 54; letter 54, n.d.
102. VPRS, 7570/P1, Unit 1, File 99/1789, Bundle 2, 2 July 1899.

## 5 Tracing Families for Maintenance Payments

1. W. L. Cleland, 'Australian Lunatic Asylums – Remarks on their Economic Management in the Future', *Intercolonial Medical Congress of Australasia,*

*Transactions of Second Session held in Melbourne, Victoria* (Melbourne: Stilwell and Co, 1889), p. 876.

2. YCAA, 1044 Record Book of Maintenance Investigations, folio 31.
3. However, some patients admitted to public asylums in England were pursued for maintenance payments; see Melling and Forsythe, *The Politics of Madness*, pp. 173; 194; 221, n. 24. Very little scholarship about private institutions in the Australian context exists, as the first chapter of this book explained. In some cases the institutional archival evidence is very slight.
4. The subject of maintenance payments for deserted wives has received some attention; see Christina Twomey, *Deserted and Destitute: Motherhood, Wife Desertion and Colonial Welfare* (Melbourne: Australian Scholarly Publishing, 2002); Bronwyn Dalley, 'Criminal Conversations: Infanticide, Gender and Sexuality in Nineteenth-Century New Zealand', in *The Gendered Kiwi,* edited by Caroline Daley and Deborah Montgomerie (Auckland: Auckland University Press, 1999), pp. 63–85; Fiona Kean, 'Illegitimacy, Maintenance and Agency: Unmarried Mothers and Putative Fathers in Auckland, 1900–1910', Unpublished Masters Thesis in History, University of Waikato, 2004.
5. W. Pember Reeves, *State Experiments in Australia and New Zealand* , vol 2 (Melbourne: Macmillan Australia, 1969 [1902]), pp. 243–9; Tennant, *Paupers and Providers*, pp. 163–80. See, for instance, Dickey, *No Charity There*; Garton, 'Rights and Duties', pp. 23–38. For New Zealand, see Tennant, *Paupers and Providers;* Thomson, *A World Without Welfare*. In particular, note the discussion about the shift towards notions of 'universal' welfare policies, away from the conceptions of 'charity', in Garton, 'Rights and duties', and see also Margaret McClure, *A Civilised Community: A History of Social Security in New Zealand 1898–1998* (Auckland: Auckland University Press and Historical Branch, 1998), pp. 17–23
6. See the description of 'Maintenance Bonds' for the Yarra Bend at the Public Record Office of Victoria (PROV) VA 2839, VPRS 7568.
7. Tennant, *Paupers and Providers*, p. 39; Dickey, *No Charity There,* p. 57.
8. Tennant, *Paupers and Providers*, p. 13.
9. See the *Destitute Persons Relief Ordinance* (New Zealand), 10 Vict., no , 1846, preamble.
10. The Lunatics Act (1868) in New Zealand gave power to Justices to seek maintenance payments from relatives (s. 155). The Lunacy Act (1878) in New South Wales gave powers to the Master-in-Lunacy seek legal assistance to collect maintenance fees from families or inmates' estates; this was also true in Victoria. In Queensland, the Curator of Insanity was granted similar powers under the terms of the Insanity Act (1884).
11. Twomey, 'Gender, Welfare and the Colonial State', p. 171.
12. Stephen Garton, *Out of Luck: Poor Australians and Social Welfare* (Sydney: Allen & Unwin, 1990), pp. 44–54; Dickey, *No Charity There,* pp. 21–47; Tennant, *Paupers and Providers*, p. 15. Christina Twomey has argued that in colonial Victoria and New South Wales, some women exercised their agency and sought assistance and welfare services from state-run institutions; see Twomey, 'Gender, Welfare and the Colonial State', pp. 169–86. See also Twomey, *Deserted and Destitute*.
13. Brunton, 'Colonies for the Mind', pp. 12–13.

14. Tennant, *Paupers and Providers*, p. 13; 'Reports on the Lunatic Asylums in New Zealand, 1876', *AJHR*, H-4, p. 2.
15. 'Royal Commission appointed to inquire into the Management of Woogaroo Lunatic Asylum and the Lunatic Reception Houses of the Colony', *Queensland Parliament, Legislative Assembly, Votes and Proceedings*, vol 1 (Brisbane: James C Beal Government Printer, 1877), p. xiii.
16. 'Lunacy Act Administration', *Sydney Morning Herald*, 2 April 1913, p. 12.
17. See Michael Horsburgh, 'Some Issues in the Government Subsidy of Hospitals in New South Wales: 1858–1910', *Medical History*, 21 (1977), p.172. Anne Crichton also comments on these issues of hospitals and charity in her work; see *Slowly taking control? Australian governments and health care provision, 1788–1988* (Sydney: Allen & Unwin, 1990), pp. 14–17.
18. Garton, *Out of Luck*, p. 43; Dickey, *No Charity There*, p. 27; Thomson, *A World Without Welfare*, pp. 18–19.
19. Horsburgh, 'Issues in the government subsidy of hospitals in New South Wales', p. 174.
20. R. A. Cage, *Poverty Abounding, Charity Aplenty: The Charity Network in Colonial Victoria* (Sydney: Hale & Iremonger, 1992), p. 20.
21. Garton, *Medicine and Madness*, p. 109.
22. *Auckland Weekly News*, 3 January 1891, p. 23.
23. 'Report on the Yarra Bend Lunatic Asylum 1856', *VPP*, p. 8.
24. On rates of pay for attendants in asylums, see Monk, *Attending Madness*, p. 189.
25. Manning, *Report on Lunatic Asylums*, p. 159.
26. Manning, *Report on Lunatic Asylums* , p. 117
27. 'Report on the General Conditions of the Hospital for the Insane, Tarban Creek, 1869', *Journal of the Legislative Assembly New South Wales*, p. 10. Geoffrey Reaume shows that in Canada at the Toronto Hospital for the Insane, only 260 patients paid for their care in 1895 out of a total of 698 patients. Here, separate spaces were devised for each class of patient. See Reaume, *Remembrance of Patients Past*, pp. 8; 262 n. 36. On Canada and maintenance payments also see Wright, Moran and Gouglas, 'The Confinement of the Insane in Victorian Canada, p. 117.
28. 'Hospital for Insane, Gladesville, 1876–7', *Journal of the Legislative Council of New South Wales,* p. 5.
29. 'Report of the Inspector of Lunatic Asylums 1879', *VPP,* p. 15.
30. 'Report of the Inspector of Lunatic Asylums on the Hospitals for the Insane 1879', *VPP,* p. 15.
31. 'Annual Report of Lunatic Asylums in New Zealand, 1880', *AJHR,* H- 6, pp. 1–2.
32. 'Annual Report of Lunatic Asylums in New Zealand, 1880', *AJHR,* H-6, p. 5
33. The Inspector of Asylums in Victoria, Dr Edward Paley, devoted a considerable amount of space in his report to justifying relatively costly practices of care in Victorian institutions, and to the problem of maintenance collection; see 'Report of the Inspector of Lunatic Asylums 1879', *VPP*, pp. 12–15.
34. The costs of three colonies were outlined in the report for New South Wales: Victoria, just over 13 shillings per week; New Zealand, almost 13 shillings

per week; and New South Wales, just over 12 shillings per week; see 'Report of the Inspector General of the Insane for 1879', *NSW Council*, p. 10.

35. See the specific and cumulative figures provided in separate reports: 'Report of the Inspector of Hospitals for the Insane for 1905', *QPP*, p. 3; 'Hospitals for the Insane, Report of the Inspector of Lunatic Asylums 1904', *VPP*, pp. 10–11; 14; 'Report of the Inspector-General of the Insane 1905', *NSW Parliamentary Papers*, pp. 5; 7–8; and 'Report on Mental Hospitals for 1905', *AJHR*, H-7, pp. 2; 22.
36. W. Beattie Smith, 'The Housing of the Insane in Victoria, with Special Relation to the Boarding-Out System of Treatment', *Intercolonial Medical Congress of Australasia* (1889), pp. 898–908. The history of boarding out in the colonies is discussed in the following chapter.
37. Manning, *Report on Lunatic Asylums*, p. 162.
38. SRNSW, CGS 5034, Letters concerning patients, 4/8206, 10 July 1893.
39. Garton, *Out of Luck*, p. 66, p. 68. On New Zealand pay rates, see the *New Zealand Official Year-Book* (Wellington: John Mackay, Government Printer, 1898), pp. 290–7. However, economic historians have argued that in nineteenth-century Victoria, 'average' men and women left very little personal property, although increases in personal wealth occurred in the 1860s and the 1880s; see W D Rubenstein, 'The Distribution of personal Wealth in Victoria 1860–1974', *Australian Economic History Review*, xix (1979), p. 38. As Jim McAloon has demonstrated for the wealthy in New Zealand, family and household mattered in the accumulation of wealth, see *No Idle Rich: The Wealthy in Canterbury and Otago 1840–1914* (Dunedin: Otago University Press, 2002), p. 76.
40. 'Reports on General Condition of Hospital for the Insane, Tarban Creek, 1869', *NSW Council*, p. 8.
41. Donella Jaggs, *Asylum to Action: Family Action 1851–1991* (Melbourne: Family Action, 1991), p. 7.
42. Finnane, 'Asylums, Families and the State', p. 140.
43. John Ramsland, *Children of the Backlanes: Destitute and Neglected Children in Colonial New South Wales* (Kensington: New South Wales University Press, 1986), pp. 70–4; Dickey, *No Charity There*, pp. 42–7.
44. Tennant, *Paupers and Providers*, p. 90
45. YCAA, 1044, 1887, folio 27
46. SRNSW, Maintenance Books 1879–1884, CGS 3/14225; 3/14234; Patient case files, 4/8179, folio 154.
47. Annie was described in her notes as a 'pay patient'; see VPRS, 7400/P0001, unit 1, folio 370.
48. Garton, *Medicine and Madness*, p. 118; QSA, A/45643, 25 October 1905, letter 26.
49. Garton, *Medicine and Madness*, p. 109.
50. SRNSW, Maintenance Books, 1879–1884, CGS 3/14224, vol 1.
51. *The Brisbane Courier*, 29 August 1879, p. 2. See also the earlier debates; in 1879, the *Brisbane Courier* reported the introduction of the Bill in parliament, commenting that no real attempt was made to enforce the laws of asylum maintenance.
52. Dickey, *No Charity There*, p. 102.
53. 'Lunacy Act Administration', *Sydney Morning Herald*, 2 April 1913, p 12.

54. VPRS 7400/P0001, unit 2, folio 106.
55. *Argus,* 03 July, 1872, p. 6; 23 July 1872, p. 5; 25 July 1872, p. 7; 3 August, 1872, p. 5; p. 7.
56. QSA, A/45607, letter 93, 30 November 1885.
57. YCAA, 1044, 1889–1898, folio 52; folio 150.
58. YCAA, 1044, 1894, folio 38.
59. YCAA, 1044, 30 September 1886, folio 22.
60. YCAA, 1044, July 1889.
61. YCAA, 1044, folio 38.
62. YCAA, 1044, folio 52, 150.
63. YCAA, 1044, folio 299; folio 309.
64. Burke, Maori Patients in the Auckland Lunatic Asylum, 1860–1900, p. 45.
65. Fisher, 'The family and the Sydney economy', p. 154.
66. YCAA, 1044, folio 21.
67. YCAA, 1044, folio 74; correspondence dates from 1876 to 1893, when the patient died.
68. QSA, A/45611, folio 269, 17 September 1888.
69. QSA, A/45607, folio 212, Letter 212.
70. YCAA, 1044, Letter from the Public Trust Office, Wellington, 5 April 1898, to the Lunatic Asylum, Auckland.
71. YCAA, 1026/12, patient case files no 4119–4141, case 4125, 22 January, 1913. Thanks to Jennifer Robertson for this reference. See also VPRS, 7417/P1, unit 11.
72. Tennant, *Paupers and Providers*, p. 14
73. Garton argues that in New South Wales, attempts to encourage paying patients from the latter decades of the nineteenth century was a failure, also citing data from the 1920s; see *Medicine and Madness*, p. 109. Brunton comments that in 1932, despite a better centralised system of maintenance collection in New Zealand, 59 per cent of patients remained a 'full charge on the State'; 'Colonies for the Mind', p. 13.

## 6 Porous Boundaries: Families, Patients and Practices of Extra-Institutional Care

1. VPRS, 7400 P00001 Unit 5, Folio 214.
2. SRNSW, 4/8177, Folio 49, 23 August 1888
3. Wright, 'Getting out of the asylum', p. 155
4. Harriet Sturdy and William Parry-Jones, 'Boarding-out insane patients: the significance of the Scottish system 1857–1913', in *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000*, edited by Peter Bartlett and David Wright (London and New Brunswick NJ: The Athlone Press, 1999), p. 86. Studies of earlier practices of community care in Britain are also valuable for understanding the development of these ideas; see Akihito Suzuki, 'The Household and the Care of Lunatics in Eighteenth-century London', in *The Locus of Care: Families, communities, institutions, and the provision of welfare since antiquity*, edited by Peregrine Horden and Richard Smith (London and New York: Routledge, 1998), p. 153–75.
5. Sturdy and Parry-Jones, 'Boarding-out insane patients: the significance of the Scottish system 1857–1913', pp. 110–11.

6. Burdett, *Hospitals and Asylums of the World*, p. 485; see also William Parry-Jones, 'The Model of the Gheel Lunatic Colony and its Influence on the Nineteenth-Century Asylum System in Britain', in *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, edited by Andrew Scull (Philadelphia, Pennsylvania: University of Pennsylvania Press, 1981), pp. 204–5.
7. F. A. Bland, 'Unemployment Relief in Australia', in *Social Policy in Australia: Some Perspectives 1901–1975* (Sydney: Cassell Australia, 1976), p. 165. See also Catherine Helen Spence, *State Children in Australia: A History of Boarding Out and its Developments* (Adelaide: Vardon and Sons Ltd, 1907).
8. Suzuki, *Madness at Home*, p. 121.
9. Tomes, *A Generous Confidence*, p. 262.
10. Reaume, *Remembrance of Patients Past*, p. 212.
11. While similar associations did not exist in the other colonies examined here, there was a 'Patients' and Prisoners' Aid Society' operating in Dunedin, New Zealand, in the last decades of the nineteenth century. See 'Report on Mental Hospitals of the Colony for 1905', *AJHR*, H-7, p. 2.
12. 'Reports on the Lunatic Asylums in New Zealand 1877', *AJHR*, H-8, p. 24. The Trial release register is at YCAA, 1024, 1878–1919. In Victoria, the word 'probation' is used interchangeably in official reports, and mentioned in legislation in relation to leave, but also appears to apply to a form of boarding-out, as the chapter discusses. The word 'parole' is also used.
13. YCAA, 1024/1, Register of patients absent on trial, 1878–1919. Of the New Zealand patients sampled for this study, only 7 appear in this register, although more patients were released for periods of leave.
14. VPRS, 7570, 1899 – 1923.
15. Eric Sinclair, 'Presidential Address', *Transactions of the Australasian Medical Congress* (Melbourne: Government Printer, 1909), p. 225.
16. Warsh, *Moments of Unreason*, p. 98.
17. 'Treatment of the Insane. Chat with an Official Visitor', *New Zealand Herald*, 20 May, 1896, p. 3.
18. This finding is also supported for families and institutions in other contexts. See for example Melling and Forsythe, *The Politics of Madness*, p. 113
19. VPRS, 7570/P1, I, F99/1770, Bundle 1; VPRS 7400 P0001, Unit 12, Folio 83, 23 December 1897.
20. Garton, *Medicine and Madness*, p. 36.
21. 'Report of the Inspector-General of the Insane 1885', *Journal of the Legislative Council of New South Wales*, p. 8.
22. Garton, *Medicine and Madness*, pp. 36; 51.
23. Garton, *Medicine and Madness*, p. 37.
24. SRNSW, Gladesville Hospital, 4/8182, folio 238; CGS 5035, Letters from patients, 4/8203, no 228, January 1895.
25. 'Report of the Inspector of Hospitals for the Insane 1905', *QPP*, p. 3.
26. QSA, A/45633, folio 64, Letter c. July 1899.
27. Smith, 'Hints' (February 1874) p. 44.
28. Smith, 'Hints', p. 44.
29. VPRS, 7417/P1, Unit 1, and VPRS 7570/P1, Unit 1, Bundle 99/1513, Letter 1 July 1899.
30. VPRS, 7400/P1, Unit 12; VPRS 7570/P1, F 1900/1836 Bundle 4, Letter 6 October 1900.

31. VPRS, 7570/P1, F 1900/1836 Bundle 4, Letter 13 October 1900.
32. QSA, A/45648, folio 64, Letter 24 February, 1908.
33. 'Report on Mental Hospitals of the Colony for 1905', *AJHR,* H-7, p. 2.
34. QSA, A/45611 folio 33.
35. QSA, A/45619, folio 134.
36. QSA, A/45643, letter 26 November 1890.
37. SRNSW, 4/8194, folio 229.
38. Robertson, 'Unsettled, Excited, and Quarrelsome', p. 23. See also Toynbee, *Her Work and His: Family, Kin and Community.*
39. Labrum, 'Looking beyond the Asylum', pp. 137–41. This finding is supported by research conducted in other contexts; see Kelm, 'Women, Families and the Provincial Hospital', pp. 186–7.
40. VPRS, 7570/P1, F 99/1789, Bundle 2, Letter 2 July 1899.
41. VPRS, 7399 /P1, Unit 11, folio 151; 7570/P1, M99/1534, Bundle 2, Letter 12 March 1900, Telegram 14 March 1900.
42. SRNSW, CGS 4/8179 folio 38.
43. SRNSW, CGS 4/8165 folio 286.
44. SRNSW, CGS5034, 4/8206, n.d.
45. SRNSW, CGS5034, 4/8207, 27 December 1896.
46. SRNSW, 4/8185, folio 219, 12 April 1897.
47. SRNSW, 4/8186, folio 165.
48. Eric Sinclair, 'Presidential Address', p. 225.
49. YCAA1026/23/4539; material in this file dates from 1912 to 1915.
50. See YCAA, 1048/9, folio 5; 1026/14. See also Robertson, 'Unsettled, Excited, and Quarrelsome', p. 92.
51. YCAA, 1048/9, folio 5.
52. QSA, A/45627, Folio 126; Letter 18 March 1902.
53. QSA, A/45627, Folio 126; Letter 18 March 1902.
54. QSA, A /45611, folio 159; Letter 18 April 1886.
55. QSA, A /45611, folio 159; Letter 18 April 1886.
56. QSA, A/45616 folio 133; Letter 8 January 1889.
57. QSA, A/45643, folio 91; Letter 18 January 1896.
58. QSA, A/45606, folio 60.
59. QSA, A/45639, folio 97; Letter 1 December 1903.
60. On asylum visiting, see for instance Melling and Forsythe, *The Politics of Madness*, p. 100; see also Catharine Coleborne, 'Challenging Institutional Hegemony: Family visitors to hospitals for the insane in Australia and New Zealand, 1880s–1900s' in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting,* edited by Graham Mooney and Jonathan Reinharz (London and Amsterdam: Clio Medica Series, Wellcome Institute, Rodopi, 2009), pp. 289–308.
61. Historians including Geoffrey Reaume have shown that both official correspondence and visiting could trigger important response among families of the inane, and could sometimes hasten discharge. See Reaume, *Remembrance of Patients Past*, pp. 188–91.
62. SRNSW, CGS 4/8183, folio 247.
63. This Visitors' Book is not paginated, but contains a record of approximately 20 visits per page, in a book of around 200 pages or more, over this time period of 1891 to 1911. As the only extant record of asylum visiting to Auckland, it provides only a fraction of information about the practice,

suggesting that either such visiting continued from an earlier period, and was retained after 1911, but that records have been lost; or that the visiting of institutions was only common to this period. I argue that visiting most was likely more common in the later decades of the nineteenth century, as family networks and awareness of institutions had increased by this time.

64. YCAA, 1075/1, Visitors' Book 1891–1911, 23 June 1902.
65. YCAA, 1048/9, 10 May 1900.
66. YCAA, 1048/9, 15 June 1900, folio 20. Several mentions in the Visitors' Book covered the period of his committal; see YCAA, 1075/1, Visitors' Book 1891–1911.
67. Burke, Maori Patients in the Auckland Lunatic Asylum, 1860–1900, p. 43.
68. YCAA, 1048/4, folio 65, 15 May 1885.
69. 'Te Kopuru', *Auckland Weekly News*, 20 October 1883, p. 21.
70. *Auckland Weekly News,* 22 August 1891, p. 17.
71. Garton, *Medicine and Madness*, p. 37.
72. See for instance a case reported in the *Sydney Morning Herald,* 18 June 1902, p. 4.
73. *Argus*, 27 December 1870, p. 5.
74. *Argus,* 5 June 1879, p. 5.
75. *Auckland Weekly News*, 30 May 1891, p. 18.
76. *Auckland Weekly News*, 13 July 1905, p. 19.
77. SRNSW, CGS 4/8175, folio 278.
78. SRNSW, CGS 4/8175, folio 69; CGS 4/8177, folio 280.
79. VPRS, 7570/P1, M99/1546, Bundle 3, Letter 23 June 1900.
80. VPRS, 7570/P1, M99/1546, Bundle 3, Letter 19 June 1900.
81. See SRNSW, CGS 4/8177, folio 149; and CGS 4/8176, folio 64. In both cases, newspaper reports were pasted into the patient case file following the suicides.
82. YCAA, 1026/14/4189, letter 5 September 1915.
83. YCAA, 1026/14/4189, letter 14 September 1915.
84. Manning, 'President's Address', p. 822.
85. W. Beattie Smith, 'The Housing of the Insane in Victoria, with Special Relation to the Boarding-Out System of Treatment', *Transactions of the Intercolonial Medical Congress of Australasia* (1889), pp. 899–901. The points were echoed by J. V. McCreery in his 'Report of the Inspector of Lunatic Asylums', *VPP,* pp. 14–5.
86. W. Beattie Smith, 'Treatment of the Insane in Private Practice in Victoria', *Transactions of the Australasian Medical Congress* (1908), pp. 244–50; W. Beattie Smith, 'The Housing of the Insane in Victoria, with Special Reference to Licensed Houses and Border-line Cases', *Journal of Mental Science* (July 1909), pp. 482–9.
87. Eric Sinclair, 'Presidential Address', p. 227.
88. On the different findings of the Zox Commission, see Monk, *Attending Madness*, pp. 209–21; and Coleborne, *Reading 'Madness'*, pp. 143–61.
89. C.R.D. Brothers, *Early Victorian Psychiatry 1835–1905* (Melbourne: A.C. Brookes, Government Printer, 1950), p. 136.
90. Frederick Allman 'Our treatment of the insane', *Sydney Morning Herald* 6 April 1907, p. 6; 'A Sympathiser', *Sydney Morning Herald*, 12 April 1907, p. 3.
91. The Public Record Office of Victoria houses the series of Maintenance Bonds for the Yarra Bend Asylum, VPRS, 7568, 1851–1884. The same series contains a different form of bond, a bond paid by a family member for the

care of the insane person confined at the Yarra Bend, as the previous chapter has explored.

92. On earlier practices of probation in Victoria, see 'Report of the Inspector of Lunatic Asylums on Hospitals for the Insane 1876', *VPP*, p. 9.
93. 'Report of the Inspector of Lunatic Asylums, 1890', *VPP,* p. 5.
94. William Armstrong, 'Lunacy legislation in the Australian colonies', *Transactions of the Intercolonial Medical Congress of Australasia* (1889), p. 885.
95. Brothers, *Early Victorian Psychiatry*, pp. 163–4.
96. 'Report of the Inspector of Lunatic Asylums, 1890', *VPP,* p. 15.
97. Brothers, *Early Victorian Psychiatry*, p. 164.See also 'Report of the Inspector of Lunatic Asylums 1904', *VPP,* p. 3.
98. 'Report on Mental Hospitals of the Colony for 1905', *AJHR,* H-7, p. 2.
99. 'Report on Mental Hospitals of the Colony for 1905', *AJHR,* H-7, p. 2.
100. For a brief history of the organisation, see Peggy Mitchell, *A Place to Go ... The Story of the After Care Association of NSW* (Sydney: The After Care Association, 1987).
101. Judith Godden, Unpublished text of a talk given at the Centenary Celebrations of Aftercare Association NSW, 10 October 2007, kindly supplied by the author (3pp). Reports of this event were made in the NSW Parliament on 19 October 2007, and in the news media.
102. Mitchell, *A Place to Go,* p. 5.
103. Manning, *Report on Lunatic Asylums*, p.161.
104. Eleventh Annual Report, After Care Association, 1917, p. 2, Mitchell Library, Sydney NSW, Pamphlet collection, Manuscripts no 361.
105. See the minutes of the first meeting of the After Care Association, printed as a circular, July 1907, p. 2, Mitchell Library, Sydney NSW, Pamphlet collection, Manuscripts no 361.
106. Fourth Annual Report, After Care Association, 1910, p. 3; Mitchell Library, Pamphlet collection, Manuscripts no 361.
107. Fourth Annual Report, After Care Association, 1910, pp. 2–3; Mitchell Library, Pamphlet collection, Manuscripts no 361.
108. Seventh Annual Report, After Care Association, 1913, p. 2, Mitchell Library, Pamphlet collection, Manuscripts no 361.
109. Eight Annual Report, After Care Association, p. 2, Mitchell Library, Pamphlet collection, Manuscripts no 361.
110. Eight Annual Report, After Care Association, p. 2, Mitchell Library, Pamphlet collection, Manuscripts no 361.
111. 'The After-Care Association', *Sydney Morning Herald*, 8 June 1911, p. 8.
112. See 'The After Care Association: To Assist Persons Discharged, Recovered, from Mental Hospitals and Psychiatric Clinics, Appeal, Sydney 1927', Pamphlet collection, Mitchell Library, Sydney NSW; see also the minutes of the first meeting of the After Care Association, printed as a circular, July 1907, p. 3, Pamphlet collection, Mitchell Library, Sydney NSW.

## 7 Conclusion: Families, Insanity and the Archive

1. Warsh, *Moments of Unreason*, p. 63.

2. Dwyer, *Homes for the Mad*, p. 89.
3. Davidoff et al., *The Family Story*, p. 51.
4. Davidoff et al., *The Family Story*, p. 244.
5. Antoinette Burton, *Dwelling in the Archive: Women Writing House, Home, and History in Late Colonial India* (Oxford and New York: Oxford University Press, 2003), p. 5.
6. Tony Ballantyne, 'Rereading the Archive and Opening up the Nation State: Colonial Knowledge in South Asia (and Beyond)', in *After the Imperial Turn: Thinking With and Through the Nation*, edited by Antoinette Burton (Durham and London: Duke University Press, 2003), p. 113.
7. Thomas Richards, *The Imperial Archive: Knowledge and the Fantasy of Empire* (London and New York: Verso, 1993).
8. Ballantyne, 'Rereading the Archive', p. 106. See also Tony Ballantyne, 'Archives, Empires and Histories of Colonialism', *Archifacts* (April 2004), pp. 21–36; Ann Laura Stoler, 'Colonial Archives and the Arts of Governance: On the Content in the Form', in *Refiguring the Archive,* edited by Carolyn Hamilton et al. (Dordrecht, Boston and London: Kluwer Academic Publishers, 2002), pp. 83–100.
9. See for instance Swartz, 'Lost Lives', pp. 152–8.
10. Ballantyne, *Orientalism and Race*, p. 10.
11. Antoinette Burton uses this phrase as she constructs the separate sections of her book *Archive Stories: Facts, Fictions, and the Writing of History*, edited by Antoinette Burton (Durham and London: Duke University Press, 2005), p. 25; Florencia Mallon, 'The Promise and the Dilemma of Subaltern Studies: Perspectives from Latin American History', *American Historical Review* 99:5 (1994) p. 1539.
12. Wright, 'Getting out of the Asylum', pp. 147–9.
13. YCAA, 1048/11, folio 95.
14. Garton, *Medicine and Madness*; Labrum, 'Looking Beyond the Asylum', pp. 125–44, and Labrum, 'The Boundaries of Femininity: Madness and Gender in New Zealand, 1870–1910', in *Women, Madness and the Law: A Feminist Reader*, edited by Wendy Chan, Dorothy E. Chun and Robert Menzies (London, Sydney, Portland Oregon: Glasshouse Press, 2005).
15. SRNSW, Gladesville Hospital, 4/8191, folio 226.
16. Burke, Maori Patients in the Auckland Lunatic Asylum, 1860–1900.
17. See work in this area by Moran, 'The Signal and the Noise', pp. 281–301.
18. Swartz, 'Lost Lives', p. 157.
19. Michel Foucault, 'Madness, the Absence of Work', translated by Peter Stastny and Deniz Şengel, *Critical Inquiry* 21 (1995), p. 291.
20. SRNSW, 4/8193, Discharged, 13 November 1906.
21. SRNSW, Gladesville Hospital, 4/8175, folio 69.
22. Wright, 'Getting out of the Asylum', p. 153.
23. VPRS, 7570/P1, F99/1787, Bundle 2, Letter 7 June 1899.
24. My thanks to Stephen Garton for reminding me about this more than once, and at important moments for my project.
25. Spooner, Digging for the Families of the 'Mad'.
26. For an extended argument about the asylum archive, see Emma C. Spooner, '"The Mind is Thoroughly Unhinged": Reading the Auckland Asylum Archive, New Zealand, 1900–1910', *Health and History,* 7: 2 (2005), pp. 56–79.

27. Ann Laura Stoler, *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense* (Princeton and Oxford: Princeton University Press, 2009), pp. 50–1.
28. Rosenberg and Golden (eds), *Framing Disease*, p. xvi; Theriot, 'Women's Voices in Nineteenth-Century Medical Discourse', pp. 1–31.
29. Tracey Banivanua-Mar, *Violence and Colonial Dialogue: The Australian-Pacific Indentured Labor Trade* (Honolulu: University of Hawai'i Press, 2007), p. 149.
30. Some research has been conducted about families, violence, discharge and readmission in New Zealand in the period as part of the wider research project described here; see Robertson, 'Unsettled, Excited and Quarrelsome'.

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