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**‘The voices caused him to become porangi’:
Maori Patients in the Auckland Lunatic Asylum,
1860-1900**

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Abstract

Histories of the asylum have raised a number of important questions about the way 'race' intersects along colonial, medical and legal boundaries. The experience of Maori patients at the Auckland Lunatic Asylum was a site where colonial attitudes towards 'race' were played out along such lines. By employing 'race' as a category of historical analysis, one can attempt to investigate how the asylum processes in Aotearoa/New Zealand exemplified the question of 'race' in an effort to make more visible the experiences, attitudes and responses of Maori asylum patients.

This thesis examines colonial 'madness' by investigating the experiences of Maori patients at the Auckland Lunatic Asylum from 1860-1900. Using patient case records from this period this thesis interrogates the experiences of Maori patients in a colonial asylum, away from their whanau, communities, and tribal networks; what factors contributed to this, and how colonial attitudes towards these patients were acted out. The first chapter therefore, explores the 'medico-legal' management of these Maori patients, followed in Chapter Two by a broad overview of the Maori patients themselves. Chapter Three analyses the case records in more depth illustrating the complex interplay between 'race', gender, 'whiteness' and culture. Chapter Four looks at the way Maori dealt with the insane away from European institutions such as the asylum, emphasising how colonial histories of medicine now paying attention to Indigenous peoples in their context, and to medical pluralism, which reflects European models on one hand and on the other, Maori modes.

In considering Maori patients, this thesis reflects on the very 'human experience' that can be revealed by using asylum case files, and what such sources may suggest about 'race' as an implicit part of colonial asylum administration. More widely, the paper also reflects on colonisation, Maori and the asylum, and the ways in which Maori used the asylum.

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Introduction

Eighteen year-old Emma Matilda O. died in institutional care on 18 September 1897. The apparent cause of death was phthisis, a respiratory disorder associated with tuberculosis.¹ Seven years earlier Emma had been admitted to the Auckland Lunatic Asylum via an order issued under the *Lunatics Act* 1882. Emma's congenital epilepsy had become increasingly difficult to manage, and with five other children to support, her father Arthur, a farmer in the King Country, agreed to the institutional confinement of his daughter.²

Emma's journey north at the end of January 1890 from her home in Te Kopua near Otorohanga was a day's train ride from the small King Country community in the North Island of New Zealand. The area was still, to a large extent, isolated from European settlement. The North Island Main Trunk Railway had only reached Otorohanga in 1887.³ Emma's first and only stay in the asylum may also have been the first time she had ever encountered people of a different ethnic and cultural background to her own.

On her arrival at the asylum, Emma's admitting physicians Doctors Purchas and Bond noted that 'she has been idiotic from infancy, cannot speak, and during the last two years has been subject to periodical fits of excitement during which she is dangerous to others'.⁴ Admitted at the age of eleven, Emma was left to grow up in an asylum environment as one of the few younger patients to inhabit the institution between 1860 and 1900. Yet, at this early stage of her confinement Emma still acted as any younger person might, 'running about the airing court with a pannikin in

¹ YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/5, Case Continuation Book 1890-1892, folio 430.

² YCAA 1044/1, Record Book of Investigations into Relatives' Ability to Pay Maintenance 1890-1899, folio 2.

³ From 1893, and especially after 1900, farm land in the King Country was being made increasingly available for Pakeha settlement. See Dick Craig, *Land of the Maniapoto* (Te Kuiti: King Country Chronicle, 1951).

⁴ YCAA 1048/5, Case Continuation Book 1890-1892, folio 430.

hand'.⁵ Two years on, Emma's notes describe a different series of events, and show the once lively Emma as quiet and introverted.

Emma's experiences as a Maori asylum patient are poignant not only due to her age and state at committal, but also because of the many encounters she had with medical professionals and other patients while in institutional care. Following one such experience, where Emma was wounded on the scalp by another patient who struck her with a boot, her notes suggest that the normally noisy, restless and troublesome Emma was now comparatively easily controlled, and quiet. Apart from a brief mention of two epileptic fits over her seven year confinement, Emma's notes reflect a gradual withdrawal from all aspects of asylum life. It seems Emma remained in the same sullen state for the greater part of her confinement. She died there in 1897 at the age of eighteen.

Similarly, for thirty-seven old Iharaira W., asylum life was also a cultural experience very different to the life he had led in Gisborne on the East Coast of New Zealand's North Island.⁶ Suffering from 'mania', Iharaira was described as being delusional, performing gymnastic feats on the road, and as dangerous and suicidal. Like Emma, Iharaira was reluctant to speak, tentatively answering questions directed towards him. Iharaira's case strikes an important chord due to his obvious indifference when asked where his tribe was, saying 'no tribe for me, no people'.⁷ This apparent lack of family or community involvement sets part of the scene for this thesis, and hints at why Maori were found in asylum care at a time when some historians have argued that Maori relied on tribal networks to look after their insane.⁸

Emma's and Iharaira's stories are just two of the 72 Maori patient accounts which fill the pages of the historical Auckland Asylum archive between 1860 and 1900. As in

⁵ YCAA 1048/5, Case Continuation Book 1890-1892, folio 430.

⁶ YCAA 1048/8, Case Continuation Book 1898-1900, folio 73.

⁷ YCAA 1048/8, Case Continuation Book 1898-1900, folio 73.

⁸ See Raeburn Lange, *May the People Live: A History of Maori Health Development, 1900-1920* (Auckland: Auckland University Press, 1999); L. K. Gluckman, *Tangiwai: A Medical History of 19th Century New Zealand* (Auckland: Whitcoulls, 1976).

former colonial contexts elsewhere, hospital records, such as asylum patient cases and files, are an essential source for research in the area of madness, psychiatry, and public health history.⁹ This thesis is a study of the way in which 'race' featured as part of Indigenous patients' experiences of madness in Aotearoa/New Zealand, and it uses a total sample of the Maori patients at the Auckland Lunatic Asylum as a case study. It is concerned with Maori, insanity and the asylum in Aotearoa/New Zealand from 1860 to 1900 during a time of intense British colonisation. While it is not intended as a comprehensive study of Maori experiences of insanity and the asylum during this period, it makes a comprehensive account of Indigenous patients at the Auckland Asylum as an introduction to characteristics of that history informed by both archival evidence and recent historical writing, both national and international.

Information about Maori asylum patients is scarce in the historiography of Aotearoa/New Zealand and institutions for the insane. It is therefore important to trace the national and international scholarship which has informed my research, revealing the broader framework shaping my approach to an under researched topic. How 'race', class, medicine and colonialism interacted in the past has been the focus of a number of recent investigations. Scholars have examined the ways in which Indigenous bodies, both 'raced' and gendered, have been symbolically and materially constituted through colonial technologies of power.¹⁰ International literature about Indigenous peoples and asylum histories, especially in settler colonies, provides a rich comparative perspective through which to explore notions of madness and psychiatry in Aotearoa/New Zealand. For example, Robert Menzies and Ted Palys explore the histories of Aboriginal patients in the British Columbia psychiatric system from 1879-1950, highlighting the very human experience that can be revealed by using asylum case files as an indicator of colonial power. The authors raise questions about 'race' and ethnicity as not only having been infused by colonial

⁹ Robert Menzies and Ted Palys, 'Turbulent Spirits: Aboriginal patients in the British Columbia Psychiatric System, 1879-1950', in *Mental Health and Canadian Society: Historical Perspectives*, edited by James Moran and David Wright (Montreal/Kingston: McGill-Queen's University Press, 2006), pp. 149-75. This volume is forthcoming 2006.

¹⁰ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver: UBC Press, 1998), pp. 219-21.

asylum administration, but also as part of the experiences of the Aboriginal patients themselves.¹¹

The social construction of Aboriginal bodies was encouraged by colonial views. Historians like Mary-Ellen Kelm have shown how, in British Columbia, in the Canadian context, Aboriginal bodies were made, or what might be termed 'socially constructed', due to the social and cultural forces which came about as a result of the colonising endeavour.¹² Kelm draws on a range of official documentary sources to illustrate how Aboriginal bodies were constructed by the colonial views, attitudes, and actions of the state, the medical profession, the churches, and the British Columbia provincial government. By concentrating on health and healing, she highlights the impact that disease, environment, medicine, and health services had on the colonial Aboriginal body, and also the way the Aboriginal body responded to these changes. In this light, agency and survival emerge as two themes which suggest that, especially in the case of the First Nations people, health services and social policy, medical services to Indigenous peoples was not necessarily widespread in practice. Many Aboriginal communities rejected colonial health services in favour of Indigenous medicine, and while non-Native medicine and hospitals, which aimed at the treatment and containment of Aboriginal bodies, were being utilised, often this only complemented Indigenous medicine.¹³ This sort of 'medical pluralism' invites comparison with the Aotearoa/New Zealand experience where Maori used colonial hospitals and asylums. This raises the question as to whether, like the First Nations people in British Columbia, Maori continued to treat their sick using traditional methods despite the introduction and growing pervasiveness of Western medicine.

The concept of 'race' is highly contested and ever evolving. However, in terms of medicine and culture, there is a consensus among most historians and scholars of postcolonial and subaltern studies that the subject of 'race', and thus its historical construction, was linked with colonial rule. 'Race', medicine and colonial rule

¹¹ Menzies and Palys, 'Turbulent Spirits', pp. 149-75.

¹² Kelm, 'Colonizing Bodies', pp. xvi-xvii.

¹³ Kelm, 'Colonizing Bodies', pp. 129-52.

became intimately linked as ideas of 'racial' superiority and Western scientific and medical hegemony surfaced as a result of colonial expansion. While we can link 'race' to medicine and culture more generally, it is important to contextualise these frameworks in more specific terms highlighting the experiences of people situated within such power structures. By using the Auckland Lunatic Asylum as a focused case study this thesis seeks to do exactly that: to write 'race' into the colonial asylum histories of this country at the level of individual experience. Moreover, 'race' will be positioned alongside the social realities implicit in its creation. The discourses of medical and legal officials, incorporating notions of gender, culture, ethnicity and whiteness, all feature in the analysis of 'race' at the Auckland Asylum, and highlight the complex interplay between 'race' and social forces.¹⁴

Situating 'race' within asylum/medical discourse in Aotearoa/New Zealand has rarely been attempted. Megan Vaughan argues that colonial medical discourse was, without a doubt, preoccupied by difference urging for research analysed not only by gender, but also 'race'.¹⁵ Exploring this idea specifically in terms of whiteness, Warwick Anderson has highlighted how whiteness was negotiated in colonial medical discourse.¹⁶ Moreover, Leigh Boucher argues in relation to white bodies and medical discourse that the 'European', 'settler' and 'white' body was ever present at the 'apex of racial entitlement'.¹⁷ In this context Boucher reasons that settler medical discourse associated whiteness with power. Any combination of frail, 'raced', or gendered bodies which could not be situated within this 'artificial' category became Othered; thus the construction of the racialised colonial body as the Other.¹⁸ White bodies and colonial space framed asylum/medical discourse by creating differences based on 'race' and gender. Frameworks for managing the white (male) European self in the colonies also produced a significant amount of anxiety for colonial medical

¹⁴ Waltraud Ernst and Bernard Harris, eds., *Race, Science and Medicine, 1700-1960* (London and New York: 1999), p. 8.

¹⁵ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (California: Stanford University Press, 1991), pp. 77-99.

¹⁶ Warwick Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia* (Melbourne: Melbourne University Press, 2002), Chapter 1.

¹⁷ Leigh Boucher, 'Masculinity Gone Mad: Settler Colonialism, Medical Discourse and the White Body in Late Nineteenth-Century Victoria', *Lilith*, 13 (2004), pp. 54.

¹⁸ Boucher, 'Masculinity Gone Mad', p. 54.

officials.¹⁹ As Catharine Coleborne argued with Chinese patients in the Australian context, the classification and management of racial difference was clearly a concern for colonial authorities, and established boundaries upon which white (colonial) authority was dependent.²⁰ The implications this had for asylum populations, especially Maori, is explored in this thesis through a detailed reading of the Auckland Asylum records.

However, there were alternative patterns, as Jonathon Sadowsky found when he examined institutional confinement in Nigeria and the rise of colonial medicine. Examining colonial policy towards the confinement of the insane, Sadowsky emphasised how, in the Nigerian context, institutions in the south-west of the country were relatively 'non-colonial'. By this he meant that Western psychiatry was not an all-intrusive power as it was in several other colonial outposts. Rather, in Nigeria, there was a general unwillingness to deliver psychiatric and even medical care, despite the acknowledgement by foreign administrators that there was a need for it.²¹ Although similar to other colonial peripheries Nigeria operated slightly differently.

Other scholars have discussed similar issues. Among these, Roy Porter and David Wright have negotiated international patterns of asylum confinement. Key themes in their work focus on how and why asylum patients were confined in different national contexts and how this related to existing social, economic and legal frameworks.²² The scholarship about colonial asylums has generally paved the way for more

¹⁹ See Anderson, 'The Cultivation of Whiteness'; Boucher, 'Masculinity Gone Mad'.

²⁰ David Arnold, 'Medicine and Colonialism' in *Companion Encyclopaedia of the History of Medicine, Volume Two*, edited by W.F. Bynum and Roy Porter (London and New York: Routledge, 1997), pp. 1393-1416. See also Catharine Coleborne, 'The Scientific Management of the Insane and the Problem of Difference in Colonial Victoria', *The Australasian Victorian Studies Journal*, 2 (1996), p. 87, and by the same author, '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*, edited by Diane Kirkby and Catharine Coleborne (Manchester and New York: Manchester University Press, 2001); Anne McClintock, *Imperial Leather: Race, Gender, and Sexuality in the Colonial Conquest* (New York: Routledge, 1995); Vaughan, 'Curing their Ills'.

²¹ Jonathon Sadowsky, 'Confinement and colonialism in Nigeria', in *The Confinement of the Insane: International Perspectives, 1800-1965*, edited by Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), pp. 313-14.

²² Roy Porter and David Wright, eds., *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003).

analytical studies of 'race', class and gender. Literature in this field has traced colonial interpretations of 'race' and science in colonial contexts. For example, Shula Marks shows how, in the Valkenberg Mental Asylum in the Cape Colony, medical knowledge was intimately linked with ideas of 'race'. Moreover, she also explores the way in which patients were classified and/or defined along these 'racial', classed and gendered boundaries.²³ In Australia the volume of work in this area is impressive. Dolly MacKinnon, Coleborne, Boucher, Anderson and a number of others have all produced innovative contributions in this field. Of further note also is Andrew Scull's work on the history of asylumdom. Scull reflects on the ongoing need for a more comprehensive survey of the history of psychiatry which incorporates not only concerns relevant to Victorian and colonial psychiatry, but also concerns prior to and beyond the present focus on the nineteenth century. He also suggests that the current focus by social historians on patients and their families could be complemented with a more extensive look at what the medical profession did in treating asylum patients.²⁴ Roy Porter has also called for more studies of colonial and international asylums.²⁵

In New Zealand, by contrast, there are few historical accounts of Maori health focused particularly on psychiatry during the colonial period. Limited attention has been given to colonial medical scholarship, let alone Maori mental health in this period. The paucity of existing accounts about Maori and mental health was the key factor in my selection of a research topic. No-one has ever attempted to undertake a comprehensive examination of Maori, let alone 'race', at any asylum. Some, however, have turned their attention to exploring Maori health in general. The

²³ Shula Marks, '“Every facility that modern science and enlightened humanity have devised”: race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910', 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. 280.

²⁴ Andrew Scull, 'Rethinking the History of Asylumdom', 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), pp. 295-96. See also Diane Kirkby and Catharine Coleborne, eds., *Law, History, Colonialism: The Reach of Empire* (Manchester and New York: Manchester University Press, 2001).

²⁵ Roy Porter, 'Madness and its institutions', in *Medicine in Society: Historical Essays*, edited by Roy Porter and Andrew Wear (Cambridge and New York: Cambridge University Press, 1993), pp. 277-301.

following discussion explores this literature, paying specific attention to those scholars who provide some understanding of not only Maori health history, but also the issues surrounding 'race' and their implications, and Maori psychiatric history.

As Warwick Brunton has noted, research in the field of psychiatric history, asylum history and the history of mental health in New Zealand, while extensive, has been confined largely to theses, research essays, conference papers and short articles, such as M.S. Primrose's 1968 thesis using asylum records to survey the 'social and occupational origins of patients' at the Auckland Lunatic Asylum.²⁶ Brunton has acknowledged, along with a number of other medical historians, that there is a 'paucity of historical research on Maori experiences of mental illness and mental health services'.²⁷ This is evident in the work of many distinguished health historians who have also chosen not to concentrate specifically on this area. Derek Dow, for example, has defended his choice to skim over this area by commenting that it appears, in relation to Maori and mental health, that few Maori were treated by Western medical officials prior to 1940.²⁸ This thesis offers evidence that challenges this finding. While his overall approach to Maori health is enlightening, such comments are not reason enough to skim over the area. From the early twentieth century there was an increase in the number of Maori utilising Western health institutions. Likewise, influential Maori health historian Raeburn Lange has not specifically considered psychiatry and/or mental illness.²⁹ Although his investigations into Maori health during the colonial period offer rich insight into the interactions between Maori and the medical profession, and into historical understandings of Maori health in general.

²⁶ Warwick Brunton, '“A Choice of Difficulties”: National Mental Health Policy in New Zealand' (PhD thesis, University of Otago, 2001), p. 35. See also M.S. Primrose, 'Society and the Insane: A Study of Mental Illness in New Zealand, 1867-1926 with special reference to the Auckland Mental Hospital' (MA thesis, University of Auckland, 1968).

²⁷ Brunton, '“A Choice of Difficulties”', p. 36.

²⁸ Derek A. Dow, *Maori Health & Government Policy, 1840-1940* (Wellington: Victoria University Press, 1999), p. 13.

²⁹ Lange, 'May the People Live'.

Moreover, Peter Buck's (Te Rangihiroa) early research about medicine among the Maori in ancient and modern times has the potential to contribute to our understanding of Maori and mental illness.³⁰ From a medical-oriented perspective, Laurie Gluckman has explored accounts of madness in Maori, and provides some tentative suggestions about traditional Maori methods of treating and dealing with mental illness.³¹ Similarly, Mason Durie, a former practicing psychiatrist, has examined Maori health dating from pre-European times. His discussion centres mostly on contemporary issues facing Maori, particularly the application of the Treaty of Waitangi to Maori health, changes in Maori leadership, and past and current health reform and policies.³² He outlines the Maori spiritual world and its relationship with treatment and healing, ultimately arguing that contemporary developments in Maori health cannot be separated from historical influences.³³

More notably for the purposes of this thesis, Bronwyn Labrum made extensive use of the Auckland patient records in her 1990 MA thesis concluding that 'the social significance and explanations behind the resort to asylum care by people in the community remains obscure'.³⁴ Labrum analysed gender as a category of analysis in her investigation of the Auckland Lunatic Asylum. Labrum, as one of the few scholars to examine Maori experiences in the Asylum, has gone on to suggest that the issue of 'race', and similarly the critical analysis of 'whiteness' as a category, alongside issues of Indigeneity, still require more thorough attention.³⁵ Labrum's consideration of the colonial nature of New Zealand society during her defined

³⁰ P.H. Buck, 'Medicine Amongst the Maoris, in Ancient and Modern Times' (MD thesis, University of New Zealand, 1910).

³¹ Gluckman, 'Tangiwai'.

³² Mason Durie, *Whaiora: Maori Health Development*, 2nd edition (Auckland: Oxford University Press, 1998), p. 6.

³³ Durie, 'Whaiora', p. 6.

³⁴ Bronwyn Labrum, 'Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum, 1870-1910' (MA thesis, Massey University, 1990), and 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26 (1992), pp. 125-44.

³⁵ Labrum recently revisited this work with a chapter exploring madness and gender in New Zealand. See '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, Portland, Oregon: Glasshouse Press, 2005), pp. 59-77.

period, 1870-1910, features 'race', alongside gender, as one of the more significant factors in the categorisation of Maori in the Auckland Lunatic Asylum. Whether, as Labrum suggests, this was because of the way medical officials perceived the appropriate modes of respectability for Maori, or whether female Maori patients were perceived as 'un-English', Labrum defines 'race' as central to the asylum process.³⁶ In Aotearoa/New Zealand, histories of the asylum and psychiatry have generally been interrogated in terms of social history, and as such have the very real potential to be built upon and analysed in terms of 'race'.³⁷

It is with this literature in mind that a number of major research themes and questions will be explored in this thesis. These include an investigation of both the legal and medical management of Maori patients in the asylum. The theme of confinement takes into account admission, discharge and death amongst the Maori asylum population at Auckland, in order to build a more exact population profile. The gendered and 'raced' body and how Maori are present in the asylum is also examined. This incorporates both 'performative' aspects, such as how the Maori body operated within the asylum, and medical diagnoses, including 'dying race' discourses. 'Moral therapy', or the reform and civilising of Maori through European work models and religion is also explored, especially as this relates to religious conversion rates and adherence. Further, 'cultural alienation' is considered in relation to land, communication, the concept of 'mate Maori', and the withdrawal of Maori patients from the asylum process. This last theme also involves a discussion of the effects of colonial discourses about the management of Maori. Lastly, traditional Maori health and healing of the insane is explored.

This thesis analyses all the case records of every Maori patient committed to the Auckland Lunatic Asylum from 1860 to 1900. This sample of 72 Maori patients is complemented by a wider reading of asylum records including Pakeha patients, also from the same asylum and period. Following Labrum and other historians of the

³⁶ Labrum, 'The Boundaries of Femininity', p. 77.

³⁷ See Barbara Brookes and Jane Thomson, eds., *Unfortunate Folk: Essays on Mental Health Treatment 1863-1992* (Dunedin: University of Otago, 2001).

asylum, these case files are placed in the broader context of other written sources about the patients, in an effort to inform and validate existing historical understandings.³⁸ This selection of all Maori patients over such a broad time frame was pursued with the intention of collecting a sample size which has the capacity to more fully represent the demographics of this chosen patient population. Such a large sample was also required in the knowledge that, in the earlier part of my period, the case notes for all patients are shorter and less informative. I found during my research that even less detail was recorded for the Maori patients than for Pakeha. This proved the major reason behind my decision to broaden my sample size to include forty years of patient records.

The choice of Auckland as the site for a lunatic asylum, in the North Island of Aotearoa/New Zealand, was as much an intellectual decision as it was an exercise in practicality.³⁹ With a Maori population of around 40,000 living in Te Tai Tokerau (Northland) and the Waikato by the latter nineteenth-century, the greater Auckland area boasted a Maori population larger than anywhere in the country.⁴⁰ Moreover, the focus on Auckland takes into account the accepted trend in Aotearoa/New Zealand asylum historiography which has identified that in the South Island, in this period at least, Maori were simply not visible in psychiatric, albeit Western, institutions of this kind.⁴¹ In addition, because the majority of Maori were rural dwellers at this time, they are visible in the Auckland Asylum which serviced a wide geographical area and was specifically used by both urban and rural districts. Although, as Labrum notes, the asylum's catchment area encompassed greater Auckland and to the north of Auckland, and patients also came from remote areas such as the East Coast and

³⁸ Labrum, 'Looking beyond the Asylum', p. 128. See also Brookes and Thomson, 'Unfortunate Folk'; Coleborne, 'Making "mad" populations'.

³⁹ The Auckland Lunatic Asylum was also known as the Whau, or Te Whau, named after a nearby creek. Similarly, the significance of a Maori name used to describe the asylum suggests a familiarity with the area for Maori in this period.

⁴⁰ David Green, 'The Explosive Frontier, 1852-1884', in *Frontier of Dreams: The Story of New Zealand*, edited by Bronwyn Dalley and Gavin McLean (Auckland: Hodder Moe, 2005), p. 127. See also R. C. J. Stone, *From Tamaki-makau-rau to Auckland* (Auckland: Auckland University Press, 2001), for history on the founding of Auckland.

⁴¹ Barbara Brookes and Jane Thomson, eds., 'Introduction', in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992* (Dunedin: University of Otago, 2001), p. 17.

Ruapekapeka in the heart of the North Island. This pattern reflected some of the more practical considerations required for patient transfer due to the closure of smaller asylums in the 1880s, and the effort to counteract the problem of persistent overcrowding in the country's asylums more generally.⁴²

This thesis focuses on the qualitative analysis of archival records. Archival materials such as asylum records, policing records, and primary sources such as medical journals, official government documents, and newspapers have been read and analysed for their official attitudes towards certain sectors in society. I have borne in mind the way in which texts can serve to create paradigms by which ideas, groups and people may be marginalised and excluded. It is important to remember that patient records document not only the asylum population, but also the conduct of the medical professionals and physicians dealing with patient populations. Such documents offer access to knowledge about how such features as ethnicity, 'race', class, gender, and even geography shaped medical and psychiatric behaviour.⁴³ Patient records are crucial to our understanding of such aspects as whether certain ethnic groups in the asylum were treated differently. It is for this purpose that patient records can help us define what this actually meant for the historical actors involved. Patient records allow us to decipher the patient's experience of madness. Researchers are witness to patient's stories about what brought them to the asylum, which often says less about mental and physical symptoms than social circumstances, their various interactions within the asylum, and about how medical and legal professionals regarded these patients.⁴⁴

In relation to this methodology there is a clearly identifiable theoretical approach which lends focus to my research: postcolonialism. Postcolonial theory provides an analytical tool in which the dynamics of colonialism can be critiqued.⁴⁵ The diffusion

⁴² Labrum, 'The Boundaries of Femininity', p. 61.

⁴³ John Harley Warner, 'The Uses of Patient Records by Historians', *Health & History*, 1 (1999), p. 105.

⁴⁴ Warner, 'The Uses of Patient Records', pp. 105-06.

⁴⁵ Giselle Byrnes, *Boundary Markers and the Colonisation of New Zealand* (Wellington: Bridget Williams Books, 2002), Introduction.

of medical power in which law and history are implicated, through the control of colonised peoples, operated along intersections of 'race', gender, and class. While postcolonialism infuses this research I am aware, in deference to Anne McClintock's comments, that by integrating postcolonial theory in my research to critique imperial power, I am reinscribing such control in another form.⁴⁶ As much as possible, I have endeavoured to be aware of this.

The first chapter of this thesis explores three particular interpretations of 'race' in this period in New Zealand's asylums, and how such ideas permeated the thoughts, words and actions of patients, medical and legal professionals. First, 'race' is considered, as it is throughout the whole thesis, in relation to the theoretical understandings of the construction of whiteness. Secondly, official knowledge about the insane Maori is explored through the observations and attitudes of administrators and 'medical-men' towards Maori patients. Thirdly, the 'medico-legal' authority of colonialism in the management of the insane Maori is analysed in relation to policing and other relevant legislation. This also involves a discussion of the medico-legal role played by police. A careful analysis of Maori patients in Chapters Two and Three illustrates selected aspects of the patient body and Indigenous experiences of colonial madness in Aotearoa/New Zealand. The first of these chapters provides a broad overview, while Chapter Three analyses case material in more depth. Attention is also directed towards the complex interplay between patient, family, community and the medical profession. Chapter Four reveals how Maori families and communities dealt with the insane away from European institutions. While looking at comparisons with and differences from institutional treatment, this chapter also seeks to provide a method by which future researchers might develop this kind of historical account.⁴⁷

By including 'race' as a category of analysis, we may be able to represent more fully the experiences of the mad in Aotearoa/New Zealand. This thesis attempts to re-

⁴⁶ Nan Seuffert and Catharine Coleborne, eds., 'Law, History and Postcolonial Theory and Method', *Law Text Culture*, 7 (2003), p. 2.

⁴⁷ The impetus for this thesis came as part of a Royal Society of New Zealand Marsden Fund research grant, awarded to Dr Catharine Coleborne, in order to enable research into family strategies involving madness in colonial Australia and New Zealand from 1860 to 1914.

define asylum history by making Maori more visible in the historical record. Special consideration is given to the interactions between Maori and the asylum, as constructed in the asylum record. This thesis ultimately attempts to address issues of 'race' and insanity by exploring some Maori experiences of madness in order to uncover how colonial Indigenous perceptions of asylum life may or may not have equated with colonial European ideals. In turn, this thesis also considers how these ideals shaped clinical/medical encounters, bearing in mind the way in which such encounters are constructed through the asylum archive, from a European perspective.

1

‘She is quiet and harmless and very easily managed’: ‘Race’, ‘Medico-Legal’ Management and the Asylum

As the Introduction has outlined, the question of ‘race’ is fundamental to histories of the asylum and histories of medicine more generally. Postcolonial and subaltern studies have shown in more recent times that the representation of ‘race’ is considered a key project for writing colonial histories and an intrinsic part of the wider power structures within which these histories were played out.¹ This chapter argues that the asylum processes in Aotearoa/New Zealand exemplified the question of ‘race’. It aims first to provide a general overview of such processes, leading on to a more detailed discussion of ‘race’ at the Auckland Lunatic Asylum. Three aspects are explored: first, ‘race’ is considered, as it is throughout the whole thesis, in relation to recent theoretical examinations of the constructions of ‘race’, ethnicity, and whiteness (and the asylum, medicine and culture). Second, the medico-legal authority of colonialism in the management of insane Maori at the Auckland Asylum will be analysed in relation to relevant governing legislation, and the medico-legal role the police played in committal. Third, official knowledge about insane Maori will be explored through the observations and attitudes of asylum administrators and medical-men at the Auckland Lunatic Asylum.

The conditions of Maori health during the mid to late nineteenth century were far behind that of Pakeha. Following the arrival of Europeans to Aotearoa/New Zealand there was a collapse in Maori health and a demographic decline as a result. New-found contact with the outside world also plagued the health of the Indigenous New Zealanders.² Along with this, postcolonial dislocation of Maori had some of the most serious impacts on Maori standards of health. While the impact of new diseases was

¹ Waltraud Ernst, ‘Introduction: Historical and Contemporary Perspectives on Race, Science and Medicine’, in *Race, Science and Medicine, 1700-1960*, edited by Waltraud Ernst and Bernard Harris (London and New York: Routledge, 1999), p. 1.

² Lange, ‘May the People Live’, p. 17.

severe, adapting to a new way of life and new living conditions, social, economic and cultural, meant Maori were highly susceptible to all kinds of afflictions. Even more notable, according to Lange, was the decay of traditional models of Maori leadership, and the authority that these tribal leaders had. The subsequent waning of an unquestioned faith in the concept of tapu also prompted the decline of many customary measures aimed at safeguarding Maori health standards.³ However, this decline in numbers due to European contact was steadily reversed from 1900-1920, as Maori leaders' efforts, and Maori resistance to disease, became more widespread.⁴

The Auckland Lunatic Asylum

The Auckland Asylum was officially opened on 8 March 1867, with the majority of patients transferred from the Grafton Asylum, also in Auckland. Contemporary press commentary from that era emphasised the adverse conditions that persisted at the Grafton Asylum. When the *Southern Cross* newspaper learned of plans for the replacement of Grafton and the establishment of a new asylum, it described the condition of the Grafton Asylum as unacceptable to a 'professedly Christian community'. It commented that the Auckland Lunatic Asylum would, 'in some respects', never compare with the likes of the infamous British institutions of St Luke's and Bethlem, and concluded that at least something was being done to alleviate the 'horrors' associated with its overcrowding and improper management.⁵ Scholars such as Labrum and Brunton confirm this public sentiment arguing that the asylums were used as provincial amenities, in an effort to counter the problem of overcrowding in all seven of Aotearoa/New Zealand's asylums at this time.⁶

During this period, part of the patient population at the Auckland Asylum consisted of white males, the majority of whom were labourers. Most female patients were

³ Lange, 'May the People Live', p. 20.

⁴ For a comprehensive account of Maori health see Lange.

⁵ *Southern Cross*, 7 February 1863, cited in Primrose, pp. 188-89.

⁶ Labrum, 'Looking Beyond the Asylum', p. 127; Warwick Brunton, Warwick Brunton, ' "A Choice of Difficulties": National Mental Health Policy in New Zealand' (PhD thesis, University of Otago, 2001), p. 325.

white, and worked in domestic service, or were recorded as having no occupation prior to committal, as was common at the time.⁷ Maori inmates were an obvious minority, as were the three Chinese inmates recorded over the forty year period from 1860 to 1900, and did not fit the perceived patient profile.⁸ However, the annual reports of the lunatic asylums for the colony show that the incidence of Maori admissions to the Auckland Asylum between 1860 and 1900 were consistently higher than elsewhere in the country. The main reason for this difference was due to the larger concentration of Maori residing in the greater Auckland area. Census figures for the asylum population from 1860 to 1900 indicate that more Maori lived in the North, rather than the South Island, and by 1911 most of the Maori population were dwelling in the Auckland province.⁹ The records of the Auckland Lunatic Asylum also reflect this trend, demonstrating that they are ideal indicators of the detection of madness among Maori in colonial Aotearoa/New Zealand. Insight into the interactions between Maori and colonial officials, and between 'race', medicine and the law, can be gleaned in a more comprehensive way, based on population density, than observations taken from any one of Aotearoa/New Zealand's other mental asylums during this period.¹⁰ While the relevance of the Auckland area to this study is important to the overall context of this thesis, and without wanting to deflect the significance of Maori society in the greater Auckland area more generally, in the remainder of this chapter the focus shifts to Maori and the asylum in terms of constructions of 'race' with specific focus on the Auckland Asylum.

Colonial ideas about, and attitudes to, Indigenous madness and the policies and practices aimed at the containment of Maori, as well as the power relationships that unfolded between asylum and wider society, produced a highly contested set of events. The medico-legal management of patients is one example of these power relationships, and as exemplified through legislation and policing practices, it illustrates the ubiquity of 'race' in the treatment of Maori patients.

⁷ Primrose, 'Society and the Insane', p.189.

⁸ YCAA 1048/1-8, Casebooks 1853-1900.

⁹ Primrose, 'Society and the Insane', p. 267; *New Zealand Census (Census)*, 1874, 1878, 1881, 1886, 1891, 1896, 1901.

¹⁰ Primrose, 'Society and the Insane', p. 167.

Legal Management

The *Lunatics Act* of 1868 outlined the necessary provisions when dealing with a person deemed to be a ‘lunatic’ under the Act. The *Lunatics Act* of 1882 reaffirmed these stipulations, amending only the procedure for treating habitual drunkards, and the procedure for the administration and management of an inmate’s estate.¹¹ For my purposes, Part One of the 1868 Act outlining committal procedures, and Part Two of the same Act outlining administration within the asylums, are particularly useful. It is also notable that there is no specific mention of Maori in this legislation. It was clearly aimed at the settler population.

Part One of the Lunatics Act governed the proceedings by which a lunatic was committed or placed in institutional care. An order for committal was carried out by either a Justice of the Peace or such persons as a policeman, and required the accompaniment of two medical certificates which also set forth the manner in which the patient was to be treated. Of course, an order of committal could be amended and the patient automatically released upon finding out whether he or she was, in fact, sane. Provisions in Part One also covered the procedures to follow should the detention and treatment of drunkards be required in a lunatic asylum.¹² As Coleborne has identified in the colonial context of Victoria, Australia, the police were fundamental to constructions of madness of asylum patients, and as such featured as part of the complex interactions between the family and asylum officials.¹³

In the context of colonial New Zealand from the 1840s onwards, the role of the police was that of imposing order upon a population – both Maori and Pakeha – that was

¹¹ *Statutes of New Zealand (Statutes)*, 1868, No. 16, The Lunatics Act. *Statute of New Zealand (Statutes)*, 1882, No. , The Lunatics Act; Primrose, ‘Society and the Insane’, p. 21.

¹² Primrose, ‘Society and the Insane’, pp. 1-2. See also Labrum, ‘The Boundaries of Femininity’, pp. 62-3; ‘Looking Beyond the Asylum’; ‘Gender and Lunacy’.

¹³ Catharine Coleborne, ‘Passage to the asylum: the role of the police in committals of the insane in Victoria, Australia, 1848-1900’, in *The Confinement of the Insane: International Perspectives, 1800-1965*, edited by Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), pp. 129-48.

perceived by the state to be ‘turbulent and untamed’.¹⁴ The situation by 1886 reflected a social order based on the dominant exercise of ruling power, as ‘socio-racial’ trends had been imposed by coercive state force, through military conquest and ‘civilisation’ of the ‘native’ race. According to Richard Hill, while there was resistance by some Maori and Pakeha to the authority of organised social and bureaucratic control, the social context of war and disorder in the latter nineteenth century, ‘complemented the fundamental social, economic, “racial” and ideological processes’. Thus the transition to a structured policing unit was enabled.¹⁵ Policing then, like medicine, was able to assert its ‘legal gaze’ over a colonial Indigenous population, defining and observing Maori in the course of imposing social control and order.

The police were often the first point of contact in dealing with lunacy and in many cases the role of the police was central to the process of defining madness as both a legal and medical concern. At the Auckland Lunatic Asylum this was equally as pertinent to Maori as it was to non-Maori patients. The comments recorded about the Maori patients in the patient case files reflect this attempt by the police ‘to “manage” the bodies of lunatics’.¹⁶ These comments ranged from legal observations, to remarks about the individual’s mental and physical condition. More specific mention is made of methods of restraint, patient violence, bodily condition, their general behaviour, conduct, state of mind, and family/community involvement. Not only were police observations shaped by ideas about appropriate standards of behaviour, both in terms of sex and gender, but these observations also indicate the extent to which ‘race’ was used to construct ‘mad identities’.¹⁷

In most, if not the majority of cases involving Maori, a lack of communication or an inability to understand the inmate’s language is revealed in the case material. For

¹⁴ Richard S. Hill, *The History of Policing in New Zealand, Volume Two, The Colonial Frontier Tamed: New Zealand Policing in Transition, 1867-1886* (Wellington: GP Books, 1989), p. xi.

¹⁵ Richard S. Hill, *The History of Policing in New Zealand, Volume Three, The Iron Hand in the Velvet Glove: The Modernisation of Policing in New Zealand, 1886-1917* (Palmerston North: Dunmore Press, 1995), pp. 1-2.

¹⁶ Coleborne, ‘Passage to the asylum’, p. 138.

¹⁷ Coleborne, ‘Passage to the asylum’, p. 140.

example, in January 1899, Ani M., a 25 year-old woman from Mongonui, North of Auckland, was described by Constable Manning as ‘talking’ and ‘rambling’ irrationally, in her native language’.¹⁸ Constable Manning was also told by ‘the Maoris’ that Ani had a ‘mania for burning houses’, and that she had not slept for the past two nights.¹⁹ The use of family or tribal members by Manning to determine Ani’s state of mind is significant, especially because this was the only time other people were consulted as an interpreter for Ani, who spoke very little English.

Another feature of police descriptions of their encounters with Maori inmates was the tendency to make observations such as ‘general Maori circumstances’ as a suitable description to encompass all aspects of Maori life.²⁰ What was meant by this is uncertain. However, such phrases were used by medical officials where Maori patients had lived in traditional communities prior to committal. This is evident in the records of Pohipi H., who lived a ‘usual Maori life until she was about 19 years old, when she went to live with a Surveyor named Clayton’.²¹

Police also frequently commented on violent behaviour. In May 1896, Tamati T. an elderly Maori man from Whangaroa, north of Auckland, aged 73 years, was described by Constable William Sefton as ‘very violent’, who also commented that Tamati had been ‘more or less insane’ since the death of his wife three years previously.²² In June 1896, Ranohi, a 50 year-old male from Thames, was described as ‘dangerous’ by Constable Charles Butterworth. However, his notes confirmed that the patient’s physical condition was much older than his stated age and that he was merely suffering from dementia. Doctors noted that he was better situated in the old Maori home, an early rest home caring for the elderly in Auckland, rather than the asylum.²³ Problems with overcrowding at this home also meant that elderly Maori patients were deflected to asylum care.

¹⁸ YCAA 1048/8, Case Continuation Book 1898-1900, folio 123.

¹⁹ YCAA 1048/8, Case Continuation Book, folio 123.

²⁰ YCAA 1044/ 1, Record Book of Investigations into Relatives’ Ability to Pay Maintenance 1890-1899, folio 223.

²¹ YCAA 1048/6, Case Continuation Book 1893-1896, folio 317.

²² YCAA 1048/7, Case Continuation Book 1896-1898, folio 20.

²³ YCAA 1048/7, Case Continuation Book 1896-1898, folio 32.

Another frequent aspect of police observation was the medico-legal role conferred upon them. In this capacity the police were also quick to offer medical diagnoses. For example in August 1897 Constable William Sefton was quick to link heredity as a cause of insanity noting that Tia P's father was also a 'lunatic'.²⁴ As Coleborne also recognised in Victoria, Australia, with 'raced' Chinese inmates, the role of the police was pivotal in the medical diagnoses of these patients.²⁵

Medical Management

Part Two of the 1868 Act specified the procedures for administration in the asylums. It was compulsory for each asylum to have a medical officer and clerk, who were required to keep a register of patients, a medical journal, and a casebook.²⁶ This part of the legislation emphasises the medico-legal role performed by and required of medical-men and administrators of the asylum. The actions and practices of such medical-men and administrators has been closely critiqued by some medical historians who have analysed the observations and language used by such officials in order to deconstruct the 'official voice'. This also involves a close analysis of the voice of the patient, or the Other. As Nikolas Rose contends, by deconstructing the 'medical gaze', new themes emerge. For instance, the family, 'race', sexuality, attention to disease, cleanliness and the body, all surface as particular lines of enquiry by which to critically evaluate the actions of the medical profession.²⁷

This ascendancy of Western notions of thought is entirely evident in the actions and practices of the Auckland Asylum's medical administrators and doctors, the medical-men. The focus on medical-men as a colonial construct in this chapter is because at this time, 1860s to 1900s, women did not hold medical posts, except as matrons or nurses. It was as late as 1898 before Dr Emily H. Siedeberg was elected a member of the New Zealand Medical Association. She was the first medical graduate of the

²⁴ YCAA 1048/7, Case Continuation Book 1896-1898, folio 145.

²⁵ Coleborne, 'Passage to the asylum'.

²⁶ Primrose, 'Society and the Insane', p. 2; *Statutes*, 1868, No. 16, Part II.

²⁷ Nikolas Rose, 'Medicine, history and the present', in *Reassessing Foucault: Power, Medicine and the Body*, edited by Colin Jones and Roy Porter (London and New York: Routledge, 1994), p. 48.

University of New Zealand.²⁸ The following discussion highlights the importance of these medical professionals, all men, in the context of colonial psychiatry and the Auckland Asylum.

The observations of these medical officials both defined and confined constructions of patients along 'racial' and gendered boundaries. This is the case with the patients in the Auckland Asylum between 1860 and 1900. One recurring theme in the cases of these patients is that differing bodily descriptions are assigned along gendered and 'racialised' lines. For example, patients were described as having the 'usual Maori features', or being of 'average intelligence for a native'. Male Maori patients were described in terms of their strength and masculinity, while female Maori patients were commented upon more for their 'unfeminine' use of filthy language or 'untidy' appearance. As Labrum discovered, Maori women were among the first to be described in terms of their sexual promiscuity in the Auckland Asylum.²⁹ Moreover, as mentioned above, most of these patients spoke little English and were examined by Pakeha doctors with limited knowledge of Maori. In these circumstances it is important to remember that the services of an interpreter to assist the doctors in assessment were very rarely used, and when they were used, the interpreter was also, more often than not, another patient.³⁰

Toeolesulusulu Damon Salesa suggests that apart from operating as colonial agents, mediators and healers, doctors were perhaps the most prevalent group of 'scientific' intellectuals in colonial Aotearoa/New Zealand, especially in the last third of the nineteenth century.³¹ In the asylum, the medical-man acquired both a moral and professional status. Physicians had the authority to apply both medical treatment, for the physical/mental illness, and to enforce moral treatments which could reform the

²⁸ R.E. Wright-St Clair, *A History of the New Zealand Medical Association* (Wellington: Butterworths, 1987), p. 44.

²⁹ Labrum, 'Looking Beyond the Asylum', p. 133.

³⁰ YCAA 1048/1-8, Casebooks 1853-1900.

³¹ Toeolesulusulu Damon Salesa, ' "The Power of the Physician": Doctors and the "Dying Maori" in Early Colonial New Zealand', *Health and History*, Vol. 3, No. 1 (2001), p. 15.

lunatic by imposing self-restraint.³² The contact these men had with Maori in health and treatment, whether in hospitals and asylums or outside of them, was a systematic manifestation of colonial expansion. In other words, Western methods of health and healing were reaching beyond the limits of empire to new parts of the globe permeating the traditional habits and customs of non-Western peoples.³³ And, as such, Western medicine was promoted over traditional systems, at the expense of these non-Western and Indigenous peoples' a theme Chapter Four explores in more detail.

The role of medical-men as a tool of empire has also been discussed by David Arnold in the context of how the disease of malaria was constructed in colonial Bengal, India. While Arnold does not focus on psychiatric medicine in this chapter, his ideas are relevant. Arnold argues that Bengal became a crucial site for the 'presentation, internalisation and reformulation of Western 'race' ideology'.³⁴ Medical sites became places where the power of such ideas, asserted by medical officials were hegemonic.³⁵ The interconnectedness of medical practice at the asylum and colonial rule was important, because they combined to produce and maintain colonial order. The management of patients was part of this arsenal.³⁶

The custodial and domestic nature of patient management for the asylum medical attendants has been likened by Warwick Brunton to that of 'male prison officers and female domestic servants'.³⁷ While the case notes surveyed in this thesis contained no references to female attendants, the prominent Inspector-General of Lunatic Asylums, Duncan MacGregor, appointed on 1 April 1886, sought to instigate a policy

³² Matthew Philp, 'Scientific Pastors: The Professionalisation of Psychiatry in New Zealand 1877-1920', in *'Unfortunate Folk': Essays on Mental Health Treatment, 1863-1922*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago, 2001), p. 189.

³³ Salesa, p. 16.

³⁴ David Arnold, ' "An ancient race outworn": Malaria and Race in Colonial India, 1860-1930', in *Race, Science and Medicine, 1700-1960*, edited by Waltraud Ernst and Bernhard Harris (London and New York: Routledge, 1999), p. 132.

³⁵ Arnold, ' "An ancient race outworn"', p. 132.

³⁶ Roy MacLeod and Milton Lewis, eds., 'Introduction', in *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London and New York: Routledge, 1998), pp. 4-5. See also Coleborne, 'Making "mad" populations', p. 108.

³⁷ Brunton, ' "A Choice of Difficulties"', p. 325.

transforming female attendants into the mould of hospital nurses. MacGregor considered this a necessary concern because female staffing was the 'weak spot of the service'.³⁸ This would be easily achieved because female attendants received one-third less payment as their male counterparts, meaning the likelihood of employing more female attendants into the profession. For MacGregor, such policy changes would ensure discipline amongst staff and patients and would be in the best interests of all concerned.³⁹ Patients were separated by sex, yet the lack of segregation between Maori and non-Maori patients in all of Aotearoa/New Zealand's medical facilities was, according to Michael Belgrave, an indication of the degradation associated with admittance rather than enlightened attitudes to 'race'.⁴⁰

The records from the Auckland Asylum reveal the attendants' role rarely. Where they are mentioned, violence was inevitably involved, painting the attendants as both enforcers and victims of patient violence. For example, some attendants were subject to patient violence, like Attendant Land who was attacked by Te Au R.⁴¹ However, other attendants were the perpetrators. For instance, forty-eight year old Wetini was thought to have received a wound on the forehead as a result of a blow by an attendant.⁴² This sort of behaviour was not condoned by asylum officials or the Inspector-General of the asylums, although it was difficult to control.

Duncan MacGregor came to New Zealand as a foundation professor of mental and moral philosophy in the University of Otago, and quickly became known for his determination to reform the health system. He died in 1906 while still in office.⁴³ MacGregor encouraged the disciplining of both staff and patients, and as such took an authoritarian approach imposing institutional order from the top down. Brunton notes that within his first eighteen months of appointment, he held formal enquiries into the workings of the Auckland, Sunnyside and Seacliff Asylums. One of the casualties in

³⁸ Brunton, ' "A Choice of Difficulties"', p. 333.

³⁹ Brunton, ' "A Choice of Difficulties"', p. 333.

⁴⁰ Michael Belgrave, ' "Medical Men" and "Lady Doctors": The Making of a New Zealand Profession, 1876-1941' (Wellington, PhD thesis, 1985), p. 212.

⁴¹ YCAA 1048/6, Case Continuation Book 1893-1896, folio 173.

⁴² YCAA 1048/8, Case Continuation Book 1898-1900, folio 243.

⁴³ Wright-St Clair, 'A History of the NZMA', p. 46.

this process was Dr James Young who was appointed medical superintendent of the Auckland Asylum in January 1885 as successor to his brother, Dr Alexander Young. A few months after taking office he had resigned, critical of the level of government funding for the asylum.⁴⁴ Whether this denotes the ‘hard-line’ MacGregor enforced, or whether Young simply deemed funding to be insufficient, it is interesting to note that only the medical superintendent of Mount View Asylum retained his position and probably more importantly, MacGregor’s confidence.⁴⁵

Following the resignation of Young, Dr John Cremonini was appointed to the Auckland Asylum by MacGregor in November 1886 to ‘redeem’ the situation in the overcrowded Asylum. Following his resignation in 1889, the *New Zealand Medical Journal* reported that:

He has displayed conspicuous ability as an administrator and has transformed the institution completely. His reforms and improvements remain as a lasting testimonial to the energy with which he devoted himself to the true welfare of the institution, in spite of ignorant and frequently unjust and malignant criticism.⁴⁶

According to this tribute it seems that Cremonini was successful in enforcing MacGregor’s custodial strategies of obedience and discipline amongst staff and patients. Brunton provides an account from the *Auckland Star* where Cremonini, in accordance with English asylum protocol, required staff to salute him. Brunton also contends that throughout the 1890s and 1900s medical superintendents gained the reputation as being ‘veritable autocrats’ due to what he describes as their ‘extreme use of power’.⁴⁷ This was mostly in relation to the way in which the superintendents dealt with staff, rather than patients. Under MacGregor, a significant amount of authority was designated to and entrusted in medical superintendents to appoint

⁴⁴ R.E. Wright-St Clair, *Medical Practitioners in New Zealand From 1840 to 1930* (Hamilton: 2003), p. 412.

⁴⁵ Brunton, ‘“A Choice of Difficulties”’, pp. 325-28.

⁴⁶ *New Zealand Medical Journal*, 2 (1888/89), p. 187.

⁴⁷ Brunton, ‘“A Choice of Difficulties”’, pp. 329-32.

attendants or dismiss staff in mitigating circumstances.⁴⁸ According to Brunton, during the years of Duncan MacGregor's inspectorate, medical attendants at all the asylums were a 'motley' group. MacGregor was concerned at their competence and urged the 'utmost vigilance and promptitude of action' when dealing with the interests of patients who did not have a voice of their own.⁴⁹

While MacGregor fixed his concern on the attendants, the experiences of the medical and psychiatric doctors employed in Aotearoa/New Zealand's asylums provide a wealth of information about the asylum, science and medicine, and also the link colonial psychiatry had with British medicine. For example, in a further article written by Brunton on the historical underpinnings of New Zealand's mental health policy, he argues that in colonial New Zealand British links with Pakeha psychiatry have formed the basis of the discipline. He illustrates this point by suggesting that since 1876 British medical graduates have been favoured as the principal mental health advisers to the government.⁵⁰ This imperial link is also evident in the somatic approach of Auckland Asylum doctors, with their focus more on the body than the mind; this also tends to sit with wider social forces in the imperial world which treated colonial contexts as scientific observatories.⁵¹

The men who treated the patients at the Auckland Asylum were a group of mainly British qualified, highly-skilled individuals. As was often the case with these men, they were both psychiatrists and physicians, working in the asylum, hospitals, and in private practices. The importance of considering the observations of these medical-men through their language contained within the Auckland Asylum archive is that these documents 'create a set of social messages wrapped in medical language'.⁵²

⁴⁸ Brunton, ' "A Choice of Difficulties"', p. 331.

⁴⁹ Inspector-General to Minister of Justice, 26 June 1896, Inspector-General's Letter Book, p. 467, formerly held in the Department of Health head office but current whereabouts unknown, cited in Brunton, ' "A Choice of Difficulties"', p. 326.

⁵⁰ Warwick Brunton, 'Out of the Shadows: Some Historical Underpinnings of Mental Health Policy', in *Past Judgement: Social Policy in New Zealand History*, edited by Bronwyn Dalley and Margaret Tennant (Dunedin: University of Otago Press, 2004), p. 77.

⁵¹ MacLeod and Lewis, 'Disease, Medicine an Empire', Introduction.

⁵² James H. Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857-1900* (Houndmills, Basingstoke, Hampshire and London: Macmillan Press, 2000), p. 5.

The study of the asylum records therefore has the ability to illustrate how case notes in particular assisted in perpetuating dominant themes of 'race', gender, and even validated the ascendancy of medical knowledge, as explored in the following chapters.⁵³

Dr Thomas Philson was provincial surgeon and medical superintendent of the Auckland Hospital from 1859 to 1883. He was born in Ireland 1817 and educated in Scotland and came to New Zealand upon his appointment as assistant surgeon to the British Army in 1845. Philson's observations account for a majority of the case notes of Maori patients at the Auckland Asylum.⁵⁴ Another doctor of British origin whose observations and comments reverberate in the records of the Auckland Asylum was Dr Charles Goldsbro. Arriving in New Zealand in 1860, Goldsbro practised as a surgeon for the Auckland militia and was coroner until his appointment as medical officer for the Auckland Hospital.⁵⁵

Dr Alex Young was of even more significance to the lives of Maori patients in the Auckland Asylum. Elder brother of the Dr James Young mentioned above, Alex Young's notes account for a large segment of medical observation at the asylum. Born in Ireland and registered in the United Kingdom in 1872, Young was appointed medical superintendent of the Auckland Asylum in June 1879.⁵⁶ His diagnosis and treatment of patients is noted more frequently than the diagnosis and treatment by any other medical superintendent.

As well as the dominating observations of Philson, Goldsbro and Alex Young, other doctors' comments and notes are evident in the records of the Auckland Asylum. Observations by Dr Bernard Beale, born in London, and who held a position as physician at the Auckland Hospital, are contained in the case notes of Maori

⁵³ Mills, 'Madness, Cannabis and Colonialism', p. 5.

⁵⁴ Wright-St Clair, 'Medical Practitioners in NZ', p. 304. See, MSS & Archives 2004/5 Casebook 1859, 1865-76 (Philson, Thomas Moore).

⁵⁵ Wright-St Clair, 'Medical Practitioners in NZ', p. 156.

⁵⁶ Wright-St Clair, 'Medical Practitioners in NZ', p. 411.

patients.⁵⁷ Born in London in 1830, Beale arrived in New Zealand in 1831 practising as a surgeon in Nelson. A prominent resident of the Waikato district, Beale became Mayor of Hamilton from March to December 1880. As Mayor, Beale was described as 'eccentric, difficult to work with, antipathetic to almost everything'.⁵⁸

The medical language of these doctors also shadows their own experiences with Maori patients, especially in terms of 'racial' difference, as these examples illustrate:

Maria R., the kept mistress of a man named Gibson, was committed to the asylum after becoming maniacal, through jealousy. According to Dr Alex Young she is subject every month to 'stripping herself half naked' and 'dancing the war dance'.⁵⁹

Eliza M., the widow of a man formerly in the service of the government, was described as 'perfectly quiet and amicable to people'. She was eventually discharged to her family who, after evaluation, were believed to 'occupy a respectable position in society'. Eliza was also described by Drs Kenderdine and Goldsbro as 'quiet and harmless and very easily managed' after eventually taking it upon herself to learn the English language.⁶⁰

Peacock R., was confined in the asylum as a result of mania. His notes expose him as a noisy, violent man who was often secluded due to his outbursts. These notes also reveal a 'great love of ornament' which, according to Drs Philson and Walker, is 'a characteristic of his race'.⁶¹

Aperahama T., a widower, was arrested and sent to the asylum after being found 'destitute and starving'. Suffering from various religious delusions, his

⁵⁷ Wright-St Clair, 'Medical Practitioners in NZ', p. 49.

⁵⁸ P.J. Gibbons, 'Beale, Bernard Charles, 1830-1910', in *Dictionary of New Zealand Biography, Volume Two (1870-1900)*, edited by Claudia Orange (Wellington: Ministry for Culture and Heritage, 1993), p. 79.

⁵⁹ YCAA 1048/1, Casebook 1853-1871, folio 61.

⁶⁰ YCAA 1048/2, Casebook 1871-1874, folio 235.

⁶¹ YCAA 1048/5, Case Continuation Book 1890-1892, folio 184.

notes indicate that he is becoming weak and lacking nutrition from not wanting to eat the asylum food. He was also noted by doctors as having continually expressed a wish for 'Maori food'.⁶²

Te Hou H., was admitted due to 'epileptic insanity' caused by fright. His notes state that while he was burying a dead body he felt the spirit of the dead person pass into his legs and creep up his body. This, according to Dr Purchas's notes, 'caused him to become porangi'.⁶³

Tamati T., an elderly widower suffering from delusions of persecution and dementia, was admitted to the asylum in fear of his life. His medical certificate by Dr Purchas noting that he was in constant fear of being 'killed by the natives', and would have killed a young boy had other 'Maoris' not intervened.⁶⁴

These doctors were mentioned throughout the historical Auckland Asylum archive and their observations show just how pervasive and powerful medical knowledge was to asylum discourse, especially when dealing with 'raced' patients.

Overall, the actions and practices of legal officials, medical administrators and medical-men were a critical part of the way in which colonial psychiatry operated in Aotearoa/New Zealand. According to Arnold, 'medicine has come to be identified as a colonizing force in its own right, a potent source of political authority and social control'.⁶⁵ The way in which medical professionals framed and constructed official medical publications and records became part of this 'potent' mix, a tool by which Western psychiatry, and medicine, was able to flourish in certain colonial contexts. As well as this, the management of patients, through legislation and policing, became

⁶² YCAA 1048/5, Case Continuation Book 1890-1892, folio 385.

⁶³ YCAA 1048/5, Case Continuation Book 1890-1892, folio 515.

⁶⁴ YCAA 1048/7, Case Continuation Book 1896-1898, folio 20.

⁶⁵ Arnold, 'Medicine and Colonialism', p. 1393.

an intrusive extension of the asylum's artillery, commanding just how the insane were to be managed in the colonies.

The following chapter moves from this investigation of the legal and medical officials of the Auckland Lunatic Asylum, to surveying the experiences of the Maori patients themselves. The patient narratives invite alternative readings and historical interpretations to those considered in this chapter.⁶⁶ The case notes record another history of experiences at the asylum, documenting the paradoxes between official and Maori views of institutionalisation. As Menzies and Palys have argued, writing about Indigenous asylum patients in Canada, the case files 'chronicle with disconcerting frequency examples of lives ruined, power abused, professional arrogance, and racial intolerance inscribed into the very foundations of our public health institutions'.⁶⁷ This, as the next chapter examines, was very much the case at the Auckland Asylum.

⁶⁶ Menzies and Palys, 'Turbulent Spirits', pp. 149-75.

⁶⁷ Menzies and Palys, 'Turbulent Spirits', pp. 149-75.

2

‘This woman is an aboriginal native...’:**The Maori Patient Population at the Auckland Lunatic Asylum**

In the previous chapter I considered aspects of medicine, law, and ‘race’ in the context of colonial asylum histories in Aotearoa/New Zealand. Such an analysis would not be complete without assessing the asylum patients themselves. Therefore, this chapter discusses the population of insane Maori at the Auckland Asylum. While similar studies have examined the patient population through gender, and also class to some extent, using individual patient case files from the asylum archive, the Maori patient experience has not been a focus. The provision of lunacy legislation in Aotearoa/New Zealand afforded no specific mention of ‘race’ and as such, lunatic asylums catered for people of all ‘races’, and thus had a diverse patient population.¹ Maori easily became obscured within that range. In this chapter, the Maori patient population at Auckland is described in broad terms with attention focused on gender, age, marital status, place of origin, tribal affiliation, length of stay, and other aspects of their committal experience.

Mental Illness and the ‘Mad Maori’

Researchers have noted that comparatively few Maori were admitted to the Auckland Lunatic Asylum in the early period between 1860 and 1900. The incidence of mental illness and institutional confinement among Maori more generally was a phenomenon which became more prevalent in the twentieth-century, from the late 1920s onwards.² This is not to say mental illness did not exist at that time, rather, this indicates shifts in the ideas and attitudes about society, mental illness and psychiatry as well as the Maori population demographic. The admission rates for all patients to the asylum

¹ Waltraud Ernst, ‘The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes’ in *A Health Country: Essays on the Social History of Medicine in New Zealand*, edited by Linda Bryder (Wellington: Bridget Williams Books, 1991), p. 75.

² See Labrum, ‘Looking Beyond the Asylum’, p. 128; Primrose, ‘Society and the Insane’, p. 263.

from 1867 to 1900 show an infrequent pattern with regards to total admissions in any one year.³ Maori admissions reflect this irregularity with some years revealing no admissions and others indicating one or more admissions, as Table 2.1 demonstrates.

Table 2.1: Maori Admissions, Auckland Lunatic Asylum, 1860-1900

Year	Male	Female	Total
1860			
1861			
1862	1		1
1863			
1864	1		1
1865			
1866	1	1	2
1867			
1868	1	1	2
1869	1	2	3
1870	1		1
1871	1		1
1872			
1873		2	2
1874		1	1
1875			
1876			
1877			
1878			
1879	1	1	2
1880	1		1
1881		1	1
1882	1		1
1883	1		1
1884			
1885	6	1	7
1886	2	1	3
1887		2	2
1888		1	1
1889	3	1	4
1890	2	1	3
1891		2	2
1892			
1893	5	1	6
1894	1	2	3
1895	1	1	2
1896	5	2	7
1897	4	1	5
1898	1	2	3
1899	2	2	4
Total	43	29	72

Source: YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/1-8, Casebooks 1853-1900.

³ Primrose, 'Society and the Insane', p. 263.

The reasons for the comparatively low rate of Maori admissions are many and varied. Some of these are explored more fully in Chapter Four. However, for the purposes of this chapter, some brief comments are useful. Generally, Maori use of European institutions and Western medicine was still a very new development, especially for the majority of the Maori population who lived rurally and had limited, if not non-existent, contact with Pakeha. Many Maori were either sceptical, or in some circumstances, unaware of these institutions and the unfamiliar methods used to treat and heal the sick and wounded, including the insane. That Maori were admitted at all therefore seems remarkable. Moreover, confinement of Maori in institutional care such as the asylum could only have occurred where Maori and European lives intersected, and very rarely as a result of Maori families/communities committing their insane voluntarily. The evidence from the Auckland Asylum patient case files supports this contention showing that in the majority of cases Maori were admitted as a result of contact with legal officials such as the police, or where Maori were married to Europeans, or where Maori lived in or around European towns and settlements, such as Auckland.⁴

While the admission register for the Auckland Lunatic Asylum portrays the low number of Maori admissions at the institution, it is by no means accurate evidence of this. According to the register, the number of Maori admissions decreased in the 1880s.⁵ Yet this contradicts the evidence in the patient casebooks which shows a constant increase of Maori admissions in all but one of the decades from 1860 to 1900. Maori admissions from 1860 to 1870 reached 10, yet from 1870 to 1880 there was a minor drop in admissions to 8. Nevertheless, in the decade from 1880 to 1890 admissions experienced a more dramatic increase, reaching 20, and this trend continued into the following decade where the number of Maori admissions reached 34.⁶ Errors in record-keeping and management may account for some discrepancies in the admission register; however, the casebooks offer a more precise set of reasons

⁴ Primrose, 'Society and the Insane', p. 263; YCAA 1048/1-8, Casebooks 1853-1900.

⁵ YCAA 1021/1-3, Register of Committed Patient Admissions 1853-1901.

⁶ YCAA 1048/1-8, Casebooks 1853-1900.

for Maori committals, and also say something more damning about the way historians have used asylum records in the past.

Therefore, my sample of Maori patients was taken from the asylum casebooks and not from the admission register. This may also be part of the reason why historians have not concentrated on Maori because, at a glance, the admission register shows that very few Maori used the asylum. However, where one consults the casebooks, Maori obviously did utilise the institution. This throws up a whole host of problems, the most significant of which concern official reporting of the number of insane in Aotearoa/New Zealand's asylums. It would appear evident that the figures derived from admission registers throughout the country and published in official government documents such as the *Appendices to the Journals of the House of Representatives* are misleading.

Such evidence is also at odds with claims that the incidence of insanity was almost non-existent among Maori, and also challenges claims about a declining Maori birth-rate.⁷ As will be explored in more depth in Chapter Four, the concept of insanity was not foreign to Maori who used the term *porangi* to refer to mental illness and the mentally ill. Even though the effects of European society on Maori were pronounced during the late nineteenth century, Maori were still more likely to deal with their disturbed members using traditional methods rather than depending on European institutions for treatment.⁸

Therefore, claims of a declining Maori birth-rate as a reason for a scarcity of Maori asylum inmates seems incorrect, considering the Maori asylum population would more than likely have mirrored the growth of the Maori population more generally. As Salesa and Lange have both indicated, the prevailing discourses of Maori as a 'dying race' in the later nineteenth and early twentieth centuries were unfounded.⁹

⁷ Primrose, 'Society and the Insane', p. 264.

⁸ Primrose, 'Society and the Insane', p. 264.

⁹ For references to the 'dying Maori' and low Maori birth-rates, see Salesa, ' "The Power of the Physician" '; Lange, 'May the People Live'; John Stenhouse, ' "A Disappearing Race Before We Came

The medical profession was an implicit part of the colonial agenda which sought to perpetuate such 'myths' as dominant ideologies, thereby extending imperial power. Newspaper opinion also reflected the myth of a dying Maori 'race', one such daily stating:

That a race which drinks native rum, builds its huts in stagnant swamps, herds with dogs at night, and lives on rotten corn and putrid shark, should show a tendency to die out is hardly wonderful.¹⁰

Similarly, in an 1878 report by the various native officers for the districts of Mongonui, the Bay of Islands, Hokianga, Pokeno, Alexandra (Waikato), Raglan, Tauranga, New Plymouth and Nelson, the decline of the Maori race was attributed to poor food, drink, inadequate clothing, bad housing, neglect of families and children, prostitution, dirt and general substandard living conditions.¹¹ While Piripi, a forty-year old male from Auckland, was admitted and described as suffering 'from abuse of rum', and Maria, a thirty-two year old 'woman of easy virtue' and who 'led a most dissolute life in Auckland', pervade the pages of the Auckland Lunatic Asylum case books, significant factors such as drink and prostitution are by no means the most prominent causes of insanity in the majority of cases.¹²

Furthermore, the colonial obsession with cleanliness and hygiene is often reflected in the case books with references to 'dirt' and the 'dirty habits', or otherwise, of both the Maori and non-Maori inmates.¹³ In some ways such interest was consistent with concerns for the preservation and protection of the Maori 'race' from some of the more adverse impacts of Pakeha settlement. However, claims of 'racial oblivion' were more in line with nineteenth century European ideals of 'progress' and

Here": Doctor Alfred Kingcombe Newman the Dying Maori, and Victorian Scientific Racism', *New Zealand Journal of History (NZJH)*, Vol. 30, No. 2 (October 1996).

¹⁰ Unidentified newspaper, quoted in John Bradshaw, *New Zealand To-day* (London, 1888), pp. 73-4, cited in Lange, 'May the People Live', p. 61.

¹¹ *New Zealand Census*, 1878, cited in Primrose, 'Society and the Insane', pp. 264-5.

¹² YCAA 1048/1, Casebook 1853-1871, folio 206. YCAA 1048/1, Casebook 1853-1871, folio 150.

¹³ YCAA 1048/1-8, Casebooks 1853-1900.

'civilisation' and Christian humanitarianism.¹⁴ Lange contends that 'expressions of hope for a Maori future were always cast in a mould fashioned by Christian humanitarianism. The tasks of protecting and preserving a savage race and of transforming savages into civilised and Christian citizens, were seen as an almost sacred trust'.¹⁵ Thus the delivery and extension of Western services to Maori was part of this civilising process and, as a corollary, the establishment of Western institutions such as the lunatic asylum. For some patients like Thepara W., being described as 'semi-civilized' highlights the pervasiveness and absolute reality of such discourses.¹⁶

The Patients

In surveying Aotearoa/New Zealand's asylum patient populations it is clear that Maori admission rates were relatively low compared with that of non-Maori. Of the entire patient population at the Auckland Lunatic Asylum in 1880, Maori comprised almost 4 per cent.¹⁷ By 1890 Maori inmates formed only 3 per cent of the total Auckland Asylum population.¹⁸ While Maori do not feature quite so prominently in terms of numbers in other asylums, they do appear. This important fact has been overlooked. In 1880, Maori were present in just one other lunatic asylum, at Seacliff in Dunedin.¹⁹ Thus the total number of Maori in 1880 was 1 per cent of the total asylum population throughout the whole country.²⁰ However, by 1890, while committals in Auckland had decreased slightly, numbers elsewhere had increased. The Dunedin Asylum comprised 0.2 per cent while the Christchurch Asylum was

¹⁴ Lange, 'May the People Live', p. 61.

¹⁵ Lange, 'May the People Live', p. 61. For humanitarianism, see: Keith Sinclair, *The Origins of the Maori Wars*, 2nd edition (Wellington: 1961), 'Chapter 3'; Alan Ward, *A Show of Justice: Racial Amalgamation in Nineteenth Century New Zealand*, revised edition (Auckland: 1995); M.P.K. Sorrenson, 'How to Civilise Savages: Some "Answers" from Nineteenth Century New Zealand', *NZJH*, Vol. 9, No. 2 (October 1975), pp. 97-105; Erik Olssen, 'Mr Wakefield and New Zealand as an Experiment in Post-Enlightenment Practice', *NZJH*, Vol. 31, No. 2 (October 1997), pp. 201-15.

¹⁶ YCAA 1048/5, Case Continuation Book 1890-1892, folio 30.

¹⁷ Annual Report on Lunatic Asylums of New Zealand for 1880, *Appendix to the Journal of the House of Representatives (AJHR)*, 1881, H-13, p. 13, Table VIII.

¹⁸ Annual Report on Lunatic Asylums of the Colony for 1890, *Appendix to the Journals of the House of Representatives (AJHR)*, 1891, Session II, H-2, p. 11, Table VIII.

¹⁹ *AJHR*, 1881, H-13, p. 13.

²⁰ *AJHR*, 1881, H-13, p. 13.

slightly higher at 0.26 per cent.²¹ While these figures remain slight, Maori at Wellington now comprised around 2 per cent of total admissions, and Maori inmates comprised around 1 percent of the total asylum population nationwide.²² Interestingly, while Maori numbers remained the same overall, total admissions increased. More significantly, Maori inmates were becoming visible in the country's other asylums.

Because Maori committal rates remained low compared with those of non-Maori, this is not a reason to ignore Maori patients in historical studies. Rather, the fact that these rates were low encourages investigation. The admission rate may have been low largely because Maori could rely on family/whanau, community and tribal networks for social support. Some of these issues are discussed in Chapter Four of this thesis. Similarly, Maori were more remote geographically, and as the Auckland Asylum records reveal, Maori in institutional care were more likely to have collided with European authorities prior to their committal. It is with this in mind that this chapter now introduces the Maori patient population at the Auckland Asylum by highlighting key aspects such as age, gender, marital status, and tribal affiliation.

For the majority of Maori the process of committal to the Auckland Asylum did not always conform to legal prescriptions represented in the records. This pattern was also a feature of non-Maori committals where historians have identified that factors such as a thorough examination of patient's previous mental health history were lacking.²³ As part of this process, the requirement for an order of committal and two medical certificates confirming insanity reveals, as Labrum has recognised, the power that the physician had in diagnosing and certifying individuals who were often unknown to the doctor prior to the process. Based on the medical evidence of the physician the committal order was then signed by the justices and the magistrate. The case materials make plain the arbitrary labelling and judgments made by the

²¹ *AJHR*, 1891, H-2, p. 11.

²² *AJHR*, 1891, H-2, p. 11.

²³ Labrum, 'The Boundaries of Femininity', pp. 62-3.

medical-men when reporting on patients particularly in cases of Maori, where family statements were less likely to be incorporated.²⁴

The ratio of male to female Maori admissions surveyed from 1860 to 1900 differs slightly to that for non-Maori. While for Maori this division confirms findings by historians which show that the majority of the total patient population was male, it differs slightly in ratio.²⁵ For non-Maori, women account for significantly less of the total patient population at around a quarter to a third of all patients, whereas Maori women formed a slightly higher proportion at around 40 per cent of the total Maori patient population, as Table 2.1 also shows.²⁶

The age range of Maori patients upon admission largely follows that for non-Maori. As Table 2.2 shows, the youngest inmate Emma O. at 11 years of age is separated by 69 years from 80 year old Whatane at the other end of the spectrum.²⁷ Nearly 60 per cent of patients fell within the 21 to 40 age bracket, with most between 26 and 40 years of age.²⁸ In 1871 the largest age groups for non-Maori were also those in the 21 to 40 year age bracket, corresponding with the general population for that year. This trend continued quite markedly into the 1880s.²⁹ Apart from these groupings, small numbers were in the 21 to 40 year bracket, and around 30 per cent of Maori patients occupied the 41 to 80 year age group. Around 4 per cent of Maori patients had no recorded age.³⁰

Accordingly, the age range provides insight into the use of the asylum as a last resort for many Maori families and communities. Maori patients' families and communities, and similarly Pakeha patients' families and communities, often used the

²⁴ Labrum, 'The Boundaries of Femininity', pp. 62-3. Also see Catharine Coleborne, '“His brain was wrong, his mind astray”: Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880s-1910', *Journal of Family History*, Vol. 31, No. 1 (Jan 2006), pp. 45-65.

²⁵ Labrum, 'The Boundaries of Femininity', pp. 61-2.

²⁶ YCAA 1048/1-8, Casebooks 1853-1900.

²⁷ YCAA 1048/5, Case Continuation Book 1890-1892, folio 430; YCAA 1048/6, Case Continuation Book 1893-1896, folio 83.

²⁸ YCAA 1048/1-8, Casebooks 1853-1900.

²⁹ Primrose, 'Society and the Insane', pp. 239-47.

³⁰ YCAA 1048/1-8, Casebooks 1853-1900.

asylum as a final option to care for their mentally ill family member.³¹ As was also the case, those on the fringes of society most often ended up in the asylums through contact with legal officials, medical officials and as a result of committal by family or community. There seems to be a trend here that those older and less productive in the community were less reluctantly committed to the asylum, a theme I explore further in Chapter Three.

Table 2.2: Ages of Maori Patients, Auckland Lunatic Asylum, 1860-1900

Age	# of admissions
0 – 5	
6 -10	
11 – 15	1
16- 20	4
21 – 25	8
26 – 30	14
31 – 35	5
36 – 40	14
41 – 45	2
46 – 50	7
51 – 55	
56 – 60	8
61 – 65	
66 – 70	1
71 – 75	2
76 – 80	3
81 – 85	
No age/unknown	3
Total	72

Source: YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/1-8, Casebooks 1853-1900.

The marital status of Maori patients is also important. From 1860 to 1900, the majority were recorded as married, a significant number as single, and even fewer were widows and widowers. Out of the 72 Maori patients in this period 67 cases include marital status. Significantly, these figures remain almost static throughout the entire period, quite possibly indicating an already entrenched acceptance of certain European values as Table 2.3 indicates.

³¹ See Labrum, 'Gender and Lunacy'; Brookes and Thomson, 'Unfortunate Folk'.

Table 2.3: Marital Status of Maori Patients, Auckland Lunatic Asylum, 1860-1900

Marital Status	# of admissions
Single	24
Married	30
Widow	4
Widower	9
Status unknown	5
Total	72

Source: YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/1-8, Casebooks 1853-1900.

Generally those Maori patients admitted to the asylum were non-professional, skilled workers prior to admission. There is a noticeable absence of Maori among the professional classes, reflecting a more general pattern within Aotearoa/New Zealand society at this time.³² As one might expect, Maori women form the majority of the significant number whose occupations are simply not recorded. Where occupation is recorded for Maori women, descriptions usually include: 'wife of native', or 'wife of a Maori chief', or alternatively refer to domestic work such as housekeeping, as with non-Maori women.³³ The range of occupations listed for Maori men is more complete and provides a good indication of the types of traditional work that survived under colonial rule, and also the emergence of Maori involvement in introduced occupations. The case books note labouring, gumdigging, farming and fishing, alongside 'native chief' as proof of occupation (see Appendix).³⁴

References to tribal affiliation are also limited (see Appendix). No specific category is set aside for this in the admission certificate and it is mentioned only sporadically in the case material. One could assume that the place of residence for each patient would equate with the various tribal boundaries, yet this is not made explicit. In many cases tribal affiliation was only determined tangentially. For example, Erama's

³² See Erik Olssen, 'Families and the Gendering of European New Zealand in the Colonial Period, 1840-80, in *The Gendered Kiwi*, edited by Caroline Daley and Deborah Montgomerie (Auckland: Auckland University Press, 1999), pp. 37-62; James Belich, *Making Peoples: A History of the New Zealanders from Polynesian Settlement to the End of the Nineteenth Century* (Auckland: Penguin Books, 1996); Michael King, *The Penguin History of New Zealand* (Auckland: Penguin Books, 2003).

³³ YCAA 1048/1, Casebook 1853-1871, folio 150; YCAA 1048/6, Case Continuation Book 1893-1896, folio 139.

³⁴ YCAA 1048/4, Casebook 1885-1887, folio 217; YCAA 1048/1-8, Casebooks 1853-1900.

notes state that the reason behind the fourteen year pause in entries in her case notes in 1882 was because of the difficulty in determining whether the patient in the asylum was the same one entered in the casebook. This predicament was eventually resolved when '[a] visit from some Kingite natives to the asylum let the matter at rest' by identifying her.³⁵ Upon this evidence it is more than likely that Erama was of Waikato, perhaps Ngati Maniapoto descent. Specific mention of tribal affiliation is otherwise only made in two other cases. Admitted in 1893, the opening comments in Hemi H's notes state that he is '[a] native belonging to the Ngapuhi tribe'.³⁶ The rest of Hemi's notes provide riveting reading especially his alleged delusions about men shooting his cattle and horses and of the accusation that he stole money from the Bank of New Zealand. Hemi 'knows that he has been out of his mind but that he has been bewitched by certain Maoris'.³⁷ Which Maori he is referring to is uncertain. In another case from 1898, Iharaira W. is reported as saying 'no tribe for me, no people'. It was learned through an interpreter that he was Ngati Porou from Gisborne on the East Coast of New Zealand's Northern Island.³⁸

It is not surprising that the former places of residence for the Maori patients correspond with the specific geographic area the Auckland Asylum serviced, both urban and rural. The asylum's catchment encompassed the greater Auckland area and to the north of Auckland, and patients came from areas as remote as the East Coast, the Coromandel, Bay of Plenty, Waikato, and from the central North Island.³⁹ As mentioned earlier, this pattern reflected some of the more practical considerations required of patient transfer due to closures of smaller asylums in the 1880s, and was often in an effort to counteract the problem of persistent overcrowding in the country's asylums.⁴⁰ The significance of their places of residence to these patients is highlighted in the case of Peacock R., who, after being admitted in 1882, attempted

³⁵ YCAA 1048/1, Casebook 1853-1871, folio 127.

³⁶ YCAA 1048/6, Case Continuation Book 1893-1896, folio 41.

³⁷ YCAA 1048/6, Case Continuation Book 1893-1896, folio 41.

³⁸ YCAA 1048/8, Case Continuation Book 1898-1900, folio 75.

³⁹ YCAA 1048/1-8, Casebooks 1853-1900.

⁴⁰ Labrum, 'The Boundaries of Femininity', p. 61.

on two occasions to escape home to Waiheko, was recaptured and returned to the asylum in both instances.⁴¹

The alleged causes of insanity for these patients follow similar patterns as the alleged causes for non-Maori admissions, with one exception. The noted prevalence of 'domestic trouble' as a cause of insanity in non-Maori was not a significant category for Maori.⁴² Overall, the psychiatric diagnosis of patients reflects a propensity by physicians to encompass a variety of wide-ranging symptoms in one very static category. In 1869 three Maori patients were admitted, two male and one female. In two of the cases the alleged cause of insanity was mania, and in the other male case, melancholia.⁴³ In 1879 the alleged causes of insanity for the one Maori female and one Maori male admitted to the asylum were chronic mania and melancholia respectively.⁴⁴ By 1889, as Maori admissions grew, the variety of insanity diagnoses continued in very much the same format. Of the four Maori admitted that year, one female and three male, all alleged causes of insanity were the same – dementia.⁴⁵ Of the four Maori admissions in 1899, two female and two male, one of the men and one of the women were diagnosed with melancholia, the remaining two both with mania.⁴⁶ In the majority of cases surveyed in these four years the prominence of 'drink' related insanity is obvious, as too is the influence of environmental and social causes, like drink, rather than hereditary factors (see Appendix).

Another aspect of asylum life for Maori inmates was the ability to pay maintenance for their keep. Payment for an inmates' keep was a critical part of the funding needed to keep the asylum afloat, and as such patients were legally required to pay for their lodgings. However, this was often at the expense of family members, and as a result of investigations by police into the relatives' actual ability to afford asylum lodging for their family members. One of the only extant sources recording such payments

⁴¹ YCAA 1048/5, Case Continuation Book 1890-1892, folio 184.

⁴² Primrose, 'Society and the Insane', pp. 271-5.

⁴³ YCAA 1048/1, Casebook 1853-1871, folio 143, 150 & 151.

⁴⁴ YCAA 1048/3, Casebook 1878-1881, folio 48, 58.

⁴⁵ YCAA 1048/5, Case Continuation Book, folio 345, 384, 385 & 394.

⁴⁶ YCAA 1048/8, Case Continuation Book 1898-1900, folio 123, 147, 167 & 243.

covers just the period from 1890 to 1899.⁴⁷ The notable feature of these payments was in the process of securing the amount (in most cases) this entailed an asset assessment conducted by the police. In the pages of this record book the payment details of 18 Maori patients are recorded, the largest part of which makes reference to the level of interest that the patient and their relatives had in land. This was the case with Emma O., introduced at the outset of this thesis, whose father, a farmer in the King Country, was reported by the investigating police officer to have ‘interests in blocks of Native land about Kopua’.⁴⁸ Similarly, patient Wikitoria W. was noted as having interests in the Waipiro block,⁴⁹ and Peata W. was further reported as having a son who was a one-eighth owner of 70 acres of land in the North Island Taranaki township of Opunake.⁵⁰ References to land are also accompanied by references to other forms of asset wealth. In his report on inmate Waihakeke, Constable Berriman from Taupo in the central North Island noted that ‘the patient has 1000 sheep’ and ‘has small interests in land’ but has had no return from the property.⁵¹ Other cases refer to the patient being ‘poor and unable to contribute’,⁵² or ‘[g]ets his living by gumdigging and has no means other than his earnings by that labour’.⁵³ The European interest in land lead to land and arguably cultural alienation, as the following chapter explores.

Many Maori remained in the asylum until the end of their lives. More often than not, discharge came not as a result of recovery or cure, but due to transfer to gaol, other asylums, or to homes which cared for the elderly.⁵⁴ The length of stay in the asylum was mostly dependent on recovery and cure, or in some cases upon the presence of relatives willing to take a patient out of the asylum. The case materials show that the number of patients discharged was disproportionately lower than the number of those who died in the asylum as Table 2.4 expresses. Of the 72 Maori patients admitted to

⁴⁷ YCAA 1044/1, Record Book of Maintenance 1890-1899; YCAA 1045/1 Maintenance Payment Ledger 1885-1889.

⁴⁸ YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 2.

⁴⁹ YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 92.

⁵⁰ YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 126.

⁵¹ YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 146.

⁵² YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 244.

⁵³ YCAA 1044/1, Record Book of Maintenance 1890-1899, folio 239.

⁵⁴ YCAA 1048/1-8, Casebooks 1853-1900.

the Auckland Asylum between 1860 and 1900, 30 were discharged and 40 died, and just 2 were transferred to the Porirua Asylum.⁵⁵ The length of stay in the asylum varied from months to years. For eighteen-year old Rangī T. this was a matter of two months, discharged ‘having quite recovered’ following successful treatment for melancholia excited by puerperal mania.⁵⁶ For others, like thirty-five year old Ripeka R., the Auckland Asylum experience was a life-long one. Admitted suffering from acute mania in 1881, Ripeka died of pneumonia twenty-five years later still in institutional confinement.⁵⁷ For nearly all of the Maori patients admitted as a result of old age, like eighty-year old Whatane, the asylum was a place to live out their final years, or as in Whatane’s case, the last four months of his life.⁵⁸

Table 2.4: Deaths, Discharges and Transfers of Maori Patients, Auckland Lunatic Asylum, 1860-1900

Deaths and Discharges	Number
Death	40
Discharges	30
Transfers	2
Total	72

Source: YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/1-8, Casebooks 1853-1900.

The causes of death for these patients paint a grim picture. For the three Maori patients admitted in 1869, death resulted in just one of the three from a lung ailment.⁵⁹ Of the two Maori patients admitted in 1879, one died from erysipelas, a severe skin condition, and the other was discharged.⁶⁰ All four of the Maori patients admitted in 1889 died in the Auckland Asylum, one from tuberculosis, another from phthisis pulmonalis, and the other two from ‘impaired health’.⁶¹ Out of the four admitted in 1899, three died, one from tuberculosis, one from phthisis pulmonalis, and the last from asthemia starvation.⁶² The causes of death for Maori were

⁵⁵ YCAA 1048/1-8, Casebooks 1853-1900.

⁵⁶ YCAA 1048/7, Case Continuation Book 1896-1898, folio 196.

⁵⁷ YCAA 1048/5, Case Continuation Book 1890-1892, folio 151.

⁵⁸ YCAA 1048/6, Case Continuation Book 1893-1896, folio 83.

⁵⁹ YCAA 1048/1, Casebook 1853-1871, folio 143, 150 & 151.

⁶⁰ YCAA 1048/3, Casebook 1878-1881, folio 48 & 58.

⁶¹ YCAA 1048/5, Case Continuation Book 1890-1892, folio 345, 384, 385 & 394.

⁶² YCAA 1048/8, Case Continuation Book 1898-1900, folio 123, 147, 167 & 243.

concurrent with causes of death for the wider asylum population and illustrate the extent to which physical illness rather than mental incapacity was a determining factor in diagnosis.⁶³ Moreover, the occurrence of respiratory disorders as a leading cause of death indicates something of the living conditions experienced by the inmates; close quarters due to overcrowding would have promoted the incidence of diseases like tuberculosis. Maori, though, were more susceptible to these diseases and the propensity of these diseases in the Maori population at large was extreme. Figures for deaths resulting from respiratory disease around the turn of the twentieth century were probably as high as 35.27 per 10,000 Maori (compared with 4.46 for non-Maori), for tuberculosis. For other respiratory diseases figures were estimated to be as high as 55.31, to 9.3 Pakeha deaths per 10,000. These figures, in such an early period, are approximate.⁶⁴

An examination of the Maori patient profile from the Auckland Lunatic Asylum, a site where the 'labelling' and categorisation of inmates was routine, reveals 'European' categories in which Maori are situated, but often inadequately. Figures outlining aspects of this profile demonstrate the extent to which the medical professionals of the Auckland Asylum grappled with these inmates; their appearance, their language, their culture. The evidence is plain in the thoughts and words of these men, whose comments fill the pages of the patient case files. Colonial notions of patient acceptability, and society's perceptions of respectability, illustrate how the Maori patient profile was imbued with such notions, and more overtly, perceptions of 'race'. Classification of patients based on age, sex, marital status, tribal affiliation, and cause of insanity while at first glance are simple categorical tools, on deeper inspection, providing insight into the Maori patient population. In the following chapter, the experiences of Maori are taken a step further and analysed in more depth.

⁶³ Primrose, 'Society and the Insane', p. 260.

⁶⁴ Lange, 'May the People Live', p. 30.

3

‘He thinks he will have to lose his dark skin and become white’: Maori Encounters with the Auckland Lunatic Asylum

For forty-year old Nga K., asylum life was to be an alien experience, and very different to the life she had left behind in Kaipara, north of Auckland. Nga’s journey south to the Auckland Asylum was in itself a traumatic affair, as she had tried to jump from the steamer into the water below. Upon arriving at the Auckland Lunatic Asylum, the ‘weary’ and ‘melancholic’ Nga was escorted by the police through the impenetrable iron gates of the asylum grounds. She ‘[kept] her eyes fixed downwards, shed[ding] tears’. Remaining very silent Nga was ushered through the entrance foyer and down the corridors of the asylum, where she was placed in a sterile, unfamiliar room awaiting medical examination. On physical examination, nothing abnormal was found: Nga was in fair bodily condition, but mentally was ‘low and depressed, self absorbed and quite uninterested in her surroundings’. Nga was transferred to a ward where she was to spend the next two years, and the remainder of her natural life. Unable to speak any English, Nga gradually withdrew from speaking, taking no notice of her surroundings at all. Deeply depressed, Nga’s condition weakened to the point where she had to be dressed and fed; she did not resist. Nga’s time now consisted of squatting all day long before the fire or in the airing court, all the while her mental and physical condition was deteriorating.¹ Nga’s experience, while accenting an obvious disinclination to interact with her new surroundings also highlights an episode of cultural encounter where two very different worlds, Maori society and asylum life, collided.

This chapter grapples with some of the more prominent issues and themes affecting the Maori patient experience at the Auckland Asylum from 1860 to 1900. The previous chapter discussed Maori patients at the Auckland Asylum in broad terms.

¹ YCAA 1048/6, Case Continuation Book 1893-1896, folio 237.

Here, I examine the emergence of colonial discourses about the management of Maori in the nineteenth century to reveal just as much about those doing the managing as about those being managed. As James Mills has argued for colonial India, '[m]edical knowledge ... reflects the values and beliefs of physicians and the medical culture of which they are a part rather than the objects of their inquiry'.² This chapter also seeks to give a voice to those 'objects' of psychiatric inquiry by reflecting on the processes of psychiatric institutionalisation for Maori as recorded in the patient records of the Auckland Lunatic Asylum. While these records are often problematic, partly because they offer evidence of the way colonial physicians and psychiatrists thought and wrote, they also provide glimpses of the Maori patient. These glimpses reveal Maori as both active, and alternatively, passive agents in their encounters with a colonial psychiatric system, and reveal how aspects such as 'race' and gender intersected with and shaped asylum life.³

In particular, this chapter surveys some aspects of the encounters between the medical profession and Maori patients at the Auckland Asylum by using patient records as 'surviving artifacts between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed.'⁴ It will address the key themes of gender, 'race', class, and the body; labour and the civilising of Maori; and cultural alienation to exemplify colonial efforts to manage a 'raced' patient population at the asylum, and the reactions of Maori to this. Overall, the chapter argues that medical discourses inscribed colonial anxieties about 'race' and, to this end, emphasises Maori patient reactions to this inscription.

² James Mills, 'The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive', in *Journal of Medical Humanities*, Vol. 21, No. 3 (2000), p. 146.

³ Lykke De La Cour and Geoffrey Reaume, 'Patient Perspectives in Psychiatric Case Files', in *On the Case: Explorations in Social History*, edited by Franca Iacovetta and Wendy Mitchison (Toronto, Buffalo and London: University of Toronto Press, 1998), p. 243.

⁴ Mills, 'Madness, Cannabis and Colonialism', p. 41.

The 'Raced' and 'Gendered' Body

The ways in which the 'body' was visible in terms of 'race' and gender for Maori in the Auckland Asylum process indicates the extent to which colonial authorities mapped that which was different or Other.⁵ The concern with recording the physical details about a patient, despite this having little bearing on the patient's actual mental illness, seems to be an overwhelming part of the medical professionals' comments in patient records of the Auckland Asylum. Much of the information in the patient records contains observations on their bodies, which, as Scull has argued, is so very prominent in the case notes due to nineteenth-century theories that mental illness was manifested in physical terms.⁶ Scull highlights the power relations of the period by suggesting that the medical profession's inclination to survey the physical origins and symptoms of mental illness gave them a specific hold over the field of psychiatry. By defining mental illness in terms of 'physiological disruption', the treatment of the mad would remain within the realm of the medically trained and not for example, become the discipline of those providing 'non-medical' religious or spiritual treatment.⁷

This also had specific implications for colonial Indigenous populations of 'mad', as James Mills shows. Mills contends that

the nature of the physical information that is included in such case notes does not reflect a natural or self-evident way of looking at the mentally ill. Rather, the physical detail is the product of the ways that nineteenth century Western doctors imagined insanity and conceived of illness in general.⁸

⁵ Mills, 'Madness, Cannabis and Colonialism', p. 35.

⁶ A. Scull, *The Asylum as Utopia: W.A.F. Browne and the mid-nineteenth century consolidation of psychiatry* (London: Routledge, 1991), Introduction, p. xxix, cited in Mills, 'Madness, Cannabis and Colonialism', p. 33.

⁷ Mills, 'Madness, Cannabis and Colonialism', p. 33.

⁸ Mills, 'Madness, Cannabis and Colonialism', p. 33.

Therefore, the physical information recorded on the mad Maori body was a site for the construction of difference, and difference lay at the heart of the power relations linked to nineteenth century colonial and medical discourse. The presence of such physical detail on the Maori body highlights the preoccupation with the ideal human body as strong, healthy, European, heterosexual and male, and any deviation from this was, in essence, different and somehow an embodiment of social and moral inferiority.⁹

The admission documents in the case files of the Maori patients at the Auckland Asylum were imbued with comments relating to their physical state as opposed to medical descriptions of their psychiatric condition. For example, remarks concerning skin colour were noted where a patient was thought to be either unusually pale or 'of dark complexion' in their appearance.¹⁰ In addition, comments about the general physical description of Maori patients were repeated in most of the case notes. Patients were described as having the 'usual cast of Maori features but rather pleasant looking', or the 'usual Maori head and cast of features'.¹¹ Frequent comment is made on the size and flatness of the nose, the colour and darkness of eyes and hair, and more interestingly the shape and size of the head.¹²

The interest in head size from the 1860s onwards, was, as historians have noted, part of a phrenological endeavour aimed at the correlation between cranial capacity and mental illness. For the colonies, this measure identified those sectors of colonial society that were Other to accepted behavioural and moral patterns.¹³ References in the Auckland Asylum case notes reflect this observation. From the 1890s, comments expressing that a patient had an 'unusually prominent cranium' are by the end of the

⁹ Mills, 'Madness, Cannabis and Colonialism', p. 35. See Anderson, 'The Cultivation of Whiteness'; Arnold, 'Medicine and Colonialism'; Boucher, 'Masculinity Gone Mad'; Coleborne, 'The Scientific Management of the Insane', and by the same author, 'Making "mad" populations'; McClintock, 'Imperial Leather'; Vaughan, 'Curing their Ills'.

¹⁰ YCAA 1048/6, Case Continuation Book 1893-1896, folio 141.

¹¹ YCAA 1048/6, Case Continuation Book 1893-1896, folio 317, 485.

¹² YCAA 1048/1-8, Casebooks 1853-1900.

¹³ Mills, 'Madness, Cannabis and Colonialism', p. 34.

decade replaced with more specific data on the patients as a routine part of their physical examination.¹⁴ The case notes of Pohipi K. read for example:

On admission: Bodily condition fairly good. Weight 9st. 6pd. Height 5ft. 3in. ... She has a long body, a flat chest and narrow hips. Eyes dark brown, pupils normal. Countenance melancholic. Head circumference 22in. Heart and lungs normal. Tongue pale, flatly tooth-marked. Teeth very good. Pulse 90.¹⁵

For Maori women in the Auckland Asylum, the 'raced' and gendered body became an important tool in distinguishing patients and as a result, men and women experienced the clinical gaze in very different ways. Men and women were frequently diagnosed as suffering from different afflictions. As feminist scholars have reminded us, female patients were defined in terms of Victorian standards of femininity.¹⁶ The female patient was expected to be silent, to show decorum, to serve, to display piety and to show gratitude.¹⁷ However, the Maori female patient problematised such imposed standards by adding the factor of 'race' to the mix.

One is immediately struck by the case of Harata R. whose defiant behaviour was in opposition to the social norms imposed by the asylum. Suffering from mania, 'violent and difficult to control', Harata was described as having 'used filthy language' and as being 'destructive. ... noisy at night', and 'abnormally active'.¹⁸ Five days after her admission it was reported that she was put in seclusion after attempting to strike one of the attendants. Before her discharge, six months after her admission, Harata's notes stated that she was 'inclined to be bold in her demeanour

¹⁴ YCAA 1048/ 6, Case Continuation Book 1893-1896, folio 169.

¹⁵ YCAA 1048/6, Case Continuation Book 1893-1896, folio 317.

¹⁶ Mills, 'Madness, Cannabis and Colonialism', pp. 36-7. See also Nancy Tomes, 'Feminist Histories of Psychiatry', in *Discovering the History of Psychiatry*, edited by Mark S. Micale and Roy Porter (New York and Oxford: Oxford University Press, 1994), pp. 348-83.

¹⁷ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Virago, 1987), p. 79.

¹⁸ YCAA 1048/5, Case Continuation Book 1890-1892, folio 541.

towards male persons as well as independent in her behaviour towards the attendants'.¹⁹

Like Harata, many Maori women threatened and sometimes carried out acts of violence towards other persons and family members, were independent and outwardly confident in their actions, and breached appropriate 'female speech conventions'.²⁰ Such actions were mentioned in the case notes for the very fact that in their defiance they were violating acceptable standards of female conduct, but it is also through this defiance that these patients were made visible.

References to gendered experiences, particularly domestic violence and neglect, were noted as causes for insanity. However, medical staff often dismissed and discredited such grounds in favour of alternative causes. Tiriti W. had her claims of domestic violence dismissed by the doctors who examined her stating that it '[a]ppears to be more a case of senile dementia'.²¹ Her continued complaints of ill treatment and assault were rejected in preference of alternative testimony by neighbours and other family members who stated that her husband was 'an inoffensive man'. Whether a case of domestic violence is answerable here remains uncertain; however, her bodily condition suggested a rather bleaker picture of her social circumstances. Allegedly thin and physically weak, Tiriti's claims that her husband starved her were also ignored.²²

The use of physical distinctions to confer particular associations of masculinity and femininity between the Maori male body and the Maori female body is another recurring theme throughout the patient records. For example, Maori male patients were described in terms of their strength and masculinity, as a 'stalwart specimen' or as 'good and strong'.²³ On the other hand, Maori female patients command attention

¹⁹ YCAA 1048/5, Case Continuation Book 1890-1892, folio 541.

²⁰ Labrum, 'Looking Beyond the Asylum', pp. 131-6.

²¹ YCAA 1048/7, Case Continuation Book 1896-1898, folio 116.

²² YCAA 1048/7, Case Continuation Book, folio 116.

²³ YCAA 1048/2, Casebook 1871-1874, folio 25; YCAA 1048/6, Case Continuation Book 1893-1896, folio 169.

more for their lack of femininity; their filthy language, dirty habits or ‘untidy’ appearance.²⁴ Moreover, where, for instance, a Maori male patient is seen to be at odds with appropriate standards of masculinity, his physical description is couched in similar terms as those used to describe the ‘weak and confused’ female Maori patients.²⁵ In this sense, the physical descriptions of Maori patients align with those for non-Maori and support findings that during this time, psychiatrists believed women were physically and mentally inferior to men, and were thus more predisposed to madness than men.²⁶ However, as historians in this country have found, committal patterns indicate the reverse; that more men than women occupied asylum space.²⁷

The intersections between gender, ‘race’, and class are also a key to understanding asylum discourse around Maori. These categories both shaped and defined patients’ perceptions of themselves, and also the perceptions of the patients held by medical professionals.²⁸ The descriptions in the patient case notes clearly reflect the differences between understandings of mental illness for patient and physician. Where a patient was more likely to explain their illness in terms of social causes, highlighting problematic social circumstances, the definitions given by the physicians quite frequently ignored the patients’ perspective by reconstructing the patients’ version of events and explaining their illness in strictly medical terms.²⁹

Labour, Gender and Class: the Civilising of Maori

Patient labour in the asylum illustrates these intersections and their effects upon patients, especially Maori patients. Just as the sickness of the Maori body was linked with ideas of whiteness and gender, patient labour was also an area of asylum life that

²⁴ YCAA 1048/5, Case Continuation Book 1890-1892, folio 106.

²⁵ YCAA 1048/1, Casebook 1853-1871, folio 133.

²⁶ Patricia E. Prestwich, ‘Family Strategies and Medical Power: “Voluntary” Committal in a Parisian Asylum, 1876-1914’, in *The Confinement of the Insane: International Perspectives, 1800-1965*, edited by Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), p. 86.

²⁷ See Brookes and Thomson, ‘Unfortunate Folk’; Labrum, ‘Gender and Lunacy’.

²⁸ de la Cour and Reaume, ‘Patient Perspectives’, p. 249.

²⁹ de la Cour and Reaume, ‘Patient Perspectives’, p. 249. See also Coleborne, ‘“His brain was wrong, his mind astray”’.

was deeply gendered. As Lykke de la Cour and Geoffrey Reaume note, patient labour was envisaged as a therapeutic endeavour which had the potential to boost self-esteem. However, they also emphasise the use of patient labour as an exploitative measure where, as was the case at the Auckland Asylum, it was often a means by which a patient was required to earn their keep.³⁰ The use of patient labour in asylums was a nineteenth century Anglo-American practice aimed at initiating a work routine which would reflect life outside of the institution. Work was seen as a step towards mental stability and would inevitably promote the reintegration of a patient back into society. In the asylum, employment was gendered. There was a distinct division between the types of work men were expected to perform and the types of work women were expected to do. For instance, women's work was in the laundry or kitchen, and men's work was largely outside in the garden.³¹

The work performed by Maori patients was viewed by them in a variety of ways, both positive and negative. One might speculate that Maori patients seemed content in their labour, possibly it was even an integral part of their lives, providing them with a sense of normalcy, pride and self-esteem. On the other hand, some Maori patients resented having to work.³² However, the problem with the patient case notes is that the thoughts and words of the Maori patients are absent. When work is mentioned it is inevitably through the words of the authority figures themselves. For example, patients are either described as 'working well in the garden', or 'works well in the laundry'.³³ Alternatively, patients are described as not attempting to employ themselves or more simply as, 'she will do no work'.³⁴ These observations are similar for non-Maori patients, and on this matter, there is no evidence to suggest that Maori were treated differently.

³⁰ de la Cour and Reaume, 'Patient Perspectives', p. 253.

³¹ YCAA 1048/1-8, Casebooks 1853-1900.

³² YCAA 1048/1-8, Casebooks 1853-1900.

³³ YCAA 1048/5, Case Continuation Book 1890-1892, folio 199, 151.

³⁴ YCAA 1048/5, Case Continuation Book 1890-1892, folio 151; YCAA 1048/4, Casebook 1885-1887, folio 303.

Additionally, the way in which occupations were recorded for these patients prior to asylum committal, suggests, nonetheless, a different pattern of work experiences for Maori in general. They were often outside of the white economy, and the focus on recording Maori occupations in the casebooks both inside and outside of the asylum is largely absent in comparison with that of non-Maori during this period. There is the same focus on recording only male occupations, as with non-Maori male patients. Whether this implies that women did not work during this period (other than in the private sphere), is not clear; what is clear is the assumption that male work occupied a central place in the colonial economy and was thus more obvious in the asylum records. A number of Maori patients were recorded as labourers, housewives, and even gum-diggers at this time; however, some occupations pertaining specifically to Maori were also evident. For example, some patients were recorded as Native farmers, and Maori chiefs, indicating the culturally specific classification of certain occupations for Maori.³⁵

Labour was also linked with what Christina Twomey identifies as the civilising of Indigenous peoples in an effort to promote models of reform.³⁶ For Maori in the Auckland Lunatic Asylum, the use of labour reinforced the notion that to contribute to colonial society, one was required to be industrious and thus through their work would overcome any 'moral weakness'.³⁷ This point suggests that the 'cure' of Maori through a process of religious observance, personal hygiene and cleanliness, and a strong work ethic, reform and recovery could be achieved and the patient would be transformed into a civilised member of colonial society. However, as Mills notes, the reform or recovery of inmates, especially women, was in effect a product of 'racial' and gendered impulses, and 'judged in these institutions not by reference to some natural standard of health and illness but by reference to a standard of

³⁵ YCAA 1048/1-8, Casebooks 1853-1900.

³⁶ Christina Twomey, 'Vagrancy, Indolence and Ignorance: Race, Class and the idea of civilization in the era of Aboriginal 'protection', Port Phillip, 1835-49, in *Writing Colonial Histories: Comparative Perspectives*, edited by Tracey Banivanua Mar and Julie Evans (Melbourne: University of Melbourne, History Department, 2002), p. 102-6.

³⁷ Twomey, 'Vagrancy, Indolence and Ignorance', p. 102.

behaviour derived from the social and cultural discourses of patriarchy'.³⁸ The Maori patient case files reflect this, especially with reference to discourses of religious observance, personal hygiene and labour. The asylum's focus on these aspects indicates just how pervasive the 'language of "civilization"' was, and how discourses of paternalism influenced colonial psychiatry specifically, and also how the asylum was modeled on outside society.³⁹

In the colonial period, asylum authorities and physicians were preoccupied with the 'civilising mission' for both Maori and non-Maori patients. The visibility of this language was particularly noticeable in descriptions such as 'industrious in her habits',⁴⁰ or 'quiet and industrious, but stupid'.⁴¹ Moreover, patients were categorised as 'clean and orderly',⁴² as having 'dirty habits',⁴³ or as 'prevailed on to stop his filthy habits'.⁴⁴ For Maori, like non-Maori, civilisation included cleanliness, orderliness and Christianity. However, for Maori, unlike non-Maori, it also meant the acceptance of Eurocentric notions of the 'self' based on whiteness. For example, Hemi Te K's acceptance of this was expressed in his case records when he revealed that 'he thinks he will have to lose his dark skin and become white'.⁴⁵

Comments about religion, particularly religious faith and respectability, also feature in the case notes of these patients. The majority of Maori patients were classified as either Roman Catholic or Church of England. However, there are cases where affiliation with the Wesleyan Church and Hauhauism, a religion originated by the prophet Te Ua Haumene, of the Taranaki tribe, in 1862, were noted (see Appendix).⁴⁶

³⁸ Mills, 'Madness, Cannabis and Colonialism', p. 37.

³⁹ Twomey, 'Vagrancy, Indolence and Ignorance', p. 106.

⁴⁰ YCAA 1048/5, Case Continuation Book 1890-1892, folio 577.

⁴¹ YCAA 1048/3, Casebook 1878-1881, folio 48.

⁴² YCAA 1049/1 Casebook of Patients at Motuihi Island 1895, folio 28.

⁴³ YCAA 1048/7, Case Continuation Book 1896-1898, folio 121.

⁴⁴ YCAA 1048/2, Casebook 1871-1874, folio 25.

⁴⁵ YCAA 1048/4, Casebook 1885-1887, folio 129.

⁴⁶ See YCAA 1048/1-8, Casebooks 1853-1900; James Belich, *The New Zealand Wars and the Victoria Interpretation of Racial Conflict*, revised edition (Auckland: Penguin Books, 1998), p. 204-5.

According to Belich, Hauhauism was an amalgamation of both Maori religion and aspects of Christianity. It was thought that Te Ua Haumene, prophet and leader, formed this religion as a response to defeat in war with the Europeans.

Religious observance was welcomed in the asylum and the following comments about Wesleyan clergyman Hauraki P., illustrate just how preferable this was. Admitted suffering from acute mania, Hauraki is favourably depicted as a 'Wesleyan Clergyman and is said to be an intelligent, well educated man which his appearance and manner corroborate'.⁴⁷ It seems that intelligence, education, manners, presentation and of course religious adherence, were desirable features for a 'civilised' Maori to possess. The perceived respectability of Hauraki did not end there. In the course of his stay at the Auckland Asylum Hauraki was employed as an interpreter by medical professionals when examining Maori patients. References to the services of Hauraki appear throughout the patient records, such as 'via interpreter Hauraki Paul'.⁴⁸ Subsequently, Hauraki was discharged having fully recovered from his illness.⁴⁹

'Cultural Alienation'

Maori patients also experienced cultural alienation, as evidenced by the patient case notes. This occurred in the context of loss of traditional land and language in the management of Maori in the asylum. Unlike non-Maori patients, land alienation and/or loss were noted in the case files as specific causes of insanity for Maori. In combination with this, communication with Maori patients, most of whom lacked English as a first language, posed a barrier for medical professionals who lacked Maori language skills. The case files also show that it was very rare to engage the use of an interpreter when examining Maori patients. The implications of this are probably underestimated, using the mad to diagnose the mad cannot have been an ideal situation. The opportunity for misdiagnosis would have proved a further cultural barrier for both patient and physician.

Durie describes cultural alienation as enabling the onset of *mate Maori*, an affliction distinctive to Maori resulting from a psychological and emotional withdrawal from

⁴⁷ YCAA 1048/4, Casebook 1885-1887, folio 99.

⁴⁸ For example, see YCAA 1048/7, Case Continuation Book 1896-1898, folio 121.

⁴⁹ YCAA 1048/4, Casebook 1885-1887, folio 99.

their surroundings, such as the asylum. Maori concepts of illness, including *mate Maori*, were and still are linked to spirituality, yet the significance of culture to Maori patients rarely featured in the words and thoughts of the majority of medical and asylum staff in this period.⁵⁰ The asylum records show that some Maori patients became sullen and withdrew from asylum life in general. Durie explains that this type of reaction is symptomatic of the continuing significance of culture to Maori where heritage dictates the ideas Maori had concerning illness. Put very crudely, traditional concepts such as *tapu* and the perception of illness as a breach of *tapu*, may explain the observations of sullenness and withdrawal amongst some Maori patients.⁵¹

The observations compiled in the patient case notes of Nga K., discussed at the outset of this chapter, illustrate this idea. Nga, a 40 year-old female widow from Kaipara, was admitted to the Auckland lunatic Asylum on 8 March 1894. Described as 'decidedly suicidal' and of 'melancholic expression', throughout Nga's notes she is noted as having a 'listless manner', and showing a lack of interest in her surroundings, despite comments before admission indicating otherwise. On 9 March 1894 Nga was reported as not being able to speak any English, and as being 'low and depressed self absorbed and quite uninterested in her surroundings'. On 3 April of the same year she was further observed as 'very listless self absorbed and taciturn'. On 9 August there was no change reported in her 'listless manner', and by 17 June the following year her condition remained much the same, 'squats all day long on floor in airing Court. Takes no interest in anything, does not speak'. These sorts of entries continue on in much the same manner until her death on 30 July 1896. The penultimate entry on 25 July 1896 noted that Nga was in an advanced state of phthisis, confined to bed, and showing little alteration to her mental state.⁵² Cases like Nga's illustrate just how incompatible the asylum world and Nga's world, prior

⁵⁰ Report on the Lunatic Asylums of the Colony, *Appendix to the Journals of the House of Representatives (AJHR)*, 1901, H-7, p. 6.

⁵¹ Durie, 'Whaiora', pp. 66-7.

⁵² YCAA 1048/6, Case Continuation Book 1893-1896, folio 237.

to her institutional confinement, were. They also demonstrate just how real cultural alienation was for these patients.

References to land alienation and conflict over land in the case notes of some patients is not only striking, but also a significant indication of events during this period when fighting between the Crown and Maori over land was predominant.⁵³ The nature and scale of land loss in the latter nineteenth century saw the transference from Maori to Pakeha, most of the land in the North Island of Aotearoa/New Zealand. The principle instrument of this transfer was the Native Land Court through the native land legislation of the period. The function of this court was to convert Maori customary rights in their land to a title under European law, and to authorise direct dealing between Maori and private purchasers for their land.⁵⁴ The cultural significance of land to Maori alongside the impact of its loss emerged as a self-diagnosed cause of insanity for some of the Maori patients at the Auckland Asylum, spanning throughout the period, as the following example shows.

Suffering from melancholia, thirty-five year old Tamihau from the Waikato was admitted to the Auckland Asylum in 1869. Tamihau was recorded as speaking in 'bitter terms of the war, and the natives engaged therein'. He was further noted as saying that '[h]is motto was "Peace" and he took very much to heart that there should be any fighting'.⁵⁵ For Tamihau, his melancholic state was a result of social causes, rather than any psychiatric condition. Similarly, Pomari K.'s mania was linked to difficulties concerning land. Described as suffering from '[d]elusions of wealth' and that 'he intends to buy the land all round the Asylum and give it to the Salvation Army. ... [h]e was very much excited and troubled about a decision of the Native Land Court and has been strange in his behaviour for about a year brooding and

⁵³ The New Zealand Wars, as they are referred to by historians, were a series of conflicts waged throughout the North Island of New Zealand from the 1860s to 1880s. For the most recent account of this conflict refer to Belich, 'The New Zealand Wars'.

⁵⁴ Alan Ward, *Rangahaua Whanui National Overview, Volume One* (Wellington: Waitangi Tribunal, 1997), pp. 65-9.

⁵⁵ YCAA 1048/1, Casebook 1853-1871, folio 151.

melancholy'.⁵⁶ Likewise, comments made by Hirini T. with reference to land issues hint at a possible cause for his melancholia when he said that 'his people are worrying him by selling all his land for drink'.⁵⁷

The reality of land alienation and conflict over land for the few patients whose notes mention such detail show that their mental health was affected by external environmental and social causes, and not seemingly because of any physical illness. It is also remarkable that issues over land are mentioned almost exclusively as an explanation for mental illness in the cases of Maori patients, and not in the cases of non-Maori patients.⁵⁸

By analysing the experiences of Maori patients we not only gain a sense of asylum life for these patients, but also of the culture of those who composed the case notes.⁵⁹ However, the analysis of such documents can be problematic; while these records speak starkly to future researchers of the imposition of medical and asylum discourses and the wider cultural frameworks from which these were derived, the same cannot be supposed for the thoughts of the Maori patient. Nevertheless, glimpses of their perspective can be gained. By approaching these documents as evidence of the former and, as Mills reasons, in the knowledge that such documents are not a 'transparent representation of the subject in the text', the information these records construct can uncover aspects of the patient experience.⁶⁰ Where Maori clashed with authority, or were presumed Other to imposed norms, a close reading of such evidence uncovers the presence of Maori in otherwise European institutions. The following chapter probes the use of non-asylum sources to uncover non-institutional care of mentally ill Maori. It focuses specifically on traditional Maori modes of treatment for the insane, and why Maori were found in psychiatric institutional facilities at a time when acceptance and knowledge of Western methods of treatment for insanity was minimal.

⁵⁶ YCAA 1048/6, Case Continuation Book 1893-1896, folio 141.

⁵⁷ YCAA 1048/7, Case Continuation Book 1896-1898, folio 144.

⁵⁸ YCAA 1048/1-8, Casebooks 1853-1900.

⁵⁹ Mills, 'The Mad and the Past', p. 147.

⁶⁰ Mills, 'The Mad and the Past', p. 147.

4

‘Maoris say he is very mad’:**Uncovering Maori Modes of Treating the Insane**

Hemi H. a native belonging to the Ngapuhi tribe present attack said to be of two months duration. Certificates by Dr Purchas and Lewis state that he is full of delusions about men shooting his cattle and horses and of his being accused of stealing money from the BNZ [Bank of New Zealand]. Says he can perform miracles. He says he has been out of his mind but that he has been bewitched by certain Maoris. A short time ago some Maoris came and told the constable that he had gone mad, but that they would take care of him. Last week they returned and asked the constable to arrest him saying that if he did not take him away they would hang him as he was running about over the roofs of their houses frightening them in various ways.¹

The use of the asylum by Maori is significant because it happened relatively rarely. Hemi's case notes demonstrate that Maori whanau/families, communities, hapu and iwi were more likely to care for their disturbed family members using their own methods, and in isolation from European institutional care. This factor largely explains the tiny presence of Maori patients in the asylum during the nineteenth century. As the above excerpt shows, caring for mentally ill family members was testing, and the resort to police intervention and inevitably asylum care for Maori patients like Hemi, as with non-Maori patients, was a difficult decision for families and communities. This chapter aims to explore this non-institutional context, as a further way of uncovering new aspects of Maori history, in particular traditional methods for dealing with the insane. It then considers what institutional records can reveal of life for Maori patients, outside the asylum, and why they ended up confined within its walls.

¹ YCAA 1048/6, Case Continuation Book 1893-1896, folio 41.

‘Juxtaposing’ Histories

Encounters between Maori and the asylum altered the shape of beliefs that were part of Indigenous systems of medicine. Such beliefs were by no means static and continued to adapt and change throughout time even following the arrival of Europeans.² Yet, the process of looking beyond the institutional care of Maori to uncover traditional methods of treatment for the insane is a fraught enterprise due to the privileging of written sources in histories. My dilemma in attempting to consider how Maori families and communities themselves dealt with the insane is that by relying solely on written texts I am perpetuating colonialist attitudes and privileging such evidence. While European written histories have prevailed, Maori forms of recording history serve an important, and sometimes complementary, historical use. Pakeha histories exist largely as written accounts of various events, whereas Maori histories were, and still are, fundamentally oral histories. Due to the primacy of written texts over oral forms, Maori histories have been largely concealed, and marginalised.³

However, such histories can be unearthed. For example, evidence suggests that in a large number of cases where some form of chronic disease was present, either physical or mental, the patient was often taken away by the *tohunga* to another village or another isolated place, to get away from the influence of the place where they had fallen ill.⁴ The numbers of Maori in institutional care, as explained in previous chapters, also indicates that the use of the asylum was, perhaps, a last resort. This certainly merits a more detailed investigation, through an examination of how Maori dealt with their insane away from Pakeha contact.

It is not the intention of this chapter to provide a comprehensive analysis of Maori modes of treating the insane using Maori sources; rather, this chapter is structured in such a way as to provide future researchers with an approach by which they may uncover otherwise

² Kelm, ‘Colonizing Bodies’, p. 83.

³ Judith Binney, ‘Maori Oral Narratives, Pakeha Written Texts: Two Forms of Telling History’, in *The Shaping of History: Essays from the New Zealand Journal of History*, edited by Judith Binney (Wellington: Bridget Williams Books, 2001), p. 3.

⁴ Buck, ‘Medicine Amongst the Maoris’, p. 64.

suppressed histories. By uncovering such Maori histories we may be able to see both the past and present in new and even more wide-ranging perspectives. As Judith Binney so aptly puts it: 'we cannot translate other histories into our own. We can merely juxtapose them'.⁵ New Zealand scholars like Binney are part of a wider inquiry into the histories of Indigenous peoples. Australian scholars have also grappled with this problem in efforts to grasp at their own non-white histories. According to Barry Smith, '[t]he European occupation invalidated Aboriginal existence', and after over two hundred years of white settlement in Australia, Aboriginal histories are only beginning to emerge from beneath the written texts of European histories of Australia.⁶

Jacqueline Leckie has also addressed such issues in relation to her work on modernity and madness in colonial Fiji, asserting that her work does not speak for the Indigenous patients themselves, rather, she is conscious of the ways it draws on colonial records and frames local voices through Western eyes.⁷ Other colonial settings and postcolonial scholars have provided varying interpretations of this, acknowledging to differing degrees the significance of recognising medicine as an 'agent of empire'.⁸ Postcolonial perspectives have been utilised by scholars to interrogate the imperial and colonial conditions implicit in histories of psychiatry.⁹ Frantz Fanon was certain that colonial psychiatry in Africa constituted part of the system of colonial control, and Waltraud Ernst has asserted the need to recognise the 'native only' lunatic asylums in India as 'showpieces and justifications' of British colonialism.¹⁰ By telling the histories of both the coloniser and colonised, as Binney encourages, it ensures that no one group is marginalised in the shaping of this past.

⁵ Binney, 'Maori Oral Narratives, Pakeha Written Texts', p. 13.

⁶ Barry Smith, 'The "History Wars" and Aboriginal Health', in *Australian Book Review* (April, 2005), <<http://home.vicnet.net.au/~abr/April05/Smith.htm>>

⁷ Jacqueline Leckie, 'Modernity and the Management of Madness in Fiji', *Paideuma*, 50 (2004), p. 251-2.

⁸ Coleborne, 'Making "mad" populations', pp. 106-123.

⁹ Catharine Coleborne and Dolly MacKinnon, 'Psychiatry and its Institutions in Australia and New Zealand: An Overview', *International Review of Psychiatry*, being edited by Sanjeev Jain, forthcoming 2006.

¹⁰ Leckie, 'Modernity and the Management of Madness', p. 267.

Traditional Treatment of Maori

There is very little recorded of the incidence of mental illness among Maori, particularly in pre-European times. This is not to say that mental illness did not exist. Rather, this suggests differences with European conceptions of mental disease in the ways it originated and was played out. As Kelm argues for British Columbia,

[Indigenous] ideas about the body, disease and medicine were not just remnants of a pre-contact past, but were living ways of viewing the world, ways of viewing that contested the colonising discourses of Western medicine.¹¹

This also came to be articulated in colonial Aotearoa/New Zealand. Through their very presence, Maori patients disrupted the intended medical monologue of non-Indigenous asylum doctors. Their perceived difference, conceptions of the body, and social practices receive mention in the Auckland Asylum records for this very reason.

The apparent incompatibility of Indigenous understandings of the self with European notions of subjectivity highlights a further difference. Maori conceptions of the human and non-human realms were Other to European understandings. The human realm was the place of everyday practices in the world of humans, characterised by the more mundane aspects of village life. The non-human realm was the place beyond the village, or pa, both geographically and spiritually, and it was inhabited by ancestors and spirits associated with Maori geography and cosmology.¹² Very few accounts exist describing traditional Maori modes of dealing with madness. The evidence of early European observers have tended to link Maori understandings of mental illness with makutu, or the work of dark spirits and incantations, and those afflicted were often exiled.¹³

¹¹ Kelm, 'Colonizing Bodies', pp. 83-5.

¹² See Gluckman, 'Tangiwai'; Lange, 'May the People Live'; Ranginui Walker, *Ka Whawhai Tonu Matou / Struggle Without End*, revised edition (Auckland: Penguin Books, 2004). For a Canadian perspective, refer to Kelm, 'Colonizing Bodies', p. 83.

¹³ L. K. Gluckman, 'Makutu: A Study in the Ethnopsychiatry of the Maori, Past and Present' (MD thesis, University of Otago, 1962).

Insanity and the ailments associated with the disease were, as mentioned, connected with spiritualism, and, according to the early medical observer W.H. Goldie, disease was believed by Maori to have been caused by magic.¹⁴ While it is important to remember that many of Goldie's observations were imbued with his own European notions and curiosity at certain Maori customs and tikanga, these early observations do give some indication as to the prevalence and understandings of insanity among Maori. A number of Maori terms used to describe insanity and mental illness documented by Goldie in the late nineteenth century are still in use today. Such words include: porangitanga, porewarewa, porangi, wairangi, haurangi, potete, apa, awhireinga.¹⁵ While these words, roughly translated as 'insanity', or 'mental illness', have remained the same, it is difficult to speculate about whether Maori understandings of mental illness have also done so. Such concepts and beliefs associated with mental illness were by no means static, and continued to adapt and change throughout time even following the arrival of Europeans.¹⁶

Reliance on such European observations can be problematic. For Goldie and others like him, these were essentially remarks on aspects of Maori custom that interested them. Goldie's description and understanding of the diagnosis of 'melancholia', for example, based on his European training and background, may not necessarily have been what Maori considered as melancholia. While the symptoms may have seemed the same to Goldie, the origin and causes may have been viewed differently. Thus, what Goldie understood as melancholia may have been anything but for Maori. The power of such observations to define a culture is crucial here. The researcher cannot overlook the role of Western medical observers in the ideological subordination and cultural representation of Indigenous peoples.¹⁷

¹⁴ W.H. Goldie, *Maori Medical Lore: Notes on the causes of Disease and treatment of the sick among the Maori People of New Zealand*, reprinted from Transactions of the New Zealand Institute, 1904 (Nelson: Southern Reprints, 1998), p. 38.

¹⁵ Goldie, 'Maori Medical Lore', p. 38. See also H.M. Ngata, *English-Maori Dictionary* (Wellington: Learning Media Limited, 1996).

¹⁶ Kelm, 'Colonizing Bodies', p. 83.

¹⁷ Lorelle Burke, 'Military Medicine and Colonial Attitudes to Indigenous Medicine: The Provision of Medical Services during the New Zealand Wars', in *Body Language: Framing Subjects of Medical Knowledge, Health, History & Culture* Group (Hamilton: Department of History, University of Waikato, 2004), p. 129. See also Arnold, 'Medicine and Colonialism'; MacLeod and Lewis, 'Disease, Medicine and Empire', Introduction; Rose, 'Medicine, history and the present'.

A *tohunga*, or expert, usually carried out any treatment of the mad, or porangi. The *tohunga*'s specialist role was to heal and invoke the gods using their ancient powers and spiritual connection with both the divine and human world in Maori society.¹⁸ The *tohunga* was often the first person with whom consultation was made to deal with illness. Goldie provides an example of the customary rituals the *tohunga* engaged in when ridding the afflicted person of their mental illness in the following *karakia*:

He and the sick man then went to the sacred pool, and the medicine-man, stripping off his clothes, took in his hand an obsidian flint. First he cut off hair from the left side of the sick man's head, and then a lock from the top of the head. The flint was then placed on the ground, and upon it the lock of hair which had been cut from the top of the head, the other lock being held aloft in the left hand of the *tohunga*, while in his right hand he held a common stone, which was also raised aloft, while the following *karakia* was being repeated by him:-

Tu, divide; Tu, split;
This is the Waitapu flint,
Now about to cry aloud
To the moon of ill omen.

Then the priest breathed on the flint, and smashed it with the stone in his right hand. After this he selected a shoot of the *toetoe* plant, pulled it up, and to it fastened the two locks of hair. Then, diving into the water, he let go of the *toetoe* and locks of hair, and when they floated on the surface he commenced his great incantation, thus:-

This is the Tui of Tu-i-rawea,
This is the Tui of Uenuku.
Where lies your sin?
Was eating kutu [lice] your fault?
Was sitting on *tapu* ground your fault?
Explain the mystery,
Explain, divulge.
Take away the fault from the head
Of the *atua* [ancestral spirit] who afflicts this man.
Take away the disease,
And the power of the sorcerer.
Turn your supernatural power against your *tohunga*,
And your *whaiwhaia* [charm].
Give me the charm
To make as cooked food.
Your demon desecrated,
Your sacredness, your incantation,
Your sacred-place-dwelling *atua*,
Your house-dwelling *atua*,
Give me to cook for food.
Your sacredness is desecrated by me.
The rays of the sun,
The brave of the world,
The supernatural power, give me.
Let your *atua* and your *tapu*
Be food for me to eat.

¹⁸ Samuel Timoti Robinson, *Tohunga: The Revival, Ancient Knowledge for the Modern Era* (Auckland: Reed, 2005), pp. 10-11.

Let the head of the magician
 Be baked in the oven,
 Served up for food for me,
 Dead, and gone to Hades.¹⁹

The latter part of this karakia consists of a number of insults and curses that were directed towards an enemy. We learn here that insanity resulted from an alleged breach of tapu, or alternatively from the negative influences of an atua.²⁰ Above all, what Goldie shows is an understanding of insanity amongst Maori and a method of treatment for the illness. Inevitably, one is sceptical whether the same methods were employed throughout Aotearoa/New Zealand given the geographical and cultural diversity among certain tribes. Moreover, Goldie hints at other modes of treatment, particularly for persons who were not violent in their insanity. They were allowed to live in villages without confinement or restraint. If they did not show any violent, suicidal, or homicidal tendencies, these people were often regarded as having the revered power of communication with their ancestors and gods, and were treated with attention and respect.²¹ In other cases, the person was treated using the medicinal properties of the juice from the pith of the tutu tree.²²

The comments and remarks of other early observers of Maori paint a simple view of mental health during colonial and pre-colonial times, with most commenting that insanity and idiocy was rare.²³ Alongside Maori ethnographer Elsdon Best, some thought that mental depression in the form of melancholia was marked and often led to suicide.²⁴ Best attributed the characteristic of 'fatalism' to the Maori character, thus predisposing Maori to mental depression. Quoting Goldie, he reasoned that melancholia, nurtured by

¹⁹ Goldie, 'Maori Medical Lore', pp. 75-6.

²⁰ Goldie, 'Maori Medical Lore', p. 76-7.

²¹ Goldie, 'Maori Medical Lore', p. 75.

²² Goldie, 'Maori Medical Lore', p. 77.

²³ See A.S. Thomson, 'On the peculiarities in the figure, the disfigurations and the customs of the New Zealanders, with remarks on their diseases and on their modes of treatment', *Medical Chiropractic Review*, 13 (1854), pp. 489-502, cited in R.E. Wright-St Clair, 'Maori Health in the Mid-Nineteenth Century', *New Zealand Medical Journal*, Vol. 101, No. 838 (January 1988), pp. 14-5; J.B. Tuke, 'Medical Notes on New Zealand', *Edinburgh Medical Journal*, 9 (1863/4), pp. 220-9 & 721-8, cited in R.E. Wright-St Clair, pp. 14-5.

²⁴ Thomson, 'On the peculiarities', pp. 489-502.

superstition, was often fatal among Maori.²⁵ Other than mental depression, however, Best argued that '[n]o retarding conditions could efface the superior mentality of the [Maori] race'.²⁶ Similarly, cases of lunacy amongst Aboriginal Australians have surfaced in the observations of early European observers. In 1889, Dr Frederick Norton Manning, Inspector-General of the Insane in New South Wales, produced evidence of just 32 cases recording observations of Aborigines and insanity.²⁷ The Reverend George Taplin also observed the incidence of 'lunacy' among the Aborigines, remarking that such cases 'were treated kindly by their tribe'.²⁸ Like the Maori in Aotearoa/New Zealand, Western conceptions and Aboriginal notions of mental illness in Australia were most likely understood according to very different systems of knowledge, though, historical research in this area is still limited.

Maori understandings of treatment for the insane remain obscure. A source which has received little analysis but deserves more thorough attention in this respect, is Buck's 1910 MD thesis which examined medicine among Maori, in both ancient and modern times. Treating this source as an ethnography containing firsthand evidence of the latter, rather than as a secondary source, the information in Buck's thesis provides an important account of Indigenous modes of medicine from a Maori perspective.

Buck argued that traditionally, in pre-European times, Maori had little conception of mental illness. Rather, like the other observers mentioned above, he argued that Maori had little cause for insanity and the manifestation of what Europeans described as mental illness or insanity was instead a symptom of the non-physical, spiritual world. Concepts such as porangi were regarded as punishment for transgressing tapu, and as such, the gods inflicted disease for this reason.²⁹ Buck provides an account of a case in point:

²⁵ Elsdon Best, *The Maori: Customs Pertaining to Sickness, Death, Burial and Exhumation, Volume II* (Wellington: Harry H. Tombs, 1924), p. 30.

²⁶ Elsdon Best, *Spiritual and Mental Concepts of the Maori*, first published 1922 (Wellington: V.R. Ward, 1986), p. 56.

²⁷ Coleborne and MacKinnon, '“Madness” in Australia', p. 8.

²⁸ Smith, 'The “History Wars”', p. 4.

²⁹ Buck, 'Medicine Amongst the Maoris', p. 103.

I saw a case of hysteria where the woman foamed at the mouth and made violent muscular movements whenever I approached her. She called for her father. This was looked upon as a typical case of *mate Maori*. It was the demon in possession who caused the struggles when the doctor approached. The woman called upon her father as he could expel the tribal demon.³⁰

Buck explains that in cases defined as *mate Maori*, or diseases peculiar to Maori, recovery came from consulting a *tohunga*. Such diseases were thought to be peculiar to Maori particularly where European medicine had failed to remedy the illness. In these circumstances, Buck suggests that Maori thought it useless to consult a European doctor because only a *tohunga* could drive away the disease, which the gods had imposed to punish the transgressor of *tapu*. The *hara* or sin would be diagnosed by the *tohunga* and then exorcised so that the patient could recover.³¹ Although he attempted to promote European medicine among Maori, Buck knew that if the doctor's efforts failed, faith in their work was lost and a *tohunga* would be consulted.³² This aspect of Maori medical treatment is particularly significant because it suggests that in the very early colonial period, Maori used European medicine to complement their own, even if it was only to a limited extent.

However, as argued by Arnold, 'for many indigenes in the first generation or two of their encounter with colonialism, medicine was a potent source of rumour and distrust, evasion and, occasionally, resistance'. As Arnold goes on to explain 'the conflict between colonial medicine and indigenous societies was accentuated by the growing tendency for the state to take charge of many areas of social and cultural life that had formerly been part of local traditions of disease control and community medicine, but which had probably never been part of any ruler's responsibility'.³³ In this way, colonial Aotearoa/New Zealand characterised the *tohunga* as a primitive medicine man and made

³⁰ Buck, 'Medicine Amongst the Maoris', p. 104.

³¹ Buck, 'Medicine Amongst the Maoris', pp. 103-4.

³² Lange, 'May the People Live', p. 41.

³³ Arnold, 'Medicine and Colonialism', p. 1409.

efforts to suppress the practice of tohungatanga.³⁴ As Ranginui Walker describes, there was no place in government health schemes for the spiritual healing of tohunga, who were banned from practising in 1907 by the *Tohunga Suppression Act*. This statute remained in law for over fifty years before it was eventually repealed.³⁵

As well as European commentators and important medical figures such as Buck, other sources, such as moteatea, or songs and laments from different areas, can capture key aspects of the various Maori experiences of sickness and health. Some moteatea, although very few, make mention of illness, and reference to mental illness is even more uncommon. Because insanity was considered an illness in much the same way as a physical malady, these moteatea give an indication of the ways in which Maori dealt with illness and their understandings of disease more generally. In a Ngati Tuwharetoa moteatea composed for leprosy sufferer Te Rohu, daughter of Te Heuheu Tukino, by his senior wife, Nohopapa, we are given an account of leprosy from a Maori perspective.³⁶

A Song for a Leperous Malady

Tera te ata iti hohoro mai koia
Matutu noa ana ko au nei anake.
Kei te mura tonu o te pua re-wi e ka ana, e pa!
I heria mai tua, kia ongo au au

I te papa koura, hei taoro iho
Mo te kino I taku tinana, ka tucketia nei.

Ko tau repara pai hoki tenei e te tangata.
Ko te tika i te pono horahia mai ra
Kia ui atu au, ko wai to ingoa?
Ko Te Ana-i-Oremu. Ko tau rakau
Kei te mata ngira tonu te ngotonganga ki roto ra.
Aue! Te mamae!

Ka ura mai t era ka koho au he mahara.
E hoa ma, e, he aha tenei hanga?

Come, quickly, thou infant morn, hasten hither;
For 'tis a wakeful vigil I alone do keep.
The fever within, O sire, is like the flaming tussock!
Brought (was I) from o'er the range, so that I might
feel

The (healing) old plates unscale entirely
The unsightliness from my body, now covered with
sores.

See now what leprosy has done (to me), O people.
If true your claim, give me the proof now,
And I will ask, who is your name?
Methinks 'tis Te Ana-i-Oremu. Yours the weapon.
Sharp as needle point as it penetrates deeply within.
Ah me! The pain of it!

With the sun aglow I have my pensive moods.
O friends, what purpose is there (in living)?

³⁴ Robinson, 'Tohunga', p. 11. See *Statutes of New Zealand (Statutes)*, 1907, No. 13, Tohunga Suppression Act; Malcolm Joyce, 'Maori Healers in New Zealand: The Tohunga Suppression Act 1907', *Oceania*, No. Vol. 2, No. 60 (Dec 1989), p. 104; R.T. Lange, 'The Tohunga and the Government in the Twentieth Century', *University of Auckland Historical Society Annual* (1968), pp. 12-38, and by the same author, 'May the People Live'.

³⁵ Walker, 'Ka Whawhai Tonu Matou', pp. 180-1.

³⁶ A.T. Ngata, *Nga Moteatea: The Songs, Part One*, translated by Pei Te Hurunui Jones, revised edition (Auckland: Auckland University Press, 2004), 'A Song for a Leperous Malady', No. 43, p. 188.

E te rau, e pae, tirohia mai ra.
 Aku pewa i taurite tenei ka titoko,
 Kei te ngaru whakateo e tere i Taupo.
 Ko te rite i taku kiri ka uru mai te rangi.
 Ka riro aku taonga i a Te Hanamai,
 I tawhiti tutata no Ngati Whatua.

Whakarongo mai ra, koro I Tongariro,
 I Te Pukeronaki te uru kite whenua;
 I mahue matou te tira o te taniwha;

Mei huruhia iho, e au ana taku moe

Ki taku makau tupu, e.

O ye hundreds assembled, look here and observe
 My eyebrows once so neat are now upthrust,
 Like the crested waves that flow on Taupo.
 My skin is like the heavens aflame.
 My treasures have been taken by Te Hanamai,
 Tho' distant he, yet came close (he), of Ngati
 Whatua.

Listen to me, O sire, at Tongariro,
 At Te Pukeronaki is your head-rest on this earth;
 Hapless were we in missing the dragon's retinue of
 thee,

If I too had been o'erwhelmed, sound would be my
 sleep

In the exalted company of my sire.

It was thought that Te Rohu contracted the disease when Te Whetu, a man of Ngati Whatua, with the power to communicate leprosy, touched her. Te Whetu had wanted Te Rohu to be his wife, but was rejected by her.³⁷ This moteatea not only conveys the physical debility associated with leprosy, but the mental and emotional anguish and shame the disease caused. Other moteatea depict further suffering at the hands of disease. In a Ngati Porou moteatea, composed by Mikaera Pewhairangi, grandson of Harata Tangikuku, Mikaera compares the effects of his asthma and tuberculosis to '[r]eeling about as one demented, Or drunken with liquor'.³⁸ The moteatea's exact date is unknown. Sir Apirana Ngata pointed to its use between the middle of the nineteenth century and very beginning of the twentieth century, indicating that the lament was in circulation well before the illness of Eruera Kawhia, who died in 1899.³⁹ The comparison of the physical symptoms associated with tuberculosis and asthma, to the psychological conditions of dementia and alcohol, suggest very early understandings among Ngati Porou of mental illness.

Institutional Treatment of Maori

Although non-institutional sources are thin and fragmentary, we can gain a limited sense of family, whanau, community and tribe for Maori patients from asylum records. Maori

³⁷ Ngata, 'A Song for a Leperous Malady', No. 43, p. 188.

³⁸ Ngata, 'The Soliloquy of an Invalid', No. 20, p. 91.

³⁹ Ngata, 'The Soliloquy of an Invalid', No. 20, p. 89.

did not always use traditional modes of treatment for their insane. Rather, as my sample of 72 Maori patients indicates, they opted for Western institutional care.

Reasons for the resort to asylum care varied. The very first case notes to provide some sort of explanation concern a patient in 1866. Twenty-five year old Hemi Te R. from the Bay of Islands was committed to the asylum suffering from mania after allegedly thrusting a stick down the throat of a Maori child, injuring the child severely. We also learn from Hemi's records that his tribe treated him with cruelty because of his insanity.⁴⁰ In another case from that year, a tribe committed thirty-eight year old Maria R. from the Port of Waikato to the asylum following ill treatment. Suffering from mania, Maria's experience was much the same as Hemi's.⁴¹ For Piripi cruel treatment was also a feature of his committal to the asylum. According to Piripi's notes, he was brought to the asylum from Papakura by a police officer and suffering from mania, because of 'abuse of rum'.⁴² His notes also state that,

he has been badly treated by the natives having been tightly bound with cords which have left marks on his wrists. He seems to have been badly fed and though a strongly built man has ardently suffered from bad treatment.⁴³

We also learn from his records that two months later Piripi was discharged and arrangements were made for his 'safe delivery to his own tribe at Poverty Bay'.⁴⁴ This reversal of fortune suggests that the poor treatment he had suffered at the hands of the 'natives', was from those not related to him by tribal affiliation.

Other records provide glimpses of the way that tribes managed insanity. Committed in the middle of 1889, Tera H. was described as having been 'partially insane for years', and

⁴⁰ YCAA 1048/1, Casebook 1853-1871, folio 50.

⁴¹ YCAA 1048/1, Casebook 1853-1871, folio 61.

⁴² YCAA 1048/1, Casebook 1853-1871, folio 206.

⁴³ YCAA 1048/1, Casebook 1853-1871, folio 206.

⁴⁴ YCAA 1048/1, Casebook 1853-1871, folio 206.

as 'suicidal and dangerous to others'.⁴⁵ This comment suggests that Tera's tribe had been dealing with his mental illness for a number of years prior to his committal. His records also imply that following one particular incident, his tribe finally sought institutional care.

He says he is visited by spirits who compel him to do acts of violence against his will, that he knew he was doing wrong and tried hard to resist but could not do so. He set fire to the burial ground of the tribe in hopes of burning the spirits but in this he did not succeed, he has often contemplated suicide because he would rather go down where the spirits are of his own accord than be dragged down by them. He says the spirits shout in his ears and hit him on the head.⁴⁶

At the same time, while obviously experiencing various religious delusions, fifty-year old Tera was diagnosed as suffering from dementia.⁴⁷ The notes of Tamati T. also reflect the tribal management of the mentally ill, and more specifically, his fear of the 'native community'. Seventy-three year-old Tamati was diagnosed with insanity attributed to the death of his wife almost three years previously. According to his notes, he had recently been in constant fear that 'the natives are intending to shoot him'. Tamati seems to have been sent to the Auckland Asylum by his tribe following an incident where he 'attacked a Maori boy ... and would have killed him had other Maoris not intervened'.⁴⁸

Perhaps even more disturbing are the situations when no reason is given for the lack of tribal involvement. Iharaira W's circumstances reflect this. His notes provide that his tribal affiliation was Ngati Porou; however, his notes record Iharaira as emphatically declaring 'no tribe for me, no people'. This may explain why, upon admission, Iharaira's

⁴⁵ YCAA 1048/5, Case Continuation Book 1890-1892, folio 384.

⁴⁶ YCAA 1048/5, Case Continuation Book 1890-1892, folio 384.

⁴⁷ YCAA 1048/5, Case Continuation Book 1890-1892, folio 384.

⁴⁸ YCAA 1048/7, Case Continuation Book 1896-1898, folio 20.

notes make mention of the fact that he resided on the East Coast of the North Island of New Zealand, Ngati Porou territory, a very long time ago.⁴⁹

While cases like these go some way in helping to explain why these patients ended up in the asylum, they do not fully explain the circumstances, which led to, or forced, their respective tribes to enable such committal. One can only speculate that in such cases, committal was sought where these patients endangered other members of the tribe, or where all other traditional avenues had been exhausted, and the patient had become unmanageable. Furthermore, the fact cannot be ignored that in some cases patients were simply victims of neglect by their tribes. The examples from my sample suggest that, as with non-Maori patients, the resort to asylum care was a complex and sometimes protracted process.

Overall, the process of uncovering Maori modes of treatment for their insane is complex, as this short chapter has shown. The idea of contested histories and multiple discourses about the past, from different communities, creates a number of obstacles when determining how to write such histories and whose histories they actually are. As Linda Tuhiwai Smith argues, '[u]nder colonialism indigenous peoples have struggled against a Western view of history and have yet been complicit with that view'.⁵⁰ How we tell these histories is just as problematic as not telling them at all. Still, it is important that these histories are heard. For researchers using asylum records, an awareness of their construction, the medical discourses implicit in their making, and the ideologies in their composition, is the first step.

⁴⁹ YCAA 1048/7, Case Continuation Book 1896-1898, folio 75.

⁵⁰ Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples* (Dunedin: University of Otago Press, 1998), p. 33.

Conclusion

The lives of the Maori patients at the Auckland Lunatic Asylum were played out in the asylum archive. These case records, the files documenting their existence, monitored and constructed views of Otherness, and undoubtedly, colonial perceptions of 'race'. The extent to which these patients have been examined in histories of the asylum has been troubling especially for Maori who, just as Coleborne identified with Chinese patients in the Australian colonial context, 'thread their way through our colonial pasts'.¹

In the course of this thesis I have outlined how, for Maori patients, articulations of 'racial' difference, imperial medicine, and legal processes functioned to produce a 'racially' specific colonial asylum population. While this 'racially' specific population was examined at the Auckland Asylum, by no means was this population concentrated here. The same study could be devised for Aotearoa/New Zealand's six other colonial asylums, all of which, at some time or another, had Maori inmates.

This thesis has grappled with the importance of 'race' to historical analyses of the asylum in Aotearoa/New Zealand. By outlining some of the more prominent issues affecting the Maori patient population at the Auckland Asylum, discourses concerning the 'raced body' and 'cultural alienation' have been brought to the fore. The representation of 'race' has come to be considered as an inherent fixture of colonial histories and more intrinsically as a part of the wider power structures within which these histories were played out.² This thesis has grounded such ideas by presenting a comprehensive case study of Maori patients in the Auckland Asylum. Along the way, this thesis has argued that various historical actors, such as medical and legal professionals, shaped the asylum and its patients to fit nineteenth-century archetypes. This, of course, was not achieved by the professionals themselves, but through a collaboration of medical and legal administrative developments for the

¹ Coleborne, 'Making "mad" populations', p. 115.

² Ernst, 'Race, Science and Medicine', p. 1.

production of the asylum and its patients in colonial settler societies.³ It was therefore no surprise that, as Roy Porter argued, psychiatry became an ‘international enterprise’ in the nineteenth century.⁴

As Labrum discovered, the experience of institutional confinement for patients at the Auckland Asylum also provides an important benchmark for future studies. She presented a case study of the patient perspective through the lens of differences between the sexes.⁵ As this thesis has argued, based on Labrum’s suggestions, the same can also be applied to ‘racial’ difference. Like gender, ideas about ‘race’ entered the discourse of medicine, and psychiatric classification became as much a problem of bodily difference in the form of physical debility and deformity, as it was a psychological condition.⁶ Coleborne argued that for Chinese patients in Australia, information about a patient’s mental state was often negligible, and, at a time when definitions of mental illness were still very much unstable, was motivated by ‘expediency’ above insanity.⁷ This certainly draws parallels with the classification and management of Maori patients in Auckland.

The monitoring and construction of colonial views surrounding the ‘raced’ patient was based on attempts to manage and regulate mad populations. For Maori patients at the Auckland Asylum life was modeled on rigid conformity to colonial ideals of good citizenship, such as respectability, restraint, and compliance. For eleven-year old Emma Matilda O., with whose story I began, who was ‘not at all amenable to control’, and was in strict defiance to these expected norms. Emma’s resistance did not last for long. Where once she rushed about, screaming loudly and refusing to wear shoes, five years later she had become accustomed to asylum life. Emma was now taking her food well, wearing her boots, and most importantly of all ‘easily controlled’. Emma, who had been ‘epileptic and idiotic from birth’, and unable to

³ Coleborne, ‘Making “mad” populations’, p. 109.

⁴ Roy Porter, ‘History of Psychiatry in Britain’, *History of Psychiatry*, 2 (1991), p. 279, cited in Coleborne, ‘Making “mad” populations’, p. 107.

⁵ Labrum, ‘The Boundaries of Femininity’, p. 61.

⁶ Coleborne, ‘Making “mad” populations’, p. 109.

⁷ Coleborne, ‘Making “mad” populations’, p. 118.

speak, had gradually learnt that conforming was easier than resisting.⁸ Like so many other Indigenous patients, the sad story of Emma's life, dying in institutional care at the age of eighteen, highlights the fate of these patients many of whom died of disease and physical illness unrelated to their mental wellbeing.

As Menzies and Palys have discerned from the Canadian context, if the experiences of Indigenous patients in the asylum tell us anything they tell us about the way in which historical actors have the capacity to transcend death through their individual identities, their agency and through their memory.⁹ The human and institutional narratives which form the Auckland Asylum archive also give a voice to many of the forgotten Maori patients confined within its walls.

As I argued in Chapter One, which explored 'race', medicine and the law, the relationship between colonial rule and lunacy legislation was important. These collectively produced and maintained colonial order.¹⁰ Colonial rule was an extension of imperial rule, and was liberally enforced by medical and legal professionals. The actions and practices of these medical administrators, medical-men, and legal agents like the police, was a critical part of the way in which colonial psychiatry flourished in Aotearoa/New Zealand. As Arnold describes it, 'medicine has come to be identified as a colonizing force in its own right, a potent source of political authority and social control'.¹¹ The way in which medical professionals framed and constructed official medical publications and records became part of this 'potent' mix. The contribution of these professionals in defining the Maori asylum population at Auckland was a crucial factor in not only how the asylum population was constructed, but also how 'articulations of racial and sexual difference' were expressed by law and medicine in colonial settler societies.¹²

⁸ YCAA 1048/5, Case Continuation Book 1890-1892, folio 430.

⁹ Menzies and Palys, 'Turbulent Spirits', pp. 149-175.

¹⁰ Linda Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991), p. 3.

¹¹ Arnold, 'Medicine and Colonialism', p. 1393.

¹² Coleborne, 'Making "mad" populations', p. 119.

As Chapters Two and Three argued, close examination of the case files of these patients, made alongside an analysis of their context, within which the documents were produced, reveals the presence of 'racialised' ideas about madness. The private lives of the Maori population at the Auckland Asylum were thus negotiated at a broader more public level through a complex network of colonial officialdom. Illustrations of this in the case notes of these patients are frequent and only begin to expose the dynamics of 'race', culture, ethnicity, identity, and of course sanity in defining these patients. These examples also highlight the reality of cultural displacement for these patients who were often left in the asylum without any contact from their tribal and family groups. This highlights an overriding notion explored in Chapter Four of this thesis, that those Maori left in asylum care were largely alienated from their tribes. Contact with Western institutional facilities at this time was still a relatively new phenomenon for Maori, and their presence in the asylums is as important as non-Maori patients to explore.

As Fanon suggested, insights into colonial pasts and their inequalities is a comparative enterprise involving both the generalisation of colonial circumstances while also paying attention to the local setting. By employing 'race' as a central category of analysis, as this thesis has done, and investigating how the asylum processes in Aotearoa/New Zealand exemplified the question of 'race', we can come to understand much more about the reproduction of privilege and exploitation in different sites and times.¹³ In re-defining colonial histories of madness, I have made the experiences, attitudes and responses of Maori asylum patients in Aotearoa/New Zealand more visible.

¹³ Frantz Fanon, *The Wretched of the Earth* (New York: Grove Press, 1966), pp. 32-3, cited in Banivanua Marr and Evans, 'Writing Colonial Histories', p. 1.

Appendix

Selected Characteristics of Maori Patients in the Auckland Lunatic Asylum, 1860-1900

Occupation	No.	Tribe/Iwi	No.
Not Recorded	39	Not Recorded	70
Labourer	13	Ngati Porou	1
Wife of Native	1	Ngapuhi	1
Wife of Chief	1		
Native Chief	3		
Clergyman	1		
Housewife	3	Religion	No.
Gumdigger	4	Not Recorded	33
Fish-hawker	1	Roman Catholic	6
Settler	1	Church of England	29
Shepherd	1	Hauhau	2
Housekeeper	3	Wesleyan	1
Sailor	1	Anglican	1
Diagnosis	No.	Exciting Cause	No.
Not Recorded	3	Not Recorded	61
Epilepsy	2	Alcohol	4
Mania ¹	39	Business Worry	1
Delusional	3	Domestic Trouble	2
Melancholia	11	Grief	2
Hallucinations	1	Senile Decay	2
Delirium	1		
Depression	1		
Dementia	6		
Senile Dementia	5		

Source: YCAA Carrington Hospital (Auckland Lunatic Asylum) 1048/1-8, Casebooks 1853-1900.

¹ Including: chronic, acute, mania 'e' potu, and puerperal.

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