

The Models of Home?

INFLUENCES ON MEDICAL PRACTICE AT ASHBURN HALL, DUNEDIN, 1882–1910



NEW ZEALAND'S FIRST PUBLIC ASYLUMS were built in Auckland and Wellington in 1853 and 1854 respectively. The following decades saw public asylums built in the country's remaining key centres and, in 1882, private asylum Ashburn Hall in Dunedin began receiving patients. Historians largely agree that models of psychiatric treatment in nineteenth-century New Zealand were based on British precedents.¹ In recent years, however, there has been increasing recognition amongst historians of colonial psychiatry that the formation of psychiatric practices in colonial settings was more complex than a simple flow of knowledge from metropole to colony.² Catharine Coleborne's trans-colonial study of Australia and New Zealand, for instance, suggests that colonial asylums were based largely on an 'English imperial model', while Warwick Brunton notes that New Zealand's lunacy laws and the adoption of a public asylum system followed English precedent for institutional care, rather than the Scottish 'boarding' system.³ More recently, Brunton argued that Scottish practice was influential in the running of the first public asylum in Dunedin, while early lunacy policy in New Zealand was influenced by Scottish asylum superintendent and author W. Lauder Lindsay's visit in 1861.⁴ Non-British intellectual influences on New Zealand asylum medicine, including European and North American thought, are yet to be considered. Consideration also needs to be given to colonial developments and influences, particularly attempts to professionalise and specialise New Zealand psychiatry, and to cultural influences, such as the gendered and classed identities of asylum superintendents that also informed practice in colonial asylums.

This article revisits the idea of the adoption of British precedent in New Zealand asylums through an investigation of medical networks and medical biography, focusing on the superintendents of a private asylum. The men who ran Ashburn Hall from 1882 to 1910, like many doctors in British colonial settings, were British trained. Medical networks, however, operated across national and imperial boundaries.⁵ The range of influences at play in Ashburn Hall reveals that non-British scholarship also informed doctors' practices, although British precedent remained a significant reference point for New Zealand psychiatry.

Ashburn Hall, with a range of useful extant patient records, and four superintendents between 1882 and 1910, provides a good case study for examining influences on New Zealand psychiatry. The four superintendents were: James Hume, the asylum's co-founder and non-medical superintendent from 1882 until 1896; Edward William Alexander, Hume's partner and visiting medical officer, then resident medical superintendent at the asylum between

1882 and 1897; Frank Hay, resident medical superintendent from 1897 until 1904; and Edward Henry Alexander, son of Edward William Alexander, and medical superintendent from 1904 until 1911.⁶

Previous scholarly consideration of Ashburn Hall and other South Island institutions has tended to focus on aspects of the social history of insanity in New Zealand, or on offering an institutional history, without engaging with transnational webs of knowledge.⁷ This article begins by outlining some context for the study of Ashburn Hall and its relation to general features of treatment of the insane in nineteenth-century New Zealand, then moves on to address the individuals running the private asylum, the varied intellectual influences informing their medical practices, and their place in seeking to make psychiatry a medical specialism. Finally, the doctors' gendered judgements of their patients will be addressed to reveal how intellectual influences interacted with cultural factors to determine asylum practice. All four men were influenced in their practices by their social positions as part of the colonial, male, middle-class elite. In addressing these aspects, the article argues that studies of individual colonial asylums must be situated in their colonial and imperial contexts.

By the time Ashburn Hall opened, care for the insane in state-run lunatic asylums in New Zealand had been available for nearly three decades. Ashburn Hall's role in New Zealand, as envisaged by founders James Hume and Edward William Alexander, was to provide for a 'better class' of patient. Concerns with respectability and definitions of 'normal' and 'abnormal' behaviour characterise the history of asylums in general. In colonial situations, as Kirsten McKenzie has pointed out in her exploration of colonial scandal, respectability was constructed under the imagined gaze of Britain, with the colonial bourgeoisie seeking to prove themselves on an equal footing with British citizens at 'Home'.⁸ The foundation of the private asylum can be read in this context. As early as 1864, Edward William Alexander, in his role as part of a committee to investigate and report on the conditions of the Dunedin Hospital and Lunatic Asylum, saw the need for separate provision for those who could afford to pay, stating that, 'To mix indeterminately, men or women holding good positions, with the insane poor, would be revolting to the feelings of friends, and detrimental to the recovery of the former class'.⁹ Alexander and James Hume exploited associations of insanity with the lower classes and established the private asylum in October 1882. The patient base of Ashburn Hall was drawn largely from middle-class New Zealanders, and the superintendents were selective in picking their clientele. If patients were too difficult to deal with or their families were unable to pay for their maintenance, they were either refused admission or transferred to one of the public asylums.¹⁰

The existence of only one private institution in New Zealand at this time contrasts with the prevalence of private asylums in Britain.¹¹ Private asylum care carried potentially negative connotations of profit-making, abuse and wrongful confinement, which may have discouraged others from establishing private asylums in New Zealand. Indeed, the uneasy history of private asylum care in England led the New Zealand government to take charge of asylum care. Ashburn Hall was unusual as a private institution that gained praise from

government officials.¹² Existing studies of Ashburn Hall focus on providing an institutional history or on the social history of insanity.¹³ Alan Somerville briefly discusses the widespread British medical acceptance of a somatic basis for insanity and preoccupation with heredity. He does not offer any explanations for how these ideas were transplanted, merely stating that New Zealand 'shared these ideas'.¹⁴ There is an underlying assumption that the influence of British psychiatry was inevitable, with no exploration of developments in psychiatry outside Britain and how these may have influenced doctors' practices. How British, European or American medical thought actually reached New Zealand asylum practice is a significant research gap, on which a closer study of Ashburn Hall can shed some light.

The private asylum's history shares commonalities with that of public asylums. Its doctors, like most of the doctors running the public institutions, were British trained, and although they were not appointed by the Inspector-General, he did comment on their competence. As with public asylums, Ashburn Hall was governed by the Lunatics Act 1882, which set out the legal guidelines for committal, asylum governance and maintenance, and statistical and general reporting to government officials. The Inspector-General of Lunatic Asylums visited Ashburn, as he did the public asylums, and reported on the standard of treatment and any developments in the running of the asylum. Finally, the main method of treatment used at Ashburn, 'moral treatment', was common to New Zealand's public asylums.

'Moral treatment' as a distinct therapeutic regime is usually associated with the English York Retreat, opened in 1796 by William Tuke, or with Philippe Pinel, the physician superintendent at the Salpêtrière asylum in Paris in the 1790s.¹⁵ In New Zealand, Wendy Hunter Williams identifies a current of public opinion in the early 1850s that the insane should be 'treated properly, without mechanical restraint and with appropriate regimes'.¹⁶ By 1864 moral treatment was entrenched in New Zealand asylum practice. Edward William Alexander observed that, 'The method of treating the insane, by a combination of occupation and amusement is so generally adopted as not to need special reference'.¹⁷ Those who instituted moral treatment in New Zealand saw themselves as intellectually indebted to the figures of both Tuke and Pinel. Indeed, when Ashburn Hall opened in 1882, Hume and Alexander named the wing for female patients Pinel. The male ward was called Mitchell, most likely after the American neurologist Silas Weir Mitchell, who pioneered the famous 'rest cure' for nervous disease.¹⁸ The naming of the Ashburn Hall buildings after heroes of psychiatry and neurology can be situated in the context of the ongoing struggle for recognition of psychiatry as a medical specialism. Singling out 'great names' was one way in which the founders of Ashburn Hall attempted to establish their professional credentials. The second male ward, completed in 1896, was named Tuke, while an influential English asylum doctor, John Conolly, was the namesake for the second female wing completed in 1891.

Although moral treatment was not a uniquely English system, some English reforms in the practice of caring for the insane were adopted in New Zealand. John Conolly's non-restraint system, introduced at Hanwell Asylum in England

in the early 1840s, reached both Australia and New Zealand. In colonial Victoria, as Lee-Ann Monk has shown, reform was driven by official discourse rather than by an asylum superintendent.¹⁹ Non-restraint was by the 1850s ‘the “orthodox doctrine” in English asylums, even if not universally applied in practice, and “a litmus test of progress and modernity”’, leading Australian reformers to advocate its adoption.²⁰ Conolly’s writings also influenced New Zealand policy.²¹ By 1882, it was normal practice for patients who were violent to be secluded in their rooms rather than mechanically restrained. Official discourse on the treatment of the insane was influential in Ashburn Hall; the proprietors wished to maintain a reputation for being medically up-to-date. The asylum did not, however, receive government funding, and changes made at Ashburn Hall were driven by the asylum’s medical superintendents and proprietors.

The use of biographies to demonstrate developments in the history of psychiatry has been undertaken effectively by historians such as Andrew Scull, Charlotte MacKenzie and Nicholas Hervey in *Masters of Bedlam*. These studies often focus on ‘heroes’ of asylum medicine such as England’s John Conolly, or Scotland’s W.A.F. Browne.²² New Zealand’s Truby King, meanwhile, was instrumental in establishing the Plunket Society, and is the subject of several studies, revealing that his views on mothercraft stemmed from his career as an asylum superintendent and lecturer in mental diseases.²³ The Ashburn Hall superintendents did not hold lasting influence like King. With the exception of Frank Hay, who became the Inspector-General of Mental Hospitals for New Zealand, they were not vocal social critics. Their chief area of influence lay within the walls of the asylum, with some extension into professional circles through publishing and corresponding with other practitioners. Examination of their education, employment, medical networks and gendered identities can reveal some of the range of influences on psychiatry as practised at New Zealand’s private asylum.

The first four men in charge of Ashburn Hall were British educated, and most had been employed in British institutions before their employment in the private asylum. With the slight exception of Edward William Alexander, these men’s biographies suggest that the ‘British’ influence was nearly overwhelming at Ashburn Hall. James Hume was heavily influenced by Scottish methods of moral treatment. He was born in Scotland in 1823, and, from 1844 to 1852, was employed at the Gartnavel Royal Asylum in Glasgow, Scotland, as a messenger and later as a storekeeper.²⁴ He then worked at the Midland Counties Asylum in England until he emigrated to Dunedin in 1862.²⁵ Hume was the superintendent of the public Dunedin Lunatic Asylum from 1864 to 1882, when he was downgraded to house steward and left to establish Ashburn Hall in partnership with Alexander.

From 1882 to 1896, Hume was superintendent and Alexander acted as medical officer, visiting three times a week.²⁶ Hume’s time in charge of the public Dunedin Asylum set the tone for his superintendence of Ashburn Hall. There he avidly adopted the principles of moral management as well as pioneering an approach to care in which privileges patients received were based on the level of fees paid. While in the public system he had organised

the takeover of a former boarding house adjacent to the asylum, Park House, to provide superior accommodation for those patients whose families were prepared to pay extra fees. Hume's introduction of separate facilities shows his intellectual debt to the Scottish system of mixed care for private and pauper patients at Gartnavel.²⁷

At Ashburn Hall, Hume again put into practice the policy of better facilities for higher fees. Ashburn catered entirely for private patients, with fees ranging from £2.2s to £3.3s for 'special care'.²⁸ Non-medical control of Ashburn Hall followed the pattern of Scottish public subscription asylums, most of which were under lay control in their early years. Lorraine Walsh considers that the ideas and opinions of laymen were central to the pattern of asylum development in Scotland.²⁹ Hume, through his experience at Gartnavel, was used to non-medical control, and to a moral treatment regime, which he reproduced in his positions at Dunedin Lunatic Asylum and Ashburn Hall.³⁰ Hume was the dominant partner in the Ashburn Hall enterprise. It is no surprise then that Ashburn Hall retained a 'Scottish flavour' during Hume's life.³¹ The picture can, however, be slightly more nuanced through an examination of the intellectual influences on Hume's business partner, Dr Edward William Alexander.

Alexander was visiting medical officer at Ashburn Hall until Hume's death, then resident medical superintendent until March 1897. While Hume took charge of the day-to-day aspects of asylum routine and patient care, Alexander prescribed medical treatments for patients and recorded notes in the patient case files. He made the diagnoses and treatment decisions entered in the case record, informed by Hume's insights.

Alexander was born in 1828 in the British colony of St Helena. He trained principally at King's College Hospital in London, although he also trained in Paris, at the Hôpital-du-Midi, qualifying as a Member of the Royal College of Surgeons in England in 1853.³² Alexander's first appointment was as colonial surgeon to St Helena, where he remained until 1861, before returning to London and becoming a Licentiate of the Royal College of Physicians. He then travelled through Europe, visiting a number of French, Austrian, Swiss and Italian hospitals.³³ It is unclear exactly how much experience Alexander had in the treatment of the insane before his arrival in Dunedin in 1863. Formal instruction in this was not available when he studied, although he may have attended public lectures on the topic.³⁴ Part of Alexander's post-graduate study in the 1860s was undertaken at the Salpêtrière and Bicêtre asylums in Paris.³⁵ These two asylums remained significant research and teaching hospitals for the nineteenth-century French psychiatric profession. French medicine, in particular French psychiatry, therefore, played a role in forming Alexander's medical knowledge.

In the 1860s, French psychiatry and neurology became increasingly preoccupied with ideas of heredity.³⁶ The causes of insanity listed in the Ashburn Hall admissions register reveal the influence of hereditarian notions on Alexander's medical practice. Indeed, as diagnoses and supposed causes of insanity were assigned by Alexander in conjunction with the certifying doctors, the common presence of heredity as a cause of insanity reveals that

New Zealand doctors in general accepted hereditarian notions.³⁷

While it is difficult to trace definitively French or English influences on Alexander's practice, other than the naming of a building after Pinel, some degree of influence seems likely given his education in Paris. The educational influences of Alexander's successor, Frank Hay, are considerably easier to trace. Hay was born in Lucknow, India, in 1867. He undertook a medical degree at the University of Aberdeen, graduating Bachelor of Medicine Master of Surgery (MBCM) in 1890.³⁸ At Aberdeen, the physician of the Royal Aberdeen Asylum, William Reed, was an extra-academic lecturer in mental diseases, providing an optional course on the treatment of the insane.³⁹ Unlike Alexander, Hay sat a four-year university degree to obtain his qualification, a manifestation of the standardisation of entry to the medical profession following the Medical Act 1858.⁴⁰

Hay's education continued after his graduation. Psychiatric education in the late nineteenth century was largely a matter of on-site training, and Hay worked as assistant physician at the James Murray Royal Asylum in Perth, Scotland, from 1890 to 1896.⁴¹ The New Zealand Inspector-General, Duncan MacGregor, considered Hay's training under the superintendent of James Murray Asylum, Dr Alex Reid Urquhart, to be a considerable point in his favour.⁴² Urquhart was the author of the article about asylum construction in Daniel Hack Tuke's 1892 *Dictionary of Psychological Medicine*. Urquhart's influence can be seen in Hay's preoccupation with improving the asylum buildings and grounds at Ashburn.⁴³ In March 1899 MacGregor reported that: 'The old kitchen is being greatly improved, the billiard-room is ready for occupation, a very convenient fire-escape has been provided, and a new airing court is being provided on the female side. A new day-room has quite transformed the male side.'⁴⁴ Asylum architecture was an important aspect of moral treatment; security, ventilation, drainage, as well as 'efficient classification of the different grades of lunatics', were all part of the spatial considerations.⁴⁵ Urquhart imbued his trainee Hay with ideas on the importance of asylum layout.

The move from Alexander's superintendence to Hay's was marked by other changes as well. Under Hay's management, record-keeping became more precise and detailed. Notes on patients' physical condition under Alexander had been brief unless there was a specific illness to be recorded. The admission note for William M., the first patient admitted to Ashburn, for example, recorded that he was 'rather stout and in excellent health'.⁴⁶ The notes on the first patient admitted after Hay took up his position, Regina R., were considerably more detailed. Regina's admission note was divided into three sections: on her physical condition, the history of her mental condition, and her mental condition on admission. The notes on her physical condition in particular followed almost word for word the categories and format of the *pro forma* case book used at the James Murray Asylum in the 1890s, starting with a heading of 'general appearance', followed by headings about her circulatory, respiratory, digestive and nervous systems, and so on.⁴⁷ The rest of the admission note was also detailed, including notes about birthplace, religion and education, before moving on to describe Regina's present condition as 'extremely suicidal', and addressing her level of coherence, her memory and her reaction to being admitted.⁴⁸

In 1900, Hay introduced a *pro forma* case book at Ashburn with a large number of categories on all aspects of the patient's physical and mental condition, family and personal history to be filled out. This was similar to the *pro forma* at James Murray but was set out in a slightly different manner.⁴⁹ The detailed categories of *pro forma* case books reflect the increasing emphasis in the late nineteenth century on 'scientific' approaches to mental medicine, which saw important changes being recommended for asylum case notes in England and Scotland.⁵⁰

Hay's focus on physical detail was in keeping with the somatic orientation of late nineteenth-century psychiatry. The relationship between psychiatric and physical issues received a great deal of attention in Tuke's *Dictionary of Psychological Medicine*. According to W.F. Bynum this underscored 'the extent to which psychiatrists believed that the diagnostic and therapeutic methods of late nineteenth-century medicine and surgery provided the firmest scientific foundations for psychiatry'.⁵¹ The level of clinical detail in Hay's notes demonstrated an increasingly precise categorisation of cases and a faith in scientific observation, which were part of the professionalisation of psychiatry in the late nineteenth and early twentieth centuries.

Hay left Ashburn Hall in May 1904 to become Deputy Inspector-General for Asylums and later Inspector-General. His replacement was Edward Henry Alexander, Edward William Alexander's son. Edward Henry Alexander was the same age as Hay, born in Dunedin in 1867 and educated at Otago Boys' High School. He began his medical education at the new medical school at the University of Otago, and completed it at the University of Edinburgh, graduating MBCM in 1890. He served as an assistant in the Royal Edinburgh and Fife Asylums in Scotland before returning to New Zealand in mid-1892.⁵²

Alexander's choice of Edinburgh Medical School was due in part to the availability of the course on insanity.⁵³ From 1879 to 1910, Thomas Clouston, superintendent of the Edinburgh Royal Asylum at Morningside, held the post of lecturer in insanity at the University of Edinburgh. He taught a summer course that included clinical instruction in the Edinburgh Royal Asylum, and demonstrations on the pathology of insanity using specimens and diagrams.⁵⁴ Edward Henry's position as an assistant physician at Morningside was probably gained through taking this course. His position at Fife Asylum may also have been gained through Clouston's influence. In addition to the specialist training, an education in medicine from Edinburgh carried with it a high degree of prestige. A Scottish medical education was well respected, and students from all over the world, but especially from Britain and the empire, travelled to Scottish universities to study.⁵⁵

The influences of Edward Henry's education, like those of Hay and Hume, were Scottish, while Edward William Alexander received a combination of English and French training. The influence of Scottish medicine at Ashburn Hall was indeed pronounced, particularly as Hume was the dominant partner during most of Edward William's tenure as medical officer. Despite this reliance on Scottish asylum medicine, the superintendents' practices did not remain static after their arrival in Dunedin and at times showed the influence of non-British medicine as they sought to remain up-to-date with professional

developments through reading professional literature, corresponding with other practitioners, improving the asylum facilities, and publishing journal articles or official reports.

All four superintendents were concerned with presenting the private asylum as a specialist facility. Despite Hume's non-medical status, he and the elder Alexander hoped to keep up with developments overseas and provide superior accommodation and treatment.⁵⁶ The Inspector-Generals of Asylums during this period were not critical of the lack of a resident medical officer at Ashburn. In fact, Inspector-General George Grabham recommended in 1884 that Ashburn Hall be taken better advantage of, stating, 'There is no dearth in the colony of insane persons who would be benefitted by the advantages which this well-conducted establishment offers'.⁵⁷

The lack of a resident medical officer did not become an issue for Ashburn Hall until February 1896, when a patient committed suicide. An enquiry into the death concluded that complaints that there was insufficient medical supervision were groundless. Alexander and Hume, however, conscious of the need to maintain a high professional reputation, began enquiries for a resident medical superintendent to replace Hume on his retirement. Hume died in August 1896, before any appointment had been made.⁵⁸

During their joint tenure, Alexander and Hume sought to keep up-to-date with asylum medicine, and were in some respects ahead of New Zealand trends. One notable innovation introduced at Ashburn Hall from the time it opened was the admission of 'voluntary boarders'. These were people who came to Ashburn Hall for treatment but were not certified insane.⁵⁹ One aim of voluntary admission was to facilitate the early treatment of insanity. In the nineteenth and early twentieth centuries, doctors emphasised early admission and treatment as holding out the best hope for cure. It was not until 1911 that Ashburn Hall's practice of admitting 'voluntary boarders' became legal in New Zealand's public asylums.⁶⁰ The ability to bend the statutory requirements for admission was one advantage Ashburn Hall had over New Zealand's public asylums, allowing the superintendents greater potential for innovation in dealing with mental disorder.

Edward William Alexander also advocated further innovation in the treatment of insanity in New Zealand. An 1888 article published in the *New Zealand Medical Journal* reveals that he kept abreast of developments in his chosen field. Alexander argued that the Scottish practice of boarding-out harmless lunatics to private families should be given a trial in New Zealand.⁶¹ This represented a move away from the opinions expressed in his report to the Provincial Council in 1864. At that point, Alexander had implicitly supported the provision of institutional care for all the insane in New Zealand.⁶² His opinion had changed by 1888, and he pointed to the Scottish example of boarding out and to Gheel in Belgium, which followed a similar practice, recommending that New Zealand adopt such measures. He also discussed the small 'county asylums' of Wisconsin, arguing that these would be more suitable in New Zealand than the large asylums already established.⁶³ Alexander clearly kept abreast of international scholarship, most likely through reading professional journals such as the *British Journal of Mental Science*.⁶⁴ His advocacy for

implementing such ideas in New Zealand shows that he sought to establish New Zealand psychiatry as up-to-date and innovative on a global stage, rather than shackled to British precedent.

Even after the elder Alexander handed over the reins of medical superintendence in March 1897, he remained involved with keeping Ashburn Hall in step with international psychiatry. In February 1907, only three months before his death, he discussed with the Inspector-General the 'various projects he had for continuing to maintain [Ashburn Hall] in the van by anticipating up-to-date requirements'.⁶⁵ Alexander also showed a desire for psychiatric professionalisation and specialisation in choosing his replacement. He asked Thomas Clouston to recommend a suitable doctor for the position of superintendent.⁶⁶ Clouston was a leader in Scottish psychiatry in this period.

Frank Hay, like his predecessor, engaged with international medical scholarship throughout his career. He also attempted to expand his professional influence beyond institutional care and into society more generally. In late-nineteenth-century Britain, psychiatrists extended their influence beyond the asylum walls into areas of morality and social engineering with a view to the prevention of insanity.⁶⁷ Thomas Clouston, for example, emphasised the importance of 'mental hygiene' and education from the 1880s. Psychological medicine came to include giving advice on many aspects of 'normal' life.⁶⁸ This expansion arose from a therapeutic pessimism brought about by continual failure to effect reliable cure rates. Psychiatry, in order to distinguish itself as a medical specialism, had to be able to show results. Prevention of insanity and 'mental hygiene' became more important in defining the profession as cure seemed less achievable.

In New Zealand, Truby King, the superintendent of Seacliff Asylum, successfully expanded his influence beyond the asylum walls. His well-known views on the importance of infant nutrition and mothercraft grew from his ideas on the prevention of insanity.⁶⁹ Frank Hay, as Inspector-General of Mental Hospitals from 1907 to 1925, also became a vocal social critic, supporting Truby King's views and offering his own commentary on New Zealand society. He addressed matters as diverse as the importance of proper nourishment of the young, modern art and the dangers of the cinema with its glamorous depiction of vice.⁷⁰ Hay's position as Inspector-General gave him the opportunity to address his views on morality and mental hygiene directly to the government in his annual reports.

Hay's reports also reveal his encouragement of the professionalisation of New Zealand psychiatry and opportunities for New Zealand scholarship to contribute to the field. In 1909, he supported Edward Henry Alexander's initiative to establish a neuropathological laboratory at Ashburn Hall to perform research autopsies on mental patients. He also recommended the establishment of a Diploma in Psychological Medicine governed by the Medico-Psychological Association of Great Britain and Ireland's guidelines. Hay was a member of the association from 1890.⁷¹ Although Hay relied on British guidelines, he sought to make New Zealand psychiatry 'local' rather than merely 'colonial', in the sense that practitioners could be trained and undertake research in New Zealand and thus contribute to global medical knowledge networks.⁷²

Edward Henry Alexander also sought to professionalise New Zealand psychiatry, and engaged with global medical networks in doing so. The younger Alexander's engagement with international medicine can be seen through his use of new European, rather than traditional British, diagnoses. These included 'hebephrenia', '*dementia praecox*', 'paranoia' and 'maniacal-depression insanity'.⁷³ These diagnostic categories were popularised by German psychiatrist Emil Kraepelin in the mid-1890s. Alexander's use of these diagnostic categories would not have been due to the continuing influence of Clouston, who 'remained critical of the concept of *dementia praecox*' — a degenerative mental disorder beginning at a young age — believing the term 'dementia' to be misleading. As Bynum notes, 'delusional insanity' was favoured by British psychiatrists over the labels of 'hebephrenia' and '*dementia praecox*'.⁷⁴ Edward Henry Alexander's diagnoses at Ashburn were, therefore, informed by international scholarship.

Practices at Ashburn Hall continued to evolve under the younger Alexander's management, showing that he, like his predecessors, sought to maintain the reputation of Ashburn as a specialist facility. In mid-1905, he placed the male ward, Mitchell, under the charge of a female nurse. This led to improvement in patient behaviour. Electric light was also installed at Ashburn Hall by 1908, in keeping with the aim to improve the premises, and a new cottage was built for male patients.⁷⁵ As well as instituting these changes, Edward Henry Alexander sought to contribute to the field of psychiatric medicine. In 1907, he attempted to employ Bernard Sampson of the City of Birmingham Asylum to engage in scientific clinical research in psychiatry at Ashburn Hall; Sampson did not take up the appointment.⁷⁶ In 1909, Alexander planned to build a neuropathological laboratory at Ashburn to perform research autopsies.⁷⁷ This laboratory helped disseminate the latest medical theories and enabled New Zealand psychiatrists to contribute to research.⁷⁸ Alexander, who resigned as medical superintendent in 1911, was, like his predecessors at Ashburn Hall, influenced by and sought to contribute to an international network of psychiatric medicine.

As well as being preoccupied with psychiatric professionalisation and influenced by international medical scholarship, the superintendents of Ashburn Hall were influenced in their judgements about and treatment of patients by bourgeois culture and standards of respectability. Medicine was a common choice of career amongst the nineteenth-century middle class, particularly for those who lacked the social connections and capital needed to make their way in other socially acceptable professions like the military or the church.⁷⁹ The three Ashburn Hall doctors and James Hume, like other middle-class colonial inhabitants, felt the value attached to maintaining and enforcing a respectable standard of behaviour in New Zealand. As McKenzie observes, respectability in colonial settings was even more precarious and contested than in Britain.⁸⁰

The standards of respectability against which the Ashburn Hall doctors measured their patients are most obvious in the comments doctors made about female patient behaviour, although male patient behaviour was also scrutinised and measured against a combination of gender and class standards. As Coleborne states, 'It is in the observations of those who scrutinized patients in the asylum that glimpses of a range of social practices and attitudes towards

them may be discovered'.⁸¹ The doctors' own gendered identities informed their interpretations of their patients. The original classification of patients was based on gender rather than on type of mental illness. Men and women were separated in the space of the asylum and held to gendered standards of behaviour.

The division of labour offered as part of moral therapy was heavily gendered. Men were encouraged to work at gardening or farming, while women were limited to the more traditionally feminine tasks of sewing and knitting, or helping in the kitchen and laundry. Anne Digby draws a link between the work therapy offered as part of moral treatment and the idealised nineteenth-century work ethic.⁸² Discourse about male patients and work in Ashburn Hall, however, shows some variation of the standard of masculinity in relation to class. In general, the Ashburn doctors made very little reference to class. Most patients came from the colonial middle class, rendering class differences largely absent. In William L.'s case, however, a class element crept into Hume and Edward William Alexander's judgement. William, a barrister admitted after a suicide attempt, was described as 'pale and soft'. He had money trouble and claimed his suicide attempt was made to save his fiancée from the 'dishonour' of marrying a man who would drag her into misery.⁸³ The story told in William's admission note reveals a deep level of introspection, high notions of honour and an emotional delicacy reminiscent of a romantic hero.⁸⁴ These characteristics, and his profession as a barrister, separated William from other male patients. Most men were expected to work as part of their recovery, but an improvement was noted in William's case when he started '[coming] out into the ground constantly to watch work at some buildings'.⁸⁵ Perhaps there was something to the idea expressed by Herbert P. on his refusal to work in the garden that 'gentlemen do not work'.⁸⁶ Herbert P. was a farmer. His claim to be a 'gentleman' was dismissed.

In female patients, class elements did not appear in judgements about individuals. Rather, all women were expected to conform to the bourgeois feminine ideal of respectability. Departure from this received comment in the case notes. Medical practitioners, according to Ann Goldberg, were implicitly engaged in defining femininity and masculinity.⁸⁷ Medical 'normality' was informed by these gender norms. Josephine R.'s behaviour, for example, was constructed as symptomatic of her insanity. She was admitted in 1888 suffering from 'acute mania' caused by 'over-excitement'.⁸⁸ In her admission note, Edward William Alexander recorded that she was 'Fond of studying phrenology and read books on physiology & psychology which *she says* enlightened her'.⁸⁹ For Alexander, scientific enquiry and education were considered a male-only domain. Elaine Showalter, in her feminist history of madness in England, considered that doctors influenced by social Darwinism linked the increase in nervous disorder in the late nineteenth century to women's ambition.⁹⁰ Education in this instance was unhealthy and exciting, not an appropriate pursuit for a respectable woman.⁹¹

The doctors commented on unfeminine behaviour throughout the course of a patient's stay.⁹² Imperiousness and forwardness in women, especially when expressed towards the superintendent, received comment in several cases.⁹³ The

structure of authority in the asylum was similar to that within an ideal bourgeois family, with the superintendent as head of the household. This family-like structure of authority was common to all asylums but was even more explicit in private asylums, where the medical superintendent had a deeper knowledge of and greater interaction with all his patients.⁹⁴ Failure to display deference to the superintendent might be cast as symptomatic of insanity. Hay described Felicia G.'s 'self-assertive manner & a tendency to show a want of respect for others' as 'either morbid or the result of ill-breeding'.⁹⁵ The doctors at Ashburn Hall sought to instil in their female patients behaviour befitting daughters, wives and mothers of bourgeois households. Female patients ought to be quiet and well-behaved, working at feminine tasks such as sewing or knitting and giving the proper deference to the medical superintendent.

The superintendents' gendered judgements about patients were legitimated by the medical perception of the weakness of the female body.⁹⁶ The scientific 'discovery' of the biological opposition of male and female legitimated the gendered division of labour and authority within families in the nineteenth century.⁹⁷ The medical belief that a woman's madness could be linked to her biological cycle reinforced the perceived superiority of men by casting women as inherently unstable. Nine women admitted between 1882 and 1910, for example, had some form of puerperal insanity.⁹⁸ Hilary Marland attributes the rise of puerperal insanity in England to increasing medicalisation of childbirth. Medicalisation of one area, childbirth, contributed to medicalisation of another, insanity. Women's minds, like their bodies, were increasingly defined as at risk, and care for them became the province of medical men.⁹⁹ The male-dominated medical profession also believed that other stages of women's biological cycle caused or contributed to mental instability. Lactation and the climacteric (menopause) also appeared as causes of insanity.¹⁰⁰ As Bronwyn Labrum has pointed out, 'Doctors saw in menopause further signs of woman's subjection to her biology'.¹⁰¹ Women's menstruation was closely monitored and sometimes linked to the symptoms of insanity. In November 1886, for example, Edward William Alexander noted of Janet B. that her 'menstrual periods are always times of excitement'.¹⁰² This perception of women's biology as liable to cause mental instability lent support to patriarchal authority, both within the asylum and more widely in society. Theories of biological sexual difference gave scientific weight to narrow Victorian bourgeois ideals of femininity.¹⁰³ Gendered judgements about female patients were thereby explicitly linked to medical science, networks of knowledge and psychiatric professionalisation.

The four superintendents' reliance on British precedent in their practices at Ashburn Hall is evident and extensive. All four, like New Zealand's other asylum superintendents, were British trained. Their education and employment in England and Scotland formed the basis for much of their knowledge in the treatment of the insane, while reading of journals such as the *Journal of Mental Science*, or membership of the British Medico-Psychological Association meant that British medical thought continued to be influential.

The influence of British medicine, however, was not exclusive and should not be assumed. The superintendents' biographies reveal other influences. Edward William Alexander studied partly in French asylums, for example,

while Edward Henry Alexander used diagnoses popularised in Germany in a period before they had gained wide recognition in the Scottish asylums he had trained in. Medical networks and asylum medicine was 'global' in nature, and British psychiatry itself was not homogenous. Scottish asylum medicine was influential on the Ashburn Hall superintendents, particularly Hume, Hay and Edward Henry Alexander, who had all worked in Scottish asylums. And British medicine itself engaged with and was influenced by medicine in other countries. Reading British professional journals opened doctors up to international practice, such as the Gheel colony mentioned in Edward William Alexander's own scholarship.

As well as professional networks of medical knowledge influencing doctors' practices, the four superintendents were also subject to the cultural influences contingent on being part of the male, middle-class colonial elite. Concerns with respectability led them to judge normality and abnormality with reference to bourgeois norms, particularly when those judgements were about women. These judgements, especially ideas of women's biology as likely to cause mental instability, were in turn backed up by contemporary medical science and the increasing medicalisation and professionalisation of both reproduction and the treatment of insanity.

The nature of New Zealand psychiatry in this period was influenced by the struggle for psychiatric professionalisation. The naming of Ashburn's buildings after heroes in the treatment of mental disease, recommendations for changing New Zealand's system of caring for the insane, advocating for the teaching of psychological medicine, and attempts to establish research elements in the running of the private asylum were all ways in which the superintendents sought to professionalise New Zealand psychiatry and make it 'local' rather than just an offshoot of British medicine.

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NOTES

1 Catharine Coleborne and Dolly MacKinnon, 'Psychiatry and its Institutions in Australia and New Zealand: An Overview', *International Review of Psychiatry*, 18, 4 (2006), p.371. The authors cite Warwick Brunton, 'Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand', in Warren Brookbanks, ed., *Psychiatry and the Law: Clinical and Legal Issues*, Wellington, 1996, p.4.

2 See, for example, Richard C. Keller, 'Taking Science to the Colonies: Psychiatric Innovation in France and North Africa', in Sloan Mahone and Megan Vaughan, eds, *Psychiatry and Empire*, Houndmills, Basingstoke, Hampshire, 2007, pp.17–40; Waltraud Ernst, 'Practising "Colonial" or "Modern" Psychiatry in British India? Treatments at the Indian Mental Hospital at Ranchi, 1925–1940', in Waltraud Ernst and Thomas Mueller, eds, *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective c.1800–2000*, Newcastle UK, 2010, pp.80–115.

3 Catharine Coleborne, 'Making "Mad" Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum', in Diane Kirkby and Catharine Coleborne, eds, *Law, History, Colonialism: The Reach of Empire*, Manchester, 2001, pp.106, 109. In Scotland, harmless lunatics were boarded out with families. See Warwick Brunton, "'A Choice of Difficulties": National Mental Health Policy in New Zealand, 1840–1947', PhD thesis, University of Otago, 2001, particularly ch.3. See also Warwick Brunton, 'The Place of Public Inquiries in Shaping New Zealand's Mental Health Policy, 1858–1996', *Australia and New Zealand Health Policy*, 2, 1 (2005), p.24.

4 Warwick Brunton, 'The Scottish Influence on New Zealand Psychiatry before World War II', forthcoming.

5 M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution*, Cambridge, 2007, p.5.

6 I am indebted to the Ashburn Clinic for allowing me access to these records, which are stored at the Hocken Collections, University of Otago. Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, Hocken Collections, University of Otago (hereafter HC); Ashburn Hall, Report Book — Intermediate Case Book, Vol. 3, AG-447-6/05, HC; Ashburn Hall, Report Book — Intermediate Case Book, Vol. 4, AG-447-6/06, HC; Ashburn Hall, Case Book 1882–1907, AG-447-6/01, HC; Ashburn Hall, Case Book 1908–1927, AG-447-6/02, HC. The volume containing the case files for the period from mid-1890 until late 1895 is unfortunately missing from this archive. See also Ashburn Hall, Register of Admissions, 1882–1948, AG-447-5/01, HC.

7 A number of studies of Dunedin institutions by students at the University of Otago form the basis for an edited collection. See Barbara Brookes and Jane Thomson, eds, *Unfortunate Folk: Essays on Mental Health Treatment 1863–1992*, Dunedin, 2001.

8 Kirsten McKenzie, *Scandal in the Colonies: Sydney and Cape Town, 1820–1850*, Melbourne, 2004, pp.12–13.

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

10 The advertised fees of Ashburn Hall were £2.2s. per week for ordinary cases, or £3.3s. per week for cases requiring special care and for inebriates. Private sitting rooms and special attendants cost more again. See Alan Somerville, 'Ashburn Hall and its Place in Society, 1882–1904', MA thesis, University of Otago, 1996, pp.37–38.

11 In England, provision for the insane prior to the mid-nineteenth century was a mixed economy of charitable asylums and private institutions. The famous York Retreat was a combination of both types of administration, providing care at cheaper rates for Quaker patients as well as providing for wealthy private patients. See Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796–1914*, Cambridge, 1985. One of the most famous of England's private asylums, the Ticehurst Asylum, was the focus of Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792–1917*, London, 1992. In Scotland in the nineteenth century, public subscription asylums formed the basis of institutional care, although there were also profit-making establishments. These charitable institutions catered for both pauper and paying patients, although later in the century the asylums at Perth and Glasgow expelled their

pauper patients in favour of catering for private patients only. See Jonathan Andrews, 'Raising the Tone of Asylums: Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century', in Joseph Melling and Bill Forsythe, eds, *Insanity, Institutions and Society, 1800–1914*, London, 1999, pp.200–22.

12 The early Inspector-General's reports about Ashburn are overwhelmingly positive and recommend greater advantage being taken of the institution. See, for example, *Appendices to the Journal of the House of Representatives* (AJHR), 1884, H-7, p.15.

13 Cameron Duder, *The Ashburn Clinic: The Place and the People*, Dunedin, 2007; Judith Clare Medlicott, 'The History of Ashburn Hall, 1882–1947', MA thesis, University of Otago, Dunedin, 1972; Caroline Hubbard, 'Lunatic Asylums in Otago 1882–1911', BA(Hons) dissertation, University of Otago 1977; Somerville. All three theses have sections included as chapters in Brookes and Thomson.

14 Somerville, pp.160–64.

15 Nancy Tomes, for example, gives both William Tuke at the Retreat and Pinel in Paris status as the originators of the moral treatment that was practised in American asylums in the nineteenth century. See Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840–1883*, Cambridge, 1984, p.62.

16 Wendy Hunter Williams, *Out of Mind Out of Sight: The Story of Porirua Hospital*, Wellington, 1987, p.5.

17 Alexander, 'Observations', p.46.

18 Duder, pp.17–18.

19 Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum*, Amsterdam, 2008, p.86.

20 *ibid.*, p.84, quoting Akihito Suzuki, 'The Politics and Ideology of Non-restraint: The Case of the Hanwell Asylum', *Medical History*, 39 (1995), p.1. Monk also cites Nancy Tomes, 'The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century', in W.F. Bynum, Roy Porter and Michael Shepherd, eds, *The Anatomy of Madness: Essays in the History of Psychiatry, III The Asylum and its Psychiatry*, London, 1988, pp.190, 196–97, and Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade*, Princeton, NJ, 1996, pp.69, 152.

21 Brunton, 'A Choice of Difficulties', p.78. Conolly's publications were *The Construction and Government of Lunatic Asylums and Hospitals for the Insane, 1847* and *The Treatment of the Insane without Mechanical Restraints, 1856*.

22 Scull et al ch.3 focuses on Conolly while Browne is the subject of ch.4; see also, for example, Michael MacDonald, *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England*, Cambridge, 1981, ch.2 in particular which focuses on Richard Napier.

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

24 Brunton, 'The Scottish Influence', p.12.

25 Duder, p.15; 'The Late Mr James Hume', *Otago Daily Times*, 31 August 1896, p.3.

26 The Lunatics Act 1882 required licensed houses of the size of Ashburn Hall to have a medical officer visit this often.

27 Brunton, 'The Scottish Influence', pp.12–13. Brunton states that Hume's philosophy of care can be found succinctly outlined in Dunedin Asylum Keeper's Journal, 20 April 1864, Healthcare Otago Ltd Archives, Archives New Zealand, Dunedin, DAHI D264.

28 Brunton, 'The Scottish Influence', p.22. Private sitting rooms and special attendants were also available at extra cost.

29 Lorraine Walsh, "'The Property of the Whole Community": Charity and Insanity in Urban Scotland: The Dundee Royal Lunatic Asylum, 1805–1850', in Melling and Forsythe, p.184. Walsh highlights that, in its first 40 years of existence, most of the directors of the Dundee Royal Asylum were laymen, with only three medical men.

30 *ibid.*, pp.183–84. Scottish asylums adopted moral treatment from the mid-1830s on. W.A.F. Browne was the first to introduce it at the Montrose Royal Asylum, but other institutions were also quick to extol its virtues. Alexander MackIntosh, who was a medical officer at Dundee, and later at Glasgow Royal, favoured a regime of moral and intellectual treatment, and considered the value of medical treatment to be somewhat limited.

31 Brunton, 'The Scottish Influence', p.22.

32 R.E. Wright-St. Clair, *Medical Practitioners in New Zealand, 1840–1930*, Hamilton, 2003, p.33; *The Cyclopaedia of New Zealand: Volume 4, Otago and Southland*, Christchurch, 1905, p.245.

33 R.V. Fulton, *Medical Practice in Otago and Southland in the Early Days: A Description of the Manner of Life, Trials and Difficulties of Some of the Pioneer Doctors, of the Places in Which, and of the People among Whom, They Laboured*, Wellington, 1983, pp. 290–91.

34 Alexander Morison, for example, delivered such a lecture series in London in the 1840s. See Scull et al, pp.135–40. Alexander may have attended another, similar course of lectures, although I have been unable to find evidence of this.

35 Medicott, p.9.

36 Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the Fin de Siècle*, Oxford, 1989, p.64. One French doctor whose work shows the increase of hereditarian ideas is Moreau de Tours. His work on hysteria suggested that the baffling nature of this and other nervous diseases was due to their hereditary nature. See Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century*, Cambridge, 1987, p.328.

37 'Hereditry' was the most commonly listed cause of insanity, appearing in the entries for 45 patients. Ashburn Hall, Register of Admissions, 1882–1948, AG-447-5/01, HC.

38 'Obituary: Dr Frank Hay', *New Zealand Medical Journal* (NZMJ), 24, 123 (October 1925), pp.265–67.

39 Brunton, 'The Scottish Influence', p.19.

40 Carolyn Pennington, *The Modernisation of Medical Teaching at Aberdeen in the Nineteenth Century*, Aberdeen, 1994, p.16.

41 W.F. Bynum, 'Tuke's *Dictionary* and Psychiatry at the Turn of the Century', in German E. Berrios and Hugh Freeman, eds, *150 Years of British Psychiatry, 1841–1991*, London, 1991, pp.175–76. 'Obituary: Dr Frank Hay', p.267.

42 AJHR, 1904, H-7, p.12.

43 'Obituary: Alex Reid Urquhart', *British Medical Journal*, 2, 2955 (18 August 1917), p.237.

44 AJHR, 1899, H-7, p.12.

45 Roy Porter, 'Madness and its Institutions', in Andrew Wear, ed., *Medicine in Society: Historical Essays*, Cambridge, 1992, p.297.

46 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.2.

47 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 3, AG-447-6/05, HC, pp.110–11; Murray's Royal Asylum, Extract of patient case book, 1890, THB 29/8/6/7, Folio 90, University of Dundee Archive Services, Dundee, United Kingdom. I am indebted to Jennifer Johnstone of the University of Dundee Archive Services for this example of the Murray Royal *pro forma* case book.

48 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 3, AG-447-6/05, HC, p.111.

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

50 Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11, 2 (1998), p.260. Although changes towards more scientific record-keeping were 'recommended', they were not always adopted. Andrews states the James Murray asylum was one of those which adopted much more systematic records in response to these recommendations and the impact of the highly classificatory approach to mental disease taken by physicians David Skae and Thomas Clouston at the Edinburgh Royal Asylum,

51 Bynum, 'Tuke's *Dictionary*', p.167. Daniel Hack Tuke was one of British psychiatry's most prominent figures in the second half of the nineteenth century. He was the great-grandson of William Tuke, the founder of the York Retreat and the son of Samuel Tuke, whose *Description of the Retreat* (1813) had articulated the practice of 'moral treatment' and increased the profile of the Retreat.

- 52 AJHR, 1900, H-7, p.11; Wright-St Clair, p.33.
- 53 Somerville has found evidence to suggest Edward William Alexander wished his son to hold a permanent position in Ashburn Hall. E.W. Alexander probably encouraged his son to study at Edinburgh in the hope that Edward Henry would follow in his father's footsteps. See E.W. Alexander, Rotorua, to Hay, 20 July 1903, Inward Correspondence of Ashburn Hall, cit. Somerville pp.78–79. This correspondence seems to have been lost from the archive when the records were moved to the Hocken Collections.
- 54 Crowther and Dupree, p.213.
- 55 *ibid.*, pp.2, 22–26.
- 56 Medicott, pp.11–12.
- 57 AJHR, 1884, H-7, p.15.
- 58 Somerville, pp.35–36.
- 59 The word 'voluntary' is somewhat misleading. Many of the patients admitted to Ashburn Hall as 'voluntary boarders' did not seek treatment for themselves, but were admitted by family members. Those admitted either did not meet the statutory requirements for certification, or their families did not wish to have them certified.
- 60 The Mental Defectives Act 1911 made voluntary admission available to public asylums.
- 61 E.W. Alexander, 'Insanity in New Zealand, with Suggestions for the Disposal of the Chronic Insane', NZMJ, 1, 3 (March 1888), pp.162–64. The NZMJ was first published in 1887.
- 62 He had analysed how many insane were likely to be in Otago, to determine how many patients a new Dunedin asylum would need to provide for. Alexander, 'Observations', p.46.
- 63 Alexander, 'Insanity in New Zealand', pp.160–62.
- 64 Gheel was often discussed in the *Journal of Mental Science* in the late nineteenth century. See, for example, 'Dr Kitching on the Gheel Question', 13 (1867), pp.131–33; 'Gheel in the North', 14 (1868), pp.431–32, which explores how to apply the Gheel system in a Scottish context; W. Lauder Lindsay, 'The Family System as Applied to the Treatment of the Chronic Insane', 16 (1871), pp.497–527 also explores Gheel in relation to Scotland; D. Hack Tuke, 'On A Recent Visit to Gheel', 31 (1886), pp. 481–97.
- 65 AJHR, 1907, H-7, p.32.
- 66 Somerville, p.36.
- 67 See, for example, Michael Clark, "'Morbid Introspection", Unsoundness of Mind, and British Psychological Medicine. c.1830–c.1900', in W.F. Bynum, Roy Porter and Michael Shepherd, eds, *The Anatomy of Madness: Essays in the History of Psychiatry, III The Asylum and its Psychiatry*, London, 1988, p.72; W.F. Bynum, 'Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry', *British Journal of Addiction*, 79, 1 (1984), pp.61–62.
- 68 MacKenzie, pp.172–73. Clouston's main published works were *Female Education from a Medical Point of View*, London, 1882; *Clinical Lectures on Mental Diseases*, London, 1883; *The Neuroses of Development*, Edinburgh, 1891; *The Hygiene of Mind*, London, 1906; *Unsoundness of Mind*, London, 1911; and *Before I Wed*, London, 1913.
- 69 AJHR, 1897, H-7, p.6, quoted in Philp, p.198.
- 70 Philp, p.199.
- 71 The proposed laboratory and Hay's support for it were discussed in Hay's 1910 report. See AJHR, 1910, H-7, pp.5–6.
- 72 This characterisation of New Zealand psychiatry becoming 'local' rather than merely 'colonial' echoes Waltraud Ernst's observations about psychiatry in British India in the 1920s and 1930s. Ernst examines the practice of Major J.E. Dhunjibhoy to reveal that his practice owed as much to American and European medicine as to British, and to show how he sought to contribute to the field of psychiatry through experimentation and publishing his findings. See Ernst, 'Practising "Colonial" or "Modern" Psychiatry in British India', in particular pp.84–85.
- 73 Ashburn Hall, Register of Admissions, 1882–1948, AG-447-5/01, HC.
- 74 Allan Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry', in Berrios and Freeman, p.376; Bynum, 'Tuke's Dictionary', p.173.
- 75 Medicott, pp.40–41; AJHR, 1908, H-7, p.21.
- 76 AJHR, 1907, H-7, p.32; Medicott, p.42.
- 77 AJHR, 1910, H-7, p.5.
- 78 Frank Hay to the Hon. G. Fowlds, Minister of Mental Asylums, 27 June 1910, M.H. 1910/781, Archives New Zealand, Wellington, cit. Philp, p.196.
- 79 Scull et al, p.85.

- 80 McKenzie, p.12.
- 81 Catharine Coleborne, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848–1888*, Perth, 2007, p.63. Her reading of the archive as both reflecting and producing wider views of colonial madness and its administration draws on the scholarship of James Mills. See James H. Mills, *Madness, Cannabis and Colonialism: The Native-Only Lunatic Asylums of British India, 1857–1900*, London, 2000, pp.1–13.
- 82 Digby, p.48.
- 83 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.7.
- 84 The figure of the romantic hero and the use of this rhetoric are described by Ruth Harris in her exploration of male crimes of passion in late nineteenth-century France: Ruth Harris, p.304.
- 85 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.7.
- 86 Ashburn Hall, Case Book, 1882–1907, AG-447-6/01, HC, Folio 100.
- 87 Ann Goldberg, *Sex, Religion and the Making of Modern Madness: The Eberbach Asylum and German Society 1815–1849*, New York, 1999, p.95.
- 88 Ashburn Hall, Register of Admissions, 1882–1948, AG-447-5/01, HC.
- 89 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.155. Emphasis added.
- 90 Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980*, New York, 1985, pp.121–23.
- 91 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.155.
- 92 Coleborne, *Reading 'Madness'*, p.88.
- 93 See, for example, Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.155; Ashburn Hall, Report Book — Intermediate Case Book, Vol. 3, AG-447-6/05, HC, p.182; Ashburn Hall, Case Book, 1882–1907, AG-447-6/01, HC, Folio 93.
- 94 MacKenzie, pp.22–24.
- 95 Ashburn Hall, Case Book, 1882–1907, AG-447-6/01, HC, Folio 93.
- 96 Coleborne considers the perceived weakness of the female body to be one of two factors which were key in assessing women's experience of insanity in the nineteenth century. The other was the dangerousness of the woman outside the family or community. This was not such a factor in Ashburn Hall as it was in colonial public asylums, as most patients were admitted by their families. Coleborne, *Reading 'Madness'*, pp.58–62.
- 97 Barbara Brookes, Annabel Cooper and Robin Law, 'Situating Gender', in Barbara Brookes, Annabel Cooper and Robin Law, eds, *Sites of Gender: Women, Men & Modernity in Southern Dunedin, 1890–1939*, Auckland, 2003, p.4, citing Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge, Mass., 1990.
- 98 Ashburn Hall, Register of Admissions, 1882–1948.
- 99 Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*, Houndmills, Basingstoke, Hampshire, 2004, p.20.
- 100 See Ashburn Hall, Register of Admissions, 1882–1948, AG-447-5/01, HC.
- 101 Bronwyn Labrum, 'Gender and Lunacy: A Study of Women Patients at the Auckland Lunatic Asylum, 1870–1910', MA thesis, Massey University, Palmerston North, 1990, p.169.
- 102 Ashburn Hall, Report Book — Intermediate Case Book, Vol. 1, AG-447-6/04, HC, p.71.
- 103 Showalter, p.121.