

# The Embodiment of Gender and Madness in Colonial Fiji

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## *Abstract*

*This paper presents findings into the history and construction of madness in colonial Fiji, primarily through the lens of gender. It is based upon original research at St Giles, currently still a major psychiatric institution in the Pacific Islands that was founded as Fiji's Public Lunatic Asylum in 1884. The paper emphasises a gendered history of madness that was embodied. Moral insanity remained a dominant discourse but was reflected in the corporeal world, as the mad (gendered) body was the object that was worked on. This paper also explores this in Fiji concerning a specifically female form of insanity, considered inextricably linked with women's bodies: the once common diagnosis of puerperal insanity. The bulk of the paper concerns the gendering of madness discourse. I consider this through narratives of gender roles, constructs of madness, especially sex and ethnic stereotypes, in which work and sexuality were embodied.*

## **Introduction: Two women and the journey into Fiji's history of madness**

We open this exploration of gender and madness in colonial Fiji with Mrs J and end with Mrs DV.<sup>1</sup> Of different ethnicities, the former European and the latter Indo-Fijian, both were confined as insane subjects in Suva's Public Lunatic Asylum during separate periods. Mrs J was sub-

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<sup>1</sup> Pseudonyms are used except when a subject is in the public record. Unless referenced, primary citations in this paper are from doctors' and patients' records located at St Giles Hospital, Suva. To protect patient confidentiality, specific references are not given. Publically accessible archival references (Fiji National Archives, Suva) are cited in footnotes but not in the final bibliography.

jected to the old technologies of discipline and treatment from 1896 until her death in 1909 while half a century later Mrs DV was experimented upon with the new psychiatric technologies (Leckie, 2005). Both women were middle class 'housewives', initially suffering from post-partum psychosis. Among documentation of their lives at the asylum are those of hundreds of other mental patients; sequestered lives recorded through archival and medical discourse. Such texts offer snippets of both 'concrete and sensory memories' (Stoler and Strassler, 2000: 5). The asylum was a microcosm of Fiji's wider society, embracing different ethnic groups, destitutes, those of high economic or customary status, the colonial and the indigenous. Common to all was certification as insane and a madness that was strongly gendered and embodied.<sup>2</sup> Although this is the lens through which paper unfolds, I stress that gendered subjects were always constituted within the multiple subject locations of the historical and spatial context of colonial Fiji.

Mrs J's journey through madness, constructed through the medical gaze was regarded as an interesting 'case'. This was possibly because she was a European woman or because she exhibited unusual physical and 'delusional violence for a woman. Admission observations included:

...wild, neglected and frightened appearance; talks incoherently of persons and things; says [Doctor] is Jack the Ripper... hallucinations of sight and hearing, hears voices and sees butterflies flying around her; illusions of sight and hearing; calls people she knows by other names (not incoherently); in mid conversation jumped up, is continually moving foolishly, no reasonable purpose (Doctor's Notes, 1896).

...has long been melancholic and apathetic but during last few days has changed to restless state and in last 24 hours threatened to cut off hands of one of her children, got large knife and threatened child, recovered from her with difficulty; got out of bed and escaped from the house in the night screaming (Husband's Testimony, 1896).

During this period, the medical superintendent made twice weekly visits to the asylum, and while entries in the asylum's case book were cursory, for example, 'Natives as usual' or 'women rather excited', (Public Lunatic Asylum, casebook [cb], 23 Dec 1904; 5 Jan 1914) greater detail was recorded concerning Mrs J when her condition deteriorated after a second admission in 1905. We will never know why her body became the object of different interventions; from drugs (a soporific mixture, the salts, a

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<sup>2</sup> See eg Grosz (1994), Price and Shildrick (1999). Ahmed (1998: 46) points out that Grosz says very little about the racialized nature of multiple and differentiated bodies.

bowel tonic) to mufflers, knee and ankle straps, a straight jacket, solitary confinement, constant watching, to a gynaecological operation. This is indicative of how madness was gendered and embodied in Fiji.

Uncovering and writing gendered histories of Pacific pasts is segmented and as Jeanette Mageo (2001), Ann Laura Stoler and Karen Strassler (2000) remind us, is gleaned and becomes for the historian, 'memory work' from scattered documentary collections, offering fragments of conversations, silences or indications of the nuances of comportment and affect, reflected through the prisms of colonial discourse, time, space and culture. The dilemmas faced in relying on colonial memories are suggestive of a hidden history; methodically more so with madness, which as Michel Foucault (1967) emphasised in *Madness and Civilization* became hidden and silenced with modernity. Reading the quiescent voices of madness through the multiple subject locations of time, space, gender, class, ethnicity and sexuality in colonial Fiji is especially problematic. Just as colonial studies now recognises colonialisms' many cultures (Thomas, 1994), so too these archives comprise diverse discourses and '...are themselves cultural artifacts, built in institutional structures that erased certain kinds of knowledge, secreted some and valorized others' (Cooper and Stoler, 1997: 17). The data for my project ranges from the 'exactitude' of published quantitative data to scrawled medical notations. Lunacy records pose specific problems in writing this colonial history. First, surviving 'madness' texts are highly fragmentary. Secondly, these records were discursive accounts that reflected and produced mad subjects; equally they contain multiple colonial discourses of gender, race and class. Thirdly, the reliability of apparent objective medico-scientific data is questionable (see Mills, 2000: 42). Institutional records also represent only a tiny percentage of those considered severely mentally ill in Fiji's past. My project is constrained by available sources. This focuses on Fiji's former mental asylum, which although renamed St Giles hospital in 1960 still evokes a specific physical and discursive presence in contemporary Fiji. Occupying a prominent site, the hospital commands a breathtaking view of Suva harbour. St Giles' architecture of imposing white walls, wooden and concrete buildings are adjacent to other spaces of confinement: the prison and cemetery. The discursive association with St Giles evokes ambivalent reactions in the popular imagination. This is a site of confinement and treatment, where the 'sick mad' are 'sent' regardless of gender, ethnicity or class. The insane in Fiji's past and present are linked with this institution.

Fiji has long been a society with ethnic complexity but this paper emphasises a gendered and embodied history of madness. Madness ap-

pears to be about the state of the mind: firmly in psychological territory. Yet contemporaries did not neatly separate the mind from the body and regarded madness, especially women's madness, as embodied. Moral insanity remained a dominant discourse but was reflected in the corporeal world. Indeed, from commitment through diagnosis to treatment, the mad (gendered) body was the object that was worked on. A later section of this paper explores this in Fiji concerning a specifically female form of insanity, considered inextricably linked with women's bodies: the once common diagnosis of puerperal insanity.

I begin by tracing how gender and madness has been framed by feminist debates and then briefly set the historical context in Fiji. I then comment on how Fiji's lunatic asylum was spatially and structurally gendered. Admission and outcome patterns to the asylum were gendered but equally striking were ethnic patterns. The bulk of the paper concerns the gendering of madness discourse, which is considered through narratives of gender roles, constructs of madness, especially sex and ethnic stereotypes, in which work and sexuality were embodied. The final section examines how treatment of the mind (whether control, care or cure) was primarily embodied in Fiji. While Foucauldian theory and reworkings of this in the colonial context (for example, Stoler, 1995) inform this paper, constructions about madness and its containment are also derived from localized discourse and available options of care and control.

### **Feminist Discourse and Gendering Madness**

Interest in the relationship between gender and madness, specifically women's multiple subject locations as subordinate in society and categorization and treatment as mentally ill, emerged from 'second-wave' feminism and the 'anti-psychiatry movement' (Goffman, 1961; Laing, 1960; Szasz, 1961). This emphasized the social construction of madness and the repressive role of psychiatry and asylums. Foucault's *Madness and Civilization* was seminal in exploring links between modernity and the discursive construction of madness and incarceration of the insane but possibly his other works, *Discipline and Punish* and *The History of Sexuality* have more applicability to the colonial context. In 1972, Phyllis Chesler analyzed the embodiment of gender in constructs of mental disorder: 'the 'norm violations' in madness-cum-deviance involved a transgression of the core male/female identity' (Tomes, 1994: 354). Chesler (1972) also identified agency in women's attempts to escape confining subject locations; that is, when such transgressions were perceived as madness. A decade later Showalter (1985) developed these links between madness

and gender through cultural history and literary criticism. The representation of madness as a female malady was linked with women's repression, to operate as 'ways of controlling and mastering feminine difference itself' (Showalter, 1985: 17). Although Chesler and Showalter were heavily critiqued, (for example, Busfield, 1996; Ernst, 1996; Tomes, 1990, 1994) they were pivotal in addressing history, madness and gender roles, as well as opening up debates about women, madness and social control and the treatment of women in asylums (see Ripa, 1990; Russell, 1995).

The 'women and madness' literature has not been able to avoid the centrality of the body. Alison Bashford (1998) has documented how gendered morality became embodied as physical disease in Victorian medical practice. This is pertinent to many nineteenth century madness texts (including those from Fiji) in which morality and the somatic were entwined in the certification, aetiology and treatment of mad people. Foucault was foundational in theorising control, power, the body and sexuality but feminists applied this to gender and madness.

What in the past has been wrong came to be seen as diseased or unhealthy. In particular, medicine appropriated the social right to pass judgement about sexuality. It was women more than men who were associated with sexuality, embodying it, having too much of it..., rebelling against it, or disturbing men with it (Russell, 1995: 12).

### **Colonialisms' Multiple Subject Locations**

Foucault's theorisation of medicalization, the body and sexuality did not explicitly address colonialisms. However Stoler, among others, identified sexual control as central to categorising colonizer and colonized (1991: 52, 1995). Similarly, I trace the embodied links between gender and madness in Fiji but this was not isolated from other subject locations, colonial hierarchies and ethnic boundaries in colonial Fiji. A sketch of the political economy seems pertinent. After Fiji became a British colony in 1874, the state instigated land, labour, economic and administrative policies that would shape the ethnic map. Policies attempted to restrict indigenous Fijians to the subsistence sector by bolstering chiefly hierarchies through indirect rule. Although indigenous Fijians were ostensibly protected under this civilizing mission they still suffered social and mental distress. Meanwhile economic development proceeded with sugar production dependent upon the labour of c 60,000 indentured Indian immigrant labourers (*Girmityas*) (Lal, 1998). This displacement induced severe mental and physical trauma, requiring control and care. Harsh working compounded the upheaval and living conditions on Fiji's plantations

until new pressures emerged with the shift to small family farms from the 1920s. During these transitions women were essential in providing plantation, farm, domestic and reproductive labour. Europeans comprised a small but powerful group,<sup>3</sup> while other ethnicities that settled in Fiji included Chinese and other Pacific Islanders.

The state and other agents attempted to survey and moderate intimate aspects of subjects' lives and bodies (Jolly, 1998; McClintock, 1995: 48; Thomas, 1990). Interventions in health, illness and madness, (akin to Foucault's biopower and medical technologies) were part of colonialisms' modernities. The state instituted legislative structures to frame colonial minds, which were also subjectively constituted through medical and Christian discourse. How did this articulate with local and migrant cultures in Fiji? If, as Foucault insisted, the micro-site of power resides in the family, how did Fiji's cultures reproduce the framing of normal minds? The majority of ethnic Fijians admitted to St Giles were from villages. Why did families decide to commit mad kin when they had long cared for and controlled them? Under colonialism there was a shifting ambivalence towards western medicine. Hospitals were known as places of death (*vale ni mate*), but Fijians also embraced western biomedicine. Pivotal to this were the co-option of Fijians as doctors and nurses (Leckie, forthcoming) and the extension of western health care into rural areas. The state also bolstered the authority of Fijian officials, who frequently had a key role in providing testimony concerning a villager's insanity. Boundaries of acceptable behaviour shifted, as modern concepts of mental abnormality became entwined in local constructions. British notions of orderly society became articulated with indigenous worlds (Kaplan, 1995: 360). However, a greater proportion of Indo-Fijians was certified insane. Reasons for this require more research but I suggest the ethnic discrepancy was initially due to the profound social and economic dislocation brought by indenture and the subsequent impoverishment of many Indo-Fijians who lacked communal and kin networks. Many Indo-Fijians certified as insane before World War II were destitute. But even then, and increasingly in later years, Indo-Fijians of *all* classes had family members committed to the asylum.

Colonial policies drew structural and discursive boundaries between indigenous Fijians, Europeans, Indians and other ethnicities, but there were several informal and institutional sites where these lines were blurred. The lunatic asylum, established in 1884, early in the history of Pacific colonialisms, was one institution where madness disentangled any

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<sup>3</sup> Knapman (1986) documents European women, colonialism & sexuality in Fiji.

ethnic divide. The demand for an asylum derived from colonial 'civilizing' agendas concerned with social control and medical care and were embedded in the development of policing, prisons and public health (Leckie, 2004). Legal and social control became linked to the management of the insane. Fiji's lunacy legislation and the establishment of a lunatic asylum followed similar developments in the metropole (Busfield, 1986) and nearby settler colonies (Brunton, 2001; Lewis, 1988) and other British colonies, especially pertaining to gender. Unlike several other colonies (for example, Ernst, 1999: 82-7) in Fiji, separate asylums were not erected for Europeans and Natives. This was despite racial segregation within other institutions in Fiji, such as schools, residence and social clubs. As we now consider, racial, gender and class boundaries were reproduced within the asylum.

### **Gendered Space and Infrastructure**

Diana Gittins' spatial history of Severalls Hospital in Britain demonstrated the multiplicity of subject locations: 'Class, gender and categorising of illness were literally built into the hospital infrastructure and thus operated as primary determinants of power relations and a way of life' (Gittins, 1998: 5). Similarly the history of St Giles reveals how infrastructure reflected and framed multiple and hierarchical locations of gender, ethnicity and class. But gender was and remains the principal spatial divide for patients at St Giles. This has almost always superseded the severity and categorization of mental conditions, and in the past even racial locations. Initially however, the need for gendered spaces threatened colonial racial hierarchies.<sup>4</sup> In 1892, a Fijian woman had to be confined to the European women's building 'to save her from annoyance and physical danger caused by the male Indians and Fijians. This can only be done at the risk of the Europeans'.<sup>5</sup> By 1910, Fiji followed metropolitan and colonial practices of establishing separate accommodation in the asylum for men and women. In 1914, the asylum's Board of Visitors (BOV) complained that the maintenance of racial boundaries was threatened by inadequate gendered accommodation; '... the expediency resorted to of confining, during the night, Native female patients in the female European Ward owing to insufficient accommodation could not under any cir-

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<sup>4</sup> CSO 2961/1892, Meeting, Board of Visitors (BOV), 27 Sept 1892.

<sup>5</sup> CSO 2961/1892, Chief Medical Officer (CMO) to Colonial Secretary (CS), 6 Sept 1892.

cumstances be justified'.<sup>6</sup>

Throughout most of St Giles' colonial history racial locations were maintained with separate wards for European men, European women, Native men and Native women. Natives included *all* non-Europeans, although 'part-Europeans' were sometimes accommodated with Europeans, family connections and/or class may have been decisive in allocating beds. Not only were wards demarcated according to gender and race, but also the quality of accommodation was different. The European wards operated like homely cottages with better quality beds, soft furnishing and recreational amenities such as books and games. Racial distinctions were also reproduced through different food rations and clothing. These regulations were formalised in 1914<sup>7</sup> although it is not clear whether this had previously corresponded to racial or class divisions.<sup>8</sup> Not only did the asylum's infrastructure define gender, race and class locations for patients, but also for staff with different accommodation, diet, clothing, pay scales, responsibilities and spaces for male and female doctors, male and female European and Native attendants, and male and female servants.

### **Admission and Outcome Patterns: Gender, Ethnicity and Poverty**

As noted, available quantitative data relating to insanity in Fiji is incomplete, hardly objective and requires cautious interpretation. It provides some context against which to trace gender and ethnic patterns and locate the quiescent histories derived from other testimonies. The richest source is a database we have constructed from admission papers covering 3129 admissions between 1884-1964. The official sanitized, summarized and public picture was recorded in annual reports of the asylum, and the 'Blue Books', reporting mostly through statistics, on the annual state of the colony. Precise details on the asylum included the cubic space/window space per patient, type and duration of restraints, diet, and nature and therapy of mental disorders. Such data was further located according to gender and ethnicity, all contributing to colonial knowledge and rule in Fiji.<sup>9</sup>

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<sup>6</sup> CSO 8621/1914.

<sup>7</sup> CSO 8621/1914, Meeting of BOV, 28 Sept 1914.

<sup>8</sup> Paper of the Fiji Legislative Council, (CP), CP 4/1887. Daily rates for first class patients were 10/- for the first three months, then 6/- 8d, and for second class patients, 2/- for first three months then 1/- 6d.

<sup>9</sup> Foucault identifies the accumulation of knowledge (especially about bodies) and the formation of subjectivity in the concept of power-knowledge. Cohn (1987:

Feminist literature highlighted the links between women and mental illness (Busfield, 1996; Chester, 1972; Showalter, 1985), but committal rates to asylums were not always as high as men's (Brookes, 1998; Swartz, 1999; Tomes, 1990: 145). At St Giles women comprised between 20 and 50 per cent of admissions up to about 1930 but thereafter this gap gradually closed. Ethnic differences are more striking. After 1900 Indo-Fijians comprised the majority of female and male admissions. This is indicative of increased destitution among Indo-Fijians during the transition from plantation labour and the consolidation of family farm social and economic networks. Between 1919 and 1923, Indo-Fijians comprised c. 66 per cent of first admissions, compared to Fijians making up c. 21 per cent. Other ethnic groups, including Europeans, accounted for one fifth of the small number of admissions before 1900 but thereafter this proportion substantially declined. This is to be expected given that this demography was always a small part of Fiji's population.

Our database, 1884-1933, found that among *all first* admissions with a recorded outcome, c. 47 per cent died in the asylum or hospital compared to 53 per cent who were discharged. Indo-Fijians comprised 50 per cent of these deaths, compared to indigenous Fijians accounting for c. 35 per cent. High death rates are not surprising given reports of extensive physical disease among asylum patients during the early twentieth century. Mortality rates contained significant gender and ethnic differences. Men had worse mortality rates than women. This possibly reflects that some women may have been admitted with less acute mental distress but more noticeable violation of gender norms than many men. Such women possibly suffered less terminal physical illness or had already received medical care if their insanity was linked with childbirth. Most significant in disentangling the higher asylum mortality rates for men was the preference for women's early discharge if they were wives and caregivers. Mrs J's husband wrote a letter requesting her discharge only two months after admission. She was discharged the same day. But after readmission in 1905, older, widowed and presumably without dependent children, Mrs J remained at St Giles until her death in 1909.

Mortality rates were high for indigenous Fijian and Indo-Fijian patients. The highest mortality rates were proportionately among ethnic Fijians although Indo-Fijians constituted a higher percentage of total asylum deaths. The number of Fijians committed to St Giles between 1914-1923 who died there was alarmingly high. Some were vagrants with se-

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136-71) early documented links between the accumulation of colonial statistics, knowledge and governance.

vere poor mental and physical health such as a Fijian woman who had 'assaulted several people in town with sticks, tried to set fire to a house, refused all food for several days and wanders about at night, refused to work'. She died six months later in the asylum. This may reflect not only the extreme mental but also physical distress indigenous Fijians had reached before accessing state institutions. It poses questions concerning the availability and preference for community care and control, and aversion to state medical institutions. High Indo-Fijian death rates were indicative of destitution following the abolition of indentures. The sad fate of two ex-indentured Indo-Fijians admitted during 1918 revealed the physical and mental deterioration behind these statistics. A male lunatic who had been living in the bush in Macuata district was described by police as having a 'wild appearance; neglected sores on body; disconnected stories; delusions as to devils persecuting him; clothes torn up'. A female 'mental deficient' was found crawling along the road. Within eight months these patients had died at the asylum.

### **Gendered Discourse and Madness**

The gendering of 'madness' is striking, when the discourse of admission certificates and medical journals are examined. Classification as 'mad' operated at several levels in Fiji and was discursively and subjectively framed in different locations. Only a small minority of those considered mad by their communities became legally certified as insane and were committed to the lunatic asylum. Certification papers are the only remaining texts of this process and along with fragmentary archival material provide a glimpse into the categorization of madness in Fiji. Historic, ethnographic and linguistic evidence indicates that local communities in Fiji accorded madness to those with repeatedly aberrant behaviour, outside localized norms of rationality. Indigenous and Fiji Hindi words for crazy were sometimes cited on medical certificates, and are common parlance today. The Indian subcontinent was the source of an array of healing traditions (Bhugra, 2001: 47-50). Diagnosis was integral to treatment and this was frequently connected with extensive spiritual or metaphysical states. Indigenous Fijian notions of mental disorder were located within generalized concepts of wellness and illness but were entwined with the community and spirit/ancestral worlds (Becker, 1995).

In many instances the impetus to contain crazy individuals or hand them over to the care of the state came from kin or community. Certification required a doctor and a stipendiary magistrate to complete two committal schedules (or two doctors for private patients). As district medical

officers were scarce during the early years, certificates were frequently issued in Suva. The doctors who signed these often knew little about the patient's condition and relied upon their immediate observations and reports from others. Such observations revealed how madness was identified and ultimately categorized. Evidence of madness was penned from a variety of sources including patient and family histories, observations and opinions of *Rokos* (provincial heads), *Bulis* (district heads), chiefs, ministers of religion, police, local magistrates, teachers and employers. By the time these observations were recorded for certification they may have undergone several reincarnations. These remain quiescent histories, where the subject is momentarily constituted between the lines of colonial texts that impart a permanent authoritative truth about mad people in Fiji.

### Gender Stereotypes: Embodying Madness

'Gender differences first appear in the perception of emotional distress itself...' (Tomes, 1990: 145). Lay and professional categorization and diagnosis of mental illness were frequently grounded in cultural perceptions of appropriate gender identity and behaviour. The gendering of madness reflects socialization and embodied experiences of this.

The Fiji records explicitly associate women's insanity with their emotional or reproductive lives. Despite early colonial debates over suicide and sexual jealousy among *Girmitiyas* (Lal, 1985), relationships and sexuality were only occasionally linked with causing men's madness in the St Giles' records. Men's sexuality was commented upon but rarely morally judged like women's, with the exception of a few males diagnosed with 'masturbatory insanity'.

Men were more likely to have their madness caused by money or employment problems, organic illness or accidents, while women's madness was said to be precipitated by a love affair, infidelity, jealousy, 'matrimonial unhappiness', 'domestic troubles' (cf. Ernst, 1996: 362; Ripa, 1990: 62). Mrs J's second admission was attributed to shock from her husband's death and subsequent irrational behaviour; she 'jokingly alludes to serious subjects, for example, husband's recent death and funeral'. Although women were considered more susceptible to emotionally/relationally caused madness, this was embodied through behaviour and biology. Some records describe men going mad ostensibly from domestic crises but most of these texts refer to Indo-Fijians. Common causes of insanity for both men and women assigned during this period included old age, physical illness and syphilis, which was linked with general paralysis of the insane.

Patients' testimonies were often marginalized as mad performance that was animalistic, uncivilized or childlike. Insane people were not usually privileged with 'testimony' but spoke, screamed or garbled their 'delusions'. Histories of madness have tended to dismiss subject voices (cf. Mills, 2000: 146; Sadowsky, 1999: 50; Swartz, 1995). Roy Porter asserted that although '[t]he mad person's...immediate oppressors mainly existed only in their heads...they were commonly the analogues of ogres out there in society, in the culture' (1987: 231). This suggests that recorded 'delusions' and observations might offer an alternative reading of gender relations. Was Dukhni's madness delusional or indicative of her corporeal world? She was diagnosed with mania 'since meeting her husband 18 years ago...Imagines her husband continually wishing to assault her'. A police officer stated that Dukhni had repeatedly made reports of assaults, which on investigation were false. Her violent (actual? delusional?) world was also directed towards her husband. Immediately prior to her commitment she went to 'the police station with a knife saying if police couldn't find her somewhere to stay away from home she would chop up her husband'. The only record we have of actual violence is when she attempted to hang herself.

Tomes (1990) found in the USA that 'family members often cited sudden or extreme deviations from an individual's habitual behaviour, including departures from their normal sex roles, as evidence of mental disease - for example women who ceased to care for their personal appearance' (Tomes, 1990: 163). The St Giles records revealed similar trends, although men who deviated from norms (through behaviour or appearance) occasionally elicited comment. However with women the transgression was not just of 'civilized behaviour' but also of *feminine* norms, where appearance and deportment were important. Dishevelment, lack of control, excessive mobility and fighting with other women were all signs. A female Indo-Fijian labourer committed to the asylum in 1925 was 'restless, loquacious, continual gesticulation; continuously in an insane manner; apparently no regard for her femininity; general demeanour that of a lunatic...runs about without clothes; throws away husband's food; burns her husband's clothes; fights with other women in the lines; has attacked another woman with a knife' (Testimony, District Commissioner, Taveuni and Husband's Employer).

However madness was defined not only in relation to gender but also ethnic stereotypes, evidence of ethnic and gendered transgressions was primarily cast as observations of embodied appearance and behaviour. Mad people transgressed the multiple locations of gender and ethnicity:

- ? ‘...a melancholic Indian clothed “not in accordance with the custom of Indian women”’ (1920).
- ? ‘...a Fijian with dirty habits in a way “unusual among Fijians”’ (1915).
- ? ‘...general behaviour, especially head gestures “express a boldness or sometimes lustfulness not usual in Fijians”. First words [to Doctor] concerned her monthly periods, no exact meaning, but “no normal Fijian woman” mentions these unless asked or there is some corresponding disease (denies)’ (Observations, Dr Harper, District Commissioner and Medical Officer, Lau); ‘Sees S. go to church with her clothes obviously soiled by her menstrual discharge’ (Observations, *Buli*, 1918).
- ? ‘Her behaviour is the reverse of that of a normal Fijian girl in that she has a familiar manner and cannot carry on rational conversation’ (1929).

Work was a dominant trope within discourse concerning women’s insanity, especially when women neglected domestic work. Amid lurid descriptions of Emily’s ‘delusions of a sexual behaviour, erotic statements. A man has gone to the colonies and a subscription should be raised to bring him to her’, were reports that Emily had refused to work despite having a ‘large family to look after’. Even when women engaged in serious acts of violence their transgressions of everyday domestic duties also substantiated evidence of their insanity. In 1893, a Fijian missionary’s wife was committed after being ‘[f]requently violent with peculiar animosity against her husband. Threw her child down some time ago and thereby has injured its spine...Took a quantity of cooked and prepared food and threw it out to the fowls’.

Work role expectations in Fiji were framed not only by gender but also by ethnicity. Poorly paid and arduous work was normal for many Indo-Fijian women during the *Girmit* years. How do we read ‘delusions of persecution’ when a tearful female *Girmitiya* admitted to the asylum claimed ‘that her *sahib* and *sirdar* beat her and get angry with her’, given the well-documented violence of indenture (for example Sanadhya, 1991)?

Assumptions about masculine work expectations were also problematic with reference to indigenous Fijian men. Most were not waged workers so their insanity cannot be simply equated to transgressing Eurocentric masculine notions of work.<sup>10</sup> The sin of ‘idleness’ still applied to Fi-

<sup>10</sup>A study of an asylum in Dunedin, New Zealand, found that delusions of wealth

jian villagers, such as Rusiate in 1922, who was not only violent towards property but had ‘consistently neglected all communal work for the last two years’. Indo-Fijian *Girmitiyas* who refused to work were accused of ‘malingering’. Authorities were ambiguous over whether this was deliberate or beyond the workers’ control because of insanity. European men who stopped working were clearly of ‘unsound mind’ such as a plantation manager who bathed his head in a creek and prayed all day instead of working.

Following Foucault’s *History of Sexuality*, McClintock (1995) and Stoler (1991, 1995, 1997) identified sexuality as a marker of colonized subject locations. This also applied to mad bodies especially where medical discourse concerning sexuality defined normal and pathological bodies and minds (cf. Comaroff and Comaroff, 1991). In Fiji, early asylum discourse centred on women’s morality and sexuality, particularly public displays of ‘obscenity’, ‘nudity’ and ‘indecent exposure’ (cf. Showalter, 1985: 74), whether before certification, upon or after admission. Several texts refer to villagers’ complaints of mad women behaving ‘extravagantly’, ‘indecently’, and ‘desiring connection’ with men in their villages. Moral judgements are also striking on women’s admission certificates such as one from 1896 concerning a twenty-five year old indigenous Fijian woman. She had led a ‘loose and immoral life to excess lately’, including ‘indecent behavior, frequently exposing herself and using indecent language in her *mekes*’. She died at the asylum two years later. In 1898, the Native Commissioner, ‘in loco parentis’, signed the admission certificate for Saini, aged twenty-two, who had insanity that was attributed to ‘seduction’. She had the

habit of smiling inanely, sprawling on floor in unseemly way on public verandah, not seeming to know “other than seemly”; sings at inopportune time...wanders at night in and out of people’s houses without purpose when she ought by the customs of native propriety be at home with parents; easily excited and angered; came over to Suva without leave and fell into the hands of the Police as being insane.

We learn little from this about her seduction, but as in many texts, the focus is on the mad subject’s embodied madness, uncontrollable, unpredictable movements and violation of cultural spaces. The text also highlights the legal restrictions on mobility faced by indigenous Fijians, particularly women, as in many other colonies. When admitting a single Indian fe-

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and influence corresponded to the ideal image of the powerful male (Holloway, 2001: 166). This was not so clearly delineated in the Fijian context.

male labourer, to the asylum in 1884, the magistrate recounted:

She had a wild manner and expression generally, and often refused to wear any clothes during my visit. The chief conversation is of sexual intercourse and the male sex. Her gestures are often of an indecent and lascivious character.

Surviving records of the Medical Superintendent's visits to St Giles also highlighted a lurid preoccupation with the details of women's sexuality, especially that of mad European women. This may have reflected the positioning of racialized and gendered sexualities; the greater leeway assumed for Native sexuality compared to that of European women. A typical entry concerned a fifty-five year old European woman:

...obscene delusions - her language being incessantly filthy and unrestrained and always on the subject of sex and sexuality....said Governor asked to have her killed, that last night several lights turned on her, fired at with electricity by several people whom she had previously seen cutting out a girl's womb.

Mad women threatened bourgeois identity with their flagrant violation of sexual and other (for example, work) norms. Stoler (1995) argues that the delineation of European female sexuality was pivotal to colonial order:

Within the lexicon of bourgeois civility, self-control, self-discipline, and self-determination were defining features of bourgeois selves in the colonies. These features, affirmed in the ideal family milieu, were often transgressed by sexual, moral, and racial contaminations in those same European colonial homes (Stoler, 1995: 8).

However as noted, respectability, domesticity and normality were also inculcated by other ethnicities in Fiji. Christian discourse was significant but women's virtue and controlled sexuality was also central to Hindu and Muslim discourses and Indo-Fijian identities (Kelly, 1991).

### **Gender and the Mad Body**

The medicalization of sexuality was pivotal to defining the normal and pathological not only from observed embodied sexuality but also through the medical discourse of mad bodies. The prominence of sexual and moral discourse in the madness texts reinforces how madness and bodies were gendered during St Giles' colonial era. Testimonies relating to women's admissions to the asylum linked this with their reproductive bodies, specifically menstruation, pregnancy, childbirth, miscarriage and menopause (Busfield, 1996: 143-65; Showalter, 1985: 55-9). Women's reproductive functions were deemed pathological (Russell, 1995: 13), es-

pecially when associated with diseased minds.

In contrast to the rather vague and uncertain concepts of insanity in general which Victorian psychiatry produced, theories of female insanity were specifically and confidently linked to the biological crises of the female life-cycle...during which the mind would be weakened and the symptoms of insanity might emerge (Showalter, 1985: 55).

Associations were drawn between hormonal changes and female insanity in Fiji. For example, menstruation was linked to the suicide of a female *Girmiṭiya* in 1909 at Lautoka Hospital:

A few days prior to her death when in hospital her menstrual period came on, and this the Hospital Superintendent informed me often causes a depressed state of mind which might account in her case for her action in taking her own life.<sup>11</sup>

Doctors at St Giles observed women's mental susceptibility to their 'periodicity',<sup>12</sup> by tracking their menstrual cycles: '23 Sept S (Indian female) very melancholic (menstruating); 20 Oct S very violent (menstruating) (cb, 1914).

Busfield reiterates that there is little evidence of direct links between reproductive biology and specific mental states, with the possible exception of childbirth (1996: 165). Doctors once confidently made diagnoses of 'puerperal insanity' or 'mania of pregnancy' when mania or melancholia was associated with childbirth. This was an ambiguous diagnosis,<sup>13</sup> while the duration of the puerperal period was also vague. Although this period conventionally lasted for six weeks after childbirth, puerperal insanity was linked to pregnancy, miscarriage or lactation. Doctors sometimes applied this 'convenient label' (Marland, 1999: 144) to mental disorders several years after the birth. In colonies and metropolises, reproductive discourses were central to the ordering of society. Madness, linked with female reproduction, offered a 'truth' that could be identified and possibly treated.

Instead we find tragedies of post-partum depression and psychosis among the St Giles records. Between 1884-1936, approximately twenty-five admissions or twenty-one women were classified as suffering from

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<sup>11</sup> CSO 1571/1909, 1 Feb 1909, Regional Inspector of Immigrants Lautoka to Agent-General of Immigration.

<sup>12</sup> *Ibid.*

<sup>13</sup> In Victorian England 'it is likely that some cases of puerperal mania were in fact women suffering from puerperal fever and in a state of delirium' (Marland, 1999: 144).

conditions, and then considered under the ambit of puerperal insanity. This constituted around ten per cent of female patients, similar to comparisons from other asylums during this period (Marland, 1999: 143). Outside Suva's asylum many women were treated for post-partum complications, including depression (Becker, 1998: 431- 38), with traditional healing within their homes and communities. The wealthy, particularly Europeans, could hire private nursing or arrange to have mentally disturbed family treated outside Fiji. Nevertheless, among the small number of women admitted with puerperal insanity to St Giles, between 1884-1936, there were no obvious class or ethnic biases. Women's economic circumstances ranged between being destitute, villagers, *Girmitiyas*, to being married to professional men and Fijian chiefs.

One of the asylum's first patients, Annie, a European waitress, was admitted by her husband in 1884 as a private patient after suffering from 'puerperal insanity'. Aged only twenty-one, the medical superintendent reported that she had undergone two attacks of chorea and had a generally hard life. According to the district medical officer, '...she should be certified on the basis of [being] hurried and agitated, great irritability, obscenity of language and husband said she was outrageous and had strong dislike of him'. Reports described her as suicidal, paranoid that violence was being inflicted upon her, and threatening violence towards her husband.

A radical treatment was proposed in 1896 for Mrs J's 'puerperal melancholia, with homicidal impulses'. Although the Chief Medical Officer (CMO) considered Mrs J had '...so far recovered as to be rational and harmless', after a '...special gynaecological examination...as a knowledge of the sexual apparatus is essential to a proper radical treatment', he 'found a condition which could be advantageously healed at the Colonial Hospital with a fair hope of success and of permanent cure of her mental irritability'. I found no further details about this planned operation, which may have been a hysterectomy. Mrs J's plight highlights how surgery was equated with curing mental illness and the scrutiny puerperal insanity (a specifically 'female' illness) came under. 'Experts' deemed that it could be solved through a 'female' surgical operation.

However between 1884-1936, nine women were permanently discharged after being treated for puerperal insanity. These represent quiescent histories; the subjects disappear outside the asylum. The grim reality is that we can reconstruct tiny fragments concerning women who were committed and died under the diagnosis of puerperal insanity, such as twenty-two year old Veniana, admitted two months after childbirth. According to her husband she 'wanders; discards clothes; melancholy; refused to talk to anyone; complained devils after her; since birth refused to

suckle child; won't have child near her and lost all interest in her; recently filthy habits in house'. A Native Medical Practitioner (NMP) declared her insane; observations upon admission included, 'melancholy, fixed fawnlike gaze, no particular purpose to it; stoops and bends incessantly and evinces tendency to remain in any position to which guided; won't speak ... exhausted and drowsy'. Veniana died forty-nine days later following emergency gynaecological treatment at the Colonial Hospital. Other tragic lives are reduced to a few lines in my summaries of the sketchy medical texts:

? Muslim female aged 31, admitted to St Giles in 1914, died there 1919: mother of four children: manic-depressive: very poor.

? Fijian woman, aged 24, admitted 1892, died 1895: had murdered her child after which husband left her. Doctor noted 'quasi cataleptic attitudes' - more clearly reported by district constable: 'when she speaks it is only with impressions spontaneously developed in her mind and not from any resulting out of the remarks of other persons'.

? 1920, Indian mother of two admitted to St Giles. Pregnant and gives birth to third child in the asylum. Children under care of Roman Catholic Mission, Savusavu. Mother stays in St Giles until death in 1939.

? Single 32 year old Fijian woman committed to St Giles in 1929 since child 's birth in 1928. Elderly brother cares for infant but mother dies two years later.

We will never know these subjects, or their families, but the bare records indicate how this history of madness speaks to not only gender and ethnicity but also class and poverty.

### **Controlling the Body to Treat the Mind**

Fiji's lunatic asylum was erected during a period of increasing disillusionment with moral management of the mentally ill in Britain (Busfield, 1986:256-7). It was designed to sequester those certified insane within a controlled environment, but also incorporated principles of moral and humane care. In the early years there was little expectation of cure but some reference to appropriate moral therapy and relief from insanity. During subsequent decades, there was more optimism that some patients could be restored to 'normality'. This hope heightened with the advent of physical interventions (such as shock treatments introduced during the 1940s) and when the 'pharmacological revolution' brought 'curative drugs' such as chlorpromazine (Largactil) to Fiji in the mid 1950s

(Leckie, 2005).

Mad people's bodies were the focus, regardless of whether the expectation was sequestration, control, care, cure or punishment. Control and treatment of the mind was manifested through control and care of the body. Consequently the body was often a contested site between patients and caregivers and as has been emphasised, the control of gendered bodies was integral to treating insanity. Patients' bodily functions, orifices, ingestions and emissions were closely scrutinized. Conflict often broke out over bathing, eating, defecating, with forced use of laxatives, enemas and 'sats' to open the bowels, special diets, nasal and tube feeding. Early records suggest that women were possibly more prone than men to be subjected to prolonged baths and radical hair cuts to remove head lice. Normality and femininity were re-constituted with personal care of hair, body and dress (cf. Coleborne, 1997).

After Mrs J destroyed her dress, the CMO asked for reports on the 'progress' of a new dress and her acquiescence to wearing it. She was reported as 'improving' after wearing this dress. Her comportment was also observed: 'she is now in a fairly quiet and playful mood, her features relaxed, lost a good deal of that hard, set, look'.<sup>14</sup> Mrs J's behaviour towards her husband was also scrutinised: 'If Mr J asks to see his wife allow him in your presence for fifteen minutes; watch effect on her'.<sup>15</sup> A positive sign of normality during this visit was that Mrs J asked after her children.

However, the bulk of Mrs J's records relate to her bodily functions: notably menstruation and defecation. We know very little about Mrs J's mind from records, which mostly cited observations not introspections (cf. Mills, 2000: 70):

The patient remained in a fairly manageable state throughout the day, ate food fairly well, but towards 11 pm she suddenly became extremely violent, tearing at the external orifice of her vagina, and otherwise behaving in a most extravagant manner, she was immediately restrained and the Mufflers, and knee and ankle straps applied, even with these all on, it was with some considerable difficulty, that the patient was kept from injuring her head and in between one of her paroxysms, I succeeded in getting her to take a dose of the 'Mixture' and in about ten minutes, afterwards, she went off into a sound sleep, woke up again at a little after one o'clock, was noisy, and attempted to struggle about for a little while, and then gradually fell asleep

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<sup>14</sup> July 1896 Chief Warder (CW) to CMO.

<sup>15</sup> 10 Aug 1896, CMO to CW.

again.....The patient is now quiet and sullen.<sup>16</sup>

This text also indicates the struggle to control Mrs J's body through physical and spatial restraints, including drugs. Like several patients, she resisted swallowing her medication. Later during the 1960s in Fiji, the adoption of 'curative drugs', especially Largactil, was also used to restrain patients: to control mad bodies not only in the asylum but also outside. Bodies were also experimented on with 'deep sleep' or Pentothal (Thiopentone) narcosis (1947), insulin injections to induce sweating (1955), 'acid' treatment (1954),<sup>17</sup> and more extensively, Cardiozol (Metrazol) and electro convulsive (ECT) therapies. The sketchy evidence suggests that women were more likely to be subjected to such experimentation. Mrs DV was one of the first subjects under this new regime. In 1947, she was admitted to the asylum suffering from 'hysteria', only sixteen days before giving birth there. After being transferred to the main hospital she returned to St Giles, 'noisy and restless', and began convulsive therapy consisting of Cardiozol injections. The doctor's notes (cb, 1948) reduced her traumatic history to a shorthand primarily recording her varying bodily reactions. She was discharged four months later conditional on her husband re-admitting her for a tubal ligation. Instead her mental condition worsened and she was readmitted to St Giles. Her convulsion therapy changed from Cardiozol to ECT, again producing wide-ranging reactions to her body and mind. During the following decades she would be subjected to a wide range of bodily and psychotropic interventions and psychiatric diagnoses.

Control of the body and treatment of the mind extended to activities for mad bodies. During Victorian times this was known as the 'work cure'; later designated occupational therapy or ways to 'activate' the patient. Such therapies reflected the multiple subject locations of mad people and were organised along not only gendered but also racial and class lines. Initially, Native men and some women produced crops but later flower cultivation was specifically a female task that could include Europeans.<sup>18</sup> In 1938 the hospital declared: 'All the mattresses in the female ward have been remade and a complete set of dresses of a new design for the female patients have been made by the patients themselves in 1938. A

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<sup>16</sup> Reports, 1896, CW to CMO.

<sup>17</sup>It is not clear what this was. Modern psychiatric treatments during the 1940s administered nicotinic acid and glutamic acid, along with vitamin therapy treatments to treat confusion and delirium, especially with senile psychoses.

<sup>18</sup> F48/4/5, 1938 Annual Report

number of Samoan baskets and fans were also woven'<sup>19</sup>

Native female and male patients undertook cleaning for patients and staff. Occasionally some men, including Europeans, tackled more 'skilled' work (such as building and tailoring). Although European women participated in appropriate feminine activities such as needle-work, reading or playing cards,<sup>20</sup> they were expected to do some domestic work. Work indicated the restoration of femininity (but such progress was often interspersed with other bodily observations):

The castor oil has not acted in Mrs J's case, no motion passed; she however, seems to be bright and cheerful, was employed in sweeping her room out... Bowels moved 'thrice' yesterday... Actively employed yesterday (by her own request) in assisting the female attendant, in hanging out the Asylum washing, etc. Mrs J still doing well, went for a walk in the Gardens on Saturday, and again yesterday; reads a good deal now, motions regular.<sup>21</sup>

### **Conclusion: Gender, difference and the common blanket of madness**

Although the colonial management and framing of madness was markedly gendered in Fiji, ethnicity was also significant. Women had lower asylum admission and death rates than men but overall Indo-Fijians had high admission and death rates. Proportionately higher death rates were found among Fijian indigenous male patients. Destitution and class thread through this. A history of madness must be cognizant not only of gender but also the other subject locations of ethnicity and class. Indeed St Giles was managed according to social considerations (gender and other colonial hierarchies) more than any rationale based upon patients' mental conditions. As Sally Swartz emphasised in Cape colony, the classification process supposedly rendered any difference as irrelevant, as a homogenous insane population was produced, but in fact difference was reproduced within the asylum (Swartz, 1995: 401). A recovered patient conformed to the colonial norms of difference with respect to gender, compartment, ethnicity, status and class outside the asylum.

Colonial 'madness' infrastructure (buildings, legislation, regulations) reflected and framed primarily gender, then ethnic (and to a lesser

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<sup>19</sup> F48/4/5, 1938 Annual Report.

<sup>20</sup> Information from Annual Returns, Lunatic Asylum, *Blue Book of Fiji* (1884-1940) and oral testimony.

<sup>21</sup> Reports, August 1896 CW to CMO.

extent) class categories and hierarchies. Not only mad bodies, but also staff were allocated spaces within these. The embodiment of gender and madness was discursively produced through texts such as admission certificates and medical journals. Evidence of ‘madness’ was accrued from reports of mad bodies looking, smelling, sounding and acting differently (especially violently or out of control) to ‘normal’ bodies; a normality discursively framed by lay, legal and medical communities along gendered, racial and class lines. Women’s madness was especially articulated with respect to gender roles, sexuality, and linked women’s insanity with both their domestic lives and their bodies. This was notably evident in the discussion of puerperal insanity. But the transgressions of feminine norms were:

... not in themselves sufficient to guarantee committal to a mental hospital. These behaviours had to develop in a particular material and social context to warrant certification and committal. Others had to decide that such behaviours could no longer be contained or tolerated (Garton, 1988: 140).

Although power to demarcate mad subjects emanated from legal and medical knowledge, it also emanated from local (often gendered and ethnic) conceptions of normality and madness.

An embodied history of gender and madness in Fiji also extends to treatment. Foucault’s consideration of regimes of control and discipline extends to the pervasive interventions of control, treatment and cure that were directed at mad bodies, often in specifically gendered ways. Evidence of a cured ‘lunatic’ was above all through their behaviour, as measured against gender and ethnic stereotypes. Psychoanalysis had no place in colonial Fiji. As long as ‘delusions’ were confined within the ‘normal’ body, the subject was ‘treated’ or ‘cured’.

This paper ends with the advent of radical interventions on the mad body to Fiji: ‘deep sleep’ narcosis, insulin injections, Cardiozol therapy, ECT and the huge sway of psychotropic drugs. The post World War II period extended medical intervention (supposedly constituting neutral discourse on the mind/body) and re-instigated highly gendered discourse regarding women’s roles as mothers and wives; as domesticated bodies. ‘Non-domestication’ was a useful sign for incarceration of the mad. I began this paper with Mrs J and ended with the plight of Mrs DV. Both were subjected to endless bodily interventions, in different historical periods to cure their minds. Such bodily interventions probably enhanced their mental deterioration. I have worked with case-specific observations but these are unsatisfactory in contextualizing the subjects of this hidden

history. This is in contradiction to the certainty of official colonial statistics and texts; validated through association with the disciplined 'truth knowledge' of medicine, science and the law. Madness, moreover those certified as mad people, were gendered subjects; also located against ethnicity, class, politics, economics and space. Perhaps medicine and science is relevant when we consider how madness was embodied: through age, physical ability, illness, genetics and biochemistry. Such corporeality still remains a product of history and culture.

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I also acknowledge the humane motivations and the frustration professional and lay carers' experience. Mostly, I must thank the testimonies of past patients at St Giles for their inspiration and inventiveness.

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