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MODERNITY AND THE MANAGEMENT OF MADNESS IN COLONIAL FIJI*

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Long before Michel Foucault (1965) linked madness with modernity, Edward Jarvis (1852) declared that insanity is part of the price we pay for civilisation. He was also convinced that modernity could alleviate this situation (Grob 1978:183–184). How was the paradigm of modernity as a cause of, and cure for, mental disorder transposed to the colonial context,[1] and specifically to the islands of the Pacific? How should we interpret the transfer of the asylum, a major institution and symbol of modernity and of 'European civilisation', to Fiji? Was the agenda of social control primarily about the physical sequestration of 'dangerous bodies and minds', or was it part of the framing of madness and normality, of the modern civilised subject? Just as colonial projects attempted to 'colonise the mind' (Durutalo 1983), so 'modern' structures, treatments and discourse tried to tame that mind. Yet indigenous and migrant communities were equally concerned about social order, and in times of crisis they, too, resorted to the asylum to control and care for the insane.

Initially the demand for an asylum in Fiji derived from colonial 'civilising' agendas concerned with social control and medical care. Although the asylum represented an extreme in colonial social control, it did not constitute the 'great confinement' that Foucault postulated within European modernity. The asylum was only one symbol of a colonial culture in which extensive laws regulated intimate details of subjects' lives (Jolly 1998, Thomas 1990), the repository for a small number of severely mentally disordered subjects, legally classified as insane, albeit interpreted by criteria of normality. Mad subjects were identified by both indigenous and colonial observers as highly disruptive to social order. The asylum also provided a space for a minority of those who were both sick and destitute.

Madness in Fiji reflected colonial hierarchies and ethnic boundaries. The colonial state restructured the ethnic map of Fiji. Policies attempted to restrict indigenous Fijians to the subsistence sector by bolstering chiefly hierarchies through indirect rule. Simultaneously, economic development proceeded with sugar production, labour being obtained by importing indentured Indian immigrant labourers (*girmitiyas*) (Lal

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1 This dichotomy has also been noted by, for example, Goddard (1988:80–82) in Papua New Guinea, Rivera-Garza (2001) in Mexico, and Swartz (1995:44) and Vaughan (1991:108–125) in British colonial Africa.

2000). Between 1879 and 1916 approximately 60 000 indentured labourers endured harsh working and living conditions on Fiji's plantations. From the 1920s production shifted to small family farms, as the Indo-Fijian population grew to overtake that of indigenous Fijians by the 1940s.

In this article, I begin by exploring why an asylum (later called St Giles) was established on Fiji in 1884, soon after Fiji became a colony in 1874. This was early compared to the building of colonial asylums elsewhere.[2] In the next section I outline how modern madness management was transferred to the colony, specifically through lunacy legislation and the contradictions of moral management in the control, care and cure of the mentally ill. Legal authority classified subjects to be of unsound mind or insane, an idiot, a lunatic, with possible qualifiers such as wandering at large, or not under proper care and control (Colony of Fiji 1884). Equally important was the establishment of an infrastructure to contain and provide humane care, although there was little expectation that the mentally ill could be cured. In the third section I explore the discursive constructions of madness made by communities and practitioners through their observations, attribution of causes and classifications of madness. This emphasises the constitution of mad subjects and how this was cast in a western medical framework within a colony. Madness was not just a European imposition but was mediated by local constructions, tolerance and management of aberrant behaviour that was considered insane. I agree with Michael Goddard's ethnography from Papua New Guinea (1988), that local communities recognised madness that needed to be controlled by restoring individuals to social normality but did not regard this as mental illness. Because this article draws on colonial records, local voices are cast through western eyes, which refract local constructions of madness through the discourses of colonial modernity.[3] The article therefore does not speak for patients or address their agency.

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2 The British built mental asylums in India from the late eighteenth century (Ernst 1997). Robben Island asylum at Cape Colony was established in 1846 (Deacon 1999:104) but asylums came much later in most other African colonies. A psychiatric hospital was not established in Papua New Guinea until the early 1970s (Goddard 1992). I only address British colonies. Keller reviews the literature on British and French colonial asylums but omits France's Pacific colonies (2001).

3 Colonial Secretary's Office (CSO) and other files – including Annual Reports (AR), Public Lunatic Asylum – were consulted at the Fiji National Archives. Medical files were consulted at St Giles. My research project has transferred 3 129 admissions and certification papers (1884–1964) on to a database.

Lost Souls In Wrong Places: The Need For An Asylum

The stimulus for establishing an asylum in Fiji derived from British control and regulation of public institutions and spaces, and the agenda of transferring modern medical care and control to British colonies.[4] Fiji's asylum originated with the development of policing, prisons and public health. As with the establishment of lunatic asylums in other colonies, there was an imperative to separate insane from 'normal' prisoners (Vaughan 1983:220). Similar concerns were raised over patients in hospitals where there was no separate accommodation for insane patients. Fiji also faced problems of managing a growing migrant population, consisting mainly of *girmitiyas*. These included those who were both destitute and had mental and physical disabilities. Contemporaries may have linked madness to the spread of western civilisation, but this itself increased social dislocation and the need to manage the mentally distressed. Isolation or separation, whether through deportation, incarceration or other forms of restraint, was considered a modern civilised response to this development (cf. Ripa 1990:115).

In 1881 Fiji's Governor, Des Voeux, requested special accommodation for lunatics, a need originally identified by the police superintendent.[5] Mentally disturbed people could only be institutionally confined if they had been judged criminally insane. Such inmates fell under prison jurisdiction, but colonial policy introduced monitoring by medical authorities to ascertain 'fitness' for release and prevent ill treatment.[6] Multiple agendas lay behind the urgency in separating mad prisoners from normal ones, but the objective of achieving orderly prison management dominated. Qaqa was one such prisoner.[7] He was arrested in 1882 for attempted murder but found not guilty on grounds of insanity and sentenced to detention. In 1884 he attacked two European prisoners with a spade, killing one of them. Dr Patullo, a prison doctor, testified that Qaqa required constant supervision and should be sent to an asylum as soon as it was built (CSO 84/1178, 10 June 1884). Halkett, Superintendent of Prisons, admitted that he did not have the personal expertise or assistance to manage such prisoners properly.

> I have seen Qaqa on every visit. I was desirous of observing his behaviour because he was confined as a lunatic. He has been a source of anxiety to me because I was not conversant with the management of lunatics 2nd because the native warders who had charge of him were unreliable 3rd because I had to refer to the medical officer with regard to his control. I do not consider the gaol as a suitable place of confinement for Qaqa. I have often said this to the visiting surgeon. Qaqa was kept in a separate stone cell during the month of

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4 Comaroff and Comaroff (1992:215–233), MacLeod and Lewis (1988).

5 Colonial Office (CO) 83/29, Despatch 185, 30 December 1881.

6 CSO 82/849, outward letters of Secretary of State, 11 May 1882.

7 Qaqa, Wilson and Allen are patients with names in the public domain. Otherwise, to protect patient confidentiality, I use pseudonyms.

> February last. This confinement was not punishment. It was done to isolate him and prevent annoyance to the other prisoners (CSO 84/1178, 10 June 1884).

In 1884 another prison doctor, Dr Blyth, warned that excessive use of mechanical restraints was counterproductive in the treatment of mentally ill prisoners. Blyth's report on one prisoner, Wilson, indicates how the insane were separately categorised from prisoners because of the conviction that treatment was possible through isolation and moral management. Blyth's text resonated with contradictory confidence in respect of individual treatment and incarceration.

> [...] in Wilson's case the use of handcuffs is entirely uncalled for, and [...] their adoption would be highly injudicious. Restraint of this kind would greatly irritate the man, and arouse his temper, which, in the absence of restraint and unnecessary interference would not become violent, or uncontrollable [...] in Wilson's care, the use of handcuffs would be productive of incalculable mischief, and impel him to actions which otherwise he would not commit [...] The same remarks apply to Leg-irons as to handcuffs; they are unnecessary, and therefore could only be productive of evil results [...] To attempt to cure insanity in a common gaol, instead of in an Institution set apart for the reception of lunatics, would be futile, but at the same time I have all along endeavoured to carry out rational treatment in Wilson's case to the best of my ability, always recognising the fact that a line of treatment adapted to one case of insanity may be wholly unfitted to another. Solitary confinement, handcuffs, strait-jacket etc may be occasionally necessary in treating maniacs, but in Wilson's case their adoption would be a mistake in my opinion. To restrain him, and surround him with Warders, to restrict his time out of doors to two hours daily, and to load him with chains, would certainly be the most likely means of developing in the man periodical outbursts of mania [...]. Let him be s t r i c t l y w a t c h e d; have all dangerous weapons out of his reach by night and by day; instruct those in charge of him to observe him most closely, and never to repose any trust in him; but do not shut him up in his cell by day on any account; and do not adopt mechanical restraint in the shape of leg-irons etc.[8]

Part of the rationale for an asylum was that it could be a place of observation to determine if a criminal was really mad. Qaqa typified these uncertainties. In 1883 Dr Patullo was confident that Qaqa had not recently exhibited any of the usual symptoms of insanity. This opinion was challenged so it was recommended that Qaqa 'be detained in the asylum for o b s e r v a t i o n; if found eventually to be an impostor let him be dealt with accordingly; if mad he will be soon be found out under continuous observation'.[9] Unfortunately before the asylum was opened Qaqa killed a fellow prisoner.

Financial considerations also compelled the need for a separate space for insane prisoners. Halkett complained of insufficient funding to employ enough European staff to provide 'incessant vigilance' over insane prisoners. Native staff were cheaper,

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8 CSO 84/1574, from Superintendent of Prisons (memo by Blyth), 17 July 1884 (emphasis in original).

9 CSO 83/2549, writer's name indecipherable, 21 September 1883 (emphasis in original).

but Halkett argued that they 'have been proved wholly unreliable in dealing with lunatics' (CSO 84/1340, 1 July 1884).

The approval to build an asylum during a period of financial restraint (Joyce 1971:39–65) may have been granted because of concern not only for the prisons but also for public health. Plans for an asylum were submitted as part of a draft public hospital in Suva.[10] Dr (later Sir) William MacGregor, Fiji's Chief Medical Officer (CMO) between 1875 and 1888, as well as Treasurer and, after 1883, Colonial Secretary, was pivotal. He was appalled at the inadequate medical personnel and facilities in Fiji (Joyce 1971:25) and so recruited medical students from his homeland, Scotland, and founded the Fiji Native Medical School in 1885. Significantly, MacGregor had been a surgeon at the Royal Lunatic Asylum in Aberdeen and Superintendent of the Lunatic Asylum in Mauritius. A more specific 'problem' in Fiji's early hospitals was the presence of 'uncontrollable' mentally disturbed patients. In 1881 Des Voeux urged the setting up of 'A ward for lunatics, at such a distance that the latter might be out of hearing of the other patients'.[11]

MacGregor and his contemporaries in Fiji were committed to humane modern medical practices as a cornerstone of colonisation, but they were also preoccupied with social and legal regulation. Fiji was a centre of the colonial Pacific and often the intentional or unintentional destination for many 'lost souls'. 'Fiji is a great sufferer from the arrival here of insane and incurable persons'.[12] Indentured labourers in Fiji were part of modernity's ambiguous juncture of intentional and unintentional, free and unfree, global migration. Among these were a minority of mentally disturbed migrants, some being in this condition before their embarkation from India, while others found their mental state deteriorating during the voyage or under the severe conditions on Fiji's plantations. The colonial authorities vacillated over whether to confine such 'unfortunates' or repatriate them to India. Des Voeux cited the presence of insane indentured immigrants as a justification for building the asylum, although he preferred to repatriate insane immigrants.[13] Europeans were also among these lost souls in Fiji, but again the colony was reluctant to provide financial support.[14] Allen's arrival in 1883 from New Zealand provided a test case. He apparently had been promised work in Fiji, but after unsuccessfully searching for his employer, was remanded in Suva gaol for vagrancy and lunacy. The acting superintendent of police warned that if Allen stayed in Fiji, 'it is impossible to say how far the neighbouring colonies may take advantage of [this precedent] to rid themselves at the expense of this colony of inconvenient and troublesome burdens' (CSO 83/968, 9 April 1883).

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10 CO 83/34, Despatch 122, 20 October 1883.

11 CSO 83/27, address to Legislative Council, 28 December 1881.

12 CSO 86/84, minute by MacGregor, 21 April 1886.

13 CSO 83/34, Despatch 119, 27 September 1883.

14 CSO 84/1340, prison medical journal, 4 July 1884.

Managing Madness

Lunacy legislation

The legal definition and treatment of mental illness in Fiji became enshrined in the Public Lunatic Asylum Ordinance of 1884. The asylum could not be legally constituted until appropriate legislation to 'care for the maintenance of lunatics and idiots' had been enacted. Admission to the asylum was equated with the legal definition of mental illness, a lunatic being 'every person of unsound mind and every person being an idiot'. The drafting of lunacy legislation for Fiji and the establishment of a public lunatic asylum followed developments in the metropolis and nearby settler colonies.[15] Similarities in asylum legislation and management to other British colonies extended to the accumulation of quantitative information about imperial subjects (Cohn 1987:136–171). Probing extended to the most intimate spaces, including those of the insane. The institution was a means of acquiring information, defining legal categories and extending colonial control. The paper trail in Fiji began with certification papers, in which individuals were constituted as a 'case', 'an object like a branch of knowledge and a hold for a branch of power'.[16] As discussed below, case notes included lay and medical observations relating to the evidence and causes of insanity. Once certified insane and committed to the asylum, subjects became 'patients'. Doctors assigned patients to modern western categories of mental illness, which, as outlined below were neither objective nor static.

The over-seeing 'eye' observing the asylum became text in the Medical Superintendent's reports. The collective snapshot of the asylum was frozen in annual reports to the Legislative Council and the 'Blue Books', which summarised the annual state of the colony. Precise details of the asylum included the cubic and window space per patient, type and duration of restraints, diet and nature of mental disorders. These presented a semblance of pervasive efficiency, order and control and accorded legitimacy to the colonial management of madness in Fiji.

Space and social hierarchies

The small number of patients admitted to Fiji's asylum in 1884 represented a microcosm of the wider population. The asylum's complexity of gender and ethnicity grew despite severe limitations on bed space, staffing and the budget. However, in Fiji, unlike several other colonies (e.g. Ernst 1999a:82–87), separate asylums were not built for Europeans and the native population, despite racial segregation in other institu-

15 Brunton (2001), Lewis (1988), Melling (1999).

16 Suzuki (1999:116–117) referring to Foucault's "Discipline and Punish" (1977).

tions in Fiji, such as schools, residence and social clubs. However, racial, gender and class boundaries were reproduced within the asylum's structure with separate wards for European men, European women, Native men and Native women. 'Natives' included all non-Europeans (Indo-Fijians, indigenous Fijians and others such as Chinese). 'Part-Europeans' were usually accommodated with the Europeans, although family connections or class may have been decisive in allocating beds.

Not only were wards demarcated according to gender and race, but the quality of accommodation and comforts was also different. European wards operated like homely cottages with better quality beds, soft furnishings and recreational amenities such as books and games. Racial distinctions were also reproduced through different food rations and clothing. Work and occupational therapy further reproduced gender and racial stereotypes.[17] Only a few women engaged in crop production. Both female and male patients undertook cleaning for patients and staff. Occasionally some men, including Europeans, tackled 'skilled' work (such as building and tailoring). European women could take part in 'lady-like' activities such as needlework, reading or playing cards.

This mirrors the contradiction that Harriet Deacon (1999:104, 289) noted in the management of Robben Island Asylum in South Africa by the mid-nineteenth century. Moral management ideally dictated uniform treatment for the insane, but this was compromised by hierarchies of class, race and gender. Colonial hierarchies particularly prioritised race, although the class fractures of British asylums were also replicated. However, in Fiji racial boundaries were sometimes crossed in order to maintain gender segregation.[18] Conversely, disruptive Europeans could be 'demoted' to the Native wards by way of punishment.[19]

Mind, body and soul

Fiji's lunatic asylum was built during a period of increasing disillusionment with the curative and moral management of the mentally ill in Britain (Showalter 1985:18). Although the prevailing tone in the management of Fiji's asylum was the need to sequester the certified, it incorporated principles of moral and humane care. In the early years there was little expectation of cure, but some reference to moral therapy. Optimism in restoring some patients to 'normality' increased with the advent of physical interventions (such as shock treatments introduced into Fiji during the 1940s) and the 'pharmacological revolution', which brought 'curative drugs' such as chlorpromazine (Largactil) to Fiji in the mid 1950s (CB, 14 March 1955).

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17 AR, Lunatic Asylum, Blue Book of Fiji (1884–1940).

18 CSO 92/2961, CMO to Colonial Secretary, 6 September 1892; CSO 14/8621; CSO 15/3916, 3 January 1915.

19 E.g. Medical Case Book, St Giles (CB), 6 April 1951, 8 February 1953.

Initially in Fiji, treatment for the institutional insane centred on moral management similar to that practised in several nineteenth-century British asylums. Showalter defined moral management as the substitution of 'close supervision and paternal concern for physical restraint and harsh treatment, in an effort to re-educate the insane in habits of industry, self-control, moderation, and perseverance' to counteract or possibly cure insanity (Showalter 1985:29). The practice of close supervision with a minimum of restraint was articulated in Fiji's legislation. Regulations in 1887 stipulated that the chief warder should allow patients as much liberty as was consistent with their safe supervision, and that 'All officers of the Asylum must treat the patients with especial kindness and forbearance'.[20] Regulations in 1914 laid down that warders must not punish patients and that they should try to stop and prevent quarrels and violence between patients.[21] An early report suggested that moral management was followed:

> The chief warden is most attentive to his duties, and appears to have an aptitude for acquiring a kindly influence over the patients. The under-warders take an interest in their work, and are on good terms with the patients. The patients have as much freedom as is consistent with their safety. Those of them who can be trusted outside the bounds of the Asylum, are taken out for a walk every week by the Chief Warder. At other times they are permitted to amuse themselves in gardening close to the Asylum grounds, under the supervision of a warder.[22]

The onus of moral management and treatment fell upon the example set by the asylum staff. The 1887 regulations stated that warders must refrain from 'improper language and be strictly temperate in their way of living'. The 1914 regulations laid down that 'warders shall not use harsh or intemperate language'.[23]

Dr Patullo had faith in the preventative powers of close supervision, even for a seriously homicidal lunatic: 'If Qaqa had been in a lunatic asylum he would have been under the eye of a warder constantly' (CSO 84/1178; my emphasis). MacGregor supported this with the provision that only a European warder could be trusted to provide one-to-one supervision. Restraints could still be used: 'It will probably be unnecessary to use restraint [...] on the person of Qaqa in the Asylum. There the warder with only the slightest manifestation of an approaching attack [should] either put Qaqa in a restraining jacket, or lock him up in his dormitory'.[24] The asylum juxtaposed moral management, notably observation, and restraint. The discourse of confinement predominated in the asylum from the start:

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20 CP 4/87, Lunatic Asylum Regulations, 1887.

21 CP 15/14, Lunatic Asylum Regulations, 3 April 1914.

22 CSO 87/3847, BOV AR, 16 December 1887.

23 Colonial Paper (CP) 15/14, Lunatic Asylum Regulations, 3 April 1914.

24 CSO 84/1340, MacGregor, 30 June 1884.

> Clearly these unfortunates ought not to be in gaol but they will require very careful guarding wherever they are sent to. Three or four homicidal maniacs causes one very grave anxiety unless they are as securely confined as they usually are in other countries.[25]

Restraint was imposed through spatial confinement, physical mechanisms, drugs, and later, interventions such as electro-convulsive therapy (ECT). Physical restraints were given legislative sanction (CP 15/14) and especially resorted to before the widespread use of drug therapy. In the early years restraints included leather mufflers, elbow, thigh and ankle straps, and straight jackets, or being water-blasted by hosepipes. After St Giles was established, the Board of Visitors (BOV) suggested that a

> padded cell would add to the efficiency of the Asylum. At present there is no place in which a patient, who is violent, can be put and left to himself without fear of injuring himself. Violent patients have at present, when their paroxysms come on, to be confined in their movements by a careful system of strapping, which although perfectly humane and painless is hardly in accordance with modern ideas.[26]

St Giles kept up with modern madness management and although a padded cell was built, the solitary confinement of intractable lunatics in unpadded concrete rooms also continued.

As in other colonies, Fiji's mentally ill did not escape the modern globalisation of drugs. The first phase was concerned with control and maintenance. From the mid-twentieth century drugs offered therapy and long-term biochemical intervention: 'colonial asylums kept up with the latest developments in the drug treatments in the more significant centres of medicine in Europe and America' (Lewis 1988:13). Drugs prescribed during Fiji's initial forays into mind therapy included bromides (as sedatives) and the anti convulsive phenobarbital (Luminal) for treating epilepsy. The stench and strong sedative properties of paraldehyde linked patients at St Giles with those throughout the globe. Fiji embraced the first wave of the globalisation of pharmacological interventions with bismuth (for syphilis), sulphurals (to sedate), nembutal tablets and gas (to alleviate depression and insomnia during the 1940s–1960s), and the long-used remedies of morphine and sodium amytal. When 'curative drugs' such as Largactil[27] were administered in Fiji, as in European hospitals, they were also used to restrain patients (e.g. Gittins 1998:210–211).

Fiji's mentally ill were not passed over in the application of other modern treatments, notably ECT, which was introduced in 1947. This and other therapies were enthusiastically embraced as part of the application of modern scientific treatments to Fiji (F 48/10, BOV AR, 1949). Other therapeutic trials at St Giles included 'deep

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25 CSO 84/1340, extract of prison medical journal (my emphasis), 4 July 1884.

26 CSO 87/3847, BOV AR (my emphasis), 16 December 1887.

27 Introduced in western Europe and the USA in 1953, and in Fiji by 1955 (CB, 14 March 1955).

sleep' or pentothal (Thiopentone) narcosis (1947), insulin injections to induce sweating (1955), and 'acid' treatment (1954).[28] Just before ECT was administered in Fiji, selected patients were injected with cardiozol (Metrazol) to induce convulsions.

These technologies had seriously unpredictable results. Electric currents were difficult to control in Fiji, and anaesthetics and muscle relaxants were not used in the early years. Some patients sustained teeth and bone injuries, memory loss and trauma. Shock therapies were not always therapeutic. The rationale for intervention was treatment, but oral and written evidence indicates that it was also used as a threat or means of control and punishment (cf. Braslow 1997:104–111). The medical superintendent's handwritten reports during the early 1950s state that ECT was being administered to pacify rowdy patients.

Despite interventionist medical experimentation, especially from the mid-twentieth century, forms of moral treatment persisted at St Giles (cf. Melling 1999:10). Work therapy was a cornerstone of this. Asylum practice in Britain and its colonies during the late nineteenth and twentieth centuries considered work to be therapeutic, a means of restoring moral, mental and physical normality, and of providing labour for the asylum. An application in 1888 from the asylum's chief warder for temporary prison labour was refused because 'the work must be done, as opportunity occurs, by the patients who may be physically fit'.[29] The BOV considered the cultivation of bush land near the asylum to be 'of much good in affording occupation for the inmates, which has been of assistance in the general supply of fresh vegetable food' (CSO 96/1898, BOV, AR, 1897). Asylum regulations stipulated that patients should, when possible, clean the wards. Patients were not always able to provide satisfactory labour, which in 1916 included the head attendant to suggest hiring a gardener. This request was declined on therapeutic and financial grounds: 'I hope the CMO will be able to induce the chronic patients to cultivate the available land. – It is the practice at Lunatic Asylums in other Colonies' (CSO 16/2206. 22 March 1916).

Constructing Madness

New constructions of madness and the management of this were part of Fiji's modernity. Not only was infrastructure and treatment important, but equally significant was how communities, observers and practitioners constituted madness. As Martha Kaplan (1989) has shown, the colonial project in Fiji was concerned with civilising indigenous Fijians. This was to be achieved through both the strengthening of selected traditions and the inculcation of new civilised values and institutions. This process identified and

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28 possibly nicotinic and glutanic acid

29 14 January 1888, Dr B. Corney, Acting Superintendent, to Chief Warder (file at St Giles).

constructed a Fijian 'order' that was separate from 'disorder'. To some extent this dichotomy can be applied to the delineation of normal and disordered minds. This raises the question of how Fijians constructed and managed madness. However, attempts to identify an 'authentic' indigenous construction of madness are problematic. Too often such excursions into ethno-psychiatry depend upon an essentialised notion of indigeniety and culture. A further problem in reconstructing localised constructions of insanity is the paucity and bias of written sources. Late nineteenth-century European accounts are suspect, given the preoccupation in Fiji with the decline of the indigenous population (Lukere 1997). Tropes of the uncaring and brutal 'savage' extended to accounts of care for mentally disordered Fijians: 'Families had such a repugnance to having deformed or maimed persons about them, that those who met with such misfortunes were invariably destroyed. [...] If sick persons had no friends, they were simply left to perish' (Fiji Museum 1984:47). By contrast, the debates about mental disorder among *girmitiyas* have been primarily represented as suicide and violence (see Lal 2000:215–238).

Communities did restrain mentally and socially disordered kin. In 1935 a Fijian widow was admitted to St Giles in a very weak condition, with numerous septic sores and swollen hands, because her relatives had been tying her up with rope to prevent 'nocturnal wandering'.[30] A 14-year-old Indo-Fijian admitted to St Giles in 1948 died there two years later. His family considered him an idiot and had kept him tied up. 'Watching' or close supervision was also a common means of managing insane behaviour. In 1897, a Fijian from the Ra district was 'supposed to be watched, but gets away at night, gets into houses and frightens people [...] witnesses say he wanders at night, breaks into neighbours' houses; dances and sings; occasionally violent' (No. 135). Fijian and Indo-Fijian healers were also called upon to provide an array of interventions from spiritual to community negotiations to the use of herbs, medicines, massage and diet to treat the mentally unwell.

Historic, ethnographic and linguistic evidence indicates that local communities in Fiji attributed madness to those who repeatedly demonstrated aberrant behaviour outside localised norms of rationality. Indigenous and Fiji Hindi words for 'crazy' were sometimes entered on medical certificates. 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 spiritual or metaphysical states. Indigenous Fijian notions of mental disorder were located within generalised concepts of wellness and illness, and entwined with community, spirit and ancestral worlds (Becker 1995). Again, diagnosis was part of the treatment of such afflictions.

How was localised discourse on madness informed by modernity and shaped to fit new classifications and constructions of the normal rational individual? This next

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30 The following quotations are from admission papers to St. Gilles. Names are not given but admission numbers are cited, as in this case, No. 1138.

section considers first, lay, legal and medical observations of the mad; secondly, assigned causes of insanity (aetiology); and thirdly, official medical classifications of mental illness (nosology).

Admissions and observations

Classification as 'mad' operated at several levels in Fiji and was discursively framed in different social contexts. Only a small minority of those considered mad by their communities became legally insane. Certification papers are the only remaining texts relating to this process and, along with archival material, they provide a glimpse into the categorisation of madness in Fiji.

Often the impetus to hand such individuals over to the care of the state came from the lunatic's family or immediate community (cf. Suzuki 1999:116). Most certificates were issued in Suva by doctors who knew little about the patient's condition and relied upon their observations and those who described the patient's madness during their transition to certification. Such observations revealed how madness was identified and ultimately categorised: equally texts reflected the mind-sets of observers. Evidence of madness came from various sources including patients and families, provincial heads (*rokos*), district heads (*bulis*), chiefs, ministers of religion, police, local magistrates, teachers and employers. Although local observations were significant in constructing the mad subject, written documentation was also a product of European medical discourse.

The majority of ethnic Fijians admitted to St Giles came from villages. Why did families decide that members should be committed and incarcerated in this distant institution? Indigenous communities had cared for and controlled their mad people. But under colonialism this shifted along with an ambiguous attitude towards western medicine. Although hospitals were called places of death (*vale ni mate*), Fijians did embrace western biomedicine. Pivotal to this was the co-option of Fijians as doctors and nurses (Leckie n.d.) and the extension of western health care into rural areas. The state also bolstered the authority of Fijian officials, notably *rokos* and *bulis*, who assumed a key role in providing testimony concerning a villager's insanity: 'His Buli says he is mad' (No. 813, 1926). We need to consider this entanglement of colonial and indigenous structures to understand indigenous willingness to make use of the asylum. Practical problems of family care were significant, but equally boundaries of acceptable behaviour shifted, so that modern concepts of mental abnormality became entwined in local constructions. British notions of orderly society became articulated with indigenous worlds (Kaplan 1995:360).

Kin and community observations offer insight into why local communities had their members committed to the asylum. This often occurred when local codes of morality and of the toleration of violence were transgressed, but supporting evidence

of insanity frequently included defiance of customary codes.[31] When a male Fijian villager was committed to St Giles in 1903, his transgressions included having 'walked upright and spoke freely in defiance of Fijian etiquette before the Roko. [...] entered stores and helped himself to goods, entered before Bulis and eaten food prepared for them' (No. 212). At some stage such behaviour became intolerable, when the Buli Vuna complained of Nemaia 'continually removing clothes, exposing genital organs to women and others in village, making a general nuisance of self by digging up young *yagona* roots and other crops without permission' (No. 1326). Villagers did not tolerate repeated acts of violence to people, animals or property. In 1937, a Buli reported that a Fijian clerk had been beating his children without reason, had increasing tendencies to violence, was sleepless and wandered aimlessly about at night (No. 1180). An Indo-Fijian farmer was committed in 1920 after destroying his neighbours' pumpkins, pulling cane off the trucks and leaving his crops untended. In the case of many *girmitiyas*, observations were made of their experience at work or in plantation hospitals. A hospital attendant testified in a suicide enquiry during 1891 that the deceased, 'At first behaved quietly singing a little during the day alternated by bursts of laughter without apparent cause. I believe he was undoubtedly out of his mind' (CSO 91/1169).

During the early twentieth century a large proportion of patients admitted to St Giles were destitute. The majority were poor Indo-Fijians who had ended their indentures. Indo-Fijian admissions peaked after World War I, when the indenture system had been abolished but the family farm system was yet to be extensively established. The sad fate of two former Indo-Fijian indentured servants admitted in 1918 reveals this physical and mental deterioration. A male lunatic who had been living in the bush was described by police as having a 'wild appearance; neglected sores on body; disconnected stories; delusions as to devils persecuting him; clothes torn up' (No. 553). A female 'mental deficient' was found crawling along the road (No. 555). Within eight months these patients had died in the asylum. A few indigenous Fijians were admitted as a lunatic not under proper care and control, such as a Fijian woman in 1907, 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' (No. 277). She died six months later in the asylum. Some who were destitute were convicted of criminal offences, and there were always homicidal patients at St Giles who had been compulsorily admitted under 'Governor's Order'.

The gendering of medical and lay observations is striking (Leckie 2003). Discourse on women's insanity repeatedly refers to their morality and sexuality, particularly public displays of 'obscenity', 'nudity' and 'indecent exposure' (cf. Showalter 1985:74). Several texts refer to villagers' complaints of mad women behaving 'extrav-

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31 Goddard (1998:63) found that the Kaugel people accepted insane behaviour, but not when this was violent or when social obligations were ignored. Sadowsky (1999:viii) argues that not only the state but also local communities recognised mad individuals.

agantly', 'indecently,' and 'desiring connection' with men in their villages. Moral judgements are also striking on women's admission certificates, such as one dated 1898 concerning an indigenous woman who had led a 'loose and immoral life to excess lately', including 'indecent behaviour, frequently exposing herself and using indecent language in her *mekes*' (Fijian dances) (No. 119).

Aetiology in colonial Fiji

The application of modern psychiatry to Fiji came within the context of Victorian psychiatry, which by the 1880s increasingly favoured physical as opposed to moral or psychological diagnoses (Clark 1981:271). However, in practice this dichotomy was not always so extreme. Discourses of both moral and organic insanity were evident in the Fiji records. According to Showalter (1985:29), 'Moral insanity redefined madness, not as a loss of reason, but as deviance from socially accepted behavior'.

Gendered differences figured prominently in assigning cause. Women's insanity, more than men's, was attributed to domestic and sexual causes such as a love affair, infidelity, jealousy, 'matrimonial unhappiness' or 'domestic troubles'. Saini's madness, for example, 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 [...] (testimony of Native Commissioner, 1898) (No. 145).

Moral judgements also linked prostitution with female insanity. In 1899, a 17-year-old Fijian admitted from Naitasiri District with severe mental distress had attempted to kill her child and showed 'remorse for leading life of abandoned prostitute' (No. 52). Six months later she was discharged and married the child's father, considered 'generally decent' in personal habits, but, suffering from 'mania of pregnancy', she was readmitted to the asylum. By the nineteenth century western science had identified puerperal insanity as a uniquely female cause and diagnosis of madness (Marland 1999). This located women within a mire of biological and moral insanity; their physiology or the circumstances of birth were causes of insanity, but their inability to respond as 'normal mothers' could also constitute a moral assessment.

'Masturbatory insanity' (Hare 1998:146–173), another common cause and classification during the Victorian period, was rarely noted in Fiji. One exception was a Polynesian, aged 15, who was admitted to the asylum in 1884 because he 'continually masturbated and had long fits of crying' (No. 5), while another was a European admitted in 1885 with insanity said to be caused by masturbation that made him delusional and incoherent (No. 18). Alcohol and opium addiction also figured much less in the

aetiology of insanity in colonial Fiji compared to asylums elsewhere (e.g. Holloway 2001:163–164).

The main causes of men's moral insanity in Fiji were problems with money or unemployment. Men were also more likely than women to have insanity attributed to religious mania, which was considered another form of moral insanity. These delusions (or beliefs) articulated Christianity with local religions. Isoa was committed to St Giles after chasing a villager with an axe. He was convinced that the god Dakuwaqa and a 'friendly spirit' called Vodii were struggling within his head. When Vodii failed to expel Dakuwaqa, Isoa tried to drag the god out by slitting his own throat (No. 387). In another religious context, Raghu was consumed by the goddess Kali who was living within his body because he had 'offended' her. Raghu's 'attacks' were preceded by prolonged fasting and silence in order to deprecate Kali's anger (No. 51).

The gendering of madness aetiology also applied to organic causes, with men being more likely than women to have insanity attributed to an accident, usually to the head. Little moral responsibility could be apportioned when physical illnesses such as influenza, typhoid, measles or 'dengue fever' were cited as causing madness. The exception was 'general paralysis of the insane', a form of tertiary stage syphilis. Heredity, senility and dementia, which embraced all genders, ethnicities, classes, and ages, provided homogeneous causes of somatic madness in Fiji.

'Nosology' in colonial Fiji

Asylum patients, each with their own separate mental worlds and behaviour were accorded a space within early scientific classifications of mental diseases (Busfield 1986:35–79). The meanings behind these shifted, as did conceptual frames in psychiatry and nosology (Berrios 1996). Swartz's (1995) examination of the changing content of psychiatric classifications in Cape Colony in 1891–1920 highlighted the problems of retrospectively applying modern psychiatric diagnoses and showed how racial attitudes influenced the application of modern psychiatric nosology.

In colonial Fiji classifications of mental diseases varied between admission papers, annual reports and the Blue Books. From 1884 until 1922 the latter standardised mental illness into: 'Maniacal and Dangerous; Quiet Chronic; Melancholy and Suicidal; Idiotic, Paralytic, Epileptic'. Annual reports after 1909 adopted standard British categories for 'local diseases (mental)': mania, melancholia, dementia, delusional insanity, and general paralysis of the insane.

The great leap forward within the nosology of mental illness in Fiji came when doctors were armed with knowledge about manic depression, and later, schizophrenia. Such classifications remained arbitrary. The 1935 asylum report noted only two out of 124 patients with manic depressive insanity, but two years later this jumped to 77. A few patients were admitted with schizophrenia, but there is no record of depression or

melancholia. Twenty-two cases were classified under reactive and toxic insanities, but this classification soon fell out of favour in Fiji. The ambiguity of modern classifications was confirmed in the asylum's 1938 report: 'the first attempt to re-classify patients under a modern classification but suggests that the categories need re-examination'. The 1944 report classified 70 out of 107 cases as manic depressive insanity. Sixteen cases were diagnosed as paranoia and paranoid states. The rapid shift within nosology from manic depression to schizophrenia indicates how subjective disease classifications were: schizophrenia accounted for four cases in 1944 compared to 96 patients in 1956.

These nosological shifts had little relevance for management or treatment. The dramatic shift from manic depressive to schizophrenic categories (despite these being mostly the same patients) indicates that categorisations were only vaguely indicative of a patient's condition. Often for the sake of following British typology and to present classificatory neatness, different mental disorders were subsumed under homogenous headings. Swartz (1995:450) notes: 'For all doctors in the colonies, using statistical tables was a concrete expression of connectedness to British standards of expertise'. Nosology also depended upon observation, interpretation and the discourse of medical experts, which increasingly superseded lay wisdom (cf. Suzuki 1999:128). Modern western psychiatric discourse became assimilated into the 'medical gaze'. For example, the 'systemisation' of 'rational' thought and delusional worlds were assessed. By the 1930s in Fiji phrases such as 'no logical flight of ideas' are common, and a patient's 'disorientation' and 'insight' might be assessed.

Conclusion: The Colonial Asylum And Social Control

Why were an asylum and lunacy legislation introduced to Fiji? There were no global definitions of sanity or insanity, nor of the care and institutionalisation of the mentally ill (Tucker 1887). Waltraud Ernst (1999a:95) concurs: 'the way in which racial ideas informed the development of asylum institutions and official discussion in various colonial localities exhibits little trace of any single homogenising influence or of an all-pervasive, focused, colonial or psychiatric gaze'.

Fiji shared much with other British colonies, but history, environment and culture mediated the management of madness there. The timing of institutional colonialism in Fiji was pertinent, especially given the establishment of legal and medical structures in the 1880s. Fiji's colonial institutions emerged from Victorian Britain but were also influenced by colonial experience elsewhere, particularly Australia and New Zealand. This included the contradictory agendas of constraint and moral management in the care of those certified mentally ill. But Fiji was culturally and ethnically distinctive. Europeans were dominant in the colonial political economy, but they consti-

tuted a minority compared to other settler colonies. Although indigenous Fijians were ostensibly protected by the civilising mission and practice of indirect rule, they were not immune from social or mental distress. The agenda of separate Fijian development depended upon a large number of indentured labourers from India. This displacement induced mental and physical trauma, which in turn facilitated the need for care.

Contemporaries offered insights into the rationale for establishing a modern institution for the insane, the asylum, in Fiji. The humane care of the helpless and the insane was a marker of modern civilisation (cf. McCulloch 1995:43). Nineteenth-century reformers had faith in the restorative and curative potential of humane control within an asylum. They acknowledged that while the spread of civilisation and modernity increased insanity, the tools and values of westernisation could treat and reduce the incidence of madness. The expansion of a seemingly 'superior' society wrought physical, cultural and mental dislocation on millions of colonised people, not only through brute conquest and disease, but also through modernisation. Long before social scientists in Africa identified the evils of rapid modernisation leading to 'deculturation' (McCulloch 1995), in Fiji the British, along with traditional authorities, tried to 'preserve' indigenous culture and the dislocation of modernisation.

Positivist renderings of the rise of western medicine are now relegated to the dregs of post-colonialism. In assessing the 'anti-psychiatrists' of the 1960s, Roy Porter (1987:235) emphasises that 'mental illness is a repressive invention of society and/or psychiatry. To the historian they have suggested that the history of madness and psychiatry should be regarded not as a saga of scientific progress but as the extension of social policing'. This followed from Foucault's (1965) connection of the social construction of madness with modern power and social control.

How can we read social control and the management of madness in a colonial setting? Fiji's lunacy management was not just concerned with caring but with the control of the insane. This suggests that the establishment of the asylum was also located within the extension of public order and social control in Fiji. Was this sheer repression, or rather symbolic of colonial authority and civilisation? Colonial studies elsewhere provide varying interpretations, acknowledging to differing degrees the significance of medicine as an 'agent of empire' (Coleborne 2001:106). Franz Fanon was adamant that colonial psychiatry in Africa constituted part of the system of colonial control (Deacon 1999:101). Likewise, in Papua New Guinea, Goddard (1992:55) considers the modernisation of madness to be part of social control. Ernst is more ambivalent in equating asylums with social control in colonial India, but she stresses the symbolic significance of lunatic asylums as 'showpieces and justifications of British colonialism at work in India' (Ernst 1999b:246).

St Giles was never considered a grand colonial institution and has always had an uneasy representation as a 'prison' rather than a hospital. Locals referred to it as 'vale ni mate', 'tin shack', or a 'dumping ground'. It was mostly 'starved' of funds (CSO 27/3359, 19 August 1927), a similar predicament that Marks found in colonial South

Africa. 'Small, understaffed, chronically short of funds, it is difficult to see the asylum as a major agent of social control [...]' (Marks 1999:270, Vaughan 1991:120). An exaggerated emphasis on hegemonic colonial power can obscure the extent to which many colonial projects were flawed and haphazard (cf. Sadowsky 1999:115), but lunacy legislation and the asylum were still disciplinary institutions (cf. Mills 2000:7). Asylums shared functional similarities with other modern institutions like prisons, factories and schools (Gutting 1994:345). We can see the resonance of Foucault's analysis of disciplinary regimes in the pervasive interventions of control, treatment and cure directed at mad bodies. Control and treatment of the mind was manifested through control and care of the body.

Modern psychiatry had a limited impact in colonial Fiji, but classifications and decisions about mental normality or abnormality were part of what Anne McClintock (1995:48) has described as 'state intervention, not only in public life but also in the most intimate domestic arrangements of metropolis and colony'. Once individuals were certified as insane, a seemingly authoritative and homogenous law and biomedicine swung into action. The management of madness went to the heart of externally imposed constructions of personhood, delineating boundaries of sanity. Vaughan suggests that colonial social control and constructions of normality or abnormality were constitutive of the modern individual (and colonial) subject:

> in British colonial Africa, medicine and its associated disciplines played an important part in constructing 'the African' as an object of knowledge, and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power (Vaughan 1991:8).

Only a small proportion of Fiji's mentally disturbed were incarcerated in St Giles, hardly constituting a 'great confinement'. This was probably because communities normally took responsibility for their insane members themselves. But once the asylum was established, communities could to some extent negotiate their limits of care and control. Boundaries of acceptable behaviour also shifted, so that modern concepts of mental abnormality became entwined in local constructions. Rather than placing the incursion of modern madness management against the extremes of either a humane civilising mission or hegemonic social control, we need to emphasise the articulation of modern biomedicine and ordered minds with local communities.

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