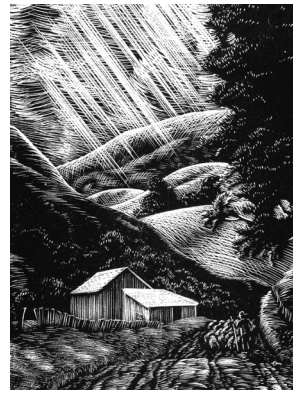

Old Black Cloud
Jacqueline Leckie
A cultural history of mental depression in Aotearoa New Zealand



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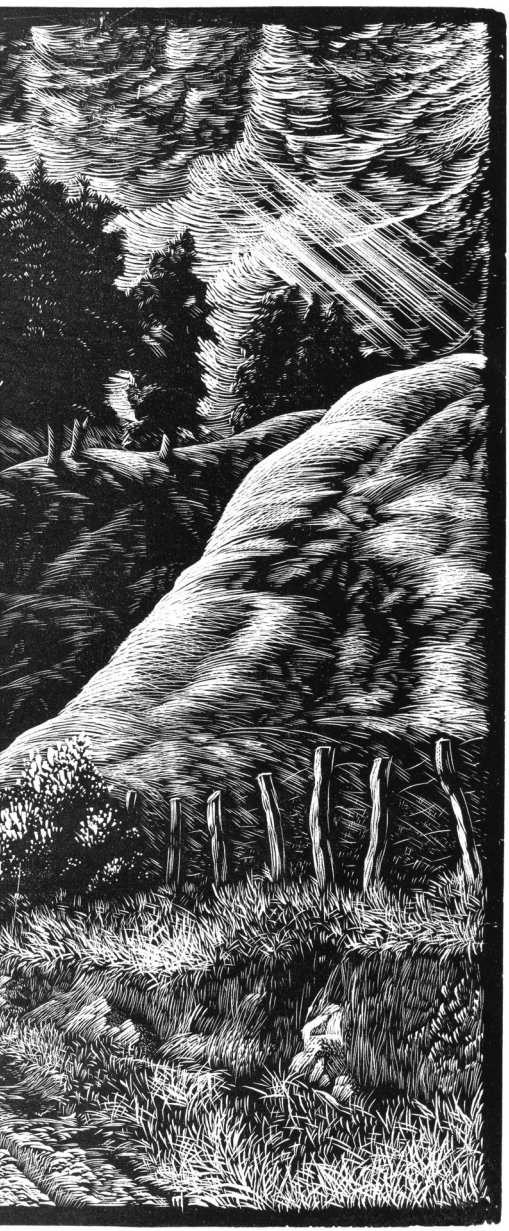

Old Black Cloud

A cultural history of mental depression in Aotearoa New Zealand

Jacqueline Leckie

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Previous page: E. Mervyn Taylor,
Dark Valley, 1937

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Introduction

When, in the 1990s, my family doctor put it to me that I was depressed, the biochemical model of brain chemistry was ascendant in the understanding and treatment of depression.[1] This science emphasised an imbalance of neurotransmitters — chemical messengers — whereby depression is linked to a lack of serotonin receptors in the brain, serotonin being responsible for many key body functions, such as mood modulation, feelings of reward, sleep, digestion and healing, among many others. The implication was that my depression was due to a biochemical imbalance instead of, or perhaps in combination with, my grief over my mother's recent death.

At times during my life I have been prescribed medications and encountered therapists who have pushed different approaches to coping with depression that seemed to relate to major loss. In 1979, after my former husband's sudden disappearance to live with another woman, an expensive therapy session involved facing a large circle of coloured cushions that I was meant to beat or embrace. I couldn't inflict such actions on those bits of fluff. This was a version of the Gestalt therapy that I had learned about in a first-year university psychology paper, but even so my imagination fell short. Fortunately — thanks to the excellent public health system of the time — I was treated by an empathetic psychiatrist at Auckland Hospital. We explored my family history and dynamics, my economically

poor background, politics and, yes, my relationship with my mother. The sessions were structured loosely within psychoanalysis.

That psychiatrist saved my life and encouraged me to complete my PhD and pursue a career.[2] I still recall walking along the Devonport waterfront in 1980, and seeing the sun setting, smelling the sea, hearing the waves and the seagulls and feeling the warmth of the day. For at least the previous year I had felt absolutely nothing except pain.

Depression still lurked in my background and could become unbearable when I experienced intimate or professional stress, or profound loneliness. But like so many people living with depression, I pressed on with hard work, a demanding but rewarding career, and immersed myself in social activism through concern for the suffering of others. My sense of loneliness did not preclude a vibrant social life and wonderful friendships.

My closest bond was with my wonderful mum, Violet, who was born in 1922. She was prone to deep sadness; probably today this would bring a diagnosis of depression. She was also very ill throughout her life with cardiovascular and kidney illness. Her own mother had died when she was only nine years old. Her family was poor, and there could have been abuse.

One of Mum's sisters, who was also my godmother, shot herself in the head in 1961.[3] She had been a patient at Seacliff Psychiatric Hospital, at Karitane, north of Dunedin, and her mental turmoil included suffering from depression. Mum was devastated by her sister's death, and Mum's unhappy marriage and financial hardship also contributed to her own despondency. Her mood disturbance may have been accelerated by the side effects of the drugs she was taking for her heart condition, such as Serpasil (reserpine). Nevertheless, Mum was full of fun and spontaneity, and taught me the exuberance and power of trying and enduring, despite living under a 'black cloud'.

My depression returned after Mum's sudden death on 4 September 1994. The grief was prolonged and numbing, so my doctor prescribed the new wonder drug Prozac, which worked for me, and I began to feel better. After I gave birth to my daughter, Tara, in 1998, I felt very low but I never reached the depths of postnatal depression that many women in Aotearoa have experienced.[4]

My mental descent resumed when redundancy faced several staff in the Division of Humanities at Otago University in 2016. When I lost my

academic position of 26 years, my decline into depression was rapid, and I knew how serious this could be if not dealt with. So, even amid the chaos of Christmas, I managed to see my fantastic family doctor. Meanwhile the wonderful support of family, friends and colleagues kept me going. As did the memory of my late mother's love and words of advice to keep trying.

Mine is just one perspective of how the black cloud can cast its shadow over people's lives, but also how they may reflect upon this experience. The book explores the much greater variation of how depression is expressed and experienced over time and place, and across cultures in Aotearoa, with individuals having a range of outcomes. It also traces how the language and treatments for depression have changed.

During the twenty-first century there has been a backlash, both globally and in Aotearoa, against the medicalisation of depression, and a view has emerged that depression is just part of life's woes.[5] After all, our ancestors went through economic depression and wars, raised families and endured difficult marriages, and yet took such adversity in their stride. Given my personal experience with mental health, and interactions with health professionals, alongside academic research in the history of mental health, including within different cultures, I am aware of the way attitudes, diagnoses and treatments change over time. I would suggest that many people in the past, as today, did *not* cope with life's upheavals, often with disastrous consequences.

Depression, far from being new, hangs over humanity. And although those who are prone to depression may endure several years of relief, the dark cloud is always on the horizon. The New Zealand writer Alistair Te Ariki Campbell wrote to his wife, Meg Campbell, in 1963:

> As you know, when you start improving, you don't as a rule climb steadily to the surface. You still have ups and downs, but the troughs get steadily shallower. So keep your pecker up, my sweet.[6]

In 2019 Wendy Parkins, an academic at the University of Otago and later a professor of English in the United Kingdom, wrote an insightful memoir

about living with depression, anxiety and obsessive-compulsive disorder in which she described the slow, but hardly dramatic, path to some kind of acceptance and recovery.

> Think of what makes you feel alive, what gives you vitality, and then think of the absence of all those qualities. You're not dead — you get up each day and drag yourself around the daily routines, or as many of them as you can still manage — but it's not much of a life. You're un-alive . . . When I did not have the energy to work I somehow always had the energy for plenty of self-reviling . . .
>
> It's like living underwater or inside a tunnel — life is going on elsewhere, where people are managing to have fun and also pay their bills on time. You can catch a glimpse of them and their world, you may even vaguely recall living there yourself, but you can't get to it. A numbing inertia robs you of the capacity to be either convivial or responsible. And the desire for recovery becomes simply a wish to live a quiet life without desperation.[7]

This book is a history of depression and its forebear, melancholia, in Aotearoa New Zealand. It is not a memoir, even less a therapy book. Rather it aims to show how diverse cultures and ethnicities have experienced and lived with mental depression in our past.

Today there is rightful concern, globally and in Aotearoa, about a contemporary and unprecedented epidemic of depression, but this book reveals that depression has long plagued people within all cultures, across wide-ranging environments and circumstances. What we now recognise as depression may have once been called melancholia, nervous disease or simply part of life's woes. Over the years people who live with depression have endured and tried to overcome it in a range of ways, from confinement in mental asylums and hospitals and care within the community to spirituality, drugs and technologies, or talking and other therapies.

The language and stories in this book can be confronting and disturbing. Depression can lead some people into extreme black holes, but most people who have encountered depression — whether their own or that of loved ones — press on; like mine, their lives are not constantly consumed by it.

The dark outcomes for some that are described in this book are neither inevitable nor unavoidable.

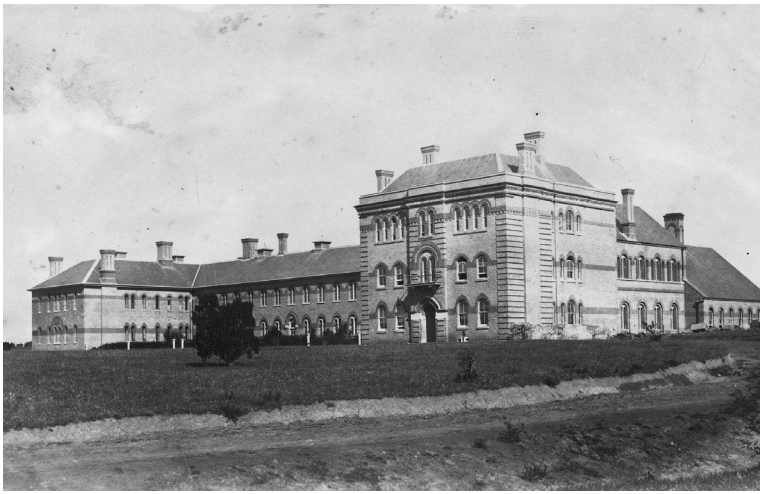
Mental health hospital records, mostly of asylums and hospitals, are key to researching the early history of depression in Aotearoa. These archives may contain patient registers, case notes and admission papers. Under the 1846 Lunatics Ordinance a mentally ill person who threatened public safety or themselves, or who was unable to care for themselves or had no one else to do so, could be certified by two doctors and a magistrate and compulsorily held in either in a gaol, a hospital or an asylum.[8]

The ordinance was replaced by the Lunatics Act in 1868, with revisions in 1882 and 1908. Its successor, the 1911 Mental Defectives Act, enabled people to admit themselves voluntarily. The current Mental Health Act was passed in 1969 and remains in force, with subsequent revisions and the lengthening of its title to the Mental Health (Compulsory Assessment and Treatment) Act in 1992.

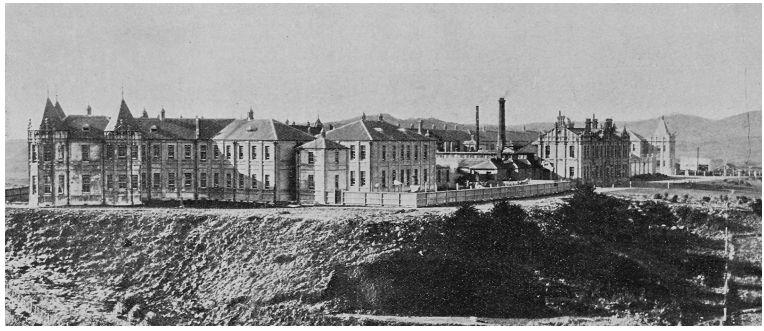
Asylum and hospital records can provide only a partial history of depression, however, because most sufferers of the condition were never certified as insane or of unsound mind, and so did not fall within the medical system's ambit. Although there are records for those who were admitted, access to these mental health records remains hugely restricted, usually for 100 years following admission. Even then, their notes may appear in case books that extend beyond that date and so are out of bounds, meaning that only part of the story is available.

For example, I tried to research the early mental health records of Jane Dick from Scotland — whose story is told in chapter 3, and who was admitted to Seacliff Mental Hospital in 1923 — but her case notes are likely to be in volumes that extend beyond that date given that she lived for many years after her first admission. Because of the privacy restrictions on New Zealand's mental health records, I could not consult most public mental hospital records after about 1916.[9]

Within those parameters I have sampled accessible records at the mental asylums and hospitals in Auckland, Dunedin, Hokitika and Christchurch. In 1911 the official term 'asylum' was nationally replaced by that of 'mental



Clockwise from top left:
Auckland Lunatic Asylum, Point Chevalier, 1870s; Seacliff Mental Hospital, north of Dunedin, c. 1917; Seaview Lunatic Asylum, Hokitika, c. 1904; Porirua Lunatic Asylum, Wellington, 1903; Sunnyside Lunatic Asylum, Christchurch, 1906.



hospital'. Auckland's first asylum was the Whau Lunatic Asylum, later named the Auckland Provincial Lunatic Asylum and then the Auckland Mental Hospital.[10] I consulted its records dating from 1853 to 1916. Otago was served between 1863 and 1878 by the Dunedin Lunatic Asylum, which from 1879 shifted further up the coast to the Seacliff Lunatic Asylum, later renamed the Seacliff Mental Hospital. Its records were available from 1879 to 1916.

Mentally ill patients on the West Coast were initially admitted to the lunatic ward at South Spit Hospital in Hokitika, then to the Seaview Lunatic Asylum, later renamed the Seaview Psychiatric Hospital. I researched its records dating from 1869 to 1916. For Canterbury patients I was able to access the records of Sunnyside Lunatic Asylum and Sunnyside Psychiatric Hospital dating from 1863 to 1917.

For public hospitals I selected records within the date ranges of the earliest available, 1900, and latest available (usually in the years before 1916). With Ashburn Hall, a private psychiatric hospital in Dunedin, I sampled records at five-yearly intervals to identify cases of melancholia and depression from 1885 until October 1945 (51 cases: 18 males and 33 females). I also examined the first 100 cases for melancholia, and checked admissions for 1948 at Ashburn. But because of access restrictions to the individuals' actual mental health records, we often do not know what happened to these patients after they were admitted to a psychiatric institution.

Record-keeping procedures also varied between asylums and hospitals, meaning that a quantitative analysis of melancholia and depression across asylums is not possible. During the early colonial years, diagnoses were not always recorded, making it difficult to identify patients who were possibly admitted with depression. For example, early records at Sunnyside Lunatic Asylum in Christchurch often only recorded terms such as 'mentally insane'. Mental health diagnoses have been and remain subjective, being heavily dependent on experts' training, knowledge and experience.[11] Doctors' assessment of patients relied on testimony provided by family, whānau, friends, police, employers and others. Patient records for Ashburn Hall often contained elaborate family trees (genealogical charts) to show how insanity could be hereditary. This early medical 'science' provides only limited insight into the history of depression in Aotearoa.

Although I draw heavily on mental hospital records before 1920 for

primary data, as I emphasise throughout the book, and elaborate on in chapter 7, in Aotearoa most people with depression either soldiered on — often denying their pain, perhaps diverting it through hard work, care for others, their faith or substance abuse — or had the support of whānau, family and friends. Family doctors might be turned to but, until antidepressants became available from the late 1950s, the medication that general practitioners could offer was limited. It is not surprising, therefore, that many people self-medicated through over-the-counter medicines or turned to alternative practitioners, known as quacks.

The asylum records I had access to provided only sparse, if any, details of the treatments patients received within the asylum or mental hospital. Before the 1950s, there was certainly very little drug therapy available for the treatment of melancholia or depression apart from the sedatives described in chapter 7. Generally, hospital regimens stressed the importance of routines such as regular meals, maintaining personal cleanliness, sleep, and working within the hospital or its grounds. At some asylums, such as Seaview in Hokitika, capable patients could work outside the asylum during the day, and some asylums had farms. In most asylums wholesome recreational and social activities — such as exercise, sports, games, needlework (for the ladies), dances and Christian worship — were encouraged for those patients able to participate. Melancholic patients were not usually restrained unless they became unruly.

Clearly, then, patient records can form only part of this history of depression in Aotearoa. In any event, as American historian Jonathan Sadowsky has pointed out, archives are not always the best source for unearthing histories of depression: 'The strength of asylums and hospitals for historical research is also their weakness: they are document factories, and historians need documents . . . Depression is often a "quiet" condition, with a lot of pain directed inward, and less "acting out".'[12]

Few public records speak to a mental state such as depression because most sufferers did not ever encounter a psychiatric professional. So how did those who were not institutionalised experience depression? And how did communities deal with melancholia and depression, and what is unique within Aotearoa?

Sadowsky has also found the use of oral history in histories of mental illness challenging because of privacy concerns. I, too, faced this ethical

issue, but in reverse: it was access to the archival evidence the historian craves that was made difficult due to privacy issues. Jane Dick's story is one example of the complexity and frustration of unearthing oral and archival histories of depression. Her grandchildren supported her narrative being retold in this book, and much of her story has been verified through non-medical public records and family memories, but persistent requests to the Southern District Health Board to access Jane's records as a patient at Seacliff Mental Hospital, Orokonui Hospital and Cherry Farm Psychiatric Hospital from 1923 to 1975 were denied. I was informed that Jane Dick was not identifiable in any of the Otago records, yet when I consulted the national index of patients at the archives in Wellington, her admission as a patient was recorded.[13]

To enrich this history, I have used sources from the media, coronial inquiries, military records, and genealogy sites and collections, many available online.[14] These sources often enable investigation of individuals well after access to asylum records is closed. Other sources for non-asylum records were memoirs, creative outputs, student dissertations, and manuscripts and oral histories deposited in the Alexander Turnbull Library and in the Hocken Collections.

There are now many governmental and non-governmental online documents and websites on mental health and depression in Aotearoa, some of which contain case studies and provide insight into diverse cultures. The epilogue makes considerable use of material available through the internet.

Citing historical data related to mental health is also contentious and complicated. Privacy guidelines and legislation must be followed. Some historians, survivors and descendants of those with mental illness consider that keeping names hidden perpetuates an unhealthy silence and stigma. Where feasible, I have followed the convention of referring to a mental health patient by their first name, followed by the initial of their surname. This style does not always apply to people with different cultural and naming practices. It is difficult to keep private earlier patients' names that are now accessible through archives. Sometimes, when a name has been published, I disclose this. In a few sensitive cases I have used pseudonyms.

Coronial inquests up until around 1970 are openly available through New Zealand's national archives. Again, I have used first names when

referring to these records. Although I was given access to some later coronial inquests, I am not allowed to publish this material — a situation very different to that faced by historian John Weaver, whose 2014 book *Sorrows of the Century* analysed data from twentieth-century coronial records that could be published.[15]

Citation from theses or secondary sources usually follows the styles those authors have used. Dissertations written by medical school students within the fifth-year programme of preventative medicine at the University of Otago from the 1920s until the 1970s provide a good insight into mental and public health in Aotearoa. However, strict conditions are imposed by the Hocken Collections on reading these dissertations to ensure the privacy of both the participants and the students. The coursework of the latter was never intended to be in the public domain, and it is also a matter of sensitivity to the authors' ages and career stages at the time of their writing.

Old Black Cloud traces a history of mental depression in Aotearoa through various themes that span the nineteenth century through to the late twentieth century, and with an epilogue that reaches into the twenty-first century. The title is a twist on Aotearoa as the 'land of the long white cloud', derived from the title of a book written in 1898 by the politician, writer and poet William Pember Reeves.[16]

This book digs into our past, long before depression was regarded as an epidemic in Aotearoa. Between 2011 and 2021 the recorded rates of depression in New Zealand increased from 14 per cent to 17 per cent; rates among Māori rose from 15 per cent to 21 per cent.[17] The 2017/18 New Zealand Mental Health Survey found that Māori and Pasifika, along with women and the poor, were most at risk of being diagnosed with depression.

Here, Sadowsky's questioning of whether there is a global and contemporary epidemic of depression seems pertinent.[18] Certainly, depression is being diagnosed more than ever, but why is this so? Is it a genuine increase in incidence, or might the burgeoning statistics indicate that feelings of depression have become more medicalised, and therefore more prone to diagnosis, perhaps partly because of the global reach

and power of the pharmaceutical industry? And as more people become unafraid to seek support for the symptoms of depression, the medical statistics will likely increase accordingly. Again, we must ask whether the actual incidence of depression has increased, or whether it is rather a matter of depression having become more visible, as more of us who experience depression 'come out' and share our experience of living with it.

This book also considers depression within New Zealand's Indigenous and immigrant societies, cultures and environments. Historical and global literature have overlooked depression in Aotearoa and the South Pacific. Can depression be considered cross-culturally? And how do we avoid cultural stereotyping while acknowledging the different ways depression is recognised and treated within cultures and is clinically diagnosed?

The exploration of historical and cultural evidence again raises the question of whether depression is a modern 'disease'. What are the links with melancholia? How have depressive conditions and moods been medicalised? Interwoven throughout the chapters are the stories of how many people have lived with melancholia and depression. Only a small percentage were ever sent to mental institutions, and far fewer committed suicide. Many New Zealanders have silently lived with depression, or indeed have regarded their 'black cloud' as part of the human experience of sadness and life's woes rather than a medical illness. New Zealanders living with depression will often laugh at themselves; humour can mask depression, but it can also bring relief.

Mental depression is a serious issue within contemporary Aotearoa, and especially affects Māori, Pasifika, women and the poor, a radically different pattern compared to the colonial era, when depression was considered predominately the curse of 'civilised' men. To date there has been no history of mental depression in Aotearoa, in part because New Zealand has been somewhat peripheral in international medical history, and also because depression has been hidden under the long black cloud of Kiwi denial that we have not always lived up to the New Zealand ideal of being pragmatic and getting on with things. Mental depression may be universal, but how it has been experienced, understood, treated and lived with varies hugely. It is timely to offer this story from Aotearoa New Zealand.

1.

Discourse and diagnosis

At the end of 1930, when Aotearoa was beset by economic depression, unemployment and suffering, the director general of mental hospitals, Dr Theodore Gray, made an extraordinary speech at the launch of new radio equipment at Porirua Mental Hospital.

> I have no hesitation in asserting that the depression itself is of less moment to this country than is the manner in which the people of the country rise to meet their difficulties. Mass psychology is not a negligible factor in time of national stress, whether of war or of peace, and when times are hard our Cassandras, our prophetesses and prophets of woe, our defeatists, have their opportunity. Depression and gloomy foreboding . . . are highly contagious in a community and are liable to end disastrously to it in the same way as fear in an individual soldier may cause panic and stampede in a company or even an army in war.
>
> Appropriate remedies have to be taken for national as well as bodily disorders, but sheer funk pessimism and alarm should not be allowed to replace or be mistaken for prudence, for they will get us nowhere except into deeper waters. The spirit of a nation is the snip of the qualities possessed by its individual

> citizens, and it is in fostering a prudent, restrained optimism, a philosophic readiness to meet reverses with a smile and a community spirit of helpfulness.[1]

Gray's use of the discourse of mental depression to refer to the economic and social wellbeing of the nation was remarkable, as was his view that an optimistic spirit could lift the nation out of its doldrums. More than many, Gray would have known that there was no simple cure for depression. His speech also indicates how the discourse of depression has been a catch-all way of referring to individual and collective depression, in both a human and a material sense; the 'Great Depression' comes to mind. Other examples conflated the discourses of mental and economic depression; the New Zealand Women's Christian Temperance Movement, for example, recommended in 1931 that a 'smile' could lift sufferers from this fog:

> How we hate to read in our weather reports that a depression is approaching us over the Tasman Sea. But we sit calmly down and wait for that depression, and endure it until it passes on, fortunately not a long endurance. But a mental depression has overtaken our country, and we are wrapped in a fog of doubt, debt, uncertainty, and unemployment. Now, Christian women should rise above this mist and fog and dwell in the radiant sunshine of God's love and the clear atmosphere of faith in His promises.
>
> Were I an absolute ruler, I would enact a law that anybody talking about depression and [b]lack should be shut away by themselves. Let White Ribboners meet everybody with a smile, and like Pippa, tell it out 'God's In His Heaven, all's right with the world.'
>
> Fear has laid its deadly grip even on our churches; they dread for the future. Let fear give place to faith.[2]

The Congregational Church in Dunedin offered pragmatic suggestions for fighting the mental depression that so often accompanied economic depression for unemployed men. In the 1930s it operated a rest room 'to assist men to fight mental depression and to keep in a happy state of mind. We deem it important to keep unemployed men from becoming

disgruntled with life by filling their time with interests.'[3] This noble initiative echoed the New Zealand attitude that activity could stave off the 'blues', even if in 1932 being busy failed to relieve starvation.

During the second half of the twentieth century, mental depression became more tightly defined in a clinical sense, but since colonial times both medical and lay observers in Aotearoa have intertwined the terms 'depression' and 'melancholia'. The latter was a common medical diagnosis until 'mental depression' became a diagnostic category in the twentieth century. As the historian Jonathan Sadowsky has noted, the term 'depression' came into use in Europe during the eighteenth century to refer to a mood, while the terms 'melancholia' and 'melancholy' were descriptions of a sickness.[4]

Melancholia embraced mania, as well as a range of conditions including psychosis, anxiety, irrationality, neurasthenia, delusions, nostalgia, suicidal attempts and ideation, and acute and chronic depression.[5] Depression could be subsumed under the terms of melancholia, neurasthenia, mental or nervous breakdowns. For example, one man admitted to Seaview for seven months during 1884–1885 was diagnosed with melancholia, although his notes described him as 'depressed'.[6]

Elizabeth S.'s case notes for 1916–1919 at Sunnyside also show how melancholia and depression were used interchangeably.[7] On admission, her doctor described her as depressed, and worrying over everything. She could not provide any reason for jumping through a window or going out in the middle of the night. Her daughter stated that no one could live with her owing to her constant depression. She was diagnosed with melancholia. In 1917 Elizabeth was allowed to leave on probation, but later returned, depressed, to Sunnyside.

In 1947 a patient admitted to hospital in Gisborne suffered from melancholia and depression. He was to be sent to a mental hospital, but he disappeared from his bed after midnight and hanged himself.[8]

Global historiography has divergent and complex views on the relationship between melancholia and depression.[9] Most of this literature has concerned Western Europe and North America. In 1892 Daniel Tuke, an

alienist (a former term for psychiatrist), recorded mental depression in the *Dictionary of Psychological Medicine* as a synonym for melancholia. Nervous depression was defined as 'a term applied sometimes to a morbid fancy or melancholy of temporary duration'.[10] Janet Oppenheim, who wrote one of the first histories of depression in Victorian and Edwardian Britain, linked depression with nervous disease and neurasthenia, and emphasised the similarity between melancholia and depression.[11]

> Nervous breakdown, a popular name for incapacitating depression, is not a specific disease that can be traced to a single cause. It is an abstract concept, encompassing many symptoms that vary from one patient to another, with invariably devastating effect. The characteristic sense of overwhelming hopelessness, emptiness, impotence, and uselessness, the incapacity to focus attention or reach decisions, the obsessive thoughts and fears, the diminished self-esteem, the extreme lethargy, and the inability to take interest or pleasure in any aspect of life make existence scarcely tolerable.[12]

In 1984 the American psychiatrist Nancy Andreasen also stressed the link between melancholia and depression through taking a biological and organic — rather than a moral or social approach — to mental illness.[13] Psychiatrist and medical historian Stanley Jackson offered an inclusive view of the relationship between melancholia and depression in a survey of medical writings from over 2000 years in the Western and Islamic worlds:

> At any particular time during these many centuries the term that was in common use might have denoted a disease or a troublesome condition of sufficient severity and duration to be conceived of as a clinical entity; or it might have referred to a symptom within a cluster of symptoms that were thought to constitute a disease; or it might have been used to indicate a mood or emotional state of some duration, perhaps troublesome, certainly unusual, and yet not pathological, not a disease; or it might have referred to a temperament or type of character, involving a certain emotional tone and disposition, and yet not pathological; or it might have meant merely a feeling

> state of relatively short duration, unhappy in tone, but hardly a disease. These states were unusual mental states but covered a much wider spectrum than that covered by the term 'disease'.[14]

In Aotearoa, terms such as 'depression', 'melancholia' and 'melancholy' were used in both medical and popular discourse by the late nineteenth century. Elsewhere, 'depression' was often included in 'descriptive accounts of melancholic disorders to denote affect or mood, rather than having yet acquired any sort of formal status' as a diagnostic term.[15] Sadowsky includes 'melancholy in the history of depression because certain features, notably sadness that appears to others out of proportion to events, or gloomy expectation that a terrible fate await, are frequently if not always present . . . Some descriptions of melancholia look very similar to modern descriptions of depression, some less so.'[16]

Many historians pinpoint the shift in recognising depression as a diagnosis to European psychiatrists Emil Kraepelin and Adolf Meyer.[17] Kraepelin used the term 'depressive insanity' during the 1880s, but still referred to forms of 'melancholia'. Depression was commonly described as affect or mood, but the melancholias were considered to be types of mental depression. Manic-depressive insanity as a disease entity was introduced by Kraepelin in 1899. In 1904 Meyer advocated renaming melancholia as 'depression'. Although 'depression' became more widespread in medical discourse, 'melancholia' as a descriptor and diagnosis continued, including in Aotearoa.

Sadowsky's synthesis of melancholia and depression diagnoses stresses that the rising rates of depression reflected a drift; those who would once have been diagnosed with nerves or nervous breakdowns have since been diagnosed as depressed.[18] The word 'depression' retained reference as a mood, but by the 1960s (and I would suggest much earlier) increasingly had meaning as a disease. The historian Åsa Jansson, who teaches at Durham University, has also argued that melancholia as understood in the nineteenth century was different from clinical depression as understood today, suggesting the historical coexistence of two types of depression:

> One is a mild to moderate form of mood disorder, what is usually meant by the term 'clinical depression' today: low mood and sadness, often accompanied by sleeplessness, appetite

> disruption, and anxiety. The other is an endogenous form that is more than a mental disorder, it is an illness where the entire system is, in effect, 'pressed down', resulting in retarded speech and slow bodily movement. This illness often manifests with delusions (psychosis) and can in its most severe forms leave sufferers in a catatonic stupor. This condition is usually referred to as psychotic or melancholic depression.[19]

The American psychologist Gary Greenberg's take on the rise of depression in the twentieth century is evident in the title of his 2011 book *Manufacturing Depression: The Secret History of a Modern Disease*,[20] in which he asks whether the disease was promoted and marketed by drug companies to sell antidepressants. This was a critique of the biomedical model of depression, whereby unhappiness was increasingly considered an illness. A similar perspective had earlier been given by American professor of psychiatry Dan Blazer, whose 2005 book *The Age of Melancholy* placed depression within society and culture and the pressures of modern life (mainly in the United States), but argued that depression was reified as a disease, obscuring our emotionally toxic world.[21]

By the late nineteenth century, the concept of melancholia had been subdivided into various definitions by European and American psychiatrists, employing a disease classification process known as 'nosology'. This resulting nosology was transferred to Aotearoa by doctors who had trained in Britain, most in Scotland. They remained in touch with the global circulation of medical knowledge through medical journals and conferences, or when overseas experts visited. These were crucial ways of keeping up to date with the changing nature of psychiatry, especially when postgraduate qualifications in psychiatry were not available in Aotearoa until the second half of the twentieth century.

Although the Otago Medical School opened in 1875, for decades it offered only limited courses in what was termed 'mental pathology' and later 'mental disease'. Truby King, medical superintendent of the Seacliff asylum from 1889 to 1921 and who had a progressive approach to the

treatment of mentally ill patients, taught the first of these courses in the late 1880s, and provided clinical instruction. In 1910 Ashburn Hall established a neuro-pathological laboratory at Dunedin Hospital to train local doctors in mental pathology.[22] However, more specialised psychiatry was not taught in Aotearoa until 1953, when Dr Wallace Ironside from Leeds University was appointed at the medical school. In 1962 he became the first professor of psychological medicine when a separate department was established at Otago.[23] The Auckland Medical School did not open until 1968. John Werry, a New Zealander, was appointed from the University of Illinois as the first professor of psychiatry at Auckland.[24]

Meanwhile, during these slow decades in Aotearoa when medical students had very little exposure to the latest advances in psychiatry, and even less to the nuances of melancholia and depression, the public might be kept informed about these conditions through newspapers that reported on local and visiting medical experts, or when mental illness was implicated in murders or suicides. After the 1951 Coroners Act came into force, only limited details of deaths due to suicide could be published, and the names of these persons could not be disclosed.

The term 'simple melancholia' was coined by the British psychiatrists John Charles Bucknill, Daniel Tuke and Henry Maudsley to denote melancholia without delusions.[25] In 1898, *The Auckland Star* reported a lecture by Dr Burnet, from Kansas City Medical College: 'The first important symptom of simple melancholia is sleeplessness. Another symptom of the greatest importance, is a dull pain in the back of the neck, extending to the back of the head . . . The third symptom is depression of spirits, accompanied by slower mental movements and retarded speech and actions.'[26]

Some doctors were reluctant to equate simple melancholia with insanity — a precursor of the way in which depression has long been regarded as a mental condition that does not always require hospitalisation or legal certification as insane. But not so for Ernest C., a patient at Mount View Asylum in Wellington in 1897, who was diagnosed with simple melancholia. Even though Ernest ultimately committed suicide, the asylum's medical superintendent, Dr Gray Hassell, testified that he should not have been sent to the asylum because he was not insane.[27]

This tragedy drew attention to overcrowding, understaffing and the need for separate facilities in mental hospitals for patients with different

mental disorders. As early as 1870, John King, New Zealand's inspector of asylums, asked in his annual report whether nervous cases and those with melancholia should be treated separately within an asylum from long-term or severely mentally ill patients.[28]

A Wellington solicitor who was admitted to Ashburn Hall for 10 weeks in 1900 was diagnosed with simple melancholia. The medical superintendent doubted his insanity, despite a family tree revealing that nervousness ran in the family.[29] He had been working too hard, and it seems that 'time out' in a supportive environment was beneficial. A month after his admission he was cheerful and attending church and the theatre in Dunedin.

When Frederick W., a 53-year-old teacher at a native school, was admitted to Auckland Mental Hospital in 1915 he had simple melancholia, attributed to stress, overwork and dyspepsia (indigestion).[30] His case notes recorded his frightened appearance and his declaration that he had made a mess of his life and thought best to end it. 'He has lost confidence in his ability to teach and dreads returning to scholastic duties and the nearer he gets to this the more he becomes depressed,' his notes stated. He was afraid to be alone, and he told a doctor that he had experienced attacks of 'great depression' over many years 'during which he quite loses control of himself and screams and yells and is seized with the desire to end his life'. Frederick was discharged after four months, but his depression continued and he was readmitted.[31]

Despite the qualifier 'simple', this form of melancholia could be associated with violence. In 1912 a 29-year-old patient was admitted to Auckland Mental Hospital after striking her mother in the throat and saying that she wished that her parents were dead.[32] She had spent several months at Porirua Mental Hospital, and remained in the Auckland Mental Hospital for eight years. A man from Waihi, with at least three admissions to Auckland Mental Hospital between 1912 and 1917, threatened self-violence and violence against others; contrary to the usual definition of simple melancholia, he heard voices telling him to commit suicide, saying 'you are going mad'.[33] His case notes recorded both the terms 'melancholy' and 'depressed'.

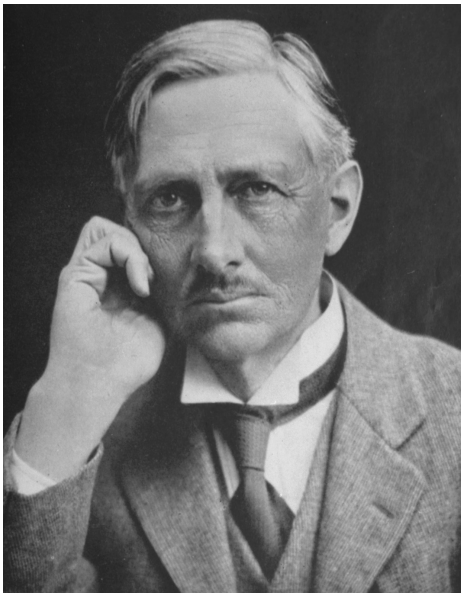
When returned soldier Jack Oldfield murdered his wife, Christine, only four weeks after they had married, in 1930 at Seadown near Tīmaru, doctors Thomas Beale and F. F. A. Ulrich, and medical superintendents

Alexander McKillop of Sunnyside Mental Hospital and T. W. J. Charles of Seacliff Mental Hospital, gave conflicting expert opinions at his trial as to whether he was insane or rational at the time of the act. They agreed that he had intended to kill himself, and that he was suffering from severe depression. Ulrich qualified this as simple melancholia brought on by the plummeting value of Oldfield's farm and probably also from the ongoing effects of war wounds, which compromised his ability to work. (Chapter 4 further discusses how depression and suicide could be consequences of the lingering effects of injuries sustained in the First World War, combined with economic worries during the Great Depression.) Did these pressures and Oldfield's mental state induce him to commit murder?[34] The jury found him not guilty on the grounds of insanity, and he was sent to Sunnyside for an indefinite period.

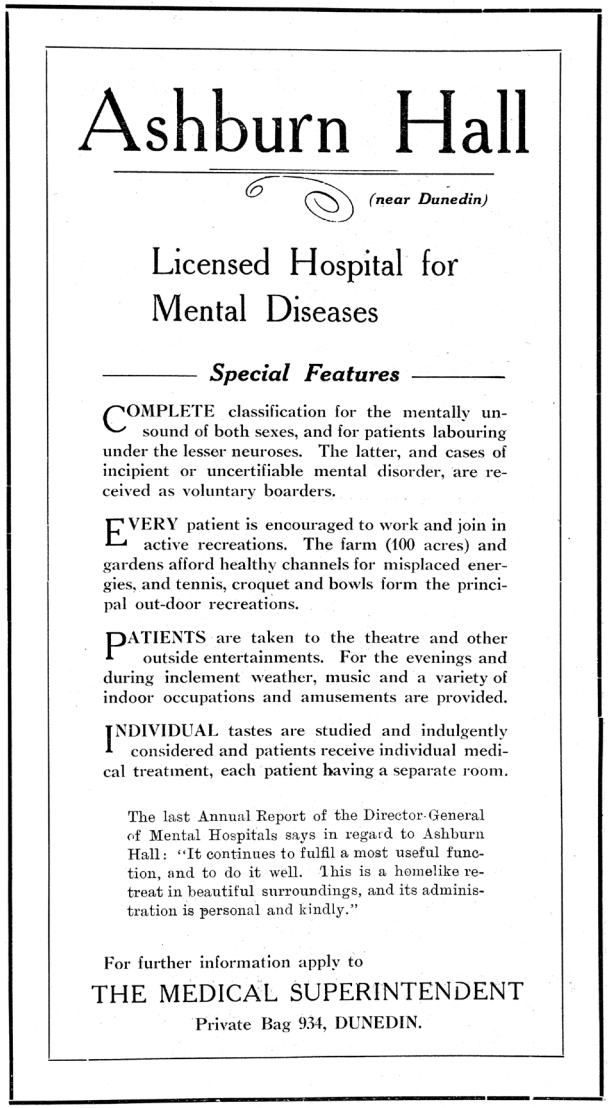
Simple melancholia sometimes embraced what doctors once called 'neurasthenia', and which may have been anxiety and/or depression.[35] At age 23, in 1915, Margaret A. tried to drown herself in a water race at Reefton on the West Coast.[36] Her husband said she had become melancholic two years earlier, and had tried to break and burn items. Margaret said that she hated her child. Yet the case notes from her time at Sunnyside described her melancholia as mild. 'She is the typical neurasthenic who swings back and forward over the borderland. She complained of the usual subject of sensations in the head, she is emotional and self centred,' her notes state.

Acute melancholia was another subtype. In 1898 Annie B., in her thirties and with two children, had 'an attack of melancholia' some months after nursing her elderly and infirm father.[37] She was brought to Hokitika, where she lived in a lodging house for six weeks and was treated by Dr Ebenezer Teichelmann, Westland's medical superintendent. She appeared to become 'almost well' and returned to her home. Annie was still suicidal, and her brother (presumably playing the devil's advocate) 'led her to the water and told her to jump in but she declined'.

Annie was subsequently admitted to Seaview Asylum in Hokitika in March 1899 in a state of acute melancholia, 'with its usual symptoms. Her face is expressive and of intense mental suffering, her attention is difficult



Some prominent doctors in Aotearoa New Zealand's history of the treatment of depression. *Clockwise from top left:* Dr Truby King; Dr Theodore Gray; Professor Mason Durie.



Ashburn Hall

(near Dunedin)

Licensed Hospital for Mental Diseases

Special Features

COMPLETE classification for the mentally unsound of both sexes, and for patients labouring under the lesser neuroses. The latter, and cases of incipient or uncertifiable mental disorder, are received as voluntary boarders.

EVERY patient is encouraged to work and join in active recreations. The farm (100 acres) and gardens afford healthy channels for misplaced energies, and tennis, croquet and bowls form the principal out-door recreations.

PATIENTS are taken to the theatre and other outside entertainments. For the evenings and during inclement weather, music and a variety of indoor occupations and amusements are provided.

INDIVIDUAL tastes are studied and indulgently considered and patients receive individual medical treatment, each patient having a separate room.

The last Annual Report of the Director-General of Mental Hospitals says in regard to Ashburn Hall: "It continues to fulfil a most useful function, and to do it well. This is a homelike retreat in beautiful surroundings, and its administration is personal and kindly."

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THE MEDICAL SUPERINTENDENT

Private Bag 934, DUNEDIN.

A 1921 advertisement for the private psychiatric hospital Ashburn Hall, near Dunedin.

to arrest, and when spoken to she will answer in monosyllables only, and in a voice little above a whisper. Appears to be troubled by delusions of impending evil,' her notes record. In Seaview she started to recover, doing some needlework and laundry, and attending a hospital dance. In September 1901 Annie was discharged to her husband's care, on a bond under the 1882 Lunatics Act for which he had applied, as he was relocating to the North Island.[38]

By the early twentieth century, some women with acute melancholia were described as 'self-centred and depressed' or having 'acute melancholia with self absorption', such as a 24-year-old music teacher admitted, 'morose and depressed', to Seacliff in 1915.[39] Her younger brother found her with a rope around her neck, talking about 'going out to meet her fate'. She was discharged within five months, continued to teach music, and lived until 1979, a happier outcome than another patient who, in 1913, tidied the nurses' mess room at the Auckland Mental Hospital after breakfast and then jumped to her death from a window. She had also been diagnosed with acute melancholia.[40] While men were diagnosed with acute melancholia, they were seldom described as being 'self-absorbed' or in other similar terms that tended to be given to women.

Diagnoses of sub-acute melancholia — a state between acute and chronic melancholia — were also given to patients. Twenty-two-year-old Ethel H. was admitted to Seacliff in 1914, probably with post-partum depression.[41] Her husband said that 'she has become listless and inattentive to work whereas she was [normally] bright and cheerful'. Ethel had delusions in which she saw angels and was violent, threatening to kill her husband's mother. Seacliff's medical superintendent, Frederick Truby King, observed that Ethel was 'markedly depressed' and 'her thoughts are seated on herself and her morbid fancies'.

Emil Kraepelin introduced the term 'involutional melancholia' to refer to serious depression presenting later in life — at about age 45.[42] For women this was also associated with the 'climacteric', an old term referring to women experiencing menopause. In 1935, only six among approximately 1230 patients at Seacliff were diagnosed with involutional melancholia,