This copy has been supplied by the Library of the University of Otago on the understanding that the following conditions will be observed:

1. To comply with s56 of the Copyright Act 1994 [NZ], this thesis copy must only be used for the purposes of research or private study.

2. The author's permission must be obtained before any material in the thesis is reproduced, unless such reproduction falls within the fair dealing guidelines of the Copyright Act 1994. Due acknowledgement must be made to the author in any citation.

3. No further copies may be made without the permission of the Librarian of the University of Otago.
"UNFORTUNATE FOLK"


J. A. Holloway

A thesis presented in partial fulfillment of the requirements for the degree of Bachelor of Arts (Hons) in History at the University of Otago, Dunedin, New Zealand, 1991.
## CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Chapter One</td>
<td>9</td>
</tr>
<tr>
<td>The System and Its Servants</td>
<td></td>
</tr>
<tr>
<td>Chapter Two</td>
<td>26</td>
</tr>
<tr>
<td>&quot;Not Her Usual Self&quot;</td>
<td></td>
</tr>
<tr>
<td>Chapter Three</td>
<td>59</td>
</tr>
<tr>
<td>Unmanageable Masculinity</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>92</td>
</tr>
<tr>
<td>Bibliography</td>
<td>97</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

There were times this year when I thought I would never get this long essay started, let alone finished, but the demands of bureaucracy and the pleasures of society notwithstanding, the end is now upon me. Writing a long essay is ultimately a lonely endeavour, but at the same time it is one which cannot be achieved without the assistance and support of others. Acknowledgment is now due all those who gave of their time and themselves to further my academic ends.

I extend my gratitude first to the Otago Area Health Board for permitting me access to the patient records of Seacliff Mental Hospital, and to the staff of Cherry Farm. To Jocelyn Grant, in particular, I am especially grateful for her encouragement and interest in my research.

I am also indebted to my supervisor, Dr. Barbara Brookes whose extensive knowledge of New Zealand's social history of madness, and constructive criticism was invaluable in the clarification of my understanding of the subject. I am further grateful to her for her tolerance of my somewhat nebulous conception of time.

Finally, a nod is due my friends for their enthusiastic participation in supping tea and swilling ale throughout the year. Your disrespect for the rigours of academia were a constant source of inspiration to me.
PREFACE

In the interests of patient confidentiality, the names used in the citation of patient records throughout the text are all fictitious.
INTRODUCTION

In the extensive international literature of madness the roles of medical practice and governmental strategy in determining the experience of mental ill-health have been subject to analysis within two broad historiographical traditions. The treatment of lunacy within the walls of psychiatric institutions throughout Great Britain, North America, and Australasia has been vaunted by those of the progressivist school as a linear evolution from the past harsh and indiscriminate confinement of society's deviants to the enlightened humanism and active therapy of modern medicine. It is an optimistic doctrine which delineates psychiatry as a beneficent and ever more efficacious institution.\(^1\) Advocates of the theories of social control, however, suggest an alternative perception of the structures of psychiatry. According to this historiographical tradition the asylum is primarily an instrument for the state regulation of industrialised social relations. In times of crisis the label of deviance is applied by a society's arbiters to those whose non-conformity challenges the maintenance of order. In its classical form the interpretation of psychiatry as social control is characterised by the emergence of the mental institution as an agency charged with managing the working class.\(^2\)

While the traditions both of social control and progressivism provide useful frameworks for the historical consideration of insanity, as with any

\(^1\)For discussion of developments within psychiatry see eg. K. A. Jones, *A History of the Mental Health Services*; G. Grob, *The State and the Mentally Ill*.

paradigm, an overly simplistic analysis is the trade-off for the accessibility of generalisation. The central thesis of progressivism, for example, assumes rather than proves a steady and positive reform of the attitudes to, and treatment of mental illness since the turn of the eighteenth century.\(^3\) Further, in its exclusive emphasis upon the emergence of the psychiatric profession as the determinant of the experience of insanity, progressivism does not allow for the contextualisation of that experience. According to the constraints of the theory, the derangement of minds, and their consequent management are realised within a vacuum.

While fundamental to the philosophies of social control is the acknowledgement of the interaction of mental hospital with the world outside its walls, the conclusions drawn by the proponents of this theory too are misleading. Concentration upon the relationships between the powerful and the powerless denies any potential for the exploitation of mental institutions outside of the hierarchies of medicine and state by either the initiators of committal or the committed themselves. Moreover, to regard the mental hospital primarily as an agent of the state intent upon the preservation of social order is to prompt the assertion that madness is a fallacy. The reality of confused behaviour and mental distress renders such a conclusion untenable.

Most significantly, the conspiratorial social control theory and the optimistic doctrine of progressivism each offer interpretations of madness which marginalise the experiences of the mad themselves. Both historiographical traditions construct insanity from the perspective of those empowered by their specialised knowledge and political authority to

\(^3\)S. Garton, *Medicine and Madness*, p.2.
delineate deviance on behalf of society. The perspective of those so delineated, however, is ignored. As theories orientated to medical and political agendas, progressivism and social control consider the mentally ill either as patients requiring treatment, or as pawns of the power structure, rather than as multi-dimensional individuals existent within complex social networks. The ideological constraints of these philosophies allow little acknowledgment of either independent agency or of the social experience of individuals outside the mental hospital. It is only by focusing upon the lived experience of the 'insane' attendant upon their certification as "mentally defective" and subsequent committal that the social profile of madness becomes accessible as a complement to its definitions as treatment and control.

It is the intention of this essay, then, to lend that complement to historiography of insanity in New Zealand by positing the experience of the judged, rather than that of the judges as central to the interpretation of mental illness. The deconstruction of a mental hospital patient population allows an alternative perception of the asylum to that advanced by the traditional theories of control and progress. From the documents of committal and the case-notes of the incarcerated there emerge the hitherto unexamined issues of psychiatric incarceration in New Zealand: Who were those received into the institution? Which social groups were most at risk of being labelled insane and consequently committed? By whom was that process initiated? What behaviours were deemed transgressions of social norms necessitating incarceration? Were definitions of normality socially specific, or were they independent of sex, age, class and familial condition?
This essay examines these questions in relation to the patients of the Dunedin Mental Hospital at Seacliff from 1928 to 1937. Opened to patients in 1882, by 1928 Seacliff was the third largest of the country's eight public institutions for the care and containment of the mentally ill. Over the decade covered in this study it housed, on average, 1187 patients per year, 230 of whom form the sample upon which my research has been based. The files of 126 male, and 104 female patients certified insane or mentally defective were examined in order to reconstruct the social experience of madness in New Zealand in the 1930s.

The scale of the study was dictated by the constraints of time and manageability. The particular years covered, however, are not irrelevant to the construction of insanity. The period opened with the legislative reassessment of mental illness in New Zealand. The 1928 Amendment to the Mental Defectives Act of 1911 extended the range of behaviour defined as mad, and instituted procedures to facilitate committal. These developments in the Dominion's mental health legislation are examined in Chapter One of this essay, as is the medical profession who were authorised

---

5 This figure has been calculated using the average number of patients resident at Seacliff in each of the ten years covered by this study. AJHR, H-7, 1928-1937.
6 The Director-General of New Zealand's mental hospitals, Dr. Theodore C. Gray, explained in 1928 the distinction between insanity and mental deficiency thus: The insane are persons who have generally been of normal mentality, but who have developed a mental disease arising from one of many possible causes such as the stresses associated with childbirth and puberty and the various toxæmias arising from within or outside the body. The mentally deficient or feeble-minded, on the other hand, exhibit from birth a less than normal capacity for full mental development. Their backwardness is due to defective inheritance, congenital syphilis, or accidents, injuries, or disease at birth or at an early age. "Treatment of Mental Defectives" in Public Lectures on Social Adjustment, p.3.
by law to detect and confine insanity.

Furthermore, the decade upon which the study is focused was one of great social change and marked economic depression in New Zealand. The various pressures these forces exerted upon the men and women committed to Seacliff between 1928 and 1937 are considered in Chapters Two and Three. In particular these chapters relate the social constructions of masculinity and femininity to the social construction of madness, in a gendered analysis of culturally specific phenomena.
CHAPTER ONE

THE SYSTEM AND ITS SERVANTS

With all its advance in science and social order, civilization has produced a sense of obligation in us towards our fellow citizens, none more so than a recognition of our obligations towards those who are unable to do anything for themselves - the flotsam and jetsam of humanity.

J. A. Young, Minister in Charge of Mental Hospitals, Health Department, 1928.\(^1\)

Throughout the period under review, the management of mental illness within New Zealand was regulated by the provisions of the 1911 Mental Defectives Act and its Amendment of 1928. The earliest of these two legislative measures sought to reconcile the rights of the insane with the welfare of the sane, in accordance with a revised professional, if not popular understanding of madness.\(^2\) Hitherto perceived as primarily the vicious phenomenon of the criminal, or the divine curse of the damned, the 1911 statute embodied a reconception of mental disturbance as manageable illness.\(^3\) Accordingly, the 1911 Act provided for six

---

3. E. Showalter, *The Female Malady*, p.8. Showalter traces the nineteenth-century reconceptualisation of insanity as a development concomitant with the emergence of medical science as a social arbiter. See also W. A. Brunton, "If Cows Could Fly", *Australian and New Zealand Journal of Psychiatry*, vol. 6, 1972, p.46.
classes of insanity to facilitate the detection of mental illness so that the
government might discharge its obligation to these "unfortunate folk", as
to the public. The six categories reflected a general perception that
social debility and mental dysfunction were interdependent. According
to the law it was in an individual's inability to sustain his or her social
role that mental illness requiring incarceration was manifest. Thus, those
identified as being of unsound mind or mentally infirm were individuals
whose psychiatric condition rendered them incapable of managing
themselves or their affairs. Those mentally deficient from birth or
childhood and unable to guard themselves against common physical
dangers or unable to earn their own living were graded as 'idiots' and
'imbeciles' respectively, while those with a similar mental condition and
incapable of competing as equals with their fellows were deemed
'feebleminded'. Positive identification of social debility consequent
upon mental aberration in all categories, as for those diagnosed epileptic,
rendered the individual thus isolated vulnerable to incarceration in one of
the eight mental hospitals of the Dominion.

The law thus framed was sufficiently expansive to countenance a
wide range of behaviour being identified as symptomatic of mental
illness. Women who failed to keep themselves clean, and men who could
not provide for themselves and their families were potentially liable to
incarceration for their inability to manage themselves or their affairs.

In 1928 a further manifestation of lunacy was recognised in

amending legislation which identified mental illness associated with anti-social conduct as "social deficiency". In the Amendment's reference in clause 7 to the welfare of both the deviant, and of the public, the dual goals of the Mental Defectives legislation were given explicit expression. As it appeared in the statute book the provision read:

"Persons socially defective" - that is, persons who suffer from mental deficiency associated with anti-social conduct, and who by reason of such mental deficiency and conduct require supervision for their own protection or in the public interest. 

This last category is suggestive of the extent to which by 1928 social interaction had become the inverse yardstick of deviance. Compliance with social mores had become institutionalised in an Act of Parliament which had the potential to punish transgression of generally accepted norms of behaviour with the label of 'mental defective' and a career of psychiatric hospitalisation. Moreover, the non-specificity of the language employed to delineate this seventh class brought within the shadow of the asylum aberration which threatened the sane, regardless of whether or not the interests of the insane were best served by incarceration. Social control was established, thereby, as equally valid grounds for committal as the progressive impulse to cure.

The implications of clause 7 of the Mental Defectives Amendment Act were clear to the law-makers in Parliament. From its introduction into the House of Representatives, debate of the Bill was lively, with a number of provisions in the proposed legislation causing contention. While clause 25 of the Amendment, promoting the regulation for

\(^6\)Ibid., p.744.
sterilisation of the mentally unfit on the grounds of racial purity was most fervently resisted, the creation of a class of social defectives was similarly opposed. The Member of Parliament for Wellington Central went so far as to threaten that he and his colleagues would oppose the passage of the Bill if their concerns about the interpretative potential of the section as drafted were not redressed.\textsuperscript{7} That draft read:

\begin{quote}
Persons socially defective - that is, persons who suffer from mental deficiency associated with or manifested by anti-social conduct, and who require supervision for their own protection or in the public interest.\textsuperscript{8}
\end{quote}

The "pernicious definition" of clause 7 of the Bill was phrased so as to cause considerable concern due to its "very wide scope", rendering it vulnerable to possible abuse by those empowered to apply it.\textsuperscript{9} Mr Sullivan, M.P. for Avon explicitly attended to this potential by demanding the provisions deletion or modification to guarantee that it cannot be used for the purpose of trapping people whose only fault is that they do not comply with the conventional standard of what is normal...it is possible to bring under the definition of social defective almost anyone whom a Government for its own purpose would desire to bring under it.\textsuperscript{10}

Furthermore, Sullivan went on to attack the clause as promoting

\begin{footnotes}
\item[	extsuperscript{7}]NZPD, vol. 217, 1928, p.625.
\item[	extsuperscript{8}]Ibid., p.611.
\item[	extsuperscript{9}]NZPD, vol. 219, 1928, p.495.
\item[	extsuperscript{10}]Ibid., pp.495-496.
\end{footnotes}
the situation whereupon the evidence of mental deficiency and the
evidence of social deficiency were manifest in the fact that an
individual requires supervision for their own protection, or for that of
the public.\textsuperscript{11} As phrased, the clause rendered possible an
interpretation which allowed the need of supervision of an individual,
whether for his/her own benefit or for the advantage of the public to
attest that person's mental deficiency. The terms "anti-social conduct"
and "social defective" inspired Mr Howard of Christchurch South to
express his concern at the clause's potential for abuse. He was

suspicious about this clause...suspicious of the people who
wrote that clause, suspicious that some other meaning was
attached to it when it was written than that which was placed
before us.\textsuperscript{12}

Introduced by the Government as a conscience issue, the Mental
Defectives Amendment Bill met with challenge from both the Labour
Opposition and Government benches. So vigorous was the debate which
ensued that Prime Minister Coates was compelled to demand of his Ministers
that party allegiance be acknowledged Thereafter, the Government was largely
unified in its defence of the contentious legislation, however, the Opposition
remained committed to their advocacy of the freedom of the individual against
the rights of the state. After much discussion the tenacity of Holland's men was
rewarded by the Government's abandonment of the divisive clause 25, and the
eventual redrafting of the similarly controversial clause 7.

\textsuperscript{11}\textit{ibid.}, p.496.
\textsuperscript{12}\textit{ibid.}, p.497.
The form of clause 7 upon which the Government and the Opposition compromised, however, was still expansive enough, and vague enough, for the delineation of the "social defective" in New Zealand society to plague the Mental Health Department throughout the thirties. As even the experts wrestled with the definition, it seemed the fears of the Bill's opponents in 1928 were to be realised. Foremost amongst those who professed to define the contentious phrases "social defective" and "anti-social conduct" was Seaciff Mental Hospital's Medical Superintendent, Dr. H. D. Hayes. In reply to a request for interpretative guidance from the Director-General of the Mental Hospitals' Department, Dr. Theodore G. Gray, Hayes proffered his understanding of the clause as one empowered to activate it. He argued that the label of social deficiency should be applied in those instances of anti-social conduct due to unsublimated primary instincts. Such instincts, he continued, worked to prevent the emotions becoming organised around social precepts and concepts as sentiments. Gray's definition of the social defective as an individual in whom anti-social conduct and the lack of both wisdom and moral sense was definitely and unequivocally associated with emotional deficiency, was augmented by Hayes. Emotional deficiency, the Superintendent stated, was a "congenital failure of emotional attachment to social precepts and concepts such as occurs in the normal". The Seacliff Superintendent further delineated the individual of clause 7 by a comparison of the criminal behaviour of the social defective with that of the congenital mental defective. While the latter, Hayes suggested, knew how to react to right and wrong, they could not judge what was right or wrong. The social defective, however, was able to judge right and wrong but could not react appropriately to the judgment.

---

14 Ibid., quoted on p. 148.
Certainly it was an exposition of the issue which testified to the inadequacy of clause 7 of the 1928 Mental Defectives Amendment Act. The definition of "social defective" as semantically created in the statute books was not able to stand as phrased, but necessarily required further qualification for its application. Over five years after the authorisation of this seventh class of mental defective, Gray was still conscious of the vagaries of the provision. In a plea for the institutional segregation of "difficult and dangerous defectives" from those who were simply unable to maintain an independent existence in the community, Gray's annual report of 1935 detailed at some length the pathology of the "social defective":

The existence of this condition cannot be diagnosed from conduct alone, however anti-social, difficult or dangerous that may be, but from a study of the patient as a whole. To understand the social defective one must realise that the infant is born without moral sense, but with instincts. Gradually through the influences of home, school, companions, and all the factors which we call environment, the primitive instincts, with their accompanying feelings or emotions, become "sublimated" or harnessed to the precepts and concepts which have been absorbed from the environment, and thus we arrive at the stage of knowing what is, and what is not "done", and of being able to hold in check instinctive or impulsive tendencies which, if translated into action, would constitute anti-social conduct.

The pathology of the social defective consists of an inability to profit from the influences of his environment, so that his instincts with his emotions are not sublimated or "conditioned" to the demands and usages of Society - his instincts and emotions remain at an infantile level, and are expressed in unrestrained and instinctive conduct which is liable to bring him into contact with the law. While he may be able to give lip

15 ibid.
service to normal standards of conduct, he has no real appreciation of the significance of either reward or punishment.\textsuperscript{16}

Again the definition of mental illness contained within clause 7 of the Amendment itself seems quite inadequate to convey the complexities of social deficiency as expressed here by the country's leading clinical psychiatrist. Evidently it was not only in the "lay mind" that there existed a "good deal of misunderstanding regarding the social defective".\textsuperscript{17} Even in 1935 the Dominion's foremost exponents of psychiatry were realising still the scope of clause 7. Moreover, their efforts to articulate the essence of social deficiency produced definitions which marginalised, rather than emphasised the evidence of mental deficiency in those thus delineated.

The assurances of the Minister of Health in 1928 that the amending provision would be read with reference to the principal act were effectively rendered bankrupt by such interpretations of the legislation. If specialists in the field of mental health were unable to articulate a definition of social defective more practicable than that proclaimed by Hayes and Gray, the application of the clause by those without such expertise was inevitably to be even less precise, and more subjective. The consistent and objective diagnosis of the social defective was facilitated neither by the Amendment itself, nor by the subsequent 'informed' expositions of the issue.

The clause became law in 1928 nevertheless. Thereafter it was amalgamated into the structure of mental management in New Zealand as one

\textsuperscript{16}AJHR, H-7, 1935,p.2.

\textsuperscript{17}ibid.
of the seven manifestations of mental deficiency recognised by the state as grounds for admittance to a psychiatric institution. The interpretative potential of the clause, however, was hardly tested in the decade which followed its enactment in law. In only two of the 230 Seacliff patients files examined in this study was the label 'social defective' assigned to define mental illness. In both cases the men so labelled were congenital mental defects. Todd F. was a thirteen year old 'imbecile' who was described as backward and destructive with a "very cruel temper". Fifty-three year old Clifford S. was a 'feebleminded man who laughed without reason and had stolen women's underwear. In both cases too, only one of the two certifying doctors identified Todd and Cliff's behaviour as socially defective. The other examiner was satisfied that their disturbed behaviour was simply a consequence of their congenital mental defects. Moreover, the actions attributed to Todd and Cliff was little different from that more commonly defined upon medical certificates by one of the other six clauses of mental illness set out by the Mental Defectives legislation. It seems then that the concern of the country's leading psychiatrists and the Government with the problem of social deficiency was not a reality for the patients at Seacliff, nor for the doctors who certified them. Alternatively, it may have been that the general practitioners empowered to commit the mentally ill were not prepared to apply a definition with which not even the foremost exponents of psychiatry were comfortable. Whatever the explanation, the Seacliff records attest to the fact that the consensus achieved by compromise within Parliament was in practice irrelevant.

New Zealand's legislation more effectively answered the needs of the

---

18Seacliff, 1933, 8317.
19Seacliff, 1937, 8949.
insane and mentally defective in the procedures it set out for admission into the mental hospitals of the Dominion. From 1928 admission was regulated by reception-order, voluntary application and by emergency request. The first of these three provisions for committal was the procedure by which most who entered Seaciff's walls over the period embarked upon their careers as mental patients. The 1911 Act authorised family, police and 'others' to detect mental illness and initiate the medical and administrative machinery empowered to label and detain the insane and the intellectually impaired. Theoretically, anyone of at least twenty-one years of age who was able to justify their motives for so doing, could apply to a Magistrate for the committal of an individual by reception-order into a mental hospital. It was then for the Magistrate to affirm the application by an examination of the alleged mental defective with the assistance of two medical practitioners. Upon the satisfaction of these representatives of medicine and law that the subject of their examinations was, in fact, mentally afflicted, committal was authorised by two medical certificates and the issue of a reception order.20

Of the committal documentation, the reception order was, in practice, a formality to satisfy the bureaucratic demands of the admission procedure, and it was widely, if critically acknowledged as such. During the debate which accompanied the reading of the 1928 Mental Defectives Amendment Bill, the Government M.P. for Gisborne spoke out against the perfunctory execution of the magisterial authorisation of committal. Quoting the case of a Magistrate who issued a reception order on the basis of looking out a back door and into the taxi of the alleged 'defective', Mr. Lysnar demanded the object of the Magistrate's involvement in the committal process, if it was not to ascertain the validity of the medical certificates.21

While the Government countered that such cursory performance of magisterial duties was not usual, the veracity of the Mr. Lysnar's claim remains probable. Certainly, in New Zealand, as elsewhere, the magistracy occupied an ambiguous position within committal proceedings. Dependent upon the various testimonies of the relatives, friends, policemen, 'social workers' and doctors, magistrates were ultimately responsible for committal, despite their own understanding of mental distress being negligible, if not non-existent. The perfunctory magisterial examination of individuals alleged mentally defective, then, was an acknowledgement of their inadequacy as civil officers versed in law to assert psychiatric judgment.

The role of the magistrate in the process of committal, therefore, was to rubber-stamp the evidence of mental deficiency discovered by the medical examiners. It was the charge of the two certifying doctors to indicate incarceration or freedom. As general practitioners rather than psychiatric professionals, however, these doctors were often only slightly more familiar with the complexities of mental illness than the legal authorities. With reference to the experience of insanity in post-famine Ireland, Finanne has suggested that the doctors responsible for certification were no better educated about aberrations of the mind than not only the magistrates who presided over committal proceedings, but anybody else as well. In New Zealand, by 1928, the advancements of psychiatric medicine, and the concomitant rise in the status of psychiatry as a profession had allowed the dissemination of the science of the mind throughout the structures of general medical instruction and

---

practice.\textsuperscript{23} It is likely that knowledge was still imperfect, however, and that the doctors empowered by law to apply it in the confirmation and certification of insanity were only somewhat more competent as diagnosticians of psychiatric illness than their nineteenth century Irish counterparts.

Certainly within the patient files of men and women committed to Seacliff Mental Hospital in the thirties there is much evidence to support such an assertion. It was not uncommon for two doctors to record conflicting diagnoses of the subject of their examination. Most often doctors did not agree as to whether a patient was of 'unsound mind' or 'mentally infirm', despite noting the same evidence of mental distress upon their medical certificates.\textsuperscript{24}

The task of the certifying doctors to ascertain that evidence of mental illness requiring the oversight, care and control of the state was structured by the limitations of the medical certificate itself. In their assessment of patient's mental condition, the doctors were required to state the facts indicating mental illness observed by them at the time of examination or on any previous occasion. Further, they were to note any facts similarly indicative communicated to them by others. The doctors were also to classify the mental distress thus evident according to the seven classes set forth in the legislation of 1911 and 1928, giving their opinions as to the probable cause of the mental defect, and as to whether the person exhibited a tendency to violence, either to themselves or to others. Finally, the examiners were to indicate the bodily health and condition of the person alleged mentally ill.

\textsuperscript{23}Extracts from the Report of the Committee of the Senate of the University of New Zealand, \textit{New Zealand Medical Journal}, (hereafter NZMJ), vol.34, no.182, August, 1935, p.36.

\textsuperscript{24}eg. Seacliff, 1928, 7602; 1928, 7641; 1933, 8418.
While, the certifying doctors had little pretension to psychiatric knowledge, the format of the medical certificate itself lent their inexpert pronouncements as to the mental condition of the alleged defective the authoritative status of fact. Their particular competence was as diagnosticians of physical disorder, but their role as certifiers of insanity assumed an expertise they often did not possess. Furthermore, it was usual for each doctor to observe the patient on only one occasion, and then the examination was typically cursory and the information submitted in favour of committal necessarily generalised. This information, too, was largely reflective of the testimony of the initiators of the process of committal, rather than being an independent assessment of individual.

The general practitioner called upon to sit in judgment of those suspected of mental instability, then, was vulnerable to charges of wrongful committal due to his/her only partial familiarity with the complexities of the mind. An article in the *New Zealand Medical Journal* in 1930 focused upon the liability of the certifying practitioner in instances where a person incarcerated within a mental institution upon his/her authority was subsequently found to be sane. Assurance was extended to doctors that their lack of psychiatric expertise was not as relevant to any investigation of wrongful committal as was their motivation for incarceration. It was an issue which turned on the good faith of the physician. The beneficient preoccupation of the law with safeguarding the rights of those not able to represent themselves, nevertheless, was given due emphasis.25

The same concern to protect individual liberty from improper

---

restraint was expressed by the Government Member of Parliament for Gisborne. While debate in the House of Representatives was most heated during the consideration of clauses 7 and 25 of the 1928 Amendment, Mr Lysnar opposed the Bill further on the grounds that it facilitated committal.26 The focus of his objection was the proposed introduction into the structure of mental management of an alternative admission procedure in cases of emergency. The offending regulation provided for the admission of patients to mental hospitals in instances where immediate detention was considered expedient for the welfare of the alleged mental defective, or in the public interest. Under this provision any person competent to apply for a reception order might request the Medical Superintendent of the hospital to admit the person alleged insane on the evidence of two medical practitioners, but without the formal committal documentation of a reception-order. Thus, primacy was given to the exigency of treatment at the expense of legal paperwork. Magisterial examination of the person thus admitted was conducted at the asylum itself. Consequent upon the satisfaction of the law of the patient's mental aberration, the committal was formalised with the issue of a reception order, in cases of emergency.27

While Lysnar expressed considerable doubt as to whether reception procedures needed to be made any more accommodating, his fears for the rights of the individual against the power of the state were ill-informed. The standard admission procedure allowed for magisterial committal upon the evidence of two 'lay' doctors; examination by a specialist in psychiatric illness was necessary only after formal reception of the patient by court order. The regulation for emergency admission, however, was satisfied only by the

assessments of three medical authorities, one of whom was to be the Medical Superintendent of the institution into which the patient was to be admitted. Only consequent upon the Superintendent's confirmation of mental deficiency was committal to be formalised at the hospital by a magistrate.\(^{28}\) Thus, in fact, section 8 provided not only the security of a third examination prior to committal, but that examination was to be conducted by a specialist in mental illness.

Lysnar's colleagues in Parliament rejected his qualms and the provision passed into law as section 8 of the Mental Defectives Amendment Act. The legislation was hailed by those responsible for the treatment of mental ill-health as recognition of the need to destigmatise aberration of the mind as criminality.\(^{29}\) Furthermore, amid mounting evidence that the longer the experience of insanity the less likely was recovery of those so afflicted, section 8 of the Amendment addressed the need for treatment to be secured as early as possible. Within a year of the Act's passage, that need was proven a reality. In the annual report of the Director-General of Mental Hospitals for 1929, note was made that "considerable advantage" had been taken of the alternative method of committal provided by section 8 of the Mental Defectives Amendment Act, with no less than 16.4% of total admissions nationwide effected in this way.\(^{30}\)

The same concern for the early treatment of mental illness informed the third legal provision for reception into an asylum. From 1911 it had been possible to secure psychiatric attention in the pre-certifiable stage of mental illness.

\(^{28}\)Ibid.

\(^{29}\)AJHR, H-7, 1930, p.1.

\(^{30}\)Ibid.
disorder under section 39 of the Mental Defectives Act. That regulation allowed for voluntary admission into a mental hospital. On the discretion of the Medical Superintendent of the hospital any person who so requested could be received into the institution for "care and treatment". The Superintendent was empowered to refuse entrance to anyone who in the opinion of the Medical Officer was not a proper case for such attention, or if that person ought more properly to be received under the provisions of a reception-order.  

By 1928 public recognition of the significance of section 39 was such that the number of voluntary boarders resident within the Dominion's mental hospitals was rapidly increasing. It was a development gratifying to Dr. Gray and his psychiatric and political colleagues, for, it was argued, not only did voluntary utilisation of psychiatric services decrease the incidence of advanced and chronic disorders, but the success of the system in New Zealand justified the reduction of the legal formalities attendant upon admission to mental hospitals. In 1930, New Zealand's psychiatric policies were further validated by England's adoption of provisions for both voluntary boarders and emergency admission in their Mental Treatment Act.

It was this legal and medical framework which the protagonists of committal, both lay and professional, encountered upon application for admission into one of the mental institutions of the Dominion. While examination of legislative provisions and medical philosophies hints at the social potential of the mental management system, it is only with recourse to the practice of committal as attested by the court orders and hospital case-notes

33 AJHR, H-7, 1932, p.4.
themselves that an impression of the social reality of mental illness is suggested. It is the utilisation of the system, rather than the system itself which delineates madness as an experience constructed as much by social contingencies and expectations as by formal structures of authority.
I did not know my own identity. I was burgled of body and hung in the sky like a woman of straw. The day seemed palpable about me yet receded when I moved to touch it, for fear that I might contaminate it. I nagged at the sky. It grew protective porcelain filling of cloud. I was not a mosquito nor a cricket nor a bamboo tree, therefore I found myself, when it was full summer, lying in a gaily quilted bed in a spotless room called an observation dormitory in Ward Seven of Treecroft Mental Hospital, up north.


Historically, women and madness have had an intimate association. Romanticised in art and literature and theorised about in medical expositions of insanity, the madwoman emerged in the nineteenth century as one morally and biologically doomed to insanity by her very femaleness.¹ Such popular and professional perceptions of women's sanity as the victim of their sex reflected the interaction of the ideology of the feminine with theories of madness. While both are social constructions first articulated in the Victorian era in Britain, Europe, North America and Australasia, their influence in the definition and toleration of various female behaviours was maintained far into the

¹E. Showalter, *The Female Malady*. Showalter provides a compelling account of the cultural and medical constructions of women's madness in nineteenth century England. It is a fault of her book, however, that she does not consider the reality of the female experience of committal and incarceration.
twentieth century.

Femininity, as a cultural construction was based upon a nineteenth century ideology which prescribed women's role as wives and mothers, and circumscribed their reality to the domestic sphere. There they were charged with the propagation of a morally, physically and mentally healthy society. The regulation of those activities deemed appropriate for women was legitimised by an understanding of the sexes as complementary rather than interchangeable. Men and women were defined in a gendered analysis of opposites as respectively strong and weak, aggressive and passive, public and private, and rational and irrational. In the delineation of sex roles, masculinity was asserted as a positive ideal and equated with normality. Femininity, as its complement, was negatively defined as a departure from the masculine ideal and, thus, to be a woman was to be intrinsically abnormal. While conformity to the sanctioned code of femininity allowed for the tolerance of that abnormality, it created women whose economic dependence, learned helplessness and limited access to resources of power rendered them vulnerable to challenges to their sanity. When women violated the conventions of their gender role, however, their non-conformity often exposed them to incarceration, as the emergent psychiatric profession assumed the function of social arbiter.

---


3Showalter, op cit., pp3-4, and p.8.

4J. J. Matthews, Good and Mad Women, p.114.

In the late nineteenth century feminists in New Zealand, as elsewhere, attacked male privilege and prejudice and sought the removal of women's civil and political disabilities. They did not dispute, however, the centrality of motherhood to women's lives, nor did they question the contribution of true womanhood to either the quantitative or qualitative advancement of society.6 The prescriptive ideology of the feminine thus persisted into the new century, its fundamental tenets unchallenged by feminism.

Moreover, in the twentieth century the prescription was shored up by the 'science' of eugenics, and fears of race suicide. Eugenics extended the theories of social Darwinism which argued that the biological progress of man resulted from the selection of the fit and the elimination of the unfit. According to eugenicists this process of natural selection had been perverted by civilisation which preserved the unfit and allowed them to reproduce. Proponents of eugenics, then, advocated intervention into the process of producing a population so as to ensure its mental and physical fitness for survival.7 Control of reproduction and nurturing centred on the education of women as to their duties to their race as wives and mothers.8 In this way the philosophies of eugenics and true womanhood reinforced one another in emphasising the moral obligations of motherhood.

7S. Robertson, "'Production not Reproduction': The Problem of the Mental Defect in New Zealand, 1900-1939", B. A. (Hons.) long essay, University of Otago, 1989, p.6.
8Giffiths, op cit., p.128.
In New Zealand, the feminine ideal was extended and codified by the Dominion's international authority on the role of motherhood and the cult of true womanhood, Dr. Frederic Truby King. First as Medical Superintendent of Seacliff Asylum (1889 - 1920), and thereafter as founder and publicist for the Plunket Society and Director of Child Welfare, King's mission was to ensure the mental and physical health of New Zealanders. His promotion of infant health, motherhood and child-rearing as fundamental to the nation's well-being, was prompted by a eugenicist vision which sought to rescue the Dominion and the Empire from racial extinction by mastering infant mortality and reversing the trend to racial deterioration. In the realisation of this grand vision mothers were targeted as both the source of past weakness and the key to future greatness. The combined forces of guilt and glory operated upon women as true motherhood based upon scientific child-rearing and hygienic home management was prescribed as a woman's first duty, and exalted as the savior of the family, the nation and the Empire.  

Confronted by the hegemonic ideology of the feminine and the maternal, women in New Zealand society rarely disputed the tenets of the prescription which confined them to home and family. In the magazines of the period, women's concerns were articulated, and the role which nature and men had determined to be appropriate for women confirmed. In the articles, fiction, advice columns and advertisements of the New Zealand Women's Weekly, for example, the

prescription of marriage and motherhood was popularised, and reinforced. Moreover, the pages of these journals failed to acknowledge to their largely female readership that there existed for women any alternatives to the domestic ideal. The fundamental and unquestioned assumption was that the home was, in fact, the female sphere. In page after page of recipes, domestic hints, advertisements for household products the assumption is rendered explicit and condoned.¹⁰

That assumption both fostered and mirrored women's reality in the 1930's in New Zealand society. In the Censuses of 1926 and 1936 the home was recorded as the particular sphere of women. Similarly, the annual reports of the Director-General of Mental Hospitals in the Dominion provided statistical evidence of women's continued orientation to the household. In 1933, for example, forty-four of the fifty-two women admitted to Seacliff were recorded as formerly being "domestics".¹¹ The report offered no explicit indication as to whether this classification encompassed only domestics who were paid servants, or alternatively, only those whose domesticity was a labour of love, or both. It is fair to assume, however, that it referred to both domestic servants and housewives, for there were no other categories of female employment listed that could account for either form of toil. In any case, both paid and unpaid domestic duties confined women to a home, whether their own or someone else's, and, thus, the figures reveal the


¹¹AJHR, H-7, 1934, p.19. The former occupations of mental hospital admissions were no longer tabulated in the Director-General's annual report to the House of Representaives after 1934.
fact of women's identification with the home, by choice or by necessity.

It is with the home, then, that any examination of women's experience of madness must first concern itself. While legal and medical arbiters defined, albeit uncertainly, mental illness and the procedural framework for its detection and detention, the family was the single most significant agent in initiating committal of women to Seacliff Mental Hospital. As the primary initiators of proceedings, the family provided the testimony upon which certifying doctors relied to augment their own often unavoidably perfunctory examination of women alleged insane, and magisterial approval followed upon those judgments. Consideration of the relationship between the initiator and the subject of certification is then fundamental to understanding the way in which women's position within society influenced their committal as mental patients.

Of the women certified mentally ill and incarcerated within Seacliff Mental Hospital in the years under review, families, were central to their committal. In only eight of the 104 cases examined were applications for the reception of women to Seacliff initiated by outside agencies. The relative lack of influence of police, general hospital authorities and charitable institutions in the female experience of committal attests to the continued orientation of New Zealand women to the domestic sphere. In an era when the cult of true womanhood defined femininity in terms of marriage and motherhood, women's exclusion from public life insulated them from outside intervention but rendered them vulnerable to familial judgments of their behaviour.
The most active agents of committal for women were their menfolk. For married women, their husbands were the primary agents of their incarceration. Common to husbands' applications for their wives' hospitalisation were assertions of breaches of the domestic ideal. John B., an iron worker from Green Island sought psychiatric care for his wife Ellen because she was "not capable of looking after herself or her family."12 Albert O. was more specific in expressing his discontent with his wife, Caroline's behaviour. He claimed that she had "forgotten how to do housework or cooking". Furthermore, she did not dress herself correctly.13 Mary N. of Port Chalmers was condemned by her husband for her neglect of her house and her family.14 For each of these women their mental condition was explicitly correlated by their spouses to their inability to fulfill their domestic roles, or at least, to their husbands perceptions of that inability. Ellen B., for example, impressed her husband as a domestic failure, yet she herself "thought" she was working all day long.15

Furthermore, the general practitioners responsible for the certification of these women were no less subjective in their appraisal of them as imperfect housewives. While the doctors certifying Ellen B. identified her as 'feebleminded' from her mathematical incompetence and failure to identify coins, they reserved their harshest judgment for her domestic incompetence and failure as a mother.16

12Sealcliff, 1937, 8938.
13Sealcliff, 1936, 8781.
14Sealcliff, 1934, 8541.
15Sealcliff, 1937, 8938.
16Ibid.
Even more indicative of the influence of prescriptive gender ideology amongst professional as well as lay arbiters of 'normality' was the prejudice exhibited by the medical men who certified Mary N. insane. Mary's husband had initiated committal proceedings against her following her flight from their home in the early hours of the morning. Arriving at a friend's house at 4.30am with her two children scantily clad, she expressed concern that her husband intended to poison them. Upon Mary's medical examination, her fear of her husband was noted by both doctors, not in order to endorse her position against the application of her husband, but as evidence of her insanity. They dismissed her assertions of her spouse's violence toward his family as "delusions of persecution", judged her dirty, and confirmed her husband's claim that she was neglectful of her home, her family and herself. The two doctors variously attributed Mary's "unsound mind" to malnutrition, hereditary and "marital incompatibility", but neither of her examiners considered the "unhappiness of her married life" a worthy excuse for her actions.\textsuperscript{17} She had failed as a wife and mother - as a woman - and her husband was justified in his intolerance of her behaviour.

Mary's inadequacies as a woman were reiterated upon her admission to Seacliff. The Medical Officer's preliminary statement confirmed that she was poorly nourished; it also confirmed her neglect of her husband, her children and her home. For this, and for her 'delusions of persecution', Mary was labelled schizophrenic and

\textsuperscript{17}ibid.
hospitalised for treatment. Her behaviour once inside Seacliff's walls, however, did give the Medical Superintendent reason to take interest in Mary's case. Usually compliant, rational, and cheerful, any mention of her husband caused Mary to withdraw and become sullen and uncooperative. Rather than regarding such conduct as further evidence of her schizophrenic nature Dr. Hayes was prompted to inquire into her domestic situation. Letters to Mary's mother and her minister confirmed the desperateness of her life outside the hospital. Her husband, a victim of gas and 'shell-shock' during his service overseas in World War One, was an unemployed alcoholic whose heavy drinking made him a "terror to the children and Mrs N.", as well as an economic liability. The family's limited income was expended on liquor, rather than clothes or food. Mary had "lost heart", her minister wrote, and consequently she had "let things go". Mary, it seemed, had every reason to give up. Powerless in a hopeless and violent domestic situation she had fled from her home, relinquishing once and for all claim to an ideal of womanhood which had long mocked the reality of her life.18

For Mary, ironically, her imposed incarceration provided her with freedom from a destructive home life. After two and a half months at Seacliff Mary was released on probation to her mother's care, well-fed, rested and able to contemplate a future for herself and her children apart from an abusive husband. Her home and marriage had represented not feminine fulfillment but domestic oppression. In turn, her desperate rebellion against an intolerable situation had been interpreted by both lay and professional judges as an unacceptable and

18 ibid.
unnatural rejection of motherhood and domesticity.

Mary N.'s experience of madness was an indicative, if extreme example of how for many women the family might be both the arena in which "insanity" was manifest and detected, as well as the source of that distress. Furthermore, her case is particularly suggestive of how the social context of disturbed behaviour influenced the experience of madness, by highlighting the relative powerlessness of women within the patriarchal family. While Mary's husband's past history and present lifestyle fulfilled the legal definition of mental illness requiring incarceration, it was his wife who was committed. Her admission to Seacliff was validated by the diagnosis of schizophrenia, but in fact it was not schizophrenic, but rebellious behaviour which had prompted her confinement.

Mary's positive response to the regime of the mental hospital was probably typical of the experience of incarceration for many married women. Variously burdened outside the asylum by onerous domestic duties, child bearing and rearing, and often indigence, the regulated moderation of a routine of diet, rest and employment within Seacliff could provide for women temporary respite from their lives as wives and mothers.¹⁹ Once physically and mentally rejuvenated, they could resume their prescribed responsibilities within the family and the home. Whatever the prescriptive ideal posited, the reality of women's lives

meant the asylum often might operate as a refuge rather than a prison.

Moreover, refuge in sickness was one means by which women might withdraw from their domestic and conjugal duties, and maintain their claim to be good wives and mothers. The prescriptive ideology of womanhood, with its emphasis upon women as naturally frail and especially vulnerable to the stresses of life legitimised the sick role for women. For many of the 'weaker sex', mental illness could offer relief from the constraints and demands of their lives. At the same time it was often a more acceptable option than desertion or divorce of their husbands.\(^{20}\)

Mary N.'s committal then suggests that while breaches of domestic ideals were often cited on the applications of husbands for the reception of their wives into Seafiff Mental Hospital, such citations are better understood as symptoms of more general domestic tensions. The fact of women's restriction to the private sphere meant that when they experienced mental distress, their disturbed behaviour necessarily influenced domestic arrangements. The equation of a woman's personality with her functions as a wife and mother made it possible for family members to identify mental disorder in her lack of interest in her home and her family.\(^{21}\) When a woman was "not her usual self" that self was usually synonymous with motherhood and marital obligations.

\(^{20}\) C. Smith Rosenberg, Disorderly Conduct, p.98.
Disruption of the family, however, did not always immediately result in committal proceedings. Seacliff patient files contain evidence that some husbands did tolerate the abnormal behaviour of their wives for extended periods. It was only when that behaviour became unmanageable within the family that men were forced to seek the professional intervention of psychiatric experts. In the cases of Mary N., Caroline O., and Ellen B. noted above, for example, their husband's had borne with their slovenly behaviour for six months, eighteen months and seven years respectively.

In those cases where committal was initiated within three months of the onset of mental illness, the behaviour of the patient was often acutely disturbed. Mary-Anne S., a twenty-five year old housewife and the mother of a three year old boy, was committed to Seacliff in 1930 after only four days. Her husband's willingness to have her hospitalised was not motivated by simple expediency, but by the reality of her illness. "Violent and threatening", as well as self abusive, prior to her committal Mary-Anne had had to be restrained at Riverton Public Hospital for the protection of those around her and herself. Her insanity was further manifest in her deluded belief that she was speaking with her mother who had been dead for some time. Mary-Anne entered Seacliff, having been diagnosed as suffering from confusional insanity. For her, however, the hospital was not the recuperative environment it had been for Mary N. She died from exhaustion only a fortnight following her admission.

Victoria C.'s committal to Seacliff by her husband after only seven
days of disturbed behaviour was in part due to her own recognition of her need for psychiatric care. Previously admitted to the hospital as a voluntary boarder, Victoria was "in great fear of going mad", and she was anxious that she might "do away with herself or harm her children".

Both these cases suggest that tendency to violence was a precipitous factor in the incarceration of women by their husbands. Exhibited within the home, such physical aggression was usually directed toward other family members. Children were particularly vulnerable, their propinquity and relative powerlessness making them ready victims. Women who struck out at their offspring may have done so in expression of their frustration with a role which their children symbolised. Regardless of provocation, however, their violent behaviour was intolerable in its victimisation of the most vulnerable members of the family. Moreover, women's violence was not only considered unacceptable but it was also condemned as unnatural. In its challenge to the feminine prescription of passivity, violent behaviour was considered a certain indication of mental illness. Women who threatened the cornerstone of social order, the family, by threatening violence thus were liable to be labelled mad rather than bad, and committed to the asylum not sentenced to prison.

While wives who expressed themselves violently were rarely tolerated for long within the home, those whose mental distress was less acutely manifest were likely to be committed only reluctantly by their

\[23^{23}\text{Seacliff, 1930, 8006.}\]
husbands. Seventy-seven year old Essie L. had been "gradually losing her memory for the last few years" but her committal to Seacliff was only initiated by her spouse when she was no longer able to feed herself or attend to any of her bodily wants.\textsuperscript{24} Similarly, Charlotte E.'s husband expressed his regret at his wife's admission to Seacliff after two years of disturbed behaviour.\textsuperscript{25} His decision to commit her upon the advice of the Medical Superintendent of Dunedin Public Hospital attests to the acceptance by the laity of medicine's role as a social arbiter. Moreover, it was an acknowledgment by Charlotte's family that her behaviour was such that it could no longer be accommodated within the home.

Both Essie and Charlotte were diagnosed upon their admission to Seacliff as suffering from senile dementia, an organic brain disease characterised by gradual deterioration of an individual's memory and cognitive powers. In the standard hand-book of mental illness in this period, obstinacy, amnesia - at first partial and eventually complete - restlessness, hoarding, hallucinations and disorientation as to time and place were all noted as typical features of the disorder.\textsuperscript{26} Most significant for the explanation of patterns of committal was the progressive nature of senility. In the early stages of its manifestation senile dementia could be no more than inconvenient for a woman's husband and family. It was only as the disease advanced that its behavioural symptoms forced relatives to acknowledge that the patient's

\textsuperscript{24}Seacliff, 1936, 8773.
\textsuperscript{25}Seacliff, 1937, 8855.
continued accommodation within the home was impracticable. Elderly and severely demented women required the constant observation and attention of an institution geared to managing those who were unable to manage themselves. The family was not such an institution, but the mental hospital was.

The same considerations influenced families in the committal of their elderly single female relatives. Invariably these women were widows, and they were senile. Their siblings or offspring sought their committal when their senility became problematical in either their own domestic environment or that of the relative with whom they lived. Again, most often these women were admitted to Seacliff only after their families had endured their disturbed behaviour for extended periods of time. Eighty three year old Mavis P. had been "getting worse for three years" before her forgetfulness and restlessness finally prompted her daughter to commit her. Mavis was "continually shifting about, having lived in at least sixteen different places during the past three years." It was perhaps not surprising then that if she left home she often forgot where she had to return to. Furthermore, she was "careless with her money, continually losing it".27 Valerie D. was committed by her daughter at the age of 94. Her continual violence and screaming finally had exhausted her child's tolerance after five years of demented behaviour.28 Jane T.'s son had borne with his mother's failing memory, incoherence and delusions for nine months before seeking her reception into Seacliff in 1931.29

27Seacliff, 1934, 8489.
28Seacliff, 1935, 8694.
29Seacliff, 8041, 1931.
In each of these instances, the families of elderly single women, as those of their married counterparts, sought out the asylum only when their capacity to cope was exhausted by the reality of their kinswomen's mental deterioration. Nevertheless, women over sixty - those most likely to be diagnosed as senile - were resident in Seacliff Mental Hospital in numbers disproportionate to their representation in the general population of New Zealand. In 1936, women aged sixty and over constituted more than 30% of the female patient population at Seacliff, while making up only 21.5% of New Zealand's total population. These figures suggest that those women who survived beyond three score years were vulnerable to incarceration, usually for senile dementia, despite the reluctance of their families to commit them.

For young spinster women committed to Seacliff Mental Hospital in this period familial tolerance of disturbed behaviour was less common. Unmarried sisters and daughters who exhibited signs of mental illness were comparatively quickly dispatched to the institution. Over three quarters of the spinsters in the sample were removed from the family environment and incarcerated within three months of the onset of their distress.

The Seacliff evidence then supports Garton’s suggestion of growing intolerance of unmarried women within the family. With reference to the committal of spinsters in the interwar years in New South Wales, he posits that smaller families and the impact of

---

30AJHR, H-7, 1936, p.16.
31New Zealand Census, 1936.
Urbanisation and suburbanisation marginalised the single woman in some families. No longer valued for her companionship and contribution to domestic labour as the colonial helpmeet of the past had been, the single woman in the 1930's had no legitimate role in the small nuclear family. Furthermore, her failure to marry and propagate the race rendered her an anomaly in an era which exalted wedlock and motherhood. In 1936 only 27.3% of the female population in New Zealand had never been married, but in Seaciff Mental Hospital unmarried female patients constituted 38.5% of incarcerated women. Unmarried women were beyond the norm of social relations, and thus were easily branded inadequate, if not insane. Spinsters were not protected by marriage and motherhood, and as a result their relatives may have been less inclined to accommodate their mental aberrations within the home.

Furthermore, in the marked economic downturn of the early 1930's spinsters living with their parents or their siblings might represent a financial burden for their families. Seaciff was a public hospital, and as such it did not bill families for the expense of their kinfolk's detention and treatment if they could not afford to contribute. Financial considerations may then have influenced the ready committal of unmarried women whose mental condition had not necessarily rendered them unmanageable, but unproductive.

33 Ibid.
34 A/HR, 1934, p.14. Figures concerning the marital status of mental patients are not available after 1934.
No doubt these various pressures each had some degree of influence upon motivation for committal of a mentally distressed single woman. The records of Seacliff Mental Hospital in this period, however, argue that as for married women and widows, the manageability of a spinster’s behaviour was fundamental to her family’s reluctance to care for her at home or to commit her. Many of those single women institutionalised within three months of the onset of their mental disorder were diagnosed upon admission to Seacliff as suffering from acute psychiatric illnesses. Twenty-seven year old Sarah F. had not slept for three days when her father initiated her committal. Her delusions that her house was on fire, hallucinations of hearing and her failure to recognise other members of her family resulted in her being labelled acutely maniacal.35 Rachel B., a fifty-seven year old retired schoolmistress was committed by her sister after exhibiting suicidal tendencies for three weeks. She was depressed, refused to eat, and had attempted to drown herself at Anderson’s Bay "as a solution to her troubles".36

Schizophrenia was also a common diagnosis among single women admitted to Seacliff in this period. While it was a psychiatric disorder characterised by a gradual disintegration of all mental functions, its progress was also insidious so that relatives only became aware of their kinswoman’s illness the disease was well advanced and the manifest symptoms acute.37 Katie J.,38 Emma T.,39 and Margaret F.40 were

35Seacliff, 1930, 7969.
36Seacliff, 1936, 8808.
37Henderson and Gillespie, op cit., p.297.
38Seacliff, 1935, 8675.
39Seacliff, 1933, 8332.
all institutionalised within a month of their relatives first detecting changes in their kinswomen's personality and behaviour, although they may have been experiencing mild schizophrenic symptoms for a much longer period of time.

As with their married counterparts, single women who exhibited violence did so toward other family members and were readily committed for their breach of domestic harmony. Unlike the threatening behaviour of wives, spinsters often directed their anger toward their parents with whom they lived. When Louise O.'s sister applied for her sibling's reception into Seacilff in 1935, her concern for her father was foremost. Twenty-six year old Louise, she claimed, was very liable to become hysterical and violent, and she had attacked her father on several occasions. Similarly, fifty-seven year old Maria M. had been subject to "fits of temper" since the age of fifteen. It was only when her rage became manifest physically and she assaulted her father and chopped up his boots with an axe that her family deemed her unmanageable and had her committed. Her dangerous tendencies were thought best managed by the controlled environment of the mental hospital.

In these two cases there was little indication in their files of the motivations of Louise and Maria's physical aggression. Both women were diagnosed as epileptic, however, and their violence may have been a consequence of that disorder's expression. Certainly, a tendency to

---

40. Seacilff, 1937, 8978.
42. Seacilff, 1937, 8955.
pick quarrels and strike out at others for no particular reason were recognised by psychiatric experts as characteristic features of epilepsy.\textsuperscript{43}

The home was the sphere in which the violence of Louise and Maria became manifest; it is impossible to determine, however, if domestic circumstances also contributed to their disturbed behaviour. For Heather R. the family was both the source of her distress and the institution at which she struck out. Committed by her brother, she had made threats against her sibling and had assaulted her mother, believing them both to be against her. Her medical judges certified her as of "unsound mind" but neither could determine the cause of her insanity. Heredity was posited uncertainly as a possible explanation, although there was no history of mental illness in Heather's family. Had they acknowledged Heather's own statement that she had been "trapped left and right", they might have more correctly attributed her violence to the frustration of a thirty-five year old woman whose marital status rendered her a non-entity in a society oriented to the ideals of marriage and motherhood.\textsuperscript{44}

In contrast to the committal experience of spinsters like Rachel B., Katie J. and Heather R., single women whose disturbed behaviour had been tolerated within the family for much longer periods were almost invariably classified upon their eventual admission to Seacliff as congenital mental defectives. Often their committal had been prompted

\textsuperscript{43}Henderson and Gillespie, \textit{op cit.}, p.540.
\textsuperscript{44}Seacliff, 1933, 8303.
by the fact of their adolescence. As idiot, imbecile and feeble-mined girls developed physically their mental retardation might make them the target of the sexual desires of unscrupulous men. Families sought to avoid the possibility of such a liaison by removing their mentally impaired daughters to the segregated and controlled environment of the asylum. Thus, Lucy W., an epileptic imbecile, was committed to Seacliff at only fourteen years of age. One of twelve children, Lucy wandered away unless kept under constant observation, an almost impossible task in such a large family.45 Her family's inability to continue to adequately manage her mental deficiency, as well as the economic hardship of supporting an unproductive daughter during the Depression were the particular motivations for Lucy's incarceration.

The evidence gleaned from the patient records of Seacliff Mental Hospital in this period suggests then that a wide range of behaviour was identified as symptomatic of women's mental distress requiring incarceration. No doubt that process was facilitated by the expansive legal definitions of mental illness which provided a framework loose enough to enable families to consider variations of their kinswomen's conduct manifestations of madness. By thus labelling women's disturbed behaviour insanity, the general social, and particular familial pressures experienced by women in this period were often disguised.

The principal assigned causes of female insanity further masked the influence of social factors upon women's minds. In line with contemporary psychiatric preoccupations with the role of biology in mental disease, women's mental disorders were most often attributed to

---

45 Seacliff, 1931, 8097.
physical causes. Hereditary taint, congenital mental defect, and senility, for example, were each responsible for many women's incarceration. The frequent citation of the first of these sources of mental illness was an indication of the currency of eugenic philosophies of inherited weakness.

A fourth group of exclusively female sources of mental ill-health were also commonly assigned in explanation of women's behaviour. Menstruation, pregnancy, lactation, puerperal, and climacteric or menopause had first been considered the biological roots of female madness in the nineteenth century. The emergent medical specialities of gynaecology and psychiatry collaborated to identify disturbances of the brain in women as sympathetic responses to irritations in the reproductive system.46

While by 1930 such theories were losing credence as the techniques of Freudian psychoanalysis were increasingly adopted by the psychiatric profession, women's periodicity continued to influence the diagnosis of female insanity.47 Relatives of those who entered Seacliff Mental Hospital in this period were expected to provide the reproductive history of their kinswomen as well as details concerning her family, education, personality and general physical health. It is difficult to ascertain, however, whether the information about menstruation and childbirth thus gleaned was interpreted by the Seacliff doctors as biologically or socially causal of a women's madness. Certainly, in an

46Dwyer, op cit., p.27.
47Carton, op cit., p.137.
era which glorified motherhood, the pressure upon a new mother to live up to the ideal may well have proved destructive to her sanity. Similarly, women who lost their claim to true womanhood when they lost the potential to reproduce may have expressed in madness a sense of purposelessness and loss conferred on them by their biology. Whether these social stresses were acknowledged when a doctor attributed a woman's disturbed behaviour to the climacteric or the puerperium is difficult to determine.

Conspicuously absent from the assigned causes of insanity in this period are the "inter-personal" sources of female insanity noted by Brookes in her study of Seacliff during the years of KING's management of the institution.\(^4\) It is possible that "domestic troubles" and "love disappointments" were subsumed within the categories of 'mental stress' and 'unknown'. Alternatively, the Seacliff psychiatrists may have regarded them symptomatic of mental disorder rather than causal at a time when somatic theories of insanity held sway. Whatever the explanation for their absence from the hospital's official tallies, inter-personal causes were acknowledged by those involved in the committal process outside Seacliff. Ursula G.'s daughter attributed her seventy-four year old mother's incoherence and disorientation to "financial worries and harsh treatment by her husband". The medical men who certified Ursula, however, were more inclined to pronounce her disturbed behaviour evidence of her senility. While both lay opinion and professional judgment may have been correct in their assignments of cause, it was the doctors' verdict which was affirmed upon Ursula's

entry to Seacliff. Familial knowledge of the patient was dismissed in favour of medical knowledge of mental disease.

When the medical certificates did cite social pressures as the cause of mental disorder it usually indicated that no more medical explanation could be assigned from the evidence with which they were presented. Katie J.'s unsound mind, for example, was attributed by her examiners to a "difference of religions". Katie was Presbyterian, and her Catholic boyfriend had threatened to commit suicide if they were not married within the month. Single, fit, only twenty-one years of age and with no history of mental illness, Katie could not be diagnosed as victim of her biology, hereditary or age and, thus, her mental distress was assigned to "inter-personal causes".50

That inter-personal causes were not listed among the principal assigned causes of insanity in the annual reports of the mental hospitals of the Dominion reflects the growing professionalisation of psychiatry and the growing medicalisation of mental illness. It does not reflect, however, the reality of New Zealand women's lives in the 1930's as intimately defined by personal relationships, and ultimately confined within the domestic sphere. Examination of the way in which women manifested their mental distress provides an insight into that reality, by allowing those who have been judged and defined by others to speak for themselves.

The women committed to Seacliff Mental Hospital from 1928 to

---

49 Seacliff, 1931, 8135.
50 Seacliff, 1935, 8675.
1937, expressed their insanity most commonly in delusions, the content of which overwhelmingly attests to their continued orientation to the home and the family. By dint of their unpaid 'occupations' as wives and mothers, the home was a source of their economic security and a symbol of their purpose in life. As a patriarchal institution, however, it also enforced the powerlessness of women. When women undertook marriage and motherhood, they entered into a bargain with their husbands which traded their autonomous identity for the feminine ideal of dependence and domesticity. Thus, for women the home and the family represented both gain and loss, and this ambivalence is expressed in the delusions of the women admitted to Seacliff in this period.

For some women, the gains conferred upon those who conformed to the domestic ideal rendered negligible the losses. These women were seen by others as primarily wives and mothers, and they too identified themselves as such. To them, any threat to their homes was a threat to their very selves. Such women were represented within Seacliff by Elizabeth K. of Clifton, and Amy C. of Riverton. Both expressed their madness in delusional fears that their homes were under threat. Amy was admitted to Seacliff suffering from secondary dementia, and labouring under the mistaken belief that her house had been taken from her. The mental distress of Elizabeth was manifest too in her delusion that she had lost her home, and, significantly, "everything". Whether real or only perceived threats to the domestic sphere were a powerful source of anxiety for many women whose focus was homebound.

51 Seacliff, 1936, 8747.
52 Seacliff, 1936, 8826.
The prescriptive power of the domestic ideology meant that many women felt that they could not meet the demands it made of them. Their sense of inadequacy as wives and mothers was often voiced explicitly in delusions of unworthiness which testify to the destructiveness of impossible expectations. Virginia J., a forty-nine year old mother of three children, for example, stated upon her admission to Seacliff in 1928 that she was a "loveless" woman who had treated her family with terrible harshness and who was unworthy of them. Her delusions were inspired by the recent birth of an illegitimate child to her daughter. Virginia blamed herself as an inadequate mother for her daughter's failure to conform to the prescribed code of feminine conduct. Like many of the deluded women committed to Seacliff in this period Virginia threatened suicide, saying her life was not worth living because she had not brought up her family properly.53

Pressure to realise the tenets of the domestic ideology was exerted upon single as well as married women. Gladys G., a sixty year old spinster admitted to Seacliff suffering from agitated melancholia worried all the time about her home because she felt she had not done her duty. She condemned herself for not having done her "best in the home".54

The delusions of many women who deemed themselves failed

---

53 Seacliff, 1928, 7619.
54 Seacliff, 1936, 8719.
home-makers were often accompanied by a sense of their personal contamination. The case of Bridget O., a fifty-eight year old housewife and mother of five children was a typical one. Upon her certification as insane she bewailed the fact that she had "ruined her family". She claimed that she had neglected her home and that it was dirty and only fit to be burnt. She too, as an entity synonymous with the home was "unclean". Bridget stated that she had leprosy and that if she went into the sea she would pollute the fish.\(^{55}\)

Disease and contamination were popular themes in the delusions of female patients whose madness could not be attributed to any particular cause. Mabel D., a housewife was committed to Seacliff by her husband in 1930. She was confused, depressed and anxious about her bodily condition, believing herself to have contracted venereal disease. Her examining doctors could find no physical basis for her claim, nor could they account for her unsound mind.\(^{56}\) Similarly, Sophia P., a sixty-six year old spinster told her certifying doctors that she was covered in vermin which she could not get rid of. They uncertainly attributed her insanity to a "previous attack" she had experienced at the age of fourteen.\(^{57}\) Medical practitioners, intent upon physical diagnoses of mental illness were perhaps unprepared to recognise the social reality of women's lives which fostered the powerlessness and lack of self-esteem evident in their delusions.

\(^{55}\) Seacliff, 1935, 8606.
\(^{56}\) Seacliff, 1930, 7873.
\(^{57}\) Seacliff, 1930, 7946.
Seacliff were those of persecution. Often they were indicative of the sense of vulnerability, and of frustration some women felt within their constricted sphere of dependence. In these delusions the family was the agent of their perceived oppression. On Deborah W.'s admission to Seacliff in 1928 she stated that she had to get in and out of bed all night because it was charged with electricity. Moreover, she demanded that her husband be "locked up" as she believed him to have poisoned her tea. The general practitioner who had certified her insane noted also in his evidence of her mental condition that she had taken her wedding ring off. He did not consider that Deborah's words and actions might have been more suggestive of unhappiness with her spouse than signs of her insanity.

Clara's C.'s "delusion" that her son and his family were all wicked to her again was noted as symptomatic of her senile dementia along with her incessant talking and praying. An eighty-three year old widow who lived with her son's family, Clara expressed in her madness feelings of vulnerability in a domestic situation over which she had little control. She depended upon the tolerance of her extended family. Her committal to Seacliff by her son indicated that that tolerance had been exhausted.

Other women were "persecuted" not by their families but by outside agents. Sometimes these persecutors were identified by their victims as their neighbours, the police or staff at the hospital. Such cases were relatively few, however, for the constraints of the domestic

---

58 Seacliff, 1928, 7624.
59 Seacliff, 1937, 8889.
sphere meant that women's interaction with others beyond that arena were limited. Nevertheless, there were a great many unidentified "people" who persecuted the women committed to Seacliff. Doris H. thought that she was being poisoned and she was also convinced that 'people' were going to burn her clothes and her house. Kate D. claimed that poison had been put in her eye and her ear, Philippa J. said that 'people' were talking against her and taking her things, and Frances S. was afraid to sleep in her own home because she believed 'people' were trying to poison her with gas. Each of these delusions expressed symbolically the vulnerability, powerlessness and low self-esteem of women in a society which rendered them dependent on men, and conferred on them an ideal of femininity impossible to achieve.

Delusions of persecution, therefore, stand as metaphors of women's total experience. Their significance is all the more striking for the dearth of exalted behaviour amongst the female patients admitted to Seacliff at this time. At Seacliff, as within the mental hospitals New South Wales, delusions of exaltation were exhibited by female patients only infrequently, and when they were present their themes were most often those of marriage and motherhood. Dorothy E. for example, a fifty year old spinster was convinced that she was pregnant. The stigma of childlessness must have been keenly

60 Seacliff, 1934, 8453.
62 Seacliff, 1937, 8365.
63 Seacliff, 1933, 8353.
64 Carton, op cit., pp.138-139.
65 Seacliff, 1934, 8442.
felt by single women at a time when personal fulfillment for their sex and women's patriotic duty were equated with motherhood. Arabella D.'s senile dementia served to sharpen her appreciation of marriage as central to womanhood. At seventy-two years of age she had already raised three children with her husband and her delusion that she was about to get married attested to her approval of that institution.66

Some women expressed their madness by voicing delusions. Many others chose to manifest their mental distress in silence and withdrawal. It was not uncommon for doctors to note that the female subjects of their examinations were "extremely uncommunicative".67 Doris H. was subject to "bouts of melancholia" when she refused to speak,68 and Victoria C. was "depressed and introverted".69 All those who withdrew in silence were coping with their distress as true women - passive, quiet and private. Their's was a learned response.

It was often the case too that female patients effected their withdrawal by the refusal of food as well as the refusal to speak. Joan Jacobs Brumberg, in her study of anorexia nervosa has provided a useful historical analysis of the interaction of social context, sex roles and disease symptomology. She concludes that middle class girls used food as a means of self expression in a world which offered them few other outlets for their personalities.70 The case of Katie J. was

---

66Seacliff, 1930, 7394.
67Seacliff, 1932, 8230.
68Seacliff, 1934, 8453.
69Seacliff, 1930, 8006.
70Jacobs Brumberg, Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease, p.188.
perhaps typical of this model. Katie had become "quite changed in her demeanour and mental outlook". She was morose and she would not answer questions. Furthermore, she would not take food. Katie was committed to Seaciff in 1935 suffering from schizoid depression. While at twenty-one years of age she was no longer a girl, it is likely that the social pressures which bore on Katie as a young unmarried women living at home were similar to those described by Jacobs Brumberg.71 The refusal to eat was a viable and visible way for women to exhibit their mental distress, and it was symptomatic of the insanity of many of Seaciff's female inmates, regardless of their age.

The most extreme and the most symbolic way in which women could withdraw from the pressures of femininity was suicide. The desire to kill herself was often accompanied by a sense of failure as a true woman, and delusions of her own contamination. Thus, Bridget O. condemned herself as unclean and as a bad wife and mother, and sought relief from her guilt in death. She continually stated her intention to kill herself and made efforts to get hold of razors and knives in order to do so.72 Similarly, prior to her hospitalisation Edith B. had not been eating well and she had sought "any opportunity to throw herself over a bank or cliff". When her freedom was taken from her upon her committal to Seaciff and constant surveillance invalidated suicide as an option, she chose to express her withdrawal in silence.73 Withdrawal was a means of coping attractive to women whose dependence on others, and limited range of experiences imbued in them passivity, not

71Seaciff, 1935, 8675.  
72Seaciff, 1935, 8606.  
73Seaciff, 1933, 8358.
assertiveness.

As Jill Julius Matthews argues for Australia, the construction of femininity was inseparable from the construction of women's madness. Families committed their mentally distressed kinswomen to Seafiff Mental Hospital because their behaviour was no longer manageable, or tolerable within the domestic sphere. Suicidal women required constant oversight; violent women had to be controlled; deluded, depressed and demented women needed the professional care and attention only available within the asylum. That reality is not in dispute. What was significant, however, was the way in which families perceived their women to be in need of institutionalisation. Often their detection of insanity was dependent upon their detection of failed womanhood. Little interest in housework, neglect of children, and threatening behaviour were all cited by women's families, and upheld by the medical profession, as evidence of female madness.

The prescription of femininity influenced not only familial and medical judgments of women's behaviour. The expectations of its compulsory ideal fostered guilt, hopelessness, and ultimately madness among women whose identity was synonymous with marriage and motherhood. Such women often confirmed their families' condemnation of their conduct by indicting themselves as poor wives and mothers. Others railed against its constraints in their delusions of persecution, and withdrawal from their responsibilities.

For both the committed and the agents of their incarceration, the

74 Matthews, op cit., especially chapter 2.
expected and accepted orientation of women to the domestic sphere was fundamental to their experience of mental illness. It defined women's disturbed behaviour as evidence of insanity, and it generated pressures upon women which they, in turn expressed in the forms their madness took. The construction of femininity in New Zealand in the 1930's, however, did not so predispose women to the label of insanity as to 'feminise' the Seacliff patient population. Throughout the period under review men out-numbered women for all but the final two years of the study, when they were admitted in fairly equal numbers.75 Furthermore, in relation to their preponderance in the general population, women were less vulnerable to incarceration than men.76

Thus, the evidence of Seacliff Mental Hospital refutes Showalter's thesis for England that women were victims of psychiatry and institutionalised in greater numbers than men as madness came to be perceived as a "female malady". Rather, the committal papers and case-notes of Seacliff from 1928-1937 confirm the findings of other historians of madness in New Zealand and elsewhere. What their evidence suggests and mine supports is that it is not the ratio of the sexes within the asylum walls which is most significant, but the differing ways in which men and women manifest their mental distress, and are judged mad.77 Accordingly, women's experience of insanity can only be fully understood in comparison with that of her male counterpart.

---

75 AJHR, H-7, 1928-1937.
76 Census, 1936.
77 see for example Tomes op cit.; Labrum, op cit.; Brookes, op cit.; Garton, op cit., chapters 6 and 7.
If women's experience of madness was defined by the construction of femininity, then men's was similarly influenced by their equally contradictory gender roles. The social construction of the New Zealand man of the 1930's reflected the values traditionally assigned to men modified to accommodate New Zealand's environment and historical experience. Masculinity, then, was no less prescribed than femininity, and indeed each was dependent upon the other. Women were the bearers and rearers of the nation's greatness; men were the personification of that greatness. By 1928, masculine values were synonymous with New Zealand's values as the Dominion struggled toward national definition.\footnote{J. Phillips, \textit{A Man's Country?}, p.vii.}

The traditional male stereotype of the strong, independent, and assertive man, was reinforced in New Zealand's pioneer days. Nineteenth-century immigrants to the colony set foot ashore a frontier world, which demanded of its new sons physical exertion and endurance, and self-reliance. Most significantly, it was a world
wherein not only 'male' values were paramount, but the male presence was dominant. In 1851, the first New Zealand-wide census recorded a European population of 15,035 men and only 11,672 women. It was an imbalance which was to become even more distinct in the decades which followed, and one which characterised the New Zealand population up to and beyond the period under review.2

The male bias of the population of the Dominion allowed New Zealand men, and New Zealand society itself to develop relatively free from female influence.3 Women did contribute vital unpaid productive and reproductive labour to the growth of the New Country, but the numerical strength of men and the realities of colonial life ensured that distinctively masculine, and physical values were glorified. The feminine and the intellectual were rigorously eschewed in an era when a significant proportion of men never married and bookish theory gave way to pragmatism of necessity.

On the eve of World War One the masculine ideal stood firm. The frontier was receding and the cities growing,4 and single men were surrendering to marriage in ever greater numbers as the female population increased,5 but these developments had made few inroads into the male culture which had been spawned in the previous century. Moreover, the experiences of New Zealand manhood in the international arena validated that culture. On the battlefields of South

2Ibid., pp.6-7; Census, 1936.
3Ibid., p.7.
5Phillips, op cit., p.9.
Africa in the Boer War, and the rugby fields of Britain in 1905, New Zealand men proved to the world that they were 'invincible'.

New Zealand men emerged from the First World War with their image not only intact but embellished. The image had withstood the German challenge, and the challenge of the medical evidence which suggested that New Zealand men were no longer the virile 'blokes' of the Dominion's early years. Over 50% of those conscripted to fight for their king and country were rejected by the army's doctors, primarily for heart disease, thus rejecting New Zealand's claim to be a social utopia, as well as New Zealand manhood's title as princes of that idyllic world. The Government responded to the threat to its nation's welfare with the creation of a new agenda for public health following the war, but the reality of male physical weakness hardly tarnished the ideal popular perception of New Zealand men. The success of the New Zealand Division against the Empire's enemies, and in comparison with the imperial sons of other countries, ensured that few would question the pioneer construction of masculinity in the Dominion. Physical prowess remained central to male identity, as did self-reliance.

Moreover, that cornerstone of male culture, the 'pub', weathered the attacks of the Prohibitionists, and emerged from the Great War as the exclusive enclave of men, and the ultimate symbol of manhood. Not only had the 'wowsers' failed to make temperance compulsory, but the

---

6Ibid., pp.141-152.
7Ibid., pp.109-118.
9Phillips, op cit., p.163.
victory they claimed in the legal institution of six o'clock closing reinforced rather than weakened drinking as a male ritual. Sexually segregated to exclude women, the public house became a refuge from the burdens and responsibilities of the outside world, where men might relive the frontier experience of men together but alone.10

A decade after the 'boys' had returned home from the front, that home had become sanctified as the keeper of social order and the insurance of national progress. The ideology of motherhood vaunted the home and the family as the fundamental units of a healthy society and the secrets to a woman's fulfillment. The prescription which so dominated women's lives in the thirties necessarily influenced the lives of New Zealand's men as well. Women could not attain true womanhood as wives and mothers without men as husbands and fathers. As the home and the family were exalted, the construction of masculinity was modified within its traditional bounds. Men were still identified as rugby players, drinkers and workers, but now, first and foremost, they were expected to fulfil the additional roles of economic provider and respectable family man. This development in masculinity reflected both the growth of a middle class in New Zealand society, and the fact that more and more of the Dominion's sons were growing up to be husbands and fathers. Hitherto masculinity had been defined by the frontier experience, but now urbanisation had undermined the applicability of that myth. Furthermore, the male culture which had evolved from the pioneer days of New Zealand's past had been one designed for the interaction of males with males in a society where

10 Ibid., pp.75-80.
women were scarce and undervalued. Now men needed a prescription for interacting with the women who were their wives and the mothers of their children, and which esteemed them in accordance with the ideology of motherhood. The result was the construction of a contradictory masculinity which expected that men should be men at the same time that men should be husbands and fathers.

In the economic adversity of the Depression years the pressures upon the New Zealand male to fulfil the expectations of his gender role were onerous. To be a man in the eyes of his fellows he had to work, and to realise his masculinity with his family he had to ensure that there was money enough to feed and clothe himself, his wife, and their offspring.

The stress upon men in the 1930's to fulfill their economic obligations to their families was heightened, then, by ideological imperative. At the same time, their ability to do so was challenged by the reality of unemployment and dependence upon government and charitable aid. In 1928-29, 4,718 cases of involuntary unemployment were recorded in New Zealand; three years later that figure had risen to 28,773.\textsuperscript{11} The implications of these statistics for New Zealand manhood were considerable. Men's identity was threatened by lack of work, economic hardship and reliance upon the charity of others.

As the construction of femininity did for women, the construction of masculinity prescribed a gender role men were often unable to fulfill in the 1930s. Its nineteenth-century tenets had suffered by the agency

\textsuperscript{11}M. Tennant, \textit{Paupers and Providers: Charitable Aid in New Zealand}, p.183.
of social and demographic changes, so that the independent "man alone" was at once glorified in myth, and increasingly elusive in reality. Furthermore, the entrenchment of men as providers for their families as a necessary corollary to the ideology of domesticity, was realised in an era when many men were discovering for the first time the indignity and indigence of unemployment. Men's response to such challenges to their masculinity was varied, but many who were committed to Seacliff sought reassurance of their identity by reasserting the same values which had made them men in the past.

The study of the files of men committed to Seacliff Mental Hospital from 1928-1937 suggest the ways in which men coped, or failed to cope with the pressures exerted upon them by the expectations of their gender roles. It provides ample evidence that the man alone was a man vulnerable to incarceration, and that men in the 1930's continued to express their frustrations through the traditional channels of violence and alcohol. In a society which increasingly valued stability, respectability and sobriety, such definitions of masculinity were liable to be deemed unacceptable as outside the bounds of tolerable behaviour.

As for women, those who most often judged men's behaviour intolerable, and initiated committal proceedings against them were their families. Over two-thirds of the sample of male admissions to Seacliff were committals from within the home. Moreover, it was common for proceedings to be prompted by the unmanageability of a kinsman's expressions of his masculinity.
Violent behaviour, in particular, often precipitated a man's family to seek his certification and incarceration. Robert T. was admitted to Seacliff Mental Hospital suffering from general paralysis of the insane, the tertiary stage of syphilis, but it was his abusive behaviour at home which had prompted his committal. On her application for his reception into the institution, Robert's wife had stated that he had caught her by the throat and punched her. He confirmed his wife's assertion of violence, admitting to his medical examiner that he was apt to go "crook" when his word was questioned. Similarly, thirty-two year old Frank L. had threatened to shoot his wife and his children, and had terrorised his neighbours in the fortnight before his committal to Seacliff in 1932.

As labourers, and servicemen in World War One, both Frank and Robert were men whose lives had been defined by the prescription of masculinity. Their violence toward their families reflected that primary orientation to muscle. Furthermore, Frank's case highlights the way in which the Depression challenged the ideal of New Zealand manhood, and forced men to express their frustrated masculinity in the destructive tenets of male culture. Out of work for two years prior to his committal, Frank had sought refuge from his failure as a provider and as a man in the bottle and had tried to reassert his wounded masculinity through violence. His delusion that people had been speaking adversely about him testified to the stigma unemployment represented to men, while his belief that his "heart had gone missing" suggests the centrality of work to a man's sense of identity.

---

12 Seacliff, 1934, 8483.
13 Seacliff, 1932, 8289.
The equation of Frank's lack of self-esteem with his lack of work was further apparent in his career as an inmate of Seacliff. At first reticent and suspicious with persecutory delusions, he became "anxious to please" upon being appointed care-taker of the institution's golf course. His misconduct with a female patient two years later, however, resulted not only in the birth of an illegitimate child, but also in the forfeit of Frank's responsibilities at the golf course. Thereafter, his delusions returned, as did his tendency to violence. His career as a mental patient at Seacliff concluded three months later when he escaped from the hospital having spent six and a half years within its bounds.

Both Frank and Robert were committed to Seacliff by their wives, as was Ernest G. whose senile dementia exposed his family to regular "fits of rage". In other cases, however, violent married men were incarcerated on the strength of information provided by male members of their family. Charlie W.'s son initiated committal proceedings against his father who had exhibited "violent fits of temper" and had threatened "to 'do' for the family". Colin M, too, was committed on the advice of his son who claimed his father had become "somewhat violent lately" having caught his daughter by the hair, maintaining his grip until relieved of it by one of her siblings.

It is possible to surmise that in these instances kinsmen were acting to commit violent husbands on behalf of the patient's spouse. Certainly,
women confronted ideological and practical disincentives to effecting their husbands' incarceration. Schooled in the values of passivity and obedience to the male upon whom they were dependent, women who initiated proceedings against their husbands were acting against the tenets of their gender role. Moreover, they were exposing themselves to the very real possibility of violent reprisal upon the patient's discharge, or in the eventuality of an application for a reception order being rejected. That possibility may have been reduced, and the breach of femininity avoided, if a son, brother or other male relative took responsibility for the committal of an abusive husband. By so doing the hostility of the patient might be directed from his wife toward other members of the family better able to defend themselves.

Certainly, families showed themselves to be unwilling to tolerate physical aggression by their menfolk, despite the economic hardship they might incur from the incarceration of the household breadwinner. Robert T.'s violent and disruptive behaviour was borne by his wife for a month before she sought his committal, while proceedings against Charlie W. were initiated only five hours after his violation of familial norms.

Where the perpetrators of violence within the home were single men there were even fewer disincentives to their removal to Seaciff. Forty year old carpenter Joe R. was committed by his brother after a

---

17Garton, op cit., p.145.
18E. Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, p.144.
19Seaciff, 1934, 8483.
20Seaciff, 1935, 8611.
week of threatening to shoot anyone who crossed him,\(^\text{21}\) while the violent outbursts, spitting and grunting of seventy-one year old widower Thomas F. were withstood by his son for only three days before his committal was effected.\(^\text{22}\)

Violence within the home was difficult to bear, whether by men or women. It is likely, however, that women were more vulnerable to incarceration for their violence than were men whose aggression was generally accepted as a valid expression of their masculinity. The ideologies of masculinity and femininity posited different levels of tolerance for male and female violence.

If male violence within the home was often censured by committal, then its expression in public similarly rendered men liable to incarceration. The detection of men's madness in the public sphere accounted for one-third of male committals to Seacliff in the sample, and for most of these men it was their violence which had exposed their behaviour to the scrutiny of police authority. Timothy D. was arrested at Tapanui in 1931 after causing a disturbance at a local tearooms. He had threatened to stab one of the women working there and then proceeded to overturn furniture and rip the telephone from the wall.\(^\text{23}\) William H. had acted in a similar manner, "knocking the furniture about" in a Dunedin cafe. Furthermore, he was unable to pay for his meal. His aggression and theft caused the police to intervene and William was subsequently removed from the public sphere into the

\(^\text{21}\) Seacliff, 1930, 7931.
\(^\text{22}\) Seacliff, 1936, 8841.
\(^\text{23}\) Seacliff, 1931, 8034.
closed and controlled environment of Seacliff.24

These two examples of the public detection of mental illness are probably typical of the committal experience of many men whose admission to Seacliff was effected by the police. They also provide the strongest evidence of the theory of social control in practice. Timothy and William had broken the law by their public expressions of violence against persons and property, but they were not convicted of their crimes and sentenced to prison, but certified insane and committed to a mental hospital. The only other evidence of Timothy's 'insanity' recorded on the police application for his reception into Seacliff was that he had been crying hystERICally upon his arrest.25 Similarly, William's need for hospitalisation rather than imprisonment was based on the fact that he had a "morose nature", and that he would "not make friends with anyone", preferring to keep to himself.26

The cases of Timothy and William suggest the dilemma public authorities, and often families, confronted in differentiating between 'bad' and 'mad' behaviour. It is a distinction which historians of incarceration have recognised as being fundamental to the concomitant rise of the asylum and the prison in the nineteenth century.27 Moreover, it is a distinction not easily made. As Goffman states in his sociological study of the typical career of a mental patient, alternative

---

24Seacliff, 1933, 8341.
25ibid.
26Seacliff, 1931, 8034.
27see, for example, S. Garton, "Bad or Mad? Developments in Incarceration in New South Wales 1880-1920", What Rough Beast?, The State and Social Order in Australian History, Sydney Labour History Group, pp.89-110 ; and S. Cohen and A. Scull, eds., Social Control and the State.
outcomes to committal often appear to have been possible.28 With regard to the evidence of the Seacliff records, the senselessness of William and Timothy's crimes was perhaps the factor which determined their fate as patients rather than prisoners. The police reports contained no clues as to what motivated their violence, thus suggesting that they themselves were baffled by such apparently unwarranted outbursts of aggression.

William and Timothy were first arrested for their violence, and only thereafter identified as mentally ill. In other instances, men were arrested primarily on the basis of their mental condition and their vagrancy as "mental defectives wandering at large". These men were often young itinerant labourers whose excessive indulgence in alcohol exposed them to police apprehension. Dick G., a thirty-one year old labourer of no fixed abode was found "wandering aimlessly round the countryside", and asking at houses for a gun. Upon his admission to Seacliff he was diagnosed as suffering from alcoholic confusion.29 Thirty-five year old Sam C., too, admitted to being a heavy drinker upon his arrest by the Ranfurly police in 1930. His confusion, hallucinations and insomnia motivated his detention by the police and ultimately by Seacliff.30

For both Sam and Dick, their status as single, rural labourers of no fixed abode was doubtless influential in their vulnerability to committal by the police. Such men were outside the social networks and local

28Goffman, op cit., p.134.
29Seacliff, 1929, 7784.
30Seacliff, 1930, 7914.
economy of the communities in which their mad behaviour was manifest. They were less likely to be tolerated than local men, with dependent wives and children, resident and working within the community who exhibited signs of madness in public. Single men were without the familial support which might have provided care for their mental illness at home, or at least, given them a refuge from public scrutiny and judgment.

It is not surprising, then, that nearly all of the men apprehended by the police and hospitalised as mad were single. Indeed, unmarried men were the population most vulnerable to incarceration in a mental hospital in New Zealand in this period. At Seacliff they were represented in numbers markedly disproportionate to their strength in the general population. While constituting only 30.35% of New Zealanders in 1936, they made up over 69.5% of committals to Seacliff in 1933. In comparison, married men were least likely to be committed to the hospital. They constituted 63.4% of the general population, but at Seacliff they accounted for just under 20% of admissions. The minds of husbands and fathers benefitted from the emotional support of their wives and children, while the role of the married man as the loyal provider could make it socially and economically difficult for their incarceration to be effected when they did exhibit mental distress.

In contrast to men who had never been married, widowers were admitted to Seacliff in numbers slightly fewer than their presence in the

31 Garton. *op cit.*, p.120.
general population of New Zealand allowed. Constituting just under 4.5% of the population, they accounted for a mere 3.5% of Seaciff's admissions. Thus, there were far fewer widowers in the population than widows, but they were also far less likely to become patients at Seaciff than their female counterparts. Like the widow women at Seaciff, however, most widowers were over sixty years of age upon their admission and most were suffering from senile dementia. These men were more likely than female dementes to be committed not from within the family but from the agency of outsiders. Seventy-six year old Arthur G. entered Seaciff on the testimony of a police constable that he had threatened to kill people. His medical examiners had found him "excited and restless", and his trouble-making at three boarding houses made him a nuisance to the community. They concluded that he was in need of control, and upheld the police application for his reception into Seaciff.

Seth R. had spent the two and a half years prior to his committal either in the Talboys Home or as a patient at Dunedin Hospital. At seventy-one years of age, and with no relatives in New Zealand to care for him, Seth had become unmanageable in both institutions. He was deluded and hallucinated upon admission, stating that he had overheard men plotting to kill him. He responded to his incarceration within Seaciff with relief, saying that he was "content" to be there, and grateful for the protection its walls offered.

Seth and Arthur both exhibited the types of behaviour which were typical of senile dementia in both men and women - delusions,

---

34 Ibid.
35 Seaciff, 1934, 8:58.
36 Seaciff, 1933, 8:24.
hallucinations, rambling and incoherent speech, and a tendency to wander away. They were symptoms of madness difficult to cope with wherever they were manifest - at home, in charitable institutions and general hospitals, or on the street. Incarceration at Seacliff was for many of those who initiated committal the only way of ensuring the oversight, care and control of the senile dments for whom they were responsible.

Over the period 1928-1937 senility was the second most commonly assigned cause of insanity for male patients admitted to Seacliff Mental Hospital, accounting for 15% of total male admissions. Similarly at other psychiatric institutions in the Dominion senile patients constituted a significant proportion of admissions. While the prevalence of these old folk within Seacliff and elsewhere attests to the public acceptance of the mental institution as a legitimate part of New Zealand's health and welfare system, it was not a situation endorsed by the country's leading psychiatrist and Director-General of Mental Hospitals, Dr. Theodore C. Gray. In his annual report to the House of Representatives in 1929, Gray opposed the practice of committing these old folk as morally reprehensible, and practically undesirable. It was

...Fundamentally wrong, and a reproach on our reputation for sound social legislation, to allow them to spend the evening of life amongst the insane...\(^38\)

Gray argued that these victims of their advancing years were better cared for within private homes, than in mental hospitals. In his

\(^{37}\) AJHR, H-7, 1928-1937.  
\(^{38}\) AJHR, H-7, 1929, p.3.
advocacy of government action to establish special institutions or homes for the elderly infirm, however, he did implicitly recognise that the management of senile dementia within families was not always feasible. Nevertheless, Gray was convinced that patients suffering from senile decay had no place in mental hospitals where they occupied an appreciable amount of infirmary space which should be freed for more legitimate purposes. In an era of economic adversity when the overcrowded conditions at Seacliff were repeatedly bewailed by the hospital's Medical Superintendents, the distinction between the chronic mental deterioration of the aged, and other, often curable psychiatric disturbances was emphasised. Those diagnosed as senile were usually prognosed as hopeless, and thus, Seacliff's psychiatrists argued that resources were being wasted upon those who would never benefit from them. Moreover, psychiatrists, intent upon establishing their legitimacy with the public as well as their colleagues in mainstream medicine, were concerned to account for recovery rates distorted by the high numbers of men and women who were committed to Seacliff only to die there.

The reality was that Seacliff housed a significant number of male inmates, other than senile dments, whose prognosis was incurable. In the period under review the hospital received 191 men into its care whose mental condition was attributed to congenital factors. Accounting for nearly a quarter of total male admissions, the congenital mental deficiency of the 'feeble-minded', the 'imbecilic', and the 'idiotic' was the most commonly assigned mental disorder among men.

39 Ibid.
40 AJHR, H-7, 1938, p.1
In contrast, congenital causes of 'insanity' were assigned to only sixty-nine, or 12% of the 575 female patients admitted to Seacliff throughout these years. The heightened incidence of congenital mental deficiency amongst men perhaps can be explained by the proximity to Seacliff of the Special School for Boys at Otekaike. At this institution intellectually handicapped boys of school age would learn the skills that would enable them to live in the world and earn their own livings upon completion of their education. That the goals of the school were often unrealised is indicated by the number of boys whose physical maturity yet mental immaturity rendered them inappropriate for both Otekaike and the world outside.

Tom K. was one such man. Admitted to the Special School as a feeble-minded and epileptic child of eleven, Tom's failure to respond to treatment there and his inability to earn his own living resulted in his being transferred from that institution to Seacliff when he was nineteen. Over the eight years Tom had been at Otekaike his mental condition had deteriorated and he had a record violence toward the smaller boys at the school. Without provocation he would bite them and strike them with sticks and stones.\(^\text{41}\) To the arbiters of his fate at Otekaike Seacliff's custodial and medical functions were seen to provide the control and care that Tom required. Concern to protect the public, as well as to ensure Tom's own welfare were then the motivations for Otekaike's decision to commit him. His life of institutionalisation was ended only by his death in 1937, nine years after he had first been admitted to Seacliff.\(^\text{42}\)

\(^{41}\)Seacliff, 1928, 7595.

\(^{42}\)Ibid.
Tom's mental condition, his violence and his career as a patient of the state, were typical of many of the congenital mental defectives who were committed to Seacliff from Otekaike. Their inability to live within the community confirmed their status as outcasts from it. Furthermore, since institutional life was for many the only life they knew, few challenged their lot as involuntary and often permanent residents of Seacliff. One exception was 'imbecile' Jack I. Sent from Otekaike to Seacliff at sixteen years of age, Jack was pronounced "an inveterate thief and liar" by his certifying doctors on the advice of the Manager of the Special School. He had also exhibited "immoral tendencies" toward the younger children at the institution, and had a record of repeated absconding. He had run away from Otekaike, he said, because he was "sick of the place". For his vices and his waywardness, as much as his mental immaturity, Jack was incarcerated within Seacliff in 1932. The mental hospital proved no more to his liking than the school, however, and throughout his sixteen and a half years there Jack escaped eleven times. On the final occasion Jack's keepers did not retrieve him but had to discharge him "unrecovered" following his failure to return from twelve months probation outside the institution.\footnote{Seacliff, 1932, 8175.}

That the burden of involuntary confinement was more onerous for the men committed to Seacliff than for their female counterparts is likely. Certainly, male patients in the sample attempted to escape more often than did women. Incarceration conferred upon men a
powerlessness irreconcilable with their gender role. Passive compliance with their lot was acceptable for women whose position within the mental hospital was congruent with their dependent status in society, but for men, their lack of autonomy as patients was an affront to their manhood.44 If the invalid role offered women a legitimate means of escape from domestic stress and responsibility, it only emphasised men's failure to live up to the tenets of masculinity. Escape from the asylum, not escape to it, was more characteristic of men's experience of madness.

Men's insanity, as opposed to their mental deficiency, was largely diagnosed as somatic in origin, reflecting both contemporary theories of madness, and psychiatry's long-standing predisposition to attribute men's mental disorders to physical, rather than emotional causes.45 As with women, heredity accounted for a significant proportion of men's psychiatric illnesses. More striking, however, was the greater incidence of alcohol and syphilis as sources of men's as compared with women's insanity. Over the period they directly accounted for 5%, and 2.9% of male admissions respectively. Women, in contrast, fell victim to the excesses of liquor and sex far less frequently. Only 0.87% of female admissions to Seacliff were attributed to each of these causes. The disparity between the sex's vulnerability to such vices was reflective of their relative tolerance within the constructions of femininity and masculinity. Entrusted with the morality of society, and excluded from bars, women not only had limited access to alcohol, but those who

indulged in liquor renounced their claim to true womanhood and respectability. Drinking, however, was an acceptable, and expected expression of masculinity. It was deemed unacceptable only when excessive consumption threatened familial harmony or social order, or when drunken men were perceived as having failed to fulfill the obligations conferred upon them by dint of their sex.

Fred H.'s wife, for example, had endured his alcohol-induced mania for five weeks before seeking his committal in 1928. Her application for his reception within Seaciff was prompted by his paranoia that everyone was against him, and his violence toward herself, his children and his neighbours. A carter from Green Island, Fred had been abusive and threatening, and had locked his family out of his house.\(^{46}\) Upon Harold S.'s committal in 1929 he denied that he had been drinking, but his inebriation and unkempt appearance at the time of his arrest suggested otherwise to his medical examiners. They concluded that his disorientation and delusions were a consequence of his addiction to alcohol.\(^{47}\) Mark C., a single fifty-seven year old returned soldier and unemployed solicitor was incarcerated at Seaciff in 1928 upon the testimony of his sister. She complained that he was an alcoholic who spent his days "wandering the streets and boring old acquaintances with fantastic tales". She also noted that her once well-dressed brother now took no interest in his appearance, and his medical judges confirmed that Mark was "untidy in dress". They further condemned him as having done no work for years.\(^{48}\)

\(^{46}\)Seaciff, 1928, 7704.  
\(^{47}\)Seaciff, 1929, 7751.  
\(^{48}\)Seaciff, 1928, 7572.
incarceration was effected upon evidence which revealed more about what constituted socially acceptable behaviour in New Zealand in the early 1930's than it did about mental illness of these men.

Tolerated if not exhorted as an aspect of New Zealand male identity, when drinking became alcoholism and moved from the controlled environment of the pub to the public arena, men's over-indulgence of liquor transgressed the line between the acceptable and the certifiable. Such conduct tested and embarrassed families, and menaced social order, and committal to a mental hospital offered a solution to the concerns of both the public and private spheres. The custodial and curative functions of the asylum worked in conjunction to remove the dangerous and the vagrant from the community, and at the same time enforced upon them an opportunity to master their addiction. Fred, for example entered Seacliff in a "very agitated condition". Two days after his admission he challenged his imposed powerlessness by smashing a window, refusing to take his medicine, and demanding his immediate release. Less than a week later, however, Fred was "settled, amenable and much more rational". His cooperation was rewarded with greater freedom in the hospital and his appointment as a gardener. Within four months of his committal Fred was discharged from Seacliff, dried out and repentant about his behaviour toward his family prior to his hospitalisation. In the days before the establishment of specialised facilities for the treatment of alcoholics, the mental hospital provided a unique service to those who fell victim to drink.

Syphilis, while less commonly attributed as a cause of insanity, was
equally male-biased in its incidence throughout this period. Most men admitted to Seaccliff whose mental condition was ascribed to syphilitic infection were suffering from general paralysis of the insane, and their prognosis was usually hopeless. For them, the mental hospital was not the recuperative environment it was for many alcoholics, but a place in which their disturbed, and demanding behaviour might be best managed until their death. In the sample, all but one of the male general paralytics admitted to Seaccliff were never fortunate enough to return home to the families which had effected their committal.

The attribution of syphilis as a cause of mental illness linked sex and insanity on a medical level, and was indicative of contemporary psychiatry's understanding of madness as physical disease, not moral failing. By 1928 "sexual vice" was no longer identified as causal of mental illness as psychiatry became medicalised. Instead, masturbation, indecent exposure, and molestation were noted by certifying examiners as symptomatic of mental disorder of organic origins. Thus, seventy year old farm labourer Noel J. was arrested on a charge of exposing himself to women at the general hospital nursing home, but his unsound mind was attributed to his senility.  

Similarly, twenty-three year old Donald B. was accused of indecent assault upon a seven year old girl, but he was committed suffering from "post lethargic disorder" caused by encephalitis. During Hamish S.'s ten day stay in Dunedin Hospital prior to his committal to Seaccliff he regularly masturbated in front of the nurses, however, his insanity was attributed to the physical disease of syphilis, not the moral failing of sexual deviance. In New

---

49 Seaccliff, 1929, 7829.
50 Seaccliff, 1928, 7629.
Zealand in the 1930's doctors identified 'abnormal' sexual tendencies as indicative, rather than explanatory of mental illness.

The shift in psychiatry from a moral to medical basis was emphasised in an article by Dr. A. D. Latham in the *New Zealand Medical Journal* in October 1937. In it Latham discussed the psychological impact of masturbation upon the mind, and concluded that "the habit itself is harmless in moderation, but the emotions of shame and fear associated with it by ... teaching resulted in ... breakdown".52 He supported his claim with reference to international psychiatric authorities. T. A. Ross, the late Medical Director of the Cassel Hospital for Functional Nervous Disorders claimed that

As a physical phenomenon, masturbation, unless practised to excess, is not a cause of neurosis. As a psychical one it is far from otherwise. It is a great cause of many depressing emotions, remorse, fear, shame, anxiety.53

Dr. J. R. Rees of the Tavistock Clinic was further convinced that masturbation was not a direct cause of insanity, and renounced past psychiatric theories as "a great deal of mischievous nonsense".54 At Seacliff, too, such 'nonsense' had apparently been eschewed by the 1930's. None of the men, or women on the sample were deemed to be victims of 'masturbative insanity', a not infrequent diagnosis in earlier years.55

---

51Seacliff, 1929, 7716.
53Ibid., p.320.
54Ibid., p.321.
The impact of the Depression upon men's sanity is difficult to gauge. The principal assigned sources of insanity in this period did not include unemployment of financial worry as specific categories of causation. The certifying doctors and the psychiatrists at Seacliff did recognise these stresses as contributory to the mental illness of many of men admitted as patients to the hospital. As with the interpersonal causes of female insanity it is possible that such motivations of men's madness were subsumed within the category of mental stress, which accounted for over 7.5% of all male admissions to Seacliff over the period. Certainly those men whom the Depression hit hardest, the unskilled, were present within the hospital in significant numbers.\(^56\)

At the height of the economic downturn in 1929-1930, over 44% of male admissions to Seacliff were labourers.\(^57\) By 1933, when New Zealand's economy was beginning to recover that number had dropped to 21%.\(^58\) The figures for those with no occupation upon their committal are somewhat less readily related to economic fluctuations. In 1929 only 14.8% of men who entered Seacliff were recorded as being without work, while that figure peaked in 1931 at 31%.

Any conclusive interpretation of these statistics is hindered by factors which effectively disguise the employment situation of those mentally distressed men who became patients at Seacliff during the Depression years. In general, the files of these men recorded the

\(^{55}\) Hubbard, *op cit.*, p.20.
\(^{56}\) Tennant, *op cit.*, p.187.
\(^{57}\) AJHR, H-7, 1930, p.20.
\(^{58}\) AJHR, H-7, 1934, p.19.
former occupation of male patients, and not their employment status at the time of their admission. It is only with recourse to the statements of kinfolk, police and charitable agencies that one becomes aware that a man recorded as a storeman by occupation is not necessarily a presently employed storeman. Frank L., for example, was recorded on his wife's application for his reception into Seacliff in 1932 as a labourer, but in her statement as to his mental condition she attributed his insanity to the fact that he had been unemployed for two years, and it was now beginning to prey on his mind. Furthermore, those men recorded in the Seacliff tallies as having no occupation were as likely to be victims of their age or their congenital mental deficiency as of economic adversity. Thus, any causal relationship between the stress of unemployment and mental distress is rendered speculative only, due to the vagaries of the information recorded within patient files and official statistics.

For men, as for women, the way in which they chose to manifest their mental distress revealed much about the pressures exerted upon them to realise their gender roles. In an era of social change and economic depression the internal contradictions of the prescriptions were heightened and the ability of men to live up to the expectations of society was marginalised.

The men admitted to Seacliff, like their female counterparts often voiced their madness through delusions of persecution. On occasions the content of these manifestations of mental distress revealed the power of the male gender role to confer upon men a sense of failure. Sixty-
six year old Allan E., for example, was convinced upon his admission to the institution that his people had got tired of him and wished to be rid of him. A single unemployed man Allan lived with his widowed sister whom he believed to be poisoning his food to punish him for being unable to contribute to his keep. His accusations were groundless, but his delusions offer an insight into the self-recrimination of men whom unemployment rendered dependent upon the support of others. Allan's distress at his inability to provide for himself was heightened by the fact that his failure had feminised him. He no longer fulfilled the male roles of worker and provider but had been forced by unemployment into the female sphere of the home and dependence. The depression and sense of vulnerability Allan felt were typical of the madness experienced by many women.

For Allan, his family became in his madness, his persecutors. Similar threats from their kinfolk were perceived by other deluded men. Archie L. claimed upon his arrest and subsequent incarceration in 1931 that his brother-in-law was set upon shooting him. Craig W. accused his wife of infidelity while under the influence of drugs given to her by immoral men, and he further asserted that members of his family were endeavouring to harm him. In these cases the Seacliff records offer little indication of what inspired such delusions in men, and the doctors' diagnoses attest to their own bewilderment as to their source. The mental distress of both Archie and Craig was labelled delusional insanity, but neither the medical men who certified them, nor

60Seacliff, 1929, 7764.
61Seacliff, 1931, 8028.
62Seacliff, 1930, 7979.
the psychiatrists at Seacliff could account for its cause.

Equally difficult to explain was the insanity of men who believed themselves persecuted by people not bound to them by the ties of kinship. Such tormenters of men, as of women, were often specifically identified. Harry T., for example thought there was a German spy in his house who was intent upon smothering both himself and his wife.\textsuperscript{63} Neville J. complained that devils were after him, and he would not stay at home by himself for fear of them.\textsuperscript{64} Roger B. was committed to Seacliff by his brother for expressing delusions of persecution by Irishmen,\textsuperscript{65} and Andrew C. asserted that his neighbours had replaced his cows with their's.\textsuperscript{66}

In each of these cases, if no organic mental disorder could be discerned, the diagnosis was general, and the cause of insanity was assigned with uncertainty, if at all. When the persecutors were referred to by the patient only as 'people' the source and nature of men's insanity was just as difficult to identify. Joe R. was a forty year old single carpenter whose delusion that 'people' were chasing him was attributed to his "surroundings". No evidence was provided in his committal records, however, of how his environment had so impacted upon his mind as to result in insanity.\textsuperscript{67} Similarly, Stephen O., a thirty-seven year old presser from Dunedin, believed that everyone was against him, but the cause of his unsound mind was never ascertained by his medical

\textsuperscript{63}Seacliff, 1932, 8274.  
\textsuperscript{64}Seacliff, 1929, 7791.  
\textsuperscript{65}Seacliff, 1932, 8181.  
\textsuperscript{66}Seacliff, 1933, 8431.  
\textsuperscript{67}Seacliff, 1930, 7931.
examiners or by Seacliff.68

In this respect, men's delusions of persecution differed little from those of women. Both were often incomprehensible to lay and professional judges of insanity. Furthermore, for the historian, men's persecutory delusions do not lend themselves as readily to interpretation as do those of their female counterparts. Women's delusions of persecution can be confidently posited as metaphors for their oppression within a patriarchal society. Nevertheless, it is possible to suggest, as Garton has in his social history of insanity in New South Wales, that as for women the construction of men's gender roles was central to the construction of their delusions.69 Archie L., Roger B., Joe R. and Stephen O., for example, were all single men aged between thirty-seven and fifty-two. For these men, as for women who had never married the prescription which exalted marriage and parenthood rendered them increasingly outside the norms of social relations symbolised by the family. In times of need they had no support networks upon which to call. Under such circumstances, mental stress might easily have become mental breakdown. Furthermore, the delusions of persecution these men experienced may have been subconscious acknowledgments that the code of masculinity they conformed to, that of the man alone, was being superseded by a male culture which endorsed men and husbands and fathers.

The presence of delusions of exaltation amongst male admissions to Seacliff in this period can also be related to the construction of

68 Seacliff, 1932, 8186.
69 Garton, op cit., p.116.
masculinity. Traditionally, men had been delineated as assertive and self-reliant providers. It was a gender model which empowered men, and assumed their ability to command their environment. It was not surprising, therefore, that frequently, mentally distressed men were deluded as to their wealth and influence. These were the qualities possessed by men who had realised the ideal masculinity, and they were often the tenets of prescriptive manhood which had eluded Seacliff's male patients. Alex C., for example was a single twenty year old seaman admitted to the mental hospital labouring under the belief that he was a professor. Peter F. too was a sailor by occupation. At twenty-two years of age he was diagnosed as suffering from delusional insanity based upon his assertion that he was blessed with the power of mental telepathy.

Other men committed to Seacliff expressed their desire for influence, and identifying themselves as respected or powerful people. Howard M. of Bluff rejected the reality of his life as a sanitary contractor, and father of eight dependent children by imagining himself to be first Queen Victoria and then Shakespeare. Bruce D.'s delusions were also changeable. Upon his arrest in 1937 he gave his name as Ned Kelly, and claimed that he could solve all the crime in New Zealand by reading people's minds. At his medical examination, however, Bruce asserted instead that he was a doctor from Scotland. In fact, he was a twenty-eight year old unmarried farmer from Oamaru who was hospitalised at Seacliff upon his diagnosis as schizophrenic.

---

70 Seacliff, 1933, 8370.
71 Seacliff, 1928, 7587.
72 Seacliff, 1935, 8577.
The delusions of exaltation of some men were influenced by religion. Often these patients believed themselves to have been promoted by God into a position of power. Brett A. had not attended church for some years before his admission to Seacliff in 1931. Upon his certification, however, he stated that he was an ambassador of the Lord, charged with the duty of proclaiming Christ throughout the world. Brett, an unemployed commercial traveller, also told his wife that their financial problems would be solved by a scheme devised by God to feed three hundred men at Lake Hawea. Douglas K. had been similarly chosen to do the Lord’s work on earth. Douglas was a forty-three year old married cheesemaker with twelve children, who had left his job eight months prior to his committal on the order of the Lord. He said that God had sent him messages on several occasions to carry on the good work as the chosen leader of a great religious revival. Douglas defended his decision to stop working by asserting that God had promised him money to pay off his debts and to provide for his family.

Such delusions of exaltation amongst the male patients at Seacliff Mental Hospital suggest the pressure upon men to realise the masculine ideal of the influential and wealthy man. Certainly no women in the sample experienced comparable grandiose ideas. The desire for power and riches was an exclusively male manifestation of madness.

73 Seacliff, 1937, 8913.  
74 Seacliff, 1931, 8017.  
75 Seacliff, 1931, 8069.
Like women, however, men also expressed their mental distress by withdrawing into themselves. A range of disturbed behaviour was exhibited by those who chose not to communicate their insanity in words. Some men refused to speak, otherstoeat, and some men took no interest in their surroundings, preferring to lie curled up on the bed or to stare without expression at the ceiling. More frequently, and in accordance with their gender role, male patients withdrew actively rather than passively. These men were out of control emotionally, "laughing all the time", singing, or weeping for no apparent reason. Men's violence toward property, people and themselves can also be seen as forms of active withdrawal, whether threatened or actual

Men's experience of madness and committal was as intimately influenced by the construction of masculinity as women's was by the ideology of femininity. Male culture in the Dominion was based upon traditional perceptions of men modified to accommodate the specific New Zealand experience. It sanctioned men as assertive, physical and independent, the appropriate complements to true women whose gender role prescribed compliance, passivity and dependence. By the 1930s, to be a man in New Zealand society was ever more to be a husband and father, as the ideology of motherhood and the national concern for

76eg. Seaciff, 1928, 7595; 1932, 8215; 1937, 8848.
77eg. Seaciff, 1932, 8157; 1937, 8967,8986.
78eg. Seaciff, 1937, 8943.
79 eg. Seaciff, 1928, 7629; 1931, 8140.
80Seaciff, 1936, 8754.
81eg Seaciff, 1933, 8341; 1932, 8206.
82eg. Seaciff, 1929, 7757; 1932, 8195.
83eg. Seaciff, 1928, 7570; 1930, 7900.
racial fitness exalted the home and family.

Those men who fell outside of the prescription by dint of their marital status were those most vulnerable to incarceration within Seacliff Mental Hospital. In the period under review the man alone was increasingly regarded as a social anomaly as the pioneer myth faded to be replaced by a new manhood which defined men as loyal and respectable providers for their families. When single men fell victim to mental illness their disturbed behaviour was rarely tolerated by society for long. Neither bolstered by the emotional support of an immediate family, nor protected from detection and judgment by a home, they were committed in numbers disproportionate to the presence in the population by relatives and moreover by outside agencies. The police were especially influential in the incarceration of bachelors to Seacliff.

While the pioneer myth of the New Zealand male was losing relevance in the Dominion in these years, the tenets upon which it was based remained influential in the construction of men’s madness. Physical prowess was manifest in insanity as violence, and drinking as alcoholism. Neither were deemed tolerable by either families or agencies charged with maintenance of social order. In an era of economic adversity, however, they were expressions of masculinity some men reasserted to compensate for attack on their manhood by indigence and unemployment.

From the sources available to the historian of madness in New Zealand in the 1930s it is difficult to accurately assess the impact of the
Depression upon the men's minds. It is likely, however, that unemployment challenged men's sanity by challenging their masculinity. Men had 'long identified themselves with their work, and their ability to provide for their dependent families. When those sources of identity were denied them, they confronted the low self-esteem which drove some mad.

The crisis which New Zealand manhood underwent during the Depression is discernible in the ways in which men manifest their madness. In delusions of persecution and exaltation, their newly sensed vulnerability, and related desires for power and wealth evince the pressures upon men at this time to maintain their independence, and their self-respect.

For men, as for women, the crisis of their sanity was frequently reflective of a crisis within their gender roles. The masculine code was inherently contradictory, and set expectations for men they often felt at a loss to achieve. This was especially so during the 1930s when men's autonomy was limited by social and economic forces over which they had little control.
CONCLUSION

The particular construction of madness advanced by the patient records of Seacliff Mental Hospital from 1928-1937 is one which challenges the analyses of control and progress as too simplistic to account for the social experience of insanity. As perceptions of mental illness and psychiatry from the perspectives of doctors and bureaucrats, both traditions have been valued as facilitating an understanding of the interdependence of madness, medical practice and government policy. Nevertheless, the validity of these traditions has been assumed, rather than proven.

With regard to the legal and medical context of committal in New Zealand, the Government and the country's leading psychiatrists were concerned to enact legislation which would allow them greater control over the fate of the mentally defective and the insane. Sterilisation, segregation, regulation and detection were the means advanced in the 1928 Mental Defectives Amendment Bill to realise the ends of racial purity and social order. Such measures were challenged, however, and the most controversial of them were rejected within Parliament so as to ensure the Bill's passage into law. Even those provisions which did withstand the challenge of the Bill's opponents were rendered bankrupt in practice. The general practitioners who were empowered to apply the law shied away from the use of the definition of "social defective" in recognition of the vagaries of the term. The only people who appeared to understand class seven of
New Zealand's mental health legislation were the psychiatrists, and then only after much debate. Furthermore, their influence in the detection of mental illness was marginal. Social control the law may have represented in theory, but in practice, it was not the state but the family which was most influential in the identification and incarceration of the insane.

Those most significant in the detection and committal of the insane and the mentally defective were those least likely to be versed in the complexities of mental illness. For many of the men and women committed to Seacliff Mental Hospital in the period under review it was their families who effected their incarceration. Eccentric or disruptive behaviour was difficult to manage within the home, and hard to tolerate. Nevertheless, many families did bear with their mentally distressed kinfolk for extended periods of time, their decision to pursue committal being prompted most often by the quality of that distress. When mental illness became acute, and was manifest in extreme behaviours, families had little choice but to seek their relatives' involuntary hospitalisation.

The experience of insanity in New Zealand was intimately bound up with dominant gender prescriptions which delineated expected and accepted behaviour for men and women. These prescriptions influenced the way in which madness was perceived by the mad themselves, as well as by their judges. Violence, for example, was not usually borne for long whether exhibited by men or women. At the same time, however, the different levels of
tolerance for threatening behaviour posited by the ideologies of masculinity and femininity rendered women more likely to be committed earlier than men.

Most vulnerable to incarceration for their disturbed behaviour were single men and their female counterparts. In an era when the values of marriage and parenthood were exalted, unmarried men and women were regarded as anomalies within excepted social relations. In smaller nuclear families, young spinsters were increasingly marginalised as social failures, and often economic liabilities, while single men were perceived as anachronisms, and threats to the social order. These men were vulnerable to committal from both within the home if they lived with relatives, and from outside it. The detection by the police of madness in young single men was a significant source of the male admissions to Seacliff from 1928-1937. The vulnerability of such men was heightened by their involvement in the community. When they manifested madness, they often did so in the public arena, and without the protection of a home and family, they were judged insane, and frequently dangerous, and incarcerated within the asylum. In this way, single women constrained to the domestic sphere might be driven mad from frustration with their lot, or a sense of failure as true women, but their distress was usually protected from public scrutiny by the confines of the home.

The relative lack of influence of agencies outside the family in the committal of female patients to Seacliff testifies to the continued rigidity, and acceptance of the doctrine of separate
spheres for men and women. The gendered madness of these "unfortunate folk" provides evidence of how destructive the prescriptions for male and female behaviour could be. Some women experienced delusions of persecution in which their home, the source of their identity, was under attack; others imagined themselves oppressed by their families; still others complained of their worthlessness or physical decay. While such beliefs were also expressed by some men, delusions of exaltation were more common amongst the male patients at Seaciff than the female. The desire for wealth and influence were reflections of the ideology of masculinity which defined men as authoritative providers. Women's role, contrarily, schooled them in passivity and dependence within the home. The sense of powerlessness their delusions convey is indicative of that orientation.

In the early years of this study men and women in New Zealand faced the challenges of economic adversity and involuntary unemployment. For women, the Depression reinforced the ideological imperatives of femininity as the home and the family were entrusted with the moral future of the Dominion. For men, unemployment and indigence challenged their masculinity, and thereby their sanity. Those most vulnerable to the consequences of the economic downturn, the unskilled, were also those who entered Seaciff in the greatest numbers.

Madness, for the men and women of New Zealand who fell victim to it in the 1930s was a social construct which embraced the
more fundamental constructions of masculinity and femininity. In judging people insane, families, police, charitable agencies, and doctors were implicitly judging them failures as men and women. That is not to deny the reality of mental illness, but rather it is to posit a new way of understanding the pressures which operate upon individuals, and ultimately drive some mad.

In the end the theories of social control and progressivism are of little relevance to a study of the social experience of madness. What emerges most clearly from the patient files of Seacliff Mental Hospital is not the unbridled power of the state or the efficacious ministrations of the medical profession, but the reality of the unmanageability of mental illness. Most often manifested within the home insanity was first and foremost a familial problem, and it was families, not doctors or agents of the state, who were most influential in the detection and committal of madness.
BIBLIOGRAPHY

PRIMARY SOURCES

UNPUBLISHED

Seacliff Mental Hospital Patient Files 1928-1937

PUBLISHED

Appendices to the Journals of the House of Representatives, 1928-1937

New Zealand Census 1936

New Zealand Parliamentary Debates 1928


SECONDARY SOURCES

PUBLISHED

Brookes, B., Macdonald, C., and Tennant, M., (eds.)

Women in History: Essays on European Women


Bunkle, P., and Hughes, B., (eds.)

Cohen, S., and Scull, A., (eds.)


Kensington, N.S.W., 1988.


Gray, T.C., The Very Error of the Moon, Devon, 1959.


Luckin, B. "Toward a social history of institutionalization", Social History, January, 1983.


Olssen, E. "Truby King and the Plunket Society: An Analysis of a Prescriptive Ideology", *New Zealand Journal of History*, vol.15, no.1, April, 1981


Szasz, T.S.,  

Tennant, M.,  

Todd, F.,  

University of Otago,  
*Public Lectures on Social Adjustment*, Dunedin, 1928.

UNPUBLISHED

Bloomfield, J.,  

Boyd, S.K.,  

Brookes, B.,  


Robertson, S. "'Production not Reproduction': The Problem of the Mental Defect in New Zealand 1900 - 1939", B. A. (Hons.) long essay, University of Otago, 1989.