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A SEPARATE WORLD?
THE SOCIAL POSITION OF THE MENTALLY ILL
IN NEW ZEALAND SOCIETY 1945 - 1955

Susannah Grant

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# TABLE OF CONTENTS

| Acknowledgements | 2 |
| List of illustrations and graph | 3 |
| Abbreviations | 4 |
| Introduction | 5 |
| **Chapter One** Mental health care professionals: mediators between madness and reason | 11 |
| **Chapter Two** Politicians and legislation: protecting the world of madness, or the world of reason? | 29 |
| **Chapter Three** The attitudes of the general public: rejection, sympathy and fear | 45 |
| **Chapter Four** Parents, siblings, partners and children: accepting or rejecting mental illness within the family? | 64 |
| **Chapter Five** Patients and ex-patients: active participants in the creation of a separate world | 77 |
| Conclusion | 93 |
| Bibliography | 97 |
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LIST OF ILLUSTRATIONS AND GRAPH

Medical staff administering E.C.T at Porirua Hospital, 1947

Graph showing proportion of voluntary admissions
to New Zealand psychiatric hospitals 1945 - 1955

Front cover of Arthur Sainsbury’s *Misery Mansion: Grim Tales of New Zealand Asylums*

Janet Frame in the 1950s
ABBREVIATIONS

AJHR  Appendices to the Journals of the House of Representatives

NZMJ  New Zealand Medical Journal

NZNJ  New Zealand Nursing Journal

NZPD  New Zealand Parliamentary Debates

INTRODUCTION

Rather than asking *what*, in a given period is regarded as sanity or insanity, as mental illness or normal behaviour, I wanted to ask *how* these divisions are operated.1

Despite its intriguing possibilities and contemporary relevance, Foucault’s question has been largely left unexplored in a New Zealand context. Accepting the disjunction between reason and madness at face value, historians of mental illness have focused on *either* government policy and psychiatric practice or the experience of incarceration. The exclusivity of these approaches has marginalised the role of families and public attitudes, and has denied the existence of a dialogue between the mad and the sane. It is the intention of this essay to delve into these gaps; to examine the manner in which the State, medical practitioners, the public, families, and patients themselves negotiated a certain degree of division between the worlds of madness and non-madness in mid-twentieth century New Zealand.

Two broad historiographical traditions may be discerned within the extensive international literature on mental illness - progressivism and social control. Progressivists depict the development of psychiatry as a linear evolution from barbarous cruelty and ignorance to modern science and enlightened humanitarianism. Reforms and their initiators are celebrated indiscriminately, and the experience of the mad is ignored completely. As an interpretive schema classical progressivism must be seen not as a constructive tool of analysis, but as an “intellectual straightjacket”.2 In a less rigid form, the progressivist model provides the framework for much New Zealand writing on the history of mental illness.

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health legislation and psychiatric practice.

In more recent years the focus has shifted to the inmates of mental institutions, and their experiences have been examined within the structure of social control theories. Proponents of these theories see the asylum and psychiatry in general, as mechanisms enabling the state to regulate social relations through the repression of non-conformity. In its most extreme form, social control history asserts that “mental illness is a myth, psychiatric intervention is a type of social action, and involuntary psychiatric therapy is not treatment but torture”. While this approach offers a useful corrective to progressivism, it is not without its own flaws and inadequacies. There is a simplistic tendency to interpret asylums purely as instruments of social control devoid of humanitarian purpose or effect, and an unhelpful emphasis on state power which denies the agency of those they are attempting to control.

In light of the problems inherent in social control and progressivist theories, David Rothman has suggested the development of an approach which borrows from both schools, integrating analysis of rhetoric with reality, of humanitarianism with repression. Rothman still fails, however, to allow for the existence of a dynamic reciprocal relationship between the spheres of madness and reason. I believe that this may be achieved by conflating his conciliatory approach with the recently articulated principles of encounter history. More conventionally applied to contact between racial groups, encounter history can be used to focus attention on the relationship between any two groups of people. Its ability to recognise the agency of both groups makes it

5 Rothman, pp.115-117.
6 M. Henare, MAOR420 seminar, University of Otago, May 1998.
the ideal tool with which to explore the dialogue between the worlds of madness and reason, and to remove the mad from the peripheries of psychiatric history. But the encounter between madness and reason must be seen as more than a simple two-way relationship. The world of reason is in fact composed of the state, medical professionals, the public, and families, all of whom have an important role in negotiating a social position for the mentally ill. The agency of each group, and of the occupants of the world of madness, must be acknowledged if holistic analysis is to be achieved.

This fusion of theoretical approaches prompts a series of hitherto unasked questions about the history of mental illness and psychiatry in New Zealand: How did the state, medical professionals, the public, and patient’s families see the mentally ill? Did they envision a position for the mentally ill within society, on the outskirts of society, or in total isolation from the rest of society? What conscious and unconscious strategies did they employ to open up / confine the position of the mentally ill? What can their rhetoric reveal about their attitudes and strategies? How did the mentally ill see themselves in relation to the rest of society? Did they make active attempts to separate themselves off from society / to fit in to society? What strategies and language did they use to do so?

These questions will be asked in relation to the social position of the mentally ill in New Zealand society between 1945 and 1955. This decade marks a period of significant change in the practice of psychiatry worldwide. A plethora of aggressive new physical treatments became widely used for the first time, including electric shock therapy, insulin coma therapy and leucotomy. There was a gradual movement towards allowing patients maximum freedom, and an increased emphasis on recreational activities. For the first time occupational therapists and psychiatric social workers became an integral part of a broadening system of caring for the mentally ill. The establishment of psychiatric outpatient
clinics and psychiatric wards in general hospitals allowed for the treatment of mental illness outside the mental hospital, and renewed emphasis on psychotherapy promised recognition of individual patients and an improved quality of treatment. All these developments ushered in an intensely optimistic era in New Zealand's mental health care system. On the surface it seems that leaps and bounds were being made in therapy and in attitudes. Doctors and politicians argued that the mad were coming to occupy a new position in society—perhaps not fully integrated, but certainly more visible and less alienated.

While analysis of the optimistic rhetoric of the period is vital to an understanding of attitudes towards mental illness, attention must also be focused on the realities of incarceration and psychiatric treatment. Promises of more humane and personalised care were impossible to fulfil in the absence of adequate staff. Between 1945 and 1955 the severe shortage of psychiatrists and psychiatric nurses in New Zealand was a matter for grave government and medical concern. Staff shortages were paralleled by accommodation shortfalls. A major programme to upgrade the existing run-down buildings and provide the necessary 1000 extra beds was constantly behind schedule, and remained incomplete in 1955. The significance of these problems for the experience of patients is highlighted in the writing of Janet Frame. Between 1945 and 1955 Frame went in and out of several different New Zealand mental institutions and has recorded in autobiography and fiction the deplorable conditions under which she was confined and the negative societal attitudes she faced. At another level, then, it seems that therapy failed to mirror rhetoric and that the mentally ill continued to be rejected by New Zealand society.

7 For discussion of these developments on an international level see: P. Bean, Mental Illness; Changes and Trends, Chichester, 1983. At a more local level, the application of these new treatments and clinical attitudes in New Zealand may be traced in the annual reports of the Director-General of Mental Hospitals found in AJHR, H-7, 1946 - 1949; H-31, 1950 - 1956.

8 Accounts of both problems are continually highlighted in the AJHR, 1945 - 1955.
To bridge the gap between these seemingly contradictory conclusions a five stranded analysis must be made. The medical profession, government policy, public attitudes, family attitudes, and patients' perspectives all played a vital role in forging a social position for the mentally ill and negotiating the boundary between the worlds of madness and reason. Hence the stories of each group must be given individual recognition if a well-rounded study of mental illness in mid-twentieth century New Zealand is to be made.

A brief note is required here on the availability of sources and consequent fullness of each group's representation. The mid-twentieth century medical profession provided a wealth of easily accessible information about its attitudes towards mental illness in the pages of the *New Zealand Medical Journal* and in the annual reports supplied to government. Official publications also provided my primary sources for investigating the role of politicians and legislation in negotiating social dynamics. Public attitudes were gauged from a variety of sources, including newspapers, magazines, publications produced by welfare agencies, and the Preventive Medicine Dissertations of fifth year medical students at the University of Otago. Information pertaining to the experience of families with mentally ill members and to the mentally ill themselves proved much more difficult to obtain. I made attempts to form contacts through a variety of avenues in the hope that oral interviews and / or written responses to a questionnaire might be elicited. The age of the men and women concerned and the sensitive nature of my topic militated against such efforts, and ultimately, only one person responded to my questionnaire. Along with overseas studies, the Preventive Medicine Dissertations and the literature of Janet Frame proved most useful in analysing the experiences of families and patients. At times I sorely lamented the absence of quantifiable and easily verifiable evidence for the final two chapters, and in particular, regretted the absence of Maori voices. In
time such evidence will become available, but it is important to recognise that the recorded feelings and beliefs of families and patients, and the kind of deep analysis possible in the case of Janet Frame, must always provide the backbone of any attempt to understand personal attitudes towards mental illness.
1. MENTAL HEALTH CARE PROFESSIONALS: MEDIATORS BETWEEN MADNESS AND REASON

As mediators between the worlds of reason and madness mental health care workers played a vital role in negotiating the social position of mentally ill New Zealanders between 1945 and 1955. Supported by a growing range of ancillary staff, psychiatrists and psychiatric nurses battled staff shortages, overcrowding, and dilapidated facilities in their effort to provide patients with adequate care. At one level, they can be analysed as members of the world of reason who employed rhetoric and behaviour intended to enforce a rigid distinction between themselves and patients. At a more subtle level they may actually be seen as members of the world of madness, drawn in by sympathy for their charges and a range of institutionalised ceremonies. In both worlds they held tremendous power and influence, giving their recommendations about the place of mental illness and its victims great significance.

During the course of treatment for psychiatric illness in the late 1940s and early 1950s a patient was likely to encounter several different health professionals. In most cases initial contact would be with his or her regular general practitioner. The G. P. was expected to assess the patient’s mental state, administer basic psychotherapy where appropriate, and facilitate admission to a psychiatric institution where deemed necessary. But despite the enormous significance of their decisions for patients’ lives, G.P.s received minimal psychiatric instruction or experience during the course of their training.¹

The next level of care was administered by psychiatrists and psychiatric nurses; men and women much more highly qualified to deal with mental illness. Psychiatrists held primary responsibility for the treatment of psychiatric

inpatients, and for the growing number treated in outpatient clinics and psychiatric wards in the general hospitals. By 1950 they were also engaging in educational and preventive psychiatry, giving lectures to interested organisations, and advising Courts of Justice, child health clinics and G.P.s. While psychiatrists held overall accountability for inpatients, it was psychiatric nurses who provided day to day, hour to hour care, assisting doctors with treatment, dispensing drugs, calming and comforting patients, administering punishment, and protecting the outside world by preventing escape.

Increasingly, both inpatients and outpatients were likely to encounter a range of other health professionals during the course of treatment. By 1948 four psychiatric social workers were attached to New Zealand psychiatric hospitals. They visited the homes of admitted patients to provide support for families, acted as a link between hospital and home, investigated patients' backgrounds, and offered ongoing support to patients and families upon discharge. Occupational therapists also played a rapidly expanding role in the treatment of mental illness. An Occupational Therapy School was established in Auckland in 1940, and by 1949 there was a trained O.T. on the staff of every psychiatric hospital in the country. They instructed patients in drawing, weaving, painting, embroidery, canework, wood-work, sewing and much more, with the expectation that such activities would "arouse interest, courage and confidence ... exercise mind and body ... overcome disability, and ... reestablish capacity for industrial and social relations" Additional inpatient services were supplied by dance and music therapists, and outside the walls of psychiatric wards and hospitals, psychologists

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4 This development must be put in context by recognising that these four women must have barely scratched the surface in their attempt to cater for the 9,270 psychiatric patients on the Division's register at the end of 1948.
played an increasingly prominent role as accepted mental health care professionals.

Although outpatient care and other extramural services witnessed unprecedented growth during this period, the psychiatric hospital remained the focus for treatment of the mentally ill. While harsh criticisms have been made of the men and women who staffed these institutions, it is vital to understand the arduous conditions under which they operated. From 1945 right through to 1955 drastic staff shortages affected New Zealand’s general and mental hospitals. The dearth of psychiatrists was attributed to poor rates of pay and unpleasant working conditions. It was exacerbated by the introduction of new forms of treatment which increased the demands of individual patients upon doctors, and so lessened the number who received adequate attention. An even more chronic shortage existed in the nursing staff, and also persisted throughout the period. The annual report of the Superintendent of Mental Hospitals paints a grim picture for the year 1950, reporting that “at most of the mental hospitals there were occasions when the effective strength was more than 50 per cent below the authorised establishment”, and consequently, staff found it difficult “to meet basic essential needs, let alone anything else”. Sarah Connelly-Spence, who started nursing at Seaview in 1945 speaks of 15 hour working days, 11 days on end, and a Porirua attendant describes nursing in the early 1950s as “very tiring, mentally and otherwise ... very, very trying”. Throughout the period sustained attempts were made to alleviate staff shortages through advertising campaigns at the local hospital level, national poster and radio campaigns, recruitment drives

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9 Ibid.
in Great Britain, and several salary increases.\textsuperscript{13} Significant improvements were made, but in 1955 staffing levels remained one of the most serious problems facing New Zealand mental hospitals.\textsuperscript{14}

Staff shortages were paralleled by an ongoing shortage of accommodation. Throughout the 1940s and 1950s the Division of Mental Hygiene remained approximately 1000 beds short, resulting in severely overcrowded wards and heightened tensions in the patient population.\textsuperscript{15} The problem was largely blamed on the increasing number of elderly patients admitted to mental hospitals due to the lack of more suitable accommodation. Although this root cause does not appear to have been confronted, significant steps were taken to reduce overcrowding. Between 1951 and 1954 government expenditure on mental hospital buildings more than doubled.\textsuperscript{16} Efforts were made to increase the quantity and improve the quality of existing institutions, and new hospitals were built at Cherry Farm, outside Dunedin, and Lake Alice, near Bulls.\textsuperscript{17} Building progress was excruciatingly slow, however, and by the end of the period, staff were still being forced to care for 1000 more patients than existing facilities were geared to cater for. Dr Gordon Short of Auckland declared it “almost impossible to do any good psychiatric work in such surroundings”.\textsuperscript{18}

The problems of understaffing and overcrowding were intensified in the rapidly changing psychiatric environment of the 1940s and 1950s. During this period a revival of interest in psychosomatic medicine was culminating in the development of two distinct but integrally related approaches to the treatment of mental illness. First, the key tenet of psychosomatic medicine - the inseparability

\textsuperscript{14} AJHR, 1956, vol.4, H-31, p.33.
\textsuperscript{15} For example: AJHR, 1949, vol.3, H-7, pp.2-3.
\textsuperscript{17} AJHR, 1945, vol.2, H-7, p.2.
\textsuperscript{18} New Zealand Truth, 28 February, 1945, p.9.
of mind and body - laid the framework upon which a growing range of new physical therapies was developed. Second, the emphasis psychosomatic medicine placed on the patient as an individual led to renewed interest in Freud’s techniques of psychoanalysis, and to attempts to improve standards of individualised care.

By 1945 a wide range of physical therapies was being practised in New Zealand mental hospitals. Of most importance were insulin coma therapy, electroconvulsive therapy, and psychosurgery. Harsh criticism has been levelled at the blind acceptance and widespread application of these radical forms of treatment in Britain and America, and evidence certainly exists to suggest that some New Zealand doctors took an overly zealous approach. Despite lacking evidence of its long term efficacy, Drs Presland and Palmer declared in 1948 that convulsion therapy was “indicated in all states of depression, whatever age the patient”. And although Dr Ian McLachlan regarded prefrontal leucotomy as “a final and irreversible procedure not lightly to be undertaken”, between 1948 and 1950, 50 were performed under his supervision in Dunedin. A very real danger exists, however, in the tendency to condemn past practice reflexively. It must be remembered that the ability of shock therapy and psychosurgery to quieten patients and alter destructive behaviour patterns seemed miraculous to the overburdened doctors and nurses in New Zealand’s mental hospitals. Furthermore, most psychiatrists seem to have taken a much more responsible and moderate approach than Presland, Palmer and McLachlan. In 1950 Dr. R. G. T. Lewis, Director-General of Mental Hospitals, argued that electroconvulsive

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19 Some would argue for an interpretation of the 1950s as a period in which psychotropic drugs revolutionised the practice of psychiatry. It is important to note, however, that such drugs were only introduced to New Zealand in the second half of the decade.


therapy was not in fact suitable for most patients, and that leucotomy was a procedure to be considered only when all other forms of therapy had failed.\textsuperscript{23} He declared that although the various physical treatments were enormously useful, none by itself was of any great value unless coordinated with psychotherapy, occupational therapy, recreation and routine.\textsuperscript{24}

One of the most beneficial effects of the new forms of physical treatment was to enhance the ease with which psychological therapy could be applied. In her study of mental illness in New Zealand between 1912 and 1948 Fennell concludes that psychotherapy was practised on a very minimal scale, and that mental hospitals focused almost exclusively on nursing care and physical treatments during this period.\textsuperscript{25} By 1953 Dr Ironside of Dunedin could assert with confidence that Freud's techniques had become almost universally accepted amongst his colleagues, and that psychoanalysis was practised successfully on a wide scale throughout the nation's psychiatric wards and mental hospitals.\textsuperscript{26} Analysis of articles on mental illness in the \textit{New Zealand Medical Journal} between 1945 and 1955 lends credence to his assertion. Heavy emphasis was placed on getting to know the patient as an individual, listening carefully to his or her story, and facilitating recovery through psychoanalysis aided by physical therapies.\textsuperscript{27} Patient : doctor ratios during the period obviously mitigated against the realisation of this ideal. A 1953 World Health Organisation report recommended that for a psychiatric hospital to fulfil its therapeutic functions adequately one physician should be provided for every 150 patients.\textsuperscript{28} In 1958 the

\begin{thebibliography}{9}
\bibitem{24} Ibid.
\bibitem{26} W. Ironside, 'Psychiatry in Undergraduate Medical Teaching', in \textit{NZMJ}, 52,1953, p.351.
\end{thebibliography}
three medical personnel in charge of Seacliff Hospital were responsible for the care of 852 men and women, 284 patients per doctor.29 A 1957 study of the same hospital reported that some patients “are lucky if they have a private conversation with their doctor once a year”.30 “There were so many people”, recalls a nurse who worked at Porirua in the early 1950s, “[y]ou really didn’t identify people easily. They were just a lot of shrivelled up faces wearing dull, dowdy clothes”.31

The new physical and psychological treatments were complemented by an attempt to improve standards of general care. Renewed belief in the value of treating patients holistically and recognising their individuality led to gradual changes throughout the period. The principle of maximum freedom was already operating in most mental hospitals by 1945, and the move to replace barracks style buildings with individual villas had also begun.32 In 1947 a small weekly ‘Comforts Allowance’ was granted for “those patients capable of its appreciation”, and in 1948 a concerted nationwide effort was made to improve the diet in psychiatric hospitals, to upgrade the quality and variety of patient’s clothing, and to make the wards more comfortable and cheerful.33 Dr Lewis reported on the changes achieved within 12 months, saying that although much work still remained to be done, already “the patients have been benefited in personal comforts but more importantly in self-esteem and consequently self-confidence”.34 Provision was also made for normal social and recreational activities which patients might have indulged in in the outside world. Tennis, bowls, cricket, and football were played at the Auckland Mental Hospital, which

29 Frew, p.2.
31 Williams, p.227.
32 Ibid., p.63.
33 AJHR, 1948, vol.4, H-7, p.3.
also provided radios and pianos in some wards.\textsuperscript{35} At Porirua Mental Hospital parole patients were free to wander the grounds, encouraged to attend films in the village once a week and weekly two hour social gatherings in the hospital, and to utilise the services of the hospital library.\textsuperscript{36} Sealcliff patients were provided with weekly film and card evenings, monthly dances, and regular ward outings and picnics.\textsuperscript{37} Towards the end of the period, musical appreciation and drama therapy were also introduced to the routine of hospital life.\textsuperscript{38} Again, however, staff shortages prevented the full realisation of this ideal. "It was Dr. Howell", writes Janet Frame,

who tried to spread the interesting news that mental patients were people and therefore might like occasionally to indulge in the activities of people. Thus were born 'The Evenings' when we played cards - snap, old maid, donkey and euchre; and ludo and snakes and ladders, with prizes awarded and supper afterwards. But where was the extra staff to supervise the activities?\textsuperscript{39}

The approach taken by mental health professionals between 1945 and 1955 may thus be described as a balance between physical therapy, psychological treatment, and social therapy. Its essence found clear expression in the 1947 report of Dr Tothill of Kingseat Mental Hospital: "All the modern forms of treatment have been carried out at this hospital, and, though physical methods are spectacular and have been much publicised, it is my opinion that without psychotherapy and treating the patient as a whole, permanent recovery is unlikely".\textsuperscript{40} While well-founded criticisms have been made of the standard of psychiatric care in mid-twentieth century New Zealand, the good intentions of Dr

\textsuperscript{37} Buckfield, p.13.
\textsuperscript{40} AJHR, 1947, vol.4, H-7, p.6.
Tothill and his colleagues, the pressures they faced, and the ubiquitous problem of establishing appropriate boundaries for the application of new therapies, cannot be overlooked.

During this period, health professionals employed a variety of means to maintain social distance between themselves and the patients for whom they cared. Both overt physical measures and more subtle signals enmeshed in psychiatric rhetoric were used to establish a boundary between themselves and patients, between madness and reason.

A number of different methods were employed in the staff’s largely unconscious task of physically differentiating between themselves and inmates. Of key significance was the official practice of housing mental hospital staff away from their place of work. Although practicality meant that staff in country areas were usually housed much closer, this policy indicates a general unwillingness to become fully integrated into the world of the mental hospital and its inmates. Moreover, it emphasised a crucial distinction between staff and patients - the freedom of movement enjoyed by the former, and the restrictions and limitations upon the latter. The official uniforms worn by doctors, nurses, and occupational therapists served to further emphasise this distinction. The ability of staff to exert physical power over the inmate and his or her possessions also contributed to the maintenance of social distance. Walls, locks, restraining devices, drugs and other ‘therapeutic’ techniques assisted doctor and nurse in their effort to curtail the physical freedom of inmates. Janet Frame writes of feelings of fear and outrage at her experience of “forced submission to custodial capture” in Seacliff mental hospital, and of the use of physical treatments to

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42 Doctors wore white coats, junior nurses wore pink uniforms, registered staff wore blue uniforms, sisters wore white uniforms, and even occupational therapists were distinguished from patients by their green uniforms.
control 'uncooperative' patients. Authorised to administer a wide range of horrendously unpleasant forms of therapy and punishment, staff may also have denied patients warning of such events, further emphasising their power.

Patients were not even allowed control over the most intimate of bodily functions; nurses regulated their toilet habits, and watched while they bathed. As extensions of the self, patient's possessions were enormously important for a sense of autonomy. The authority of staff to permanently or temporarily remove these shards of identity, inspect mail, and enforce the use of plastic cutlery constitute additional expressions of physical control, and were used to enforce social distance between themselves and patients. In *Faces in the Water* the staff of Cliffhaven, a fictitious New Zealand mental hospital distinguish their cups from patients' cups by tying red cotton around the handles. Whether fact or fiction, the anecdote is a powerful image of the kinds of ways mental hospital

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43 J. Frame, *An Angel at My Table*, Auckland, 1991, p.81. Buckfield's study of Seacliff confirms that physical 'therapies' were indeed administered as punishments, pp.26,30.


46 Goffman, pp.28, 76-77.

47 Frame, *Faces*, p.27. While *Faces in the Water* is fiction, Frame writes in *An Angel at My Table* that the fiction lies in the central character. The surroundings and events described in the novel represent her own real experiences in New Zealand mental hospitals between 1945 and 1954.
staff separated themselves out from patients through physical symbolism and the exertion of physical power.

The predominant discourse employed by mid-twentieth century New Zealand doctors functioned in a very similar manner. By speaking and writing about patients in particular ways, staff revealed a powerful sense of superiority and separateness. "The doctor - patient relationship in a case of this sort is essentially a parent - child relationship" wrote Dr Lopdell of Dunedin in 1955, encapsulating the paternalism of psychiatric thought in his era. Lopdell's simile is certainly an effective way of signalling the existence of social distance between medical staff and patients, but significantly, alludes to the possibility that this distinction is not permanent or irreversible. For while adults and children occupy different social categories, and parents exert tremendous control over their children, it is possible for a child to cross the boundary into adulthood. Furthermore, the parent / psychiatrist sees it as his or her role to stimulate personal growth in the child / patient and so facilitate movement from childhood / madness to adulthood / reason. One of the prerogatives of parenthood is the right to claim comprehensive understanding of your child's personality, and the authority to explain his or her behaviour. In a very similar way, their position of power gave doctors the necessary justification for labelling patients with specific psychiatric diseases. Thomas Szasz has vehemently denounced the use of diagnostic labels in mental health care, arguing that they are prescriptive rather than descriptive, destructive rather than helpful. Whether or not one accepts Szasz's thesis, it is impossible to ignore the fact that such labels are tools by which psychiatrists separate out the mad from the sane. A sense of superiority is also conveyed in the more general terms and phrases mid-twentieth century doctors used to describe their patients. Mentally sick men and

women were variously describing as having ‘faulty’ actions, being immature, unstable, eccentric, weak-willed, excitable, and socially incompetent.\textsuperscript{50} In 1948 Dr. D. McKenzie expressed surprise at the good results obtained from prefrontal leucotomy, despite the “poor material” upon which they were performed.\textsuperscript{51} Further evidence that mental health workers saw themselves in a completely separate social category from their patients may be found in their lack of sympathy for patients undergoing physical therapies, despite a clinical awareness of the accompanying negative side-effects. R. W. Medlicott described “apprehensiveness” as one of the many complications of convulsive therapy.\textsuperscript{52} Articles on leucotomy in the New Zealand Medical Journal discuss incontinence, confusion, muteness, seizures, and the excruciatingly slow rate of recovery in lobotomised patients with extraordinary detachment.\textsuperscript{53} Along with more obvious physical mechanisms, this paternalistic discourse of superiority encouraged the development of two different social and cultural worlds in mid-twentieth century New Zealand psychiatric institutions.

But while a deliberate effort was made to maintain the boundary between these two worlds, staff also found themselves unconsciously drawn into the world of madness. Erving Goffman’s intelligent analysis of asylums as ‘total institutions’ draws attention to a fundamental contradiction in the role of staff. Although doctors and nurses are essentially engaged in ‘people work’ which calls for compassion and humanity, they are also responsible for the administration of terrifying forms of treatment and unpleasant methods of control in a professional manner.\textsuperscript{54} However much staff may work at preserving social distance, the danger of being drawn into warm human relationships with some inmates always exists. Janet Frame movingly tells the tale of Sister Bridge’s emotional

\textsuperscript{50} For example: Lopdell, p.181; R. W. Medlicott, ‘Psychiatric Treatment’, in NZMJ, 28, 2, 1945, p.28.
\textsuperscript{52} R.W. Medlicott, ‘Convulsive Therapy’, in NZMJ, 47, 1948, pp.344-348.
\textsuperscript{53} For example: McKenzie, pp.38-39; D. G. Gilmour and M. A. Falconer, pp.522-530.
\textsuperscript{54} Goffman, pp.73-88.
career as a mental nurse. She began as a vulnerable young woman appalled and disheartened by her inability to heal the patients in her care, rapidly hardened herself to deal with reality, but still found herself sympathising with patients, and even confiding in some.\textsuperscript{55} Other incidents in \textit{Faces in the Water} offer further examples of the manner in which staff engaged in 'normal' forms of interaction and emotional involvement with patients. After an escape attempt when nurse and patient find themselves together in the 'outside world', Sister Bridge buys Istina and herself an ice cream, and points out her home as they stroll past.\textsuperscript{56} Dr. Portman reads passages aloud to Istina as together they choose library books for the hospital, and Dr Steward comforts patients by comparing their feelings and experiences with those of himself and his wife.\textsuperscript{57} While official evidence of such events is difficult to find, Frame's literary reflection of reality in New Zealand mental hospitals in the 1940s and 1950s must not be discounted as an alternative source of evidence. Her writing offers valuable insight into the processes by which staff and patients formed emotional attachments in psychiatric institutions, and the carefully established social distance between madness and sanity was diminished.

It is likely that a range of institutionalised ceremonies further cultivated a sense of unity and solidarity among staff and inmates during this period. Goffman posits that events conducive to bonding in an institutional setting include the production of a weekly newspaper or monthly magazine, group therapy, mixed dances, Christmas celebrations, theatrical productions, sports days, and visitor's days.\textsuperscript{58} Annual parties, at which staff and patients ate together, played party games and danced with one another, were an established routine in New Zealand's mental hospitals by the 1940s and 1950s. Seacliff nurses

\textsuperscript{55} Frame, \textit{Faces}, pp. 138-140.  
\textsuperscript{56} Ibid., pp. 172-174.  
\textsuperscript{57} Ibid., pp. 242-243, 180-181.  
\textsuperscript{58} Goffman, pp. 91-101.
interviewed by the *Evening Star* in 1956 spoke of dances as “hard work ... because they danced with patients no matter how tired they were”. Sports days also occurred on a regular basis and encouraged an exceptional forgetfulness of social difference. The presence of visitors at such events acted as a further stimulant to unity by emphasising the shared world of staff and patients and the boundary between hospital and outside world. Frame writes of the opening of the bowling green as one of Cliffhaven’s regular “hospital occasions”. Staff appeared in civilian clothing and brought family members to share in the celebration. Such actions represent a degree of involvement in the patient world, but the fact that a segregated afternoon tea followed suggests an equally significant unwillingness to completely ignore the boundary between madness and reason. Goffman argues that these various institutional ceremonies are well suited to a Durkheimian analysis. The psychiatric institution is seen as a society dangerously divided into inmates and staff, held together only through the regular performance of unifying rituals. At a more basic level, such events can be seen as evidence that social distance between the two groups was neither inevitable, nor unalterable.

A consideration of the ways in which psychiatric staff were drawn into the life of the mental hospital also requires analysis of their relationship with the wider medical community. In the first half of the twentieth century a very clear sense of isolation existed. Dr T. G. Gray wrote of his early experiences as a psychiatrist in New Zealand:

> The choice of psychiatry as a profession was thought to be evidence of eccentricity or perhaps an illustration of the old adage *similia similibus* and the recently qualified medical man who joined the staff of a mental hospital was regarded as having committed professional hari-kiri.

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61 Goffman, p.102.
62 Fennell, pp.35,49.
By 1947, he had experienced the ultimate acceptance of being appointed President of the New Zealand Branch of the British Medical Association.\textsuperscript{64} The sense of isolation which had similarly afflicted psychiatric nurses also appears to have diminished somewhat during the period. In 1945 the Nurses' Association had expressed hope that new legislation would alleviate the feelings of ostracism and inferiority experienced by psychiatric nurses.\textsuperscript{65} By 1955 it seems both psychiatric nurses and doctors had been accepted, to some extent, as valuable members of the medical community. A medical student writing in 1962, however, expressed the opinion that "a considerable rift" still existed between general physicians and psychiatrists, and even in the present day a distinction is sometimes made between those who care for the sane, and those who care for the mad.\textsuperscript{66} This distinction, in conjunction with the difficulty of maintaining emotional detachment and participation in institutional ceremonies, provided the means by which mid-twentieth century staff became de facto members of the world of madness. So while the physical and rhetorical strategies of mental health care workers were successful in staging a difference between themselves and inmates, they also demonstrated a willingness (conscious or unconscious) to move across that boundary, and to entertain the possibility that patients might do likewise.

Health professionals in New Zealand have traditionally possessed an enormous amount of social authority and moral suasion. Consequently, their capacity to influence the social position of the mentally ill should be seen as very significant. Between 1945 and 1955 doctors sent out strong messages to the New Zealand public about how mental illness and its victims should be treated, and about the appropriate degree of separation to be maintained between the worlds of madness and reason.

\textsuperscript{64} Ibid., p.78.
\textsuperscript{65} 'Psychiatric Nurse Training', in \textit{NZNJ}, 28, 1, 1945, p.3.
First, doctors attempted to persuade the public that mental illness was an issue of grave importance which should receive appropriate attention. The period saw a mammoth surge of medical interest in psychiatry and a corresponding increase in the number of related articles published in the *New Zealand Medical Journal*. The topics ranged from mental health in pregnant women and infants, to clinical analyses of the new physical treatments, to psychosomatic medicine in general practice, and the importance of psychiatry in undergraduate medical training. The general impression gained is that mental health was seen by mid-twentieth century New Zealand doctors as an issue of great significance which had relevance to all other fields of medicine. Assertions of its importance may also be found in the annual reports of the Superintendent of Mental Hospitals, where frequent and impassioned calls were made for both government and public to pay more attention to the situation in psychiatric institutions. In addition, psychiatrists were engaging in an increasing volume of community education work, and presenting lectures to a range of different community organisations.

Second, medical professionals sent out a strong and unequivocal message that mental illness was experienced by a high proportion of New Zealanders. The most commonly used figure to describe the prevalence of psychiatric disturbance in the general population was one third. This statistic and other comments referring to mental illness as a relatively commonplace experience were used by doctors as a means of ‘normalising’ madness. If it really was so

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widespread throughout the community, it could not be nearly as dangerous and frightening as previously supposed. Furthermore, doctors asserted that the majority of mentally ill men and women posed no threat to the community. They described their patients as confused, faulty, depressed, excitable, and nervous, but very rarely as dangerous.

Having affirmed the importance of mental illness and its prevalence in the community, health professionals also conveyed a clear impression of the way they believed its victims should be treated. They denounced the existence of prejudice, and urged the public to understand that “mental illness is as much an illness, and as little a disgrace, as any physical illness” and that “it is not the fault of the person who suffers from it”.71 Ernest Beaglehole, a prominent psychologist during the period, wrote a book entitled Mental Health in New Zealand in which he called for reactions of shame and horror to be replaced with sympathy and understanding.72 In a 1961 lecture Dr. G. Blake-Palmer still felt the necessity of discounting pessimistic beliefs about the treatability of mental disorders, and condemning other “exaggerated fears and erroneous notions”.73 Dr. T. G. Gray’s 1959 autobiography The Very Shadow of the Moon was specifically written with the purpose of dispelling “lingering prejudices and false notions as to the nature of mental disorders”.74

At first glance it seems that a gap existed between these humanitarian recommendations and the actual behaviour of mental health care professionals in the 1940s and 1950s. How could they maintain such a strong commitment to separating themselves out from patients, and yet exhibit such a sincere desire to see the public accept those patients on an equal basis? To resolve this apparent

72 Beaglehole, p.4.
74 T.G.Gray, The Very Error of the Moon, Devon, 1959, p.7.
contradiction, the metaphor of separate worlds may be gainfully employed. There can be no doubt that the staff of New Zealand’s mental hospitals between 1945 and 1955 did see their patients as inhabitants of a different world. But they also believed that the boundary between that world and theirs was fluid. In fact, psychiatrists, psychiatric nurses and psychologists saw it as their task to facilitate movement across that boundary. Through physical and psychological treatments they hoped to help patients approach the world of reason. And through publications, lectures, and exhortations they encouraged the public to accept such movement.
2. POLITICIANS AND LEGISLATION: PROTECTING
THE WORLD OF MADNESS, OR THE WORLD OF REASON?

One and all we recognise that members of Parliament in a democratic community such as ours must necessarily be watchdogs for the community ... ¹

The true functions of legislation affecting the mentally ill and mentally subnormal are to enable treatment and care to be given and at the same time to protect the patient and society.²

The tremendous power wielded by politicians and the legislation they formulated made them key players in the creation of a social position for the mentally ill in mid-twentieth century New Zealand. As watchdogs for the community they employed a number of strategies designed to minimise the degree of separation between madness and reason. Legislative steps were implemented to reduce the stigma attached to mental illness, and positive, inclusive language was used to promote the acceptance of mental illness in the rest of society. But as representatives of the world of reason occupied by numerous other political concerns, politicians failed in their role as advocates of the world of madness. The period must ultimately be characterised as one of general political inaction which not only condoned, but encouraged the public's exclusion and rejection of the mad.

The basic legal framework for dealing with mental illness in the 1940s and 1950s was laid down in the Mental Defectives Act of 1911. The act covered procedures for the reception of patients into mental hospitals, certification of the mad, procedures for admitting minors and the intellectually disabled, the licensing of public and private institutions, patient transfers and discharges, the

administration of inmates’ estates, and safeguards intended to protect patients’ rights. Its most significant innovation was the introduction of admission procedures for voluntary patients. For the first time, people were able to seek treatment of their own volition without being subjected to the humiliation and stigma of committal. A further stimulant to desegregation between the worlds of reason and madness occurred in 1925 with the establishment of out-patient clinics for psychiatric care, and the provision of in-patient services in general hospitals. A 1928 Act added an additional avenue by which treatment could be accessed without certification or committal, by allowing for the admission of patients with ‘temporary disorders’. In 1944 legislative provision was made for the state registration of psychiatric nurses, integrating them into the existing system of administration for general nurses, and recognising their need for specialised knowledge and training. By 1945, then, a fairly comprehensive framework covering admission procedures, mental hospital staffing, safeguards for the protection of patients, and treatment in general hospitals was firmly established.

During the ensuing ten years very little further mental health legislation was passed. In 1947 the Health Amendment Act provided for the incorporation of the previously autonomous Department of Mental Hospitals into the Department of Health. In 1949 a statute was passed compelling all Occupational Therapists to obtain state registration after training at an approved school.

3 *New Zealand Statutes*, 1911, No.6, pp.11-58.
5 *New Zealand Statutes*, 1928, No.23, pp.399-407. This Act actually created the Department of Mental Hospitals and the position Director-General of Mental Hospitals. It also created a Eugenics Board for the registration of imbeciles, idiots, the feeble-minded, epileptics, and social defectives, and for the administration of matters pertaining to their welfare.
7 *New Zealand Statutes*, 1947, No.52, pp.474-476.
8 Ibid., 1949, No.9, pp.161-176.
1950 amendment to the Mental Defectives Act gave the Minister of Health wider powers of delegation, required that all future Superintendents of mental hospitals be medical practitioners, and made a series of other minor changes to the 1911 act. A further amendment in 1951 addressed the procedures by which patients were transferred between hospitals, and stipulated that all medical staff appointments be approved by the minister. And a 1954 amendment, chiefly concerned with accommodation for intellectually disabled children, brought about a change in nomenclature - the ‘Mental Defectives Act’ became the ‘Mental Health Act’.

Susan Fennell has argued that the New Zealand government “showed considerable far-sightedness in its mental health legislation”. There can be no question that its legislative framework for dealing with mental illness was far more comprehensive and humanitarian than the policies of many other contemporary governments. However, closer analysis of the few acts passed during this period, of the rhetoric employed in parliament, and of the legislation left unpassed, reveals a number of ambiguities and apparent contradictions in the government’s mental health policy.

On the surface, ample evidence exists to corroborate Fennell’s argument and to suggest that mid-twentieth century politicians actively supported the integration of the mad into New Zealand society. The move towards state registration of mental health professionals indicates a willingness to recognise the importance of these occupations and of the people they cared for. Although just beyond the boundaries of this study, the Nurses and Midwives Registration Amendment Act of 1944 was of enormous significance. It brought psychiatric nurses under the control of the Nurses and Midwives Registration Board, and

9 Fennell, p.12.
established guidelines for standardised theoretical and practical training. The 1949 Occupational Therapy Act obliged occupational therapists to undergo uniform training at an approved school, pass examinations, and obtain state registration before practising. As pieces of legislation, the 1944 and 1949 acts were fairly straightforward, but as indicators of official government attitudes to mental illness they were highly significant. By incorporating psychiatric nurses into the general nurses' system of administration they exhibited a willingness to tolerate closer contact between the worlds of madness and reason than had previously been acceptable. Registration itself raised the social status of psychiatric nurses and occupational therapists, implying that their patients might also be deserving of a social position superior to that previously accorded them. Furthermore, it focused attention on the specialised training of mental health care workers, emphasising the healing role of the mental hospital and the curability of its inmates. The general effect of these two pieces of legislation was thus to promote recognition of the psychiatric patient as a temporarily ill, but important member of society.

The 1947 Health Amendment Act functioned in a similar way. By incorporating the Division of Mental Hygiene into the Health Department, the New Zealand government was effectively promoting some degree of integration between the worlds of madness and reason. The move can also be interpreted as official acknowledgement that mentally ill patients were just like physically ill patients, and could be treated and cured in similar ways.

Further evidence of positive governmental attitudes to mental illness may be found in the 1950 act requiring that the superintendents of all public and private mental institutions be medical practitioners. The principal act of 1911 had left this position open to laymen, but the major therapeutic advances made in the intervening forty years led to a widely held belief among politicians that mental
hospitals should be regarded as places of cure rather than places of custody. Insistence upon the superintendent’s position being filled by a registered medical practitioner was an effective means of establishing this principle. In the words of Mr. Watts, Minister of Health in 1950:

If we allow the suggestion at any time that a layman can be the superintendent of a mental hospital, then it will no longer be a mental hospital; it will just be a place of detention for mental patients who have no chance of recovery. Just as we have a Medical Superintendent in charge of our other hospitals ... so we shall have ... a medical man in charge of a mental hospital.\(^{11}\)

By mid century the position of superintendent had already been restricted to medical practitioners in practice, so the most important effect of the 1950 statute was to signal official government recognition of the treatability and curability of mental disorders. Furthermore, by acknowledging that psychiatric patients were capable of recovery, the legislation also implied acceptance of their potential to be reintegrated into the world of reason.

The change in terminology wrought by the 1954 Mental Health Act served as a further strategy for blurring the rigidly defined boundaries between madness and reason. A 1955 World Health Organisation study of mental health legislation reported that the shift towards more positive, medicalised terminology was a significant international trend.\(^{12}\) New Zealand had actually embarked on such changes relatively early on. In 1907 the General Assembly approved a move from the term ‘mental asylum’, with its custodial connotations, to ‘mental hospital’, suggesting treatment and cure.\(^{13}\) As early as 1911 the ‘Lunatics Act’ was replaced with the ‘Mental Defectives Act’, which would of course become the ‘Mental Health Act’ in 1954. In New South Wales and Western Australia, mental illness was still regulated by ‘Lunacy Acts’ in 1955, and Great Britain did not make the change from ‘asylum’, ‘lunatic’, and ‘attendant’ to ‘mental hospital’, ‘patient’, and

\(^{11}\) Hon. Mr. Watts, NZPD, vol.293, 1950, p.4153.

\(^{12}\) World Health Organisation, International Digest, p.78.

‘nurse’ until the late 1920s. By 1944 New Zealand had moved on from ‘mental nurse’ to ‘psychiatric nurse’, implying an even higher level of training and skill. The replacement of the ‘Mental Defectives’ with the ‘Mental Health Act’ was presented in the House as a way of recognising recent therapeutic advances in the field of psychiatry, and corresponding improvements in attitudes towards the mentally ill. “The change is small in itself”, asserted the Minister of Health, “but it is indicative of a very real change in the treatment and understanding of this problem”. The Act was not only a reflection of the greater public sympathy felt for those suffering from mental illness, but also functioned as a stimulant to further attitudinal improvements. By replacing negative, stigmatising terms, with positive words implying medical treatment and cure it was hoped to encourage the development of positive attitudes. The change of name also represented a change in focus. A ‘Mental Defectives Act’ seems obviously directed at the control of a specific section of society, whereas ‘Mental Health’ was an all-encompassing term, suggesting legislation under its heading to be of relevance to the whole community. Hence, the changes in nomenclature effected from 1907 onwards, and the 1954 Mental Health Act in particular, represent an effective strategy by which the New Zealand government mitigated against the social marginalisation of the mentally ill.

In addition to the changes brought about by specific pieces of legislation, the general policies endorsed by government must also be considered as means by which they encouraged social acceptance of the mentally ill. Of most significance is the continued support shown for the principle of out-patient care during the 1940s and 1950s. Psychiatric out-clinics had initially been set up in Auckland, Wellington, Christchurch and Dunedin in 1925, and by 1948 twelve were

15 This change was effected by the Nurses and Midwives Registration Act 1944.
17 Ibid.
operating in public hospitals around the country. Each year between 1945 and 1955 the Director-General of Mental Hospitals reported growth in the volume of work conducted at these clinics, and an increase in the number of patients treated in in-patient psychiatric wards in the public hospitals. The encouragement afforded this trend by government reveals a willingness to tolerate some degree of mental illness within the community. While the ‘real loonies’ continued to be relegated to a separate world, mildly disturbed or depressed patients who attended out-patient clinics were accepted in the community, and those with more severe problems, though prevented from actively participating in society, were accepted as ill along with other residents in public hospitals.

Government spending on mental health care provides another useful indication of the State’s commitment to improving the social position of the mentally ill. Between 1911 and 1938 a small maintenance payment was levied upon all inmates residing in mental hospitals, but with the advent of the Social Security Act this was abolished, and Dunedin’s private institution, Ashburn Hall, was the only establishment to receive paying patients during the 1940s and 1950s. Throughout the period 1945 to 1955 the vote set aside for mental hospitals grew each year, but the number of patients treated by the Division of Mental Hygiene also increased each year. During 1947 the House agreed to finance payment of a small weekly allowance to mental patients “capable of its appreciation”, and in 1949 additional money was set aside for the upgrading of patient’s clothing and the refurbishment of some wards. While the period was characterised by chronic conditions of overcrowding and understaffing in mental hospitals, the same problems were afflicting general hospitals. In 1952 the Minister of Health assured the House that the standard of accommodation and

18 Fennell, pp.49-50.
20 Fennell, p.10.
care provided in mental hospitals was comparable with that received by patients in general hospitals.\textsuperscript{22} A systematic investigation of government spending on mental health is sorely needed, but for the purposes of this study it is sufficient to note that the New Zealand government seemed aware of its financial responsibility to these marginal members of society, if not overly generous.

The extent to which members of parliament recognised their ethical and moral responsibilities to the mentally ill must also be considered. It seems likely that a majority of members did make a point of visiting mental institutions and inspecting the conditions under which patients were confined.\textsuperscript{23} In July 1952 Mr. Marshall, Minister of Health, told the House that since becoming Minister in September 1951 he had visited all but two of New Zealand's mental institutions, and carried out thorough inspections of all classes of patients, at all times of the day.\textsuperscript{24} These actions reflect a belief that the mentally ill formed an important component of each politician's constituency, and should not be ignored.

The most compelling evidence to suggest that mid-twentieth century politicians supported the social acceptance of mental patients may be found in the speeches they made before the House. Despite a shared belief that all members of parliament had a responsibility to those confined in mental hospitals, there can be no doubt that National - Labour party politics played an important role in parliamentary debates on the issue. A recurring theme centres on an opposition politician raising questions about mental hospital conditions and a National member responding with righteous praise for the work of the overburdened staff.\textsuperscript{25} Physical realities, however, were hard to argue with, and while government maintained that every possible effort was being made to improve

\textsuperscript{23} Mr. McCombs, \textit{NZPD}, vol.273, 1946, p.533.
\textsuperscript{25} For example: \textit{NZPD}, vol.274, 1946, p.641-643.
the situation in mental hospitals, they acknowledged that much still remained to be done.  

The rhetoric employed during these debates was predominantly positive and patient-oriented. Members on both sides of the House repeatedly stressed their obligations and responsibilities to the mentally ill. They spoke of the “wonderful understanding and splendid work of the doctors and nurses”, and argued that mental hospitals were “much pleasanter, brighter, and happier places than is commonly believed”. But while they encouraged a more positive public attitude towards mental hospitals and their staff, they also expressed concern for the welfare of patients. Disquiet about the serious staff shortages in mental hospitals and its effect on patients is a recurring theme in the debates. Another issue of concern was social prejudice against mental illness and its victims. Mr Bowden, member for Karori, spoke on the subject in 1946:

We are dealing with a matter that affects the interests of 8000-odd people who, unfortunately, are detained in mental hospitals. They are members of somebody's family, and their parents, their children, and their friends are very deeply concerned. The proper administration of the mental hospitals is ... a matter of the welfare of a very important section of our community.

The Honourable Mr. Algie, Minister of Education, addressed the same issue in 1954:

There was a time in history when a mental patient was treated entirely differently from the way in which we treat a person who is ill or afflicted physically. We are coming to recognise that mental illness is only another facet of physical illness and that the same human emotions should be exhibited towards the one as the other.

Both speeches express a desire to see the wider community accept the mentally ill as temporarily incapacitated, but valuable members of society. The Minister of

30 Mr. Bowden, *NZPD*, vol.274, 1946, p.642.
Health affirmed similar views in 1952, condemning the negative attitudes prevalent in society, and insisting that mental patients be treated in the same way as other sick people. He also referred directly to the social stigma attached to ex-patients: “these people should be received back into the community with the same sympathy and understanding that we give to those who are discharged from a general hospital”. Such strong assertions of the importance of mental illness and its victims, and of the need for widespread public acceptance, suggest that mid-twentieth century New Zealand politicians were actively in favour of a closer relationship between the worlds of madness and reason.

When considered in light of the registration acts, the legislative insistence on medical superintendents, the incorporation of mental hospitals into the Department of Health, the change in terminology, and other aspects of general government policy, this overwhelmingly positive and accepting rhetoric seems to clinch the matter. Politicians between 1945 and 1955 were obviously an enlightened, sympathetic and humanitarian group committed to improving the social position of the mentally ill. But what happens if we dig a little deeper, speculate about what was left unsaid, and consider what legislation was left unpassed? Were they really so strongly in favour of bridging the gap between madness and reason?

Official policy regarding the location of mental hospitals would suggest otherwise. Mental asylums had traditionally been built on the outskirts of communities, their physical segregation reflecting a social distinction between madness and reason which was almost as tangible. Isolation of the mentally ill in rural areas was thought to serve two functions. First, by ensuring the

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33 Ibid.
maintenance of a physical barrier between the mad and the sane it provided the latter with protection from the former. Second, the fresh air and tranquillity of rural life was believed to be therapeutic for sufferers of psychological disturbance. In New Zealand, eight mental hospitals - all geographically isolated from the rest of society - were in operation by 1945. Two further sites for psychiatric care were constructed during the following decade. In 1945 the first plans were laid down for Lake Alice Hospital, which would service the Taranaki, Manawatu, and Hawkes Bay regions. Rather than building in close proximity to any of the numerous towns and cities from whence its population would be drawn, the Department of Mental Hospitals located their new establishment on the outskirts of the small central North Island settlement of Bulls. Due to the deterioration of facilities at Dunedin’s Seacliff Hospital, work was begun on a new mental hospital for the Otago region in 1952. In accordance with earlier practices, it also was to be geographically isolated from the rest of the community. Named Cherry Farm, the new hospital was located a few kilometres from the small township of Waikouaiti, but over fifty kilometres north of the city of Dunedin. The social significance of a policy committed to maintaining geographical differentiation between madness and reason is obvious. Belying the positive accepting attitudes they displayed in parliamentary debates, New Zealand politicians were effectively providing justification for public fears, and endorsing the social marginalisation of the mentally ill.

The maintenance of separate systems of administration for general and mental hospitals must also be seen as a means by which government policy differentiated between the mad and the sane. I argued above that the integration

36 Levin Farm was also established under the auspices of the Department of Mental Hospitals during this period, but its function was as residential establishment for intellectually disabled children, rather than a hospital for the treatment of mental illness.
39 Ibid.
of the Department of Mental Hospitals into the Department of Health in 1947 reflected a willingness on the part of politicians to accept the mentally ill into New Zealand society. On the surface this is a plausible and compelling interpretation, and true to some extent, but the attitudes of these mid-twentieth century politicians were positive at only the most superficial level, and accepting only to a certain degree. For while the new Division of Mental Hygiene did technically come under the authority of the Department of Health, in practice it maintained a completely separate system of organisation and administration. Hence the message that mental hospitals and their patients should be integrated into the general hospital system and the community was undermined by the government's unwillingness to see this occur in reality. Furthermore, while general hospitals were administered by locally elected hospital boards, the state retained firm control of New Zealand's psychiatric hospitals throughout the period in question. In 1969 the Department of Health published a review of hospital services which explicitly acknowledged the impact of central government control on social dynamics:

an unfortunate consequence of central control was that the majority of institutions became largely separated from the main stream of local social, professional and political life. This isolation was intensified by those very deep-seated, although largely irrational, fears about the nature and implications of all forms of mental disorder which we sometimes like to stigmatise as relics of a less enlightened age.40

It was not until 1972 that the state finally relinquished control of psychiatric hospitals and allowed for their integration with general hospitals at the provincial level.41: Between 1945 and 1955, then, government policy confirmed the notion that mental illness was a separate social problem which required specialised institutions and separate administration.

The positive patient-centred rhetoric employed in parliament during the 1940s and 1950s is further belied by a thorough examination of the legislative safeguards against improper detention. First, a Magistrate’s order was required either before, or immediately after, a patient was compulsorily received into a psychiatric institution. Two signed medical certificates needed to be presented to the Magistrate before the order was granted. He was expected to evaluate the situation and determine whether involuntary committal was appropriate. Ostensibly, the procedure provided a safeguard against improper detention, but its efficacy is surely brought into question when we consider a Magistrate’s qualifications, or lack thereof, for making such important judgments. Second, all institutions accommodating mental patients were required to be inspected at least once every three months by an Official Visitor or Inspector of the Division of Mental Hygiene. Inspectors and Official Visitors had the right to examine every part of any mental hospital, and visit any person detained therein at any time of the day or night. They were charged with reporting any matters of concern, and in particular with safeguarding patients’ rights. It seems likely, however, that they rarely operated in the intended role of community watchdog. In 1952 the Minister of Health celebrated the fact that their reports were consistently and unanimously “encouraging and favourable”. What of the appalling staff shortages and overcrowding reported by mental hospital staff? In a damning critique of mental health legislation published in 1960 Professor H. R. Gray of Canterbury Law School maintained that “the opinion of the Official Visitor (who is normally a lawyer) after a few minutes conversation with the patient is really worth no more than the opinion of any other informed layman”. Arthur Sainsbury of the Auckland Mental Hospital Reform Association waxed lyrical on their shortcomings: “after all, what a futility is the

43 New Zealand Statutes, 1911, No.6, pp.35-36.
45 Gray, p.20.
Official Visitor! He is merely one government officer appointed to supervise the domain of other government officers .... The patients have no voice that reaches outside". 46 Finally, relatives and friends of committed patients had the right to make representations to the Minister of Health, but as Gray points out, they were rarely in a position to oppose the opinion of the Medical Superintendent under whose charge their mother, sister, child, or friend was detained. 47 Patients with well-grounded objections to their incarceration or to their treatment while in the custody of a mental hospital had little real hope of recourse through these ineffectual channels. So while politicians made a show of sympathy in the House, in practice no real steps were taken to safeguard patients' rights in an effective manner. Their rhetoric suggested that politicians saw the mentally ill as an important section of the community who should be protected; their lack of action indicates a degree of indifference, and an unwillingness to accept the mentally ill as deserving members of the community.

This apparent contradiction is best resolved by reference to the broader context of New Zealand politics between 1945 and 1955, and in particular, to the immediate impact of the Second World War. For the Labour government in power between 1945 and 1949, stabilisation of the economy and rehabilitation of returned soldiers constituted far more pressing concerns than the social position of the mentally ill. The National government elected in 1949 also battled to retain control of the economy in its first years of power. In addition, it faced the infamous Watersiders' Dispute of 1950 - 1951, a major disturbance which twice plunged the nation into an official state of emergency, and cost over 40 million pounds. 48 Eager to regain the losses endured in two decades of war and depression, both administrations were perhaps understandably tardy in turning

47 Gray, p.20.
their attention to the inmates of New Zealand's mental hospitals. As the Minister of Health asserted in 1956, the government “was very conscious of the need for improved facilities” in psychiatric hospitals, yet found itself restrained by the “big capital demands” of the period.49 Ultimately, it was a matter of priorities. The mentally ill formed a relatively small proportion of each politician’s constituency and while committed were ineligible to vote. Furthermore, their families and friends, and other members of the public, expressed little interest in challenging government policy relating to psychiatric patients.50 In the absence of political pressure, the Labour government of the late 1940s and the National government of the early 1950s, focused their attention upon the more pressing concerns of economic and social security.

There should be no doubt that many New Zealand politicians during the 1940s and 1950s were genuinely concerned with the legal and social position of mental patients. Nor can it be contested that the governments in power took a number of steps intended to promote closer contact and understanding between the worlds of madness and reason. In effect, however, few substantial gains were made. Psychiatric hospitals remained geographically isolated on the outskirts of urban areas; they were administered separately from general hospitals, remaining under central state control throughout the period; and their inmates endured the same deplorable lack of protection experienced by their nineteenth century counterparts. While politicians’ failure to act as advocates for the mentally ill must be contextualised within the broader context of mid-twentieth century political and economic concerns, its effect on social dynamics should not be ignored. Lack of action ultimately suggests that government viewed the mentally ill as unimportant, and undesirable in the world of reason. Certainly it served to condone the negative attitudes prevalent in wider society, and to sanction the

50 A lack of interest which will be investigated in following chapters.
relegation of the mentally ill to a separate world. Politicians and government policy thus succeeded in protecting the world of reason from the threat of madness, but failed to protect the physical or social well-being of psychiatric patients.
3. THE ATTITUDES OF THE GENERAL PUBLIC: REJECTION, SYMPATHY AND FEAR

Because of the strangeness of his behaviour and the frequently unpredictable nature of his reactions, the mental patient seems always to have inspired fear.¹

As the World Health Organisation noted in 1955, fear of madness and rejection of its victims by the public is a phenomenon which seems to span both centuries and cultures. New Zealand in the 1940s and 1950s was no exception. The mentally ill were stigmatised, mental hospitals avoided, and ex-patients rejected both in the work-force and the wider community. However, there is also evidence of the growth of more positive attitudes towards mental illness during this period, and of a concurrent rise in public concern for the welfare of mental hospital inmates. Newspaper comment in particular reflects these trends, as does the work of the Patients' and Prisoners' Aid Society, the Auckland Mental Hospital Reform Association, the National Council of Women and other groups dedicated to maintaining links between the worlds of madness and reason and ameliorating the situation in mental hospitals. But although the sympathy and understanding which began to spread through New Zealand communities in the mid-twentieth century was an important development, its significance must not be overestimated. Essentially the social position of the mentally ill remained unchanged, and their isolation and rejection would remain a feature of the 1960s, 1970s, 1980s, and 1990s.

Retrospective analysis of public attitudes to mental illness in the 1940s and 1950s is a difficult task. For while newspapers and the reports of particular interest groups are available, such sources do not adequately reflect the feelings of ordinary citizens. Surveys of public opinion in various New Zealand

communities were carried out increasingly from the mid 1960s, but the dramatic changes in mental health care which occurred in the later 1950s and early 1960s make these studies generally inadmissible as evidence for the period in question. More useful are contemporary British, Canadian, and American surveys.

In 1951 Elaine and John Cumming carried out a fascinating study in a small Canadian town dubbed Blackfoot. They succeeded in identifying a patterned social response to mental illness characterised by three steps:

first, denial of mental illness; second, isolation of the affected person in a hospital when mental illness can no longer be denied, with concomitant rationalisation of this isolation with beliefs that the hospital is a wonderful place, capable of curing mental illness, if it can be cured at all, which is doubtful; and finally, insulation of the whole vexing problem by a secondary denial that a problem exists in so far as it needs solving by ordinary citizens.²

In general, Blackfoot residents exhibited strongly negative attitudes towards the presence of mental illness in their community, and were fiercely resistant to attitudinal change despite exposure to an intensive programme of education.³ Nunnally’s study of attitudes towards the mentally ill in Illinois was conducted three years later, and produced similar results. He found that while the average man or woman was not “grossly misinformed” about mental illness, he or she possessed highly unfavourable attitudes towards the mentally ill, regarding them as “relatively worthless, dirty, dangerous, cold, unpredictable, insincere, and so on”.⁴ Research carried out in conjunction with a 1957 BBC educational series on mental illness was approached and carried out with less academic rigour than the Canadian and American studies, but still provides a useful indication of public feeling. In preparation for the series’ production a preliminary survey of 167 people thought to be representative of greater London was carried out. The

³ Ibid., pp.44-88.
sample perceived the mentally ill primarily in terms of the traditional "madman", "who could not think logically and was unpredictable, deluded and withdrawn". Furthermore, later research revealed that the television series had generally failed to affect any improvement in the negative attitudes of London viewers. In all three studies, then, the community in question exhibited an intensely negative and unaccepting attitude towards the mentally ill which appeared to be unrelated to the level of knowledge they possessed about mental illness.

From the available evidence it seems that analogous attitudes were prevalent in New Zealand society during the 1940s and 1950s. In a 1962 lecture the psychiatrist Dr. Blake-Palmer noted the existence of a common stereotype in New Zealand society which depicted "the mentally disordered person as cunning, destructive, abnormally strong, and wild in appearance, probably dangerous and certainly to be avoided socially". T. G. Gray, Director-general of New Zealand's mental hospitals during the period wrote in 1959 of the 'discourse of difference' underlying public attitudes towards the mentally ill:

If there is one thing which John Citizen firmly believes, it is that the patient in a mental hospital is someone very different from himself; that he is someone very foolish or very dangerous, and he has a general notion that a mental hospital is merely a place where these extraordinary folk are collected to prevent them doing any harm to the "ordinary" citizen.

The psychologist Ernest Beaglehole also acknowledged the existence of negative social attitudes towards mental illness in New Zealand. In particular he spoke of derogatory joking about "loonies" and "asylums", and of public reaction to the 'manpowering' of young women into mental hospitals during the war.

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6 Ibid., p.594.
8 T.G.Gray, The Very Error of the Moon, Devon, 1959, p.67.
9 E. Beaglehole, Mental Health in New Zealand, Wellington, 1950, p.4.
such joking is impossible to analyse quantitatively or qualitatively, the drastic staff shortages afflicting the nation’s mental hospital throughout the period are indeed suggestive of apathy at best, fear and revulsion at worst. The Department of Mental Hospitals’ annual reports to government repeatedly made this connection between staff shortages and negative public attitudes. In January 1946 New Zealand Truth printed a letter from ‘Father of Five Children’, which provides some insight into public feeling on the issue. “Where is the Freedom from Fear when women are ordered into jobs of which they are terrified?” the irate father asked, “[w]hy is there all this shortage of mental nurses? Is it that our mental population is growing alarmingly?” His comments allude to the existence of a widespread fear of mental hospitals and the inmates they contained, and reveal a fiercely held belief that members of the world of reason should not be forced to confront the terror of madness.

A further measure of society’s unwillingness to accept the mentally ill is the extreme difficulty of reintegrating ex-mental patients into the community during the 1940s and 1950s. The available evidence suggests that the move was often made extraordinarily difficult by the abandonment of friends and the prejudice of strangers. The attitudes of employers are also important to consider because of the extreme power they exerted over ex-patients’ social and economic status. A 1955 British study on employers and mental illness found that the commonly held assumption that job applicants with a history of mental illness were discriminated against was not based on actual practice. In contrast Olshansky, Grob and Malamuds’ survey of Boston employers’ attitudes toward ex-patients indicated the existence of widespread prejudice against hiring people

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with a previous mental illness. The 200 subjects expressed an enormous amount of anxiety over the prospect of hiring an ex-mental patient, and were most concerned about the possibility of violent and destructive tendencies, bizarre behaviour, and the need for close supervision. As a general policy, 75 per cent claimed to be willing to hire ex-mental patients, but in practice only 13 per cent had ever knowingly done so.14 No equivalent studies were conducted in New Zealand during the 1940s and 1950s, but some slightly later ones can be considered. J. R. MacDonald’s 1968 study of the employment prospects of schizophrenic patients in Dunedin identified a universal drop in employment status after a period of hospitalisation. In no case was there an improvement in the subject’s socio-economic status, and in only one case was pre-hospitalisation status maintained.15 A more general survey of public attitudes conducted in 1970 confirmed the widespread existence of misgivings about the possibility of hiring a mentally ill person. And a series of interviews conducted in Dunedin in 1963 established that on the whole ex-patients were “considered to be unpredictable, to have character weaknesses, and probably should not be trusted” by prospective employers.16 By excluding ex-mental patients from economic success, New Zealand employers signalled an unwillingness to tolerate contact between the worlds of madness and reason, let alone accept movement between the two worlds.

The surprisingly limited extent of church involvement with the mentally ill during the 1940s and 1950s is also a useful indication of wider public attitudes. Apart from Sunday services, no significant attempt was made by clergy or lay representatives of the church to minister to patients’ physical, emotional, or

spiritual needs. In her 1957 study P. M. Buckfield found no evidence of intercessory prayer groups for the mentally ill, and in relation to Seacliff asserted that “it is unknown for the priests to bless a patient in ward two’s dirty day room”. At a meeting of the Dunedin Presbytery in 1947 a resolution was passed expressing “deep concern over the conditions at Seacliff Hospital”. To a large extent, however, the concern was focused on the conditions for psychiatric nurses. “Personally, I would hate to live as the nurses have to live at Waitati”, declared the Reverend L. B. Wilson, “At present they have their meals with the patients”. His horror at the mingling of staff and inmates in a social situation indicates a deep unwillingness to consider mental patients as equals deserving of social respect and acceptance. The church as a whole cannot be judged on the basis of one clergyman, but the lack of practical assistance afforded mental hospitals, and the apparent unconcern for patients suggests that the negative stereotypes which dominated public attitudes towards the mentally ill also prevailed in the church. Informed by a discourse of difference and held back by fear, both the clergy and the vast majority of ordinary citizens refrained completely from any form of contact with the world of madness.

While the predominant response to mental illness in the 1940s and 1950s was fear and rejection, an important distinction was drawn between nervous complaints and major psychotic disorders. A 1959 World Health Organisation report suggested an international tendency to divide mental patients into “those who should be shut up” and “those who are not really mad”, with the former viewed much less favourably than the latter. Nunnally confirmed the existence of this distinction in the minds of the American public: although both neurotics and psychotics were viewed negatively, psychotics were seen as more

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19 Ibid.
dangerous, and neurotics as “more weak and delicate”. The same patterned response to different types of mental illness existed in New Zealand society. “To have a nervous breakdown is almost respectable, although to be called insane is not” wrote one observer of New Zealanders’ social attitudes to mental illness in the 1950s. Blake-Palmer agreed that the majority of the population distinguished between ‘madness’ and ‘nervous disorders’, and asserted that people with ‘nervous illnesses’ were in fact free from both stigma and responsibility. While the degree of social acceptance experienced by sufferers of mild mental disorders is certainly debatable, it seems that negative public attitudes focused to a large extent on the more severely affected sufferers, in New Zealand, as elsewhere.

War also influenced public attitudes. Mental illness incurred while defending the nation was seen as far more socially acceptable than either psychotic or neurotic conditions attributed to other causes. Speaking of the First World War, Primrose writes that the “committal of shell-shock cases to mental hospitals forced the public to consider an unpalatable fact it had long tried to ignore - the presence of mental illness in the community”. The Second World War had a similar effect, giving rise to a “quickened interest in New Zealand in psychiatry” and the expression of public sympathy for the victims of war neurosis. But although the war brought the issue of mental illness to the fore, it did not bring about major changes in public attitudes. Sympathy was extended only to ex-servicemen, and the division between madness and reason was heightened by public objections to their incarceration in the separate world of the mental hospital.

21 Nunnally, p.46.
22 K. R. Stallworthy, The Facts of Mental Health and Illness, 3rd edition, Christchurch, 1961, p.120.
23 Blake-Palmer, p.8.
Despite a dearth of source material, it seems reasonable to conclude that between 1945 and 1955 the New Zealand public exhibited strongly negative attitudes towards the mentally ill and employed a range of tactics to constrain their participation in the community. Derogatory language and stereotypes were used to describe mental hospitals and their inmates, fierce resistance was sustained to the idea of ordinary citizens working in mental hospitals, and ex-patients were consistently denied opportunities for economic and social advancement. Less stigma was attached to the sufferers of depressive illnesses and to returned servicemen, but although these differentiations lessened the social marginalisation of some, they also served to emphasise the isolation of the more seriously disturbed, and so reinforced the distinction between the worlds of madness and reason.

A number of different motivations have been discussed in relation to society’s rejection of the mentally ill. Sociologist Agnes Miles bases her argument on the notion that health is one of the most important social values in most cultures, and that ill-health, particularly mental ill-health, “represents undesirable things such as suffering and the lack of ability to achieve success and to enjoy life”. She postulates that the negative social values attached to mental illness have stimulated the development of a stereotype of madness which is learned early in childhood and reaffirmed by the media and everyday discourse. While Miles’ thesis is logical and simple, it fails to address the issue of why mental illness in particular has consistently been evaluated far more negatively than physical illness. The Cummings’ argument that rejection of the mentally ill is a way of ensuring the “solidarity of the sane”, is likewise convincing, but lacking in depth. Attention needs to be paid to the more basic

27 Ibid., pp.63-64.
28 Cumming, p.127.
idea that the public is afraid of mental illness. Mentally ill people can indeed be frightening; they often behave in strange and alarming ways, and are sometimes unpredictable and dangerous. Yet the degree of fear and antipathy felt by the mid-twentieth century New Zealand public (and many other societies across time and space), can not be fully justified by reference to the small proportion of violent and uncontrollable madmen and women. Coetzee’s analysis of racism in South Africa provides a helpful mechanism for explaining the spread of irrational fears in a community. He likens racism to a contagion which spreads through a social body already susceptible because of the attitudes and discourse in which it is immersed.\(^{29}\) But as with researchers investigating social attitudes towards mental illness, Coetzee seems at a loss to pinpoint the initial site of infection, to identify the original upsurge of fear. Some have postulated difference - between the African and European worlds, between the worlds of madness and reason - as the key to understanding fear and prejudice. Difference certainly poses a threat to society’s seen of balance, order and normality, but in itself is an unsatisfactory model for explaining the depth of public hostility towards the mentally ill. Foucault would argue that fear of madness is the reflection of a deeper fear of self disintegration.\(^{30}\) When we see others behaving in strange, uncontrolled ways, we react not only by rejecting their difference, but by displacing our own fear of losing control upon them. Perhaps it is both fear of difference, and recognition of our own potential to become ‘different’, which produces such a severe and deeply ingrained reaction to madness. The aetiology of public stigma is certainly both fascinating and enigmatic, but for the purposes of this study it is most important to acknowledge that a justifiable basis for fear of the mentally ill exists, and that over centuries, that fear has been sustained, nurtured and amplified, and acquired a life of its own.


In spite of the powerful stereotypes dominating public attitudes towards mental illness in mid-twentieth century New Zealand, there is also compelling evidence to suggest that a marked improvement occurred between 1945 and 1955. The Department of Mental Hospitals used two statistical tests to measure public attitudes. First, the ever increasing proportion of voluntary boarders in mental hospitals, as shown in the table below, was cited as strong evidence of the public’s increasing willingness to seek early treatment. In turn, this willingness was interpreted as a reflection of the public’s better understanding of mental hospitals, and of their growing faith in the efficacy of psychiatric treatments.31

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Second, the similarly rising proportion of readmissions was seen as further proof of increasing public confidence in mental hospitals, and of decreasing social stigmatisation of mental illness.33 Other more qualitative indications of improving public attitudes were also discussed in official reports. Of most significance was the increased demand for extra-mural psychiatric services, including out-patients clinics, lectures on mental hygiene, and reports for the

32 Note: two different figures for ‘total admissions’ were given from 1951 - 1955. For the sake of consistency I have used the figures given in the table ‘Admissions, Readmissions, and Deaths …’ for each year from 1945 through to 1955.
Child Welfare Department, Courts of Justice, prisons, and private practitioners. The Director of the Division of mental Hospitals identified several reasons for this increasing public interest and acceptance in his 1955 report. The more open nature of the new mental hospitals was seen as important, as were improved discharge rates resulting from modern treatments, the publicity gained in recruitment campaigns and tours of inspection by journalists, and the community work conducted by psychiatrists. So while society in general refused to accept the mentally ill within the world of reason during the 1940s and 1950s, the period did witness heightened interest in mental health and increasing tolerance of movement between the worlds of madness and reason.

Analysis of newspaper comment on mental illness between 1945 and 1955 also reveals the existence of sympathetic and accepting attitudes in some sections of the New Zealand public. Discussion of the media in any attempt to evaluate public opinion is an awkward task. For while they reflect the attitudes of society to some extent, newspaper editors and reporters also exert a very powerful influence on the formation of those attitudes. In light of this dual role, it is appropriate to consider the attitude of the New Zealand media to mental illness somewhat separately from broader public opinion.

Despite the potential for sensationalism presented by the drastic staff shortages and overcrowding which affected the Dominion’s mental hospitals during this period, mainstream newspapers maintained a positive approach to the work of the Department. Coverage was accorded the problems facing mental hospitals, but such reports were usually limited to bare and factual accounts of the situation. In any more substantial pieces, press sympathy obviously lay with

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34 This increased demand was noted frequently in the annual reports of the Director-general of mental hospitals. For example: AJHR, 1951, vol.3, H-31, p.17.
the government. In response to a letter to the editor criticising conditions at Seacliff, the *Otago Daily Times* lashed out at the dangers of public discussion on mental hospitals, which tended "to over-emphasise so-called facts, or else to distort hopelessly what may usually be assumed to be well-meaning efforts to secure reforms".\(^37\) In a 1956 article entitled 'Health Minister Impressed With Progress In Treatment of Mental Patients' a similar stance was taken, and in the same year the *Evening Star* published an almost laudatory account of a tour of Seacliff Mental Hospital.\(^38\)

A similarly positive attitude was also conveyed in regard to the patients of mental institutions. In 1945 the *New Zealand Listener* remonstrated against the public ignorance and prejudice reflected in nationwide staff shortages. "That this prejudice should not exist is obvious", claimed the *Listener*, "[t]he only difference between a general and a mental hospital is that one applies curative measures to the body and the other to the brain".\(^39\) A 1956 *Otago Daily Times* article expressed similar sentiments and added that "mental illness, like any other, strikes irrespective of social standing".\(^40\) Describing one of the female wards at Seacliff Hospital, the *Evening Star* reported that the "patients enjoying morning tea could just as easily have been guests in a hotel lounge".\(^41\) After visiting the newly opened Cherry Farm the *Star* confidently asserted that it also possessed "a very normal atmosphere".\(^42\)

In addition to conveying a generally positive attitude towards mental hospitals and their inmates, the New Zealand media during the 1940s and 1950s assumed the active role of public educator. In June 1945 the *Listener* published

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\(^37\) *Otago Daily Times*, 12 August, 1944, p.7.

\(^38\) Ibid., 24 November, 1956, p.5; *Evening Star*, August 11, 1956, p.8.


\(^40\) *Otago Daily Times*, 13 November, 1956, p.19.

\(^41\) *Evening Star*, 11 August, 1956, p.8.

\(^42\) Ibid.
an article on the newly available electric shock treatment. A very positive account was given of its success, and enthusiastic mention was also made of occupational therapy. On more general developments in psychiatry, the *Listener* was similarly optimistic:

The application of psychiatric treatment has gone ahead rapidly in recent years. It is a special branch of medical science, dealing with the causes, symptoms, and course of treatment of disorders of the mind. Its ultimate aim is to find the best means of promoting normal thought and action. In all our hospitals research work goes on continuously and the results are encouraging.43

In January 1951 the *Otago Daily Times* summarised the contents of the Director-general’s annual report and also gave an extensive summary and review of Ernest Beaglehole’s recently published *Mental Health in New Zealand*. The article acknowledged that some of Dr. Beaglehole’s suggestions were controversial in nature, but suggested “that it is time that such controversy was stimulated in the hope that thereby might be brought about some much-needed progress in the approach to a very serious problem”.44 The overwhelmingly positive *Evening Star* report of conditions at Seaciff in 1956 also possesses a strong educational focus. A minutely detailed description is given of the institution, its environment, practices, and procedures, and an attempt is made to debunk negative public images of mental hospitals.45 Later articles, including ‘Cherry Farm’s Approach to Mentally Ill ‘Advanced” published in 1957, and ‘Full Use in New Zealand of Mental ‘Open Wards’” in 1958, indicate that this focus was maintained beyond the period in question.46 Although total integration between the worlds of madness and reason was certainly never on the agenda in the 1940s and 1950s, these consistent efforts to raise public awareness and reduce stigmatisation indicate a strong thread of sympathy for the mentally ill in some quarters. The media seemed to envisage an improved social position for mental

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44 *Otago Daily Times*, 9 January, 1951, p.4.
hospital patients and ex-patients, but still believed that the appropriate venue for care of most mental illnesses was the separate world of the mental hospital.

While the mainstream press maintained a positive approach to mental illness, and even made attempts to improve the negative attitudes of the wider public, the New Zealand Truth succumbed to sensationalism. Rather than minimalising the problems prevalent in mental hospitals, Truth announced in bold print "Ward Enough to Make Patients Certifiable" and promised "Grim Disclosures" about alleged maltreatment of mental patients.47 Even in a more positive piece entitled "New Hope for Mentally Afflicted - Electric Shock Treatment", the same sensationalism was present.48 This tendency is probably more an indication of the type of newspaper it was than of any underlying negative attitude. In the same article on electric shock treatment detailed information about the new treatment was presented in a very positive light: "a boon and a blessing ... it lightened and made more pleasant the duties of the nurses and gave hope to the withdrawn".49 A number of similarly informative pieces were printed during the period, the most sympathetic of which were related to war neurosis.50 On the whole then, the spectrum of newspapers surveyed assumed a largely positive approach towards mental illness, and took an active role in educating the public about new treatments, about the conditions in mental hospitals, and about the deleterious effects of attaching social stigma to mental patients.

In addition to the media, several other groups within the broader public attempted to influence popular attitudes towards the mentally ill. Most notorious during the period was the Auckland Mental Hospital Reform

47 New Zealand Truth, 28 February, 1945, p.9; 24 July, 1946, p.15.
48 Ibid., 14 March, 1945, p.4.
49 Ibid.
50 For example: New Zealand Truth, 31 January, 1945, p.3.
Association. Twice in 1945 the association petitioned government for an investigation into the conditions in mental hospitals and for reorganisation of the Mental Hospital Department.\textsuperscript{51} Their president, Arthur Sainsbury, published a damning critique of New Zealand’s mental hospitals in the following year. \textit{Misery Mansion: Grim Tales of New Zealand Asylums} denounced the existence of low recovery rates and high death rates, and told numerous stories of abuse, most of which appear to be based on hearsay and extrapolation rather than careful collection of evidence:

\begin{quote}
Sitting in the visiting room, I heard a woman say to a woman patient she was visiting: “But what are you here for? There must be something wrong with you or you wouldn’t be here.”

The patient answered without any emotion: “They said I was too quiet. Wasn’t taking enough interest in things.”

For that they had put her into the place where insanity develops. We could hear the maniacal shrieks and laughter of those who were already finished products.\textsuperscript{52}
\end{quote}

He was contemptuous of the positive statements made by the government and the media, asserting that talk of “kindly nurses, skilled psychiatrists, wonderful psychotherapy” was purely “eye-wash”.\textsuperscript{53} But in contrast with the general public abhorrence of both mental hospitals and mental patients, Sainsbury was strongly supportive of the inmates incarcerated in these institutions. “They are our fellow citizens having the life of German forced labour camps”, he expostulated, “[l]et us stop cherishing the idea that every mental patient is a fearful monster”.\textsuperscript{54} In accord with the public tendency to distinguish between the ‘nervy’ and the ‘mad’, Sainsbury seemed most concerned with the plight of the less seriously afflicted. He sensationalised the possibility of ‘dangerous’ patients abusing the more delicate of their number, and in his proposals for reform remarked that “Criminal and other special patients will need special consideration”.\textsuperscript{55}

\textsuperscript{52} Ibid., p.12.
\textsuperscript{53} Ibid., pp.7-8.
\textsuperscript{54} Ibid., pp.13-14, 19.
\textsuperscript{55} Ibid., pp.16,4.
The sensationalism which characterises Sainsbury’s writing is also apparent in the title of his book and the illustration which graces its front cover.


The specific changes sought in relation to the care of those judged 'non-dangerous' were citizen control of mental hospitals through elected boards, and replacement of large institutions with small 100 bed “recovery houses” located within urban areas, and operating on the principle of maximum freedom.56 Both suggestions are indicative of a belief that the public held responsibility for safeguarding the rights of less fortunate citizens, and of a very real desire to promote greater social acceptance of the mentally ill. The Auckland Mental Hospital Reform Association seemed genuinely committed to obtaining social respect and acceptance for the mentally ill. Further, they believed that the

56 Ibid., pp.3-4.
majority of patients currently cared for in mental hospitals should be treated within the community, suggesting that desegregation between the worlds of madness and reason was their ultimate goal.

Women's groups also participated actively in the attempt to improve conditions for mentally ill patients inside and outside the hospital. In Wellington, the Women's Service Guild petitioned government for the establishment of locally elected boards of control for mental hospitals. The National Council of Women had expressed concern for patients in mental hospitals as early as 1901, and passed several relevant resolutions during the 1940s and 1950s. In 1944 a decision was made to draw the government's attention to the potential of psychotherapy as a method of treating mental illness. The Council urged that overseas psychotherapists be brought to New Zealand, and that local doctors should also be trained in the technique. In the same year pressure was placed on the government to reform the administration of mental hospitals in favour of elected Mental Hospital Boards. Nearly a decade passed before the next major resolution was passed expressing concern at the high incidence of mental illness in New Zealand, and asking the Division of Mental Hygiene "to advise if the N. C. W. can help to remove any of the causes". In 1958 the government was asked to increase the proportion of funds available to the Division of Mental Hygiene, and the Council's members were urged to lend full support to the newly established Mental Health Associations. While these two groups of organised women were not solely dedicated to mental hospital reform as in the case of the Auckland Mental Hospital Reform Association, the evidence suggests that it did feature as a significant item of concern. Their

57 Ibid., p.6.
59 Ibid.
60 Ibid.
61 Ibid.
resolutions indicate a belief that the mentally ill deserved care and treatment in a therapeutic environment, and suggest a willingness to actively participate in working for change in the hospital system. Ultimately, however, the mentally ill were still regarded as essentially different and a policy of segregation was upheld.

The three community organisations mentioned so far may be appropriately classed as 'pressure groups' or even 'advocacy groups'. Another group within the general social body also saw itself as fulfilling an advocacy function, but was more concerned with the day to day care of the mentally ill than with achieving political change. In Otago, the Patients' and Prisoners' Aid Society had been connected with Seacliff since the 1870s. Although their link was terminated in 1953, the 1940s and early 1950s appear to have been periods of intense involvement. In his annual report for 1950, the society's agent, Alex Steven, described the services they had provided during that year. Society members were involved in supplying the hospital with reading material, taking patients on excursions into the city and to the Winter and Summer Shows. They also arranged various entertainments for patients at the hospital itself including visits from various choirs and bands. At Christmas time the Society assumed responsibility for decorating the hospital buildings and providing patients with gifts and "all kinds of extras for the festive season". Regular assistance was provided in Seacliff's occupational therapy department, and the Society took responsibility for assisting the reintegration of probation patients back into the community. Further involvement consisted of organising Sunday church services and visiting patients on a regular basis. The members of the Patients' and Prisoners' Aid Society who participated in these activities had obviously conquered the fear of mental illness prevalent in wider society. They were willing to engage in contact with the world of madness at a personal level, and

62 Annual Report and Balance Sheet of the Patients' and Prisoners' Aid Society of Otago, Dunedin, 1951, pp.5.
63 Ibid., pp.4-6.
made attempts to encourage contact between hospital and community at a more general level also.

These few specific interest groups undoubtedly pursued their work with vigour and enthusiasm and provided much solace to the suffering. As a proportion of the New Zealand population, however, they appear relatively insignificant. The majority of ordinary citizens avoided any form of contact with the mentally ill, and seem to have been relatively unconcerned about the conditions in which they were cared for. Speaking in terms of the contagion theory, New Zealand between 1945 and 1955 can be described as a thoroughly infected social body. Language and lack of action were the primary tools by which communities revealed antipathy for the mentally ill and expressed unwillingness to accept them into the world of reason. Yet the period was also characterised by increasing interest in mental health, and the media and other interest groups made sustained attempts to promote contact between the mental hospital and the community. Integration of the mental hospital into society remained an incomprehensible prospect for the majority of New Zealanders, but throughout the period more and more concerned members of the public were beginning to recognise the existence of the world of madness, and to encourage the development of closer relations between that world and their own.
4. PARENTS, SIBLINGS, PARTNERS & CHILDREN: ACCEPTING OR REJECTING MENTAL ILLNESS WITHIN THE FAMILY?

In unconscious collusion with the medical profession and the general public, New Zealanders with family members in mental hospitals contributed to the maintenance of an inferior social position for the mentally ill. Strategies of denial and concealment, a general reluctance to visit or to receive patients back into the home, and relegation of ex-patients to a subordinate position within the family indicate an unwillingness to challenge existing social relationships. A small minority did reject society's negative attitude towards the mentally ill, but in general, the relatives of New Zealand's psychiatric inmates accepted and condoned their social marginalisation.

Before analysing familial reactions to mental illness in mid-twentieth century New Zealand, an understanding is required of the impact of psychosis or neurosis upon the family. One of the consequences of recent deinstitutionalisation has been a new focus upon the day to day problems of living with a mentally ill family member. At first glance it might seem that the families of the 1940s and 1950s experienced very few such problems, their disruptive members conveniently confined in psychiatric institutions. We must remember, however, that some families did resist incarceration, and that the spiral towards madness which preceded hospitalisation nearly always took place in the home. Moreover, while most might not have to deal with the presence of mental illness in the home on a daily basis, they were certainly forced to make major readjustments. The absence of a father, for example, threatened the family's economic security, while the absence of a mother was likely to throw the management of the entire household into chaos. As Terkelsen notes, every household function which the patient ceased to perform had to be picked up by
another family member or otherwise remained undone. In addition, new responsibilities had to be worked into the family’s routine. Janet Frame writes of relatives adjusting their lives “to the dictates of bus and train timetable”, and to “long journeys to and from the hospital for visiting hours and interviews with doctors”. The physical isolation of New Zealand’s psychiatric hospitals must have served only to enhance such difficulties.

Far more significant than the practical problems presented by mental illness in the family were the emotional and social repercussions. Again, mid-twentieth century families were generally unlikely to be faced with the roller coaster effects of mental illness on a day to day basis, but still suffered severe emotional consequences. Dramatic changes in the patient, particularly abusiveness or lack of emotional responsiveness, engendered feelings of loss, hurt and bewilderment in family members. Feelings of guilt also contributed to the emotional strain. Sociologists concur that guilt is a common response to mental illness within the family, and that it is closely linked to an assumption of family culpability.

Writing in 1957 Charlotte Schwartz describes three general interpretive frameworks by which families account for the aetiology of mental illness. First, the characterological framework which identifies something in the patient’s character or personality as defective. Second, the somatic framework which sees mental illness as a specific physical impairment, and third, the psychological framework, which attributes the illness to inter-personal causes. All three models were probably adhered to by different New Zealand families, and all had implications for relatives’ attitudes towards the patient and

3 Terkelsen, p.128.
themselves. It is likely, however, that by 1945 the characterological framework was employed less frequently than the somatic or psychological models, both of which presumed a high degree of familial culpability. Dugald McDonald describes the 1940s and 1950s as a period when the New Zealand child was viewed primarily as a psychological phenomenon. Good parenting skills were seen as vital to the production of happy, well-adjusted children; bad parenting, by extension, was blamed for the development of unhappy, maladjusted children.\(^6\)

In such an environment it is safe to assume that guilt and self-blame were major burdens for the parents of the mentally ill - the unhappiest, most maladjusted members of society. While very little hard evidence of family attitudes towards mental illness exists in the New Zealand context, the Cummings' early 1950s Canadian study reported that 66.4% of their large survey “would feel partially responsible if a member of my family had a serious mental breakdown”.\(^7\)

Feelings of guilt are also likely to have stemmed from general mental health policy in the 1940s and 1950s. By removing patients from the home medical professionals prevented families from fulfilling their traditional protective and supportive roles, and in doing so stimulated feelings of inadequacy and guilt. One New Zealand mother whose child was institutionalised in the period still spoke of guilty nightmares in an oral history interview decades later.\(^8\) Her experience is probably not unusual. Terkelsen describes mental illness in a relative as “invariably a disaster for the whole family, a disaster in which all are victims .... No one, and no part of the emotional life of the family escapes unaffected”.\(^9\) While his statement has different connotations in the

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8 May, p.152.
9 Terkelsen, p.128.
deinstitutionalised 1990s it must still be seen as entirely pertinent to the experience of families in 1940s - 1950s New Zealand.

The impact of a mentally ill family member upon social routines and relationships was probably equally severe. Agnes Miles provides a compelling analysis of the manner in which stigma spreads from a stigmatised individual to his or her close associates, particularly to family members.\textsuperscript{10} Although the idea of social marginalisation as a contagious variable failed to arise in my consideration of the general public’s attitude towards mental illness, it undoubtedly influenced the lives of mid-twentieth century New Zealanders. Describing the impact of mental illness upon North American families in the 1940s, one researcher concluded that “children are made to feel at a very early age the social stigma attached to mental illness. They are barred from the neighbourhood play groups or teased and tormented unmercifully”.\textsuperscript{11} Stigmatisation was not a purely external process. By voluntarily reducing their social contacts to avoid embarrassment, relatives unwittingly contributed to their own social isolation. As a young boy growing up in New Zealand in the 1950s, Peter Brown was well aware of the cost his mother’s mental illness posed to the family’s social interactions. In particular, her obsessive compulsive behaviours made it difficult for the young boy to invite friends home from school in the normal manner.\textsuperscript{12} The spread of stigma from patient to family thus created further emotional pressures; feelings of isolation, inferiority and rejection compounding the more general feelings of loss and pain aroused by mental illness in a close family member.

A paucity of local evidence prohibits the formation of specific conclusions about the effects of mental illness upon families in 1940s - 1950s New Zealand.

\textsuperscript{10} Miles, pp.130-133.
\textsuperscript{12} Peter Brown, Questionnaire, August 1998. Note: Peter Brown is a pseudonym.
Despite such limitations it seems reasonable to generalise that the practical, emotional and social impact upon parents, siblings, partners, and children, was dramatic.

To understand families' reactions to this impact it is necessary to consider the sociology of the mid-twentieth century New Zealand family more generally. The adults of the period had lived through war and depression, the realities of the Second World War still alarmingly fresh for many. As Olssen and Levesque note, "these people hungered for a period of quiet suburban life".\(^{13}\) In reflection of this desire the postwar family was idealised as a source of "peace and security", "refuge and fulfilment" for both adults and children alike.\(^{14}\) "Managing", writes Helen May, "was about creating an outward appearance of an untroubled and successful family life".\(^{15}\) As a threat to this ideal, the mentally ill, and the sick in general, were not to be tolerated. Olssen and Levesque describe the mid-twentieth century family as "much more nuclear" than its predecessors, including fewer extra kin or lodgers. They argue that "fewer and fewer people, even among the traditionalists, believed that the family should be expected to look after the aged or infirm".\(^{16}\) Perhaps this statement is best qualified by saying that sickness was not seen as something that families should or could deal with. The families of the 1940s and 1950s displayed a seemingly boundless faith in the medical profession; a profession staunchly opposed to the acceptance of illness within the home and dedicated to its treatment outside the home. The period was one in which new mothers were separated not only from their husbands and existing children, but also from their newly arrived infants.\(^{17}\) And the parents of the 1940s and 1950s were allowed only an hour a week in which to visit their

\(^{14}\) May, p.131; Olssen and Levesque, p.18.
\(^{15}\) May, p.155.
\(^{16}\) Olssen and Levescue, p.19.
hospitalised children, no matter how young. The mid-twentieth century New Zealand family's response to mental illness was thus militated by the pressure of maintaining socially constructed ideals, and by the power of a medical profession committed to the separation of the sick from their relatives and from the home environment.

Within this context the most common response of the families of the late 1940s and early 1950s was denial. Charlotte Green's extensive research in the 1950s led her to conclude that the process of interpreting "problematic" behaviour in others is strongly influenced by the interpreter's social and emotional closeness to the person whose behaviour is under consideration. She argues that the closer the relationship, the more inclined is the interpreter to avoid labels like deviance or mental illness in his or her effort to explain "problematic" behaviour. Her sensible thesis is borne out by a study of wives' attitudes towards their hospitalised husbands. Green found that although they inevitably believed something to be wrong with their husbands, the 20 wives interviewed were reluctant to accept mental illness as the cause. Charles Rose's study of mental illness and family reactions in Massachusetts in the mid 1950s lent support to Green's conclusions. In his sample of 100 relatives he found a striking tendency to "deny the existence of mental symptoms" in hospitalised family members. Furthermore, he noted that "relatives who were not closely related or involved with patients" exhibited a greater "willingness to consider psychological factors". While no such research was ever conducted in New Zealand, two small clues indicate that the same pattern of denial occurred here also. First, The Facts of Mental Health and Illness, published in Christchurch in 1956, noted a...

19 Schwartz, p.277.
20 Ibid., pp.276-279.
21 C. Rose, 'Relatives' Attitudes and Mental Hospitalisation', in Mental Hygiene, 43, 2, 1959, p.200.
22 Ibid., p.201.
tendency in New Zealanders to talk of their hospitalised relatives as suffering from nervous breakdown, even in the most extreme cases of insanity. Second, Janet Frame's autobiography and fiction describe one particular family's strategy of denial. On returning from six weeks in Seacliff Frame found her parents and siblings eager to distance her from the other patients and from the hospital itself:

Mother, characteristically, began to deny everything. I was a happy person, she said. There must have been some mistake. I found that everyone was pleased when I treated the matter as a joke, talking of amusing incidents at the 'country estate'.

The same theme appears again in *Faces in the Water*:

The family talked jokingly of my having been in the 'nuthouse', and I gave them what they seemed to want - amusing descriptions of patients whose symptoms corresponded to the popular idea of the insane; and I described myself, as if, by misfortune, I had been put among people who, unlike myself, were truly ill.

The unconscious denial of relatives' mental illnesses had important ramifications for social relationships. By refusing to acknowledge to themselves the presence or seriousness of psychiatric disturbance in their midst, families condoned public fears and reinforced the social marginalisation of mentally ill New Zealanders.

Whereas denial was a largely unconscious mechanism for dealing with mental illness in the family, the strategies of concealment adopted by many mid-twentieth century New Zealand families were deliberate. A 1960 survey of general attitudes towards mental illness in Dunedin found that over 50 per cent of respondents would try to hide their relative's consultation with a psychiatrist to some degree. While there is no specific evidence for the period under question, three studies conducted in Dunedin in the 1960s contain interviews with parents of mentally ill children. All three describe a range of different

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responses, from complete openness to careful and thorough concealment. In some cases knowledge of the illness was withheld from other family members, particularly from young children. Peter Brown’s mother and father both refused to discuss the issue: “it was kept secret and the younger family members usually fobbed off when they tried to question the details”. In *Faces in the Water* Istina’s mother sees her daughter’s illness “as something to be ashamed of, to be hushed up, to be denied if necessary”. And in *Owls Do Cry* Daphne’s father is painfully eager to conceal his visit to a mental hospital: “Sh-sh, not so loud, said Bob, looking around secretively. We don’t want the whole world to know where we’re going and what’s happening”. In general, it seems that families were wary about the dissemination of information pertaining to a mentally ill relative, confiding only in other family members or close and trusted friends. They were motivated by two concerns. First, they recognised the threat stigmatisation posed to the patient’s future, and second, were afraid of the social consequences for other family members. Their tactics were unhelpful, however, in mitigating the social position of the mentally ill. By concealing mental illness within their ranks, families ostensibly sanctioned the public’s negative image of psychiatric inmates and condoned their social exclusion.

The degree of family contact with the psychiatric hospital is a further measure of families’ willingness to accept the peripheral social position assigned to their mentally ill relatives by the public and the medical profession. Contact could be made between family and patient in the forms of personal visits, parcels, or letters. Again I find myself restricted by a lack of local evidence, and must rely

28 Ibid.
30 Frame, *Faces*, p.56.
32 Wilson, p.42; Fitchett, pp.8-9.
largely on overseas studies to gain a general idea of how frequently relatives utilised these different forms of contact. Rawnsley, Loudon, and Miles’ comprehensive survey of relatives in South Wales found that 28 per cent of the 230 patients under consideration had not been visited in over a year. Married patients were visited more frequently, and long term patients received less frequent visits as the length of their incarceration wore on.33 Rose’s Massachusetts’ study likewise found that prolonged hospitalisation was directly related to a decline in family visits. Differing slightly in focus, he also conducted an interesting analysis of the commitment of different family members to visitation. The mother emerged as the most common and the most frequent principal visitor, 57 per cent visiting their child at least twice a month. Sisters were the second most common principal visitor, while fathers were the principal visitor in fewer cases, but when they were, showed a stronger commitment to visitation. Wives visited the hospital more frequently than sisters or brothers, but surprisingly, less frequently than either mothers or fathers.34 Despite the accessible location of the hospital concerned, Rose found that only 22 per cent of his 180 strong sample had relatives who visited at least twice a month. While figures are unavailable for New Zealand, it is possible to speculate that visiting rates were equally low, and likely to have been further lowered by the physical isolation of many of New Zealand’s psychiatric institutions. Caroline Hubbard cites convincing evidence to suggest that many Seacliff and Ashburn Hall patients “were left unvisited and uncared for” during the period 1883 - 1911.35 In 1893 an ex-attendant claimed that 70 per cent of Seacliff patients received no visitors at all.36 For the period 1945 - 1955 we have only P. M. Buckfield’s assertion that a “fair proportion” of patients were never visited, and Janet

34 Rose, p.197.
36 Ibid.
Frame's literature. Frame describes the same pattern as Rose and Rawnsley et al.; families gradually ceasing to visit as the patient's confinement dragged on, eventually responding "only to the annual prodding of Christmas". In more general terms, her autobiography and fictitious works convey something of the family's sense of distance and detachment from New Zealand mental hospitals. Despite the unavailability of New Zealand sources, anecdotal evidence such as Frame's, and the statistical enquiries of overseas researchers suggest that New Zealand families maintained a minimal degree of contact with their hospitalised relatives. Again, their actions reinforced existing social dynamics. By treating the hospital as a separate and inferior world families exhibited the same unwillingness to accept mental illness in the world of reason as the wider New Zealand public. In doing so they condoned, and actively participated in, the social marginalisation of their family members.

Even more significant than family visiting patterns is the reluctance many relatives showed towards accepting patients back into the home. Rawnsley et. al. found that only 60 per cent of patients in their study could rely upon their families to accommodate them upon discharge. The rate declined in direct relationship to the patient's length of confinement. Rose did no quantitative analysis, but describes relatives as generally wary and resistant to the idea of their family member returning home, particularly in the case of long term patients. In addition he notes a tendency to lavish praise upon the hospital. Relatives who regarded the hospital as beneficent and its doctors as authoritative were relieved of responsibility for their patient's well-being. Rose further suggests that such tactics were designed to avoid disturbing the status quo, so as to ensure the

38 Frame, Faces, p.123.
39 For example:Frame, Angel, p.97; Frame, Owls, pp.71,94.
40 Rawnsley et al., p.9.
41 Rose, pp.201-202.
patient's continued confinement within the hospital. Chick's description of her sister's hospital fits nicely into such an analysis: "the grounds are full of flowers with wide lawns and neatly kept paths so that the place seems a paradise for the poor deranged folk. No doubt they are happier there than in the outside world". As hospital records gradually become available it will be possible to ascertain the extent to which New Zealand families accepted ex-patients back into the home. In the meantime, we can only assume that a degree of wariness existed, again reflecting relatives' adherence to the rigid social boundary between madness and reason.

Families were also the primary instigators of their relatives' removal to the separate world of the mental hospital. Without access to patient records for the 1940s and 1950s it is impossible to quantify such a statement precisely, but Judith Holloway's analysis of 230 Seacliff between 1928 and 1937 offers a useful point of reference. She found that over two thirds of male admissions and over 90 percent of female admissions were initiated from within the home. Within the context of mid-twentieth century ideals about family life and the medical model of hospitalisation it seems unlikely that the figures had altered drastically by the late 1940s and early 1950s. While it could be argued that committal forms the most overt indication of familial rejection, it is necessary to reflect on the enormous practical, emotional and social problems posed by the presence of mental illness within the home. Institutionalisation was not only presented by government policy and the medical profession as the only option for mentally ill New Zealanders; for many families it was literally the only means of ensuring the patient's safety and the survival of the family. The role of families in committing their mentally ill relatives should not be interpreted as evidence of

42 Ibid., pp.198-199.
43 Frame, Owls, p.104.
total rejection. Considered together with other patterns of behaviour, however, it did confirm the public’s vision of the mentally ill as members of a separate world frightening enough even to be excluded from their own families.

The manner in which families related to ex-patients within the home is also a significant indication of their attitude towards mental illness. In *An Angel at my Table* Janet Frame makes specific reference to the changes in family dynamics wrought by her hospitalisation. She describes “the new tone used now by Dad and Bruddie when they spoke to me, as if I had to be ‘managed’ in some way, for fear I should break or respond in an unusual way which they could not deal with”.45 Not only is a new tone employed, but her family completely avoids discussing “serious” matters with their “frail, mad” daughter and sister.46 Particularly hurtful is her mother’s refusal to share the intimate secrets of “marriage and bed and birth” so willingly disclosed to Janet’s younger sister.47 In effect, the family relegate Janet to an inferior social position, treating her once again as a child. Her father in particular is anxious that she should never leave home again, and goes to great lengths to establish her position as a permanent dependent within the family home. While accepting Janet within the home and expressing love and compassion towards her, the family’s behaviour effectively mirrored society’s social marginalisation of the mentally ill. Just as strategies of denial, concealment, avoidance, and outright rejection reinforced the inferior social status of mentally ill New Zealanders, this tendency to undermine the sufferer’s social position within the home compounded his or her social position within the community.

Not all families behaved in the same ways. Some were forthright and open about their relatives’ illnesses, vehemently rejecting popular

45 Frame, *Angel*, pp.79, 121.
46 Ibid., pp.70-71.
47 Ibid., pp.77, 85.
conceptions of madness. A few rejected the government endorsed and medically enforced model of institutionalisation. In most cases, however, the practical, emotional and social strains created by the event of mental illness in the family took up all its coping resources. Parents, siblings, partners, and children must be seen as members of the world of reason striving to achieve the ideal of the family as repository of individual and communal happiness. As a major threat to this ideal mental illness was viewed with fear and abhorrence. Yet families still loved their mentally ill relatives, and had great trouble in resolving the apparent contradiction. They responded with inaction, for the most part accepting, and expecting the social marginalisation of their hospitalised relatives. But while families certainly did not engage in an active programme of exclusion, their attitudes and behaviour achieved the same effect. Their unconscious denial of mental illness, deliberate attempts to conceal relatives' hospitalisation, avoidance of contact with mental hospitals, wariness of patients' returning home, altered behaviour towards ex-patients, and key role as the primary instigator's of committal all combined to reinforce society's negative image of mental illness and the alienation of its victims.
5. PATIENTS AND EX-PATIENTS: ACTIVE PARTICIPANTS IN THE CREATION OF A SEPARATE WORLD

We need to listen to what the mad said. Not because therein lies the key to their diagnosis, or the secret, silenced truth of the history of psychiatry; but because they participated in a dialogue definitional of normalcy and craziness.¹

In studying the social position of the mentally ill in mid-twentieth century New Zealand, Roy Porter’s words are of vital significance. Together with the medical profession, the public, government policy, and families, patients themselves were active participants in the negotiation of social boundaries between the worlds of madness and reason. From our late twentieth century vantage point we are inclined to expect the disadvantaged to stand up for themselves, to reject the negative images held by the public, and negotiate the formation of more positive attitudes. But just as mid-twentieth century families renounced all association with the world of madness and condoned the social marginalisation of their mentally ill relatives, so patients and ex-patients actually contributed to the maintenance of the rigid boundary between themselves and the outside world. The strategies by which they did so were threefold. First, patients and ex-patients, and Janet Frame in particular, consistently spoke of themselves as members of a separate world. Second, their words were reflected by behaviour which connoted the existence of the mental hospital as an autonomous country largely free from the interference of foreign lands. Third, on returning home, ex-patients showed sympathy and loyalty to their incarcerated friends, but hastened to distance themselves from the world of madness in a bid for acceptance in the outside world. Like the families discussed

in chapter four, patients and ex-patients are thus best seen as unwilling collaborators whose language and behaviour reinforced a socially created disjunction between madness and reason.

Before turning our attention to analysis of these words and actions it is important to establish the extent and credibility of 'patient texts'. "[T]he mad leave few records", writes New Zealand historian Hilary Haines, "[t]hey are without a voice, and their history comes to us through those who have incarcerated them". Roy Porter takes the opposite position, arguing that "in reality lunacy remained loquacious, a cacophony upon which few have ... eavesdropped". Two such different approaches can best be explained by geographical location, for while Porter is able to quote from numerous first hand accounts of madness written in Britain, Haines is restricted to a purely quantitative analysis of women and madness in New Zealand. Although it is incorrect to suggest that those incarcerated in New Zealand's psychiatric institutions between 1945 and 1955 are completely voiceless, it must be conceded that very few sources exist, and that even fewer are open to public examination.

The most celebrated and articulate voice of the period is undoubtedly Janet Frame's. Much has been written and refuted regarding the status of Frame's literary accounts of madness; they have variously been described as "thinly veiled autobiography", "case-history", and "writing as therapy". For the purposes of this study they are best seen as "documentary fiction", a term derived from the forward to *Faces in the Water* which bypasses questions of autobiography while

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3 Porter, p.346.
4 Psychiatric hospital records have 100, 75, and 50 year embargoes on patient and administrative files.
acknowledging the factual basis of the characters and situations related. Her second volume of autobiography - *An Angel at my Table* - provides historians of madness with a further source by which to gain access to patients' perspectives on life inside the mental hospital. In both fiction and autobiography, then, Janet Frame acts as our guide through the land of mid-twentieth century New Zealand madness. She is aided by the voices of patients and ex-patients who expressed public concern over the conditions in mental hospitals, and by those whose voices were inadvertently preserved in the studies of fifth year medical students.

![Janet Frame](image)

Pictured here in the 1950s, Janet Frame endured nearly a decade of incarceration in New Zealand mental hospitals. Her autobiographical and fictitious writing provides valuable insight into the experience of psychiatric patients in the mid-twentieth century.


The preponderance of Frame's voice requires a recognition that women and men may have manifest mental distress in different forms and experienced incarceration in different ways. The paucity of sources available for the period 1945 - 1955 does not allow me to consider gender as a key point of analysis, however, other than to recognise that female voices preponderate in the words of

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patients, whereas male voices come to the fore in the official sources which reflect medical and governmental policy.\textsuperscript{7}

In assessing various ‘patient’ sources the same critical approach applicable to all historical texts becomes even more important. Works of fiction in particular, must be weeded carefully for historical inaccuracies. A good example from \textit{Faces in the Water} is Frame’s claim that voluntary admission was still not allowed for by the Mental Defectives Act of 1928, when it was actually legislated for in 1911.\textsuperscript{8} Fiction is usually inappropriate as a source of dates, figures, and sequential events. It is more useful, and will be used here, as evidence of real people’s feelings, beliefs, and experiences. The second consideration to be made in dealing with ‘patient texts’ is the mental state of the authors / subjects. A few letters to the editor and transcribed interviews with patients show clear evidence of mental illness and lack of integration. With others it is impossible to judge the degree of psychiatric disturbance. But while some would disagree, I find myself bound to argue that such judgments are neither wise nor necessary. Although mental illness may impair the sufferer’s connection with reality and ability to express his or her self, the texts we have remain valuable as evidence of patient’s feelings, experiences, and beliefs about the psychiatric hospital and the outside world. The author’s/subject’s mental state, is to a large degree, irrelevant.

Having established the paucity of ‘patient texts’ for New Zealand between 1945 and 1955 and considered their value as evidence, we can proceed to investigate patients’ attitudes towards the concept of the mental hospital as a separate world. Even a brief examination of the limited sources available provides strong indications that patients did indeed conceptualise the hospital as

\textsuperscript{7} J. A. Holloway, \textquoteleft\textquoteleft Unfortunate Folk\textquoteright\textquoteright: A Study of the Social Context of Commital to Seaciff Asylum 1928 - 1937\textquoteright, B.A.Hons Long Essay, Otago, 1991. Judith Holloway’s dissertation is entirely structured around the proposition that men and women manifest mental distress in different ways, and are judged as mad for different reasons.

\textsuperscript{8} Ibid., p.43.
separate from the ‘Outside World’, and themselves as citizens of a foreign land. Janet Frame’s literature is heavily imbued with the image of two different worlds orbiting the galaxy side by side, or two different islands. In An Angel at my Table she talks explicitly of herself as an official resident in “the world of the mad”, and of her first six week stay in Seacull as a visit to a “foreign land”, where she learned “much of the language and behaviour of the inhabitants of the land”. The same language pervades Faces in the Water, and is particularly moving in Istina’s description of her shift from one world to another: “I was put in hospital because a great gap opened in the ice floe between myself and the other people whom I watched, with their world, drifting away .... I was not yet civilised; I traded my safety for the glass beads of fantasy”. Communications between her parents and the doctors are described as “diplomatic notes” passed “between distant foreign powers”, and her experiences in various wards as currency “sewn inside my mind” like “the banknotes that you are told to put in small bags and attach to your underclothes when you travel in a foreign land”. The concept of separate worlds also informs Owls Do Cry, and is particularly evident, though never explicitly stated, in the complete disjunction between Chicks’ life as a social climbing housewife in the outside world and Daphne’s incarceration in the lonely world of the mental hospital. Talking specifically of Faces in the Water, Gina Mercer suggests that Frame:

> depicts the hospitals as isolated punitive colonies, subject to, and empowered by, an imperialist culture, but separated from it by walls, locks, and a frightening timelessness. In this context, the women are seen as equivalent to “native” people or children, who fail to comprehend the “proper” values of the colonising culture.

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9 Note: Frame makes the distinction between inner and outer worlds and between the world of the mental hospital and the outside world. The two are different but related, for it is the move from outer to inner world which is unacceptable to the wider community and which leads to her confinement in a series of mental hospitals.


11 Frame, Faces, pp.10-11.

12 Ibid., pp.123,124.


The image holds powerful appeal, conforming to Frame’s vision of separate worlds, and providing a helpful framework for understanding power relations between the worlds of madness and reason.

Other patients in New Zealand psychiatric institutions between 1945 and 1955 also spoke of themselves as members of a separate world. One told a medical researcher that on discharge from hospital he found “the World ... a very frightening place”. In ‘Dream Haven’ Lionel Terry expresses the same sense of dislocation between the worlds of madness and reason, and a longing to return to the outside world:

I’d like to live in a little thatched house,
On a hill by the side of the sea,
In a Land where the truth is respected
And the people are happy and free.
But I’m locked up as mad in a land of fools,
Where whose idols is £. s. d.,
So I’ll dwell in my dreams till they all come true,
And the ugly realities flee!

The diary of Joan Baynes, treated for mental illness in Australia in the early 1960s, also speaks of the psychiatric hospital in such terms: “I’m finding it so hard in our world without the outside world”. An American patient interviewed in 1955 expressed the same sense of complete separation but without the ‘separate worlds’ terminology: “My family write and tell me what they are doing. The truth is I’m not interested. I have been away so long I don’t care what they are doing”.

As well as using language which acknowledged the distance between themselves and wider New Zealand society, psychiatric patients in the 1940s and 1950s behaved in a manner which confirmed their identity as members of a

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16 L. Terry, ‘Dream Haven’, in F. Tod, The History of Seacliff, place of publication unknown, 1971, p.91. Terry was first committed in 1906 and spent time in both Sunnyside and Seacliff until 1952.
separate world. Of most importance were the elaborate patterns of social interaction which governed the mental hospital. Janet Frame describes the various patient populations which she encountered as forming geographically and linguistically exclusive communities.\(^{19}\) Social acceptance was based on a new recruit’s ability to learn “the language and behaviour of the inhabitants of the land”, and a ‘bag of treasures’ was seen as final confirmation of citizenship “in the crazy world”.\(^{20}\) Excluded from participating in social relations with the wider New Zealand community, patients thus established their own criterion for regulating inclusion within the world of the mad.

In addition, patient communities created sophisticated systems for regulating social mobility within the hospital. The status of individual patients was determined not by reference to social relations in the outside world, but by hospital inmates’ own carefully delineated social hierarchy based on length of hospitalisation, institutional responsibilities, relationships with staff, and personal authoritativeness. In the first instance, different wards were attributed varying social status. In *Faces in the Water* members of Ward Four feel themselves to be infinitely superior to those from Ward Two, the disturbed ward: “Were we not the ‘sensibly’ ill who did not yet substitute animal noises for speech or fling our limbs in uncontrolled motion or dissolve into secret silent hilarity?”\(^{21}\) Later, Istina is transferred from Ward Four to Two, and becomes one of the “crazy people ... whom even the people from the observation ward and the convalescent ward looked upon as oddities and loonies”.\(^{22}\) Within wards, meal times constituted a further basis for assigning patients different social status. Frame writes of “a shipboard snobbery about eating”, and presents Istina as proud of the fact that “[o]nly once or twice during my three years’ stay was I put in the

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\(^{19}\) Frame, *Angel*, p.53.
\(^{20}\) Ibid., pp.53-54; Frame, *Faces*, pp.105, 107-108.
\(^{22}\) Ibid., p.186.
dirty dayroom and made to go to first sittings of meals". Those allowed to wait for the second sitting were by implication seen as more trusted and more civilised, accruing significant prestige from the staff imposed division. Ultimately, it is those with full parole who rank most highly on the social ladder. “I had full parole. I was going home”, boasts Istina, distinguishing herself even from the relatively superior members of Ward Four. When a new ward is built “up on the hill, with a wonderful view of the sea ... modern ... open”, the label “Chronic” is enough to turn patients off. To accept and acknowledge that they will always be in hospital is not only emotionally terrifying, but socially injurious.

Ward divisions were not the only indicators of social status. Occupation was also of vital significance, and was closely linked with staff favour. P. M. Buckfield’s 1957 study of Seacliff found that patients relished the opportunity to be part of the trusted group elected to do housework at the nurses’ home. Corlett’s 1949 study provides a more detailed picture of individualised patient tasks at the Auckland Mental Hospital, and of their relationship to social status. In Ward F7 Mrs. W. made the toast in the mornings, while Mrs. J. made the tea and was given responsibility for washing the knives after mealtimes. Miss. Y. was relied on to sweep the locked office and surgery, while Mrs. J. was exempted from all other activities as the ward’s cook. In Ward F3 three Maori patients helped the nurses to dress the more difficult patients, and had privileged access to the locked cupboard containing spoons and plates. In Ward F6, C.B. was trusted with the nurses keys to take washing to and from the laundry, Mrs. L. “reign[ed] in charge of the dayroom”, supervising mealtimes and counting

23 Ibid., p.155.
24 Ibid., p.253.
25 Ibid., p.133.
28 Ibid., p.44.
cutlery, while Mrs C. dressed patients, helped them to the bathroom, and fed bed-patients. Mrs. M. not only helped in the kitchen, but cared for a nine year old hydrocephalus child, and was "as proud and happy as any mother caring for her baby". Patients from Wolfe Home, the convalescent ward, were trusted enough to act as housekeepers for the Medical Officer’s quarters and the Doctor’s home. Speaking more generally of these trusted patients Corlett writes: “There is always someone ready to pick up broken china or a window pane. These patients have a feeling of superiority to those shouting, grabbing food and eating with their hands”. Domestic duties, often menial and unpleasant, thus represented an important avenue for acquiring power over others and improving one’s social position within the hospital community. Goffman argues that

[i]n some establishments the trusty or straw boss of inmate rank is not too far away in function and prerogatives from the lowest staff level, the guards; sometimes in fact, the highest man in the lower stratum has more power and authority than the lowest man in the highest stratum.

While we know little of its applicability to New Zealand mental hospitals in the 1940s and 1950s, Goffman’s observation is both astute and useful, in that it leads us to reflect on the trusted patient’s total commitment to the institution, and on his / her crucial role in the social cohesion and practical functioning of the psychiatric hospital.

Janet Frame’s description of the communities she encountered in mid-twentieth century New Zealand mental hospitals also affirms the importance of staff trust and occupation in securing social status. In Cliffhaven’s Ward Four it is Mrs. Everett and Mrs. Pilling who rule the roost, sharing control of the kitchen.

29 Ibid., pp.57-58.
30 Ibid., p.58.
31 Ibid., p.60.
32 Ibid., p.44.
and responsibility for the fire. Mrs Pilling, “the most trusted patient in the ward” also makes the toast, collects the ward’s bread and milk, and attends to the pig- tin. She has no husband, children, or relatives, and as a mental patient occupies a lowly social position in the eyes of the outside world. Inside the hospital, however, she is accorded great respect by both patients and staff and possesses special privileges and privacy in recognition of this fact. Other trusted patients include Minnie, personal maid to the Matron and trusted with a key to the ward, Molly and Carrie who work at the doctors’ flats, and Miss Dennis whose days are devoted to polishing silver with an air of superiority. Mrs. Hill, or Hillsie, is the mainstay of Ward Seven, cooking, cleaning, and providing nurses with cups of tea from early morning till late at night. Both patients and staff rely on her for the smooth running of their world, and like Mrs. Pilling, she is rewarded with respect and material privileges. Perhaps Frame’s most endearing portraits are those of Dame Mary-Margaret and Alice, “the real commanders” of Ward Two. Alice takes quiet charge of cleaning and polishing, while Mary-Margaret asserts control over the kitchen and more general ward affairs:

How could Sister Bridge help treating Dame Mary-Margaret as an equal, asking her advice (since her own was so frequently ignored), and apologising contritely when Mary-Margaret’s powerful voice began to point out faults in the daily routine? As relatively well and trusted patients Mary-Margaret, Alice, Molly, Minnie, Carrie, Miss Dennis and Mrs. Pilling were parole patients, free to wander as they pleased anywhere in the hospital grounds. This freedom, in combination with their closeness to staff and power over other patients, placed them in a position of social superiority unattainable in the outside world.

34 Frame, Faces, p.35.
35 Ibid., p.36.
36 Ibid., pp.42-43.
37 Ibid., pp.72-73.
38 Ibid., p.141.
39 Ibid., pp.142-143.
The separate social organisation of the mental hospital thus stands as powerful evidence of the manner in which patients saw themselves as members of a separate world. Just as different cultures employ different social scales and categories, so mid-twentieth century hospital inmates subscribed to a different social system than that which governed life for most other New Zealanders. In rejecting the social hierarchies of the outside world patients recognised and reified the complete dislocation between that world and their own.

Awareness of the distance between themselves and the outside world was also evident in other aspects of patients’ behaviour. In particular, they exhibited a striking unwillingness to leave the mental hospital and return to the community. This unwillingness must, of course, be placed in the context of negative public attitudes. As Goffman writes, patients might well find that release meant “moving from the top of a small world to the bottom of a large one”.40 This drastic alteration in social status is poignantly illustrated in the case of Dame Mary-Margaret and Alice, attributed great prestige and privilege within the hospital, yet afraid of the outside world:

Dame Mary-Margaret and Alice were the only ones allowed outside to hang up clothes. But they ventured out cautiously, looking to left and right, and returned hurriedly as if pursued, and not until they were safely inside, behind the glass of the windows, did they regain their confidence.41

Stigmatisation was not the only problem patients confronted upon release. Lack of social and practical skills required in the wider community weakened patients’ self-confidence further, and raised the frightening question: “Can I make it on the outside?”.42 They typically responded by clinging to the security of the hospital and rejecting the journey back to society as costly and unpleasant. An inmate of

40 Goffman, p.71.
41 Frame, Faces, pp.144-145.
Seacliff and Cherry Farm between 1955 and 1958 described his extreme loneliness upon discharge: "during the past three years I had been into town only once, life seemed very strange and it was a long time before I readjusted myself".\textsuperscript{43} Another ex-patient commented that while in hospital "I did not have one trip on my own to town, when I did get out the world was a very frightening place".\textsuperscript{44} While these patients were both short-term, a Dunedin women interviewed in 1961 provides a voice for the multitude of long-term patients. Unmarried at age 45, she had been admitted eight times between 1946 and 1961, mostly as a voluntary patient. During the interview she complained of extreme loneliness following discharge, and seemed "in many ways happier in the hospital".\textsuperscript{45} A similarly touching vignette is provided by a doctor's child who grew up on the estate of Porirua hospital in the mid-twentieth century:

One of my fondest memories is of a patient called T ... I remember that he had hallucinations. He'd been there since the early 1900s and he was a fabulous gardener ... In the late 1940s or early 1950s he went back home for several years and didn't like it after being institutionalised for so long and eventually he came back with his trunk of tools to do the garden. The whole thing had got run down and he made it beautiful again. He built a vegetable house, half underground, and stored the vegetables all year round there and we had strawberries and raspberries. He was still there when my father left. He just did our garden.\textsuperscript{46}

Frame also writes of the difficulties posed by release: "Early in my stay there were two or three periods of several weeks when I was allowed to leave hospital and each time I needed to return as there was nowhere else for me to live; I was fearful always".\textsuperscript{47} In \textit{Faces in the Water} Istina presents a moving picture of the mental patient as intensely ambivalent about the prospect of release. She describes "The World, Outside, Freedom" as the "abiding dream of most mental patients", but in reality is terrified by the prospect of returning home:

\textsuperscript{43} Hamilton-Gibbs, pp.25-26.
\textsuperscript{44} Ibid., p.31.
\textsuperscript{45} Ibid., pp.24-25.
\textsuperscript{47} Frame, \textit{Angel}, p.74.
Dutifully I thought of The World, because I was beyond it - who else will dream of it with longing? And at times I murmured the token phrase to the doctor, 'When can I go home?' knowing that home was the place where I least desired to be. There they would watch me for signs of abnormality, like ferrets around a rabbit burrow waiting for the rabbit to appear.48

This ambivalence must ultimately be seen as patients' recognition of the rigid boundary which separated the worlds of madness and reason in mid-twentieth century New Zealand. Their justifiable fears and consequent reluctance to leave the hospital were not merely products of this separation, but contributing factors to its maintenance. In acknowledging and accepting their exclusion from the outside world, patients essentially served as strengthening agents, joining with the medical profession, the public, and their families to affirm the existence of a separate world for mentally ill New Zealanders.

Patients who did complete a successful transition from the hospital to the home also contributed to the maintenance of this separate world. While we have little evidence, it is safe to assume that many would have tried to conceal evidence of hospitalisation or mental illness.49 In addition, ex-patients tended to distance themselves from the 'real loonies' with whom they had been confined. Shaw's 1971 interviews with Cherry Farm ex-patients found all 15 eager to differentiate themselves from the long term chronic patients. They believed a special hospital should be erected inside the city for short term patients, and that they did not deserve the stigma attached to the long term, more severely disturbed patients.50 No suggestion was made of abolishing stigma altogether. Nor did they question the need for traditional mental hospitals in which to confine more serious cases. Stevenson's 1963 study identified the existence of a similar tendency for ex-patients to distance themselves from the stigma of mental

49 Goffman, p.70.
illness. A 69 year old lady expressed awareness of social prejudice against the mentally ill, “but since her time in hospital was ‘a mistake’ this stigma did not really apply to her”.51 Another elderly patient identified her problem as “nerves” rather than “mental illness”, was aware of negative social attitudes to the latter label, and “holding this opinion herself she naturally wishes to clearly exclude herself from this category”.52 Stallworthy’s *The Facts of Mental Health and Illness* also identified the use of linguistic strategies to downplay hospitalisation and avoid stigma. He claimed that ex-patients “invariably refer when they recover to ‘my breakdown’ and not to ‘my insanity’”, taking into account the public’s relatively more accepting attitude towards nervous breakdowns.53

The same distancing technique is strikingly apparent in a series of ex-patients’ letters to the editor of *New Zealand Truth* in the last few months of 1950. Sparked by the Minister of Health’s assertion that punishment did not feature in the routine of New Zealand mental hospitals, the letters typically reject his claim and call for improvements to be made. At the same time, the authors are quick to distance themselves from the stigma of hospitalisation, presenting themselves as ‘normal’, sane people committed either by mistake or foul play. “Fair Play” of Wellington affirmed that “People should not be left in mental hospitals when they become well enough to be discharged”, depicting herself as the victim of a manipulative husband intent on procuring a divorce.54 Another letter published on the same day also protested at the treatment of mental patients and described herself as inappropriately committed, “a victim of cruelty and foul play”.55 A week later “Humanity” of Auckland offered a damning indictment of mental hospital conditions, presenting her/himself as having

52 Ibid., pp.10-11.
55 Ibid.
suffered a nervous breakdown qualitatively distinguishable from the "poor unfortunates" who formed the bulk of the hospital population. And "Ex-patient" of Invercargill also protested against the brutal punishment of patients, describing her/himself as "not sick", but rather the unfortunate victim of an unscrupulous spouse. In asserting their sanity and the inappropriateness of their committal, ex-patients thus distanced themselves from the stigma of hospitalisation and reinforced the boundary between the worlds of madness and reason.

In some ways Janet Frame occupies the same category. *Faces in the Water* in particular, is concerned to draw attention to "the horrors of insanity and the dwelling-place of those judged insane". But while she freely acknowledges her own incarceration and consciously acts as a voice for the multitude of forgotten "faces in the water" with whom she was confined, Frame is anxious to distance herself from the label of mental illness. "I had seen enough of schizophrenia", she writes, "to know that I had never suffered from it, and I had long discarded the prospect of inevitable mental doom". Yet while travelling in London in the late 1950s Frame seeks admission to the famous Maudsley Hospital to discover the "truth" and hopefully receive final medical 'clearance' from her still-troubling diagnosis. Her relief when the clearance finally comes is buoyed by a sense of triumph and success: "I smiled. 'Thank you,' I said shyly, formally, as if I had won a prize". Like the ex-patients who wrote to *Truth* and those interviewed by Otago medical students, Janet Frame was understandably anxious to distance herself from the social stigma attached to mental illness. While her writing is overtly antagonistic towards the mental hospital and consistently

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57 Ibid., 11 October, 1950, p.19.
59 Ibid., p.84.
61 Ibid., p.89.
sympathetic towards the patients they incarcerate, she never actually challenges the existence of the hospital or the need for separating the mentally ill from wider society. Her primary concern is to be freed from the stigma of mental illness and to be acknowledged as a genuine citizen of the world of reason.

To conclude, Frame, and the other patients whose voices found space in this chapter, saw the psychiatric hospital as a separate world. As inmates they typically spoke of themselves as members of a foreign land and adhered to patterns of social behaviour which reflected that belief. A reluctance to return to the outside world, and the desire to distance themselves from the mental hospital upon release, provide further evidence that patients recognised the social dislocation between madness and reason which characterised mid-twentieth century New Zealand society. In the same way that families acted as unwilling accomplices in the process of marginalising their mentally ill relatives, so patients failed to challenge the idea of the mental patient as belonging to a separate world. They accepted and lived out the distinction both as hospital inmates, and upon returning home.
CONCLUSION

The world is divided ... between those on the inside looking out, and those on the outside looking in .... The world is divided above all, while we sleep, beneath our noses, and before we notice.¹

Mid-twentieth century New Zealand was most certainly a divided world; a divided world in which the nexus between madness and reason played a central part in defining and shaping social relations. The relegation of the mentally ill to a separate physical and social world can be seen as one of the mechanisms by which New Zealanders delineated boundaries of acceptability and maintained social order and cohesion.

Language and behaviour were the primary tools by which they did so. In the case of mental health professionals, language was used both to reify the exclusion of the mentally ill from wider society, and to encourage the movement of recovered patients back into the world of reason. Complex patterns of behaviour had the same effect. On the one hand, psychiatric staff employed a range of physical measures by which to distinguish themselves from patients, and on the other, exhibited a degree of integration into the world of the mental hospital which belied the concept of two entirely separate worlds. Government policy was also a source of mixed messages in which the dialectic between language and action was clearly displayed. Politicians on both sides of the house consistently employed positive, patient-centred rhetoric in their discussions of mental illness and state psychiatric hospitals. Their verbal repudiations of social stigma were not, however, mirrored with concrete attempts to improve public attitudes. Between 1945 and 1955 only a few relatively insignificant statutes were passed in relation to the mentally ill. In addition, conditions such as central

government control and geographic isolation - which had fostered the social marginalisation of mental illness in the nineteenth and early twentieth centuries - remained effectively intact. Motivated by fear, the wider public used derogatory language and stigmatisation to enforce the separation of the mentally ill from the world of reason. But while negative attitudes undoubtedly prevailed in the general social body, there is also evidence of improving attitudes and of specific groups attempting to alleviate the physical and social marginalisation of the mentally ill. Reflecting the extent of public antipathy, families with mentally ill members also participated in the exclusion of their relatives from wider society. For the most part, they maintained a discrete silence and attempted to conceal the presence of madness within their ranks. Both strategies served to reinforce social stereotypes and condone the public's rejection of mental illness and the government's lack of action. Patients themselves also engaged in the use of language and behaviour which reified their dislocation from the rest of society. Inmates spoke of themselves as members of a separate world and behaved as such, while ex-patients typically employed rhetorical strategies designed to distance themselves from the stigmatisation of mental illness. It was Janet Frame's use of language to critique the system which first drew my attention to the period 1945 - 1955.

There can be no doubt that the language and actions of health professionals, politicians, the public, families and patients served to substantiate the existence of a separate world for the mentally ill, but the dislocation between madness and reason was never complete. As mediators between the community and the mental hospital, medical professionals provide the most striking evidence of an ongoing dialogue between madness and reason. The experience and behaviour of families is also indicative of the limitations posed by a simple dichotomy. Parents, siblings, partners and children were members of the world of reason forced unwillingly into relationship with the world of madness. Their
attempts to conceal that relationship stemmed directly from the negative attitudes prevalent in the world of reason. Patients themselves, ambivalent about their separation from the rest of society, and as ex-patients, quick to distance themselves from the stigma of mental illness, also provide evidence of this complexity. While it is tempting to hold fast to Foucault’s assertion that “modern man no longer communicates with the madman”, his vision of the mad as completely isolated from the rest of society is as untenable as the idea of mental illness as completely integrated into the world of reason.²

The wider context of mid-twentieth century New Zealand society had a significant impact upon the relationship between madness and reason. Of most importance was World War Two. The imperatives of war and its after effects not only distracted government’s attention from the plight of the mentally ill, but influenced public attitudes and families’ reactions to mental illness within the home. Other features of the social milieu of mid-twentieth century New Zealand, including the prestige attributed to the medical profession, the psychological interpretation of deviance, and ideals of family unity and happiness, also militated against the inclusion of the mentally ill in wider society.

Advances in the treatment of mental illnesses were an important part of the context in which social attitudes developed. Warwick Brunton talks of the period 1947 - 1965 as a “Therapeutic Revolution”, and Wendy Hunter Williams writes that “by the end of the war the mental hospitals stood on the edge of the era of therapeutic development which was to revolutionise the treatment and ultimately the hospitals themselves”.³ Such advances, however, were gradual and piecemeal. Staff shortages and overcrowding continued to define the

experience of psychiatric patients, and to restrict the implementation of new physical and psychological treatments throughout the period 1945 - 1955.

But while progress was slow and fragmentary in the decade under question, the seeds for more radical change had been laid. From the later 1950s deinstitutionalisation became the focus of mental health policy, and has remained in controversial favour ever since. Although it has achieved some alteration in the social status of the mentally ill, it has not completely destroyed the boundary between madness and reason which characterised mid-twentieth century New Zealand. In essence, the psychiatrist of the 1990s is still an “alienist” treating those designated as “foreigners” by their families, the public, and the medical profession.\(^4\)

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