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**Hearing Voices: The gendered nature of mental health
practices in New Zealand in the 1920s - 1940s.**

**A thesis presented in partial fulfillment of the requirements of MA in
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at Massey University, Palmerston North, New Zealand.**

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ABSTRACT

This thesis asks what insights can be gained from the oral histories of mental nurses and attendants about the gendered nature of mental health practices in New Zealand in the 1920s - 1940s. Previously recorded interviews provided the primary texts for analysis. In considering both their oral accounts and memories as constructions, feminist poststructuralist models are used to study the nurses' and attendants' experiences. Utilising gender as an analytical tool meant that the narrators' memories were understood as the gendered products of the interconnections between the practices and discourses of culture and individual subjectivity, and that gender was implicated in the practices and production of power in mental institutions.

Discourse theory and practices provided the conceptual framework and methodology for an analysis that regarded knowledge as residing in and produced by discourses. By studying the different constructions of female nurses and male attendants in discourses of mental nursing it was possible to recognise how these representations legitimised and privileged particular kinds of knowledge and power. Contextualising the narratives socially and culturally enabled consideration of how the nurses and attendants reproduced dominant discourses of femininity and masculinity in circulation at the time they were working.

The findings point to the way in which powerful discourses of gender predicated on the separation of women and men respectively into private and public spheres, intersected with gendered assumptions of mental illness and mental nursing. The oral testimonies show that the female nurses were situated between the paradigms of these discourses, but because subjectivities are not fixed and immutable, they adopted different and changing positions in relation to them at different times. Although it is argued that discourses of gender did shape the subjectivities of the nurses and attendants and were employed to support gendered institutional practices this was more complex than first appears. The voices of the female nurses can be heard sometimes embracing, sometimes resisting and sometimes transgressing gender norms.

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ABBREVIATIONS

AJHR	Appendices to the Journals of the House of Representatives
NZPD	New Zealand Parliamentary Debates
OHP	Oral History Project
NERF	New Zealand Nursing Education and Research Foundation
OHInt	Oral History Interview
NZJH.....	New Zealand Journal of History
NZH	New Zealand Herald
NZL.....	New Zealand Listener
NZT.....	New Zealand Truth
PSA	Public Service Association
NES.....	National Employment Service
ECT	Electric Convulsive Therapy
NZTNA.....	New Zealand Trained Registered Nurses' Association
NZNA	New Zealand Nurses' Association
NZNJ.....	New Zealand Nursing Journal (Kai Tiaki)
OT	Occupational Therapy
ICT	Insulin Coma Therapy
CCT.....	Cardiazol Convulsive Therapy
Dept.....	Department
UK.....	United Kingdom

INTRODUCTION

The meaning of insanity is dependent on what people say and do at particular moments in history.¹ In order to understand how meanings are socially constructed at specific times not only must people who are said to suffer from mental illness be studied but so must those assigned responsibility for their care. This study asks what insights can be gained from the oral histories of mental nurses and attendants² about the gendered nature of mental health practice in New Zealand in the 1920s - 1940s. It offers a contribution to gendered discourses of insanity by focusing on the ways in which discourses of the mental health profession, and in particular, the nursing and attendant staff within that profession, were gendered.

My interest in women's mental health began in the late 1970s when I was employed as a Community Mental Health Worker. As a member of a three-women team (two general trained nurses and a social worker), the task was to link women identified by a clinician as needing support with volunteers from the community prepared to befriend individual women. Referrals came from both Carrington Hospital³ and a Community Mental Health Centre which had been set up as part of the deinstitutionalization process.⁴ Often, however, a life crisis which had resulted in a woman needing clinical intervention triggered a reaction in the volunteer who had been assigned to her. In other words, neither woman was immune from the guilt, depression, nor self blame associated with failure to live up to expectations of her as a wife and mother. Yet why was it, we asked, that one woman was given a psychiatric label while the other was not? This questioning led to the

¹ This is not to deny that mental distress was (and is) a reality for many people. However, of interest in this thesis are the socially constructed institutional responses to this distress, including the practices of nurses and attendants.

² Following the 1944 amendment to the Nurses and Midwives Registration Act, the women and men who passed the state final exams were officially called "psychiatric" nurses. However, the term "mental nurse" and "mental attendant" remained in use until the end of the 1950s and for this reason, these terms are used in this thesis.

³ Carrington Hospital, the mental institution serving the Auckland area, was first known as the Auckland Asylum. It was, however, more colloquially known as the Whau due to its proximity to the district and stream of that name. It later became known as Avondale Asylum, then Oakley, before becoming Carrington Hospital (Brunton 2004). The buildings are now in use as a tertiary education institution.

⁴ Psychiatric care in public hospitals, limitations on the expansion of psychiatric hospitals, and anti-institutional attitudes in the late 1960s and the 1970s signalled the trend of moving people out of institutions into the community (Haines and Abbot 1985).

instigation of facilitated groups where all the women were brought together for discussion on topics that they themselves identified as important.⁵ What individual women were experiencing and regarding as personal failings, when considered within a broader social context, were understood as socially produced and shared by others. The success of this project led to an understanding that gender relations and the devaluation of women in society were significant issues for women's mental health. The current research is an extension of those concerns in its consideration of how gender was a factor in the way mental health care was practiced in New Zealand from the 1920s - 1940s.

American historian Joan Scott introduced the idea that gender, rather than being treated as a descriptive term for physical differences between women and men, should be developed as an analytic category within women's and feminist history. Scott proposed an agenda underpinned by a new definition of gender drawing attention to gender as a 'system of meaning', a 'constitutive element of social relationships' premised on 'perceived difference between the sexes', and an important method of 'signifying relations of power'.⁶ For Scott, history does not just record changes in the social organisation of the sexes, but actively participates in the production of knowledge about sexual difference. Scott's articulation of gender as an analytic category directed me to an analysis which concentrated on processes, paying particular attention to the interconnectedness of the nurses' and attendants' individual subjectivities, the social organisation of the mental health system, and wider social and cultural systems of meaning. When gender is theorised as a basic principle of social structure and cultural interpretation, femininity and masculinity are understood as cultural codes of gender and need to be understood in reference to one another. Gender in this sense permeates experiences from birth, moulds an individual's sense of identity, supports particular forms of communication, and pervades social organisations such as mental institutions.

In addressing the question of the socially constructed, gendered nature of past mental health practices, this research has used archived oral history tapes as the primary source.

⁵ The process could be described as "consciousness raising", an innovation of second-wave feminism in the 1960s and 1970s.

⁶ Scott (1988) pp.42-43.

As far as can be ascertained, the use of oral history tapes to examine mental nursing practices is not common. My research, in analysing archival interviews, used a previously untapped resource.⁷ As such, the research provides an invaluable opportunity to gain insight into the experiences of women and men who were mental nurses or attendants during the period under study. Viewing the term gender as relational necessitated that, for this project, archived interviews with both women and men were included in the analysis. Because all social relationships are conditioned by gender relations, it was likely that the very ways in which female nurses and male attendants told their stories, would not be gender-neutral.⁸

Eight of the tapes were recorded as part of an oral history project carried out by the New Zealand Nursing Education and Research Foundation (NERF) between 1982 and 1984.⁹ In addition, a tape from a year 2000 NERF oral history project, two tapes from a Sunnyside Hospital Oral History Project, one tape from the New Zealand Country Library Service Oral History Project, one from the Porirua Hospital Resource Centre,¹⁰ and one from the Auckland City Library Special Collections were accessed. My research methodology, based on a social construction approach, meant that instead of taking the narratives at face value, analysis was informed by understandings of how the nurses' and attendants' memories would have been shaped by the dominant discourses in circulation at the time they were working. This meant that rather than treating the oral histories as transparent reproductions of "reality", they were viewed as discursive representations and analysed according to the methods of discourse analysis.

Essentially, discourses can be thought of as groups of language statements produced by a particular system, (psychiatric discourse and nursing discourse are examples), through

⁷ Kate Prebble, has also used oral history tapes as one source for her recently completed (unsighted) PhD on the history of psychiatric nursing, 1939-1972 (personal communication between author and Kate Prebble).

⁸ Daley (1998).

⁹ At this time, many elderly nurses were interviewed with the aim of providing insight into aspects of nursing history. Since then, the original tapes have been added to and are collectively known as the New Zealand Nurses Education and Research Foundation (NERF) Oral History Collection. The tapes are deposited in the Alexander Turnbull Library, Wellington.

¹⁰ The "Porirua Hospital Resource Centre" was formerly known as the "Friends of the Porirua Hospital Museum."

which ideologies circulate in the form of texts containing signs and codes. As a way of thinking, a discourse often represents a structure of knowledge and power. A discursive analysis exposes these structures and locates the discourse within historical, cultural and social relations. The notion that within discursive fields individuals are presented with a range of possible subject positions for constructing meaning, underpins the current study. Arising from this is the question: How did discourses of gender shape the understandings and experiences of the nurses and attendants under review? The idea that social power is centred and cohesive, was replaced with the concept of power as dispersed constellations of unequal relationships, discursively constituted in social “fields of force”. This provided the conceptual language for understanding the boundaries which may have constrained the oral narrators.¹¹ These concepts of power also provided opportunity for reinterpretation of the texts including exploring the possibility of the oral history project participants’ resistance to social norms. Understanding history as a practice which produces and sanctions particular forms of knowledge, meant that in my research, I not only wanted to fill gaps in the records, but also to explore how history operated as a site for the production of gender knowledge about mental health practices.

To provide a contextual background for this current research, Chapter One is mainly descriptive and presents an overview of the social and cultural environment, the construction of insanity, legislation and policy, institutional organisation, care and treatment of patients, the making of professional staff, and community perceptions. This information is based on primary and secondary sources relating to the period of focus. Chapter Two is also contextual and draws on literature which specifically relates to the nursing and attendant staff of mental institutions. It assesses the extent to which discourses concerned with the positioning,¹² responsibilities, and culture of these staff, were informed by gender constructs and how these findings relate to the present study. The methodological framework for the study is discussed in Chapter Three. This chapter outlines the research process and the methods used in analyzing the data. Specific methodological issues discussed include: the use of oral history as text, and memory as

¹¹ See Weedon (1987), Davies (1992) and Scott (1988).

¹² Davies and Harre (2001) maintain that the concept of “positioning” facilitates the thinking of linguistically oriented social analysis in ways that the concept of “role” does not.

construction. In Chapter Four, the findings of the tapes are presented according to the selected themes of : reasons for commencing nursing, mental nurse training, working conditions and the culture of the institutions, perceptions of the mentally ill, mental illness and its treatment, thoughts on general nursing and mental nursing, gender relations and the gender order, and the effects of wider events. Chapter Five provides an analysis of the texts and a discussion on how discourses of gender both overtly and covertly permeated the organisation of society, including the mental health system, and how these shaped the subjectivities of mental hospital staff, particularly the nursing and attendant staff, and were employed to support particular forms of gender relations and practices. The Conclusion offers some reflexive comments on the research process, and the significance of the gendered nature of mental nursing and attendant care in New Zealand from the 1920s - 1940s.

CHAPTER ONE

PLACING THE STAFF OF MENTAL HOSPITALS IN CONTEXT

History cannot be studied as if it happened in a vacuum; social, economic, cultural, political and philosophical forces important to the era must be considered.¹

As the quote above indicates, it is not sufficient to look at historical events in isolation. This chapter presents a descriptive overview of the social and cultural contexts within which mental nurses and attendants worked in the 1920s - 1940s. Issues covered include: dominant social constructions of insanity, relevant legislation and policy frameworks, organisational aspects of mental institutions, dominant practices in the care and treatment of patients, the training of professional staff, and community perceptions of mental hospital patients and staff. Based on extant literature, this chapter considers the extent to which these were informed by gender and as such provides a backdrop for the chapters that follow.

The Social and Cultural Environment

In the early decades of the twentieth century, ideas about the importance of motherhood and the social institution of the family gained strength, and in the struggle for national and economic power, a new emphasis was given to racial fitness. Concerns about the nation's diminishing virility coincided with ideas coming from England and America regarding Darwinism and the "survival of the fittest". Ultimately, women were held responsible for moral probity and propagating the empire. Psychiatrists capitalised upon these notions of womanhood and the faith in science, to extend their territory beyond the insane. For example, women who refused to conform to the moral order and whose waywardness was put down to their faulty genetic inheritance, became a target for doctors in their support for the eugenic movement.² In his 1934 report to government, Theo Gray, the Director-General of the Mental Hospitals Department, stated that

¹ Christy (1978) p.6.

² See Phillips (1980), Fleming (1981), Olssen (1981), and Robertson (2001).

‘responsible opinions point to defective inheritance as being by far the most potent cause of mental defect and mental disorder’.³

Most people were reluctant to have anything to do with the “insane”, but when the Great Depression hit New Zealand, work in a mental hospital was one of the few options available. If women workers, Māori, underemployed and unregistered male unemployed are counted, it is estimated that at the height of the Depression between 1929 and 1935, 32 per cent of the labour force was out of work. The 1930 Unemployment Act was the foremost government response to unemployment and promised relief payments for those who registered with the proviso they join government “make-work” schemes. A levy was charged against all males over 20 which was later broadened to include other taxpayers, including women, although unemployed women had been unable to register.⁴

Mental institutions were perennially short of staff and with the onset of the Second World War, the number of women prepared to work in them dropped even further. Under the manpower regulations women could be ordered to work in traditionally female, yet essential services, such as nursing. However, there was considerable public opposition to women being sent to work in mental hospitals, as demonstrated in letters to newspapers, higher numbers of applications for exemption from essential services from women than men, and some women walking off the job. In response to criticism that women and girls were being ‘blindly bulldozed’ into these jobs, the Auckland district manpower officer pointed out that ‘of the 960 women of the ages 20-23 interviewed during August 1942, only 61 had been directed to change their jobs and only one of those directions had been to a psychiatric hospital’.⁵

Those already working in mental hospitals were not permitted to leave unless they first gained permission from the National Services Department and those sent to work in mental hospitals were expected to stay for the duration of the war. There was a strong social presumption that paid work was not women’s prime interest and the Manpower

³ Dept. Mental Hospitals AJHR 1934 H-7 p.2.

⁴ See Ebbett (1981), Belich (2001), and King (2003).

⁵ Auckland district manpower officer quoted in Montgomerie (2001) p.110. See also Montgomerie (1999), Dept. Mental Hospitals AJHR 1940 H-7, and Dept. Labour and Employment AJHR 1946 H-11A.

Appeals Committee would sometimes be approached by husbands who objected to their wives being required to work outside the home. According to Deborah Montgomerie, although wartime roles were strongly gendered, a shared 'ideology of the family' held the sexes together.⁶ Postwar, motherhood became paramount and many women left the work force to concentrate on home-making and raising the children.

Mental hospital work was never popular, particularly with women, and by December 1945, the Department of Mental Hospitals was 253 nurses and 85 attendants short of requirements.⁷ One of the first initiatives of the newly created National Employment Service (NES) was to take steps to address the shortage by mounting campaigns in Britain. Recruitment focused on untrained women and the first draft arrived in Wellington in October 1946. However, some trained and semi-trained nurses did come to New Zealand at the time, and it was this group who caused the most trouble. Areas of contention included the prerogative of doctors to carry out particular procedures that they (the nurses) felt they were more than capable of performing, and what they saw as the general lack of autonomy of mental nurses in New Zealand in comparison to Britain.⁸

The migrant nurses were also dismayed by the conditions they encountered. One said she found 'both the work and the wards depressing' and considered 'the work was wrongly classified as nursing'. The duties, in her opinion, 'were similar to those required of charwomen and prison attendants'.⁹ This type of complaint resulted in the New Zealand Director of Employment asking the New Zealand High Commissioner in London not to send any experienced nurses in future. He wrote that only 'girls of a suitable type who are inexperienced in nursing work of any kind, who are willing to settle down to hard work, and are not going to raise any objections to domestic work, including cooking', should be sent.¹⁰

⁶ Montgomerie (1999) p.166. In applying for an exemption for his wife, one man said he required her at home to prepare his meals (*NZH* cited in Montgomerie 2001).

⁷ Dept. Mental Hospitals AJHR 1946 H-7 p.3.

⁸ Hutching (1999). The main reason untrained women were originally sought was because mental nurses were also in short supply in Britain and the NES did not want to risk offending the British Ministry of Labour.

⁹ Unnamed nurse quoted in Hutching (1999) p.47.

¹⁰ Director of Employment quoted in Hutching (1999) p.49.

Constructions of Mental Illness

Although this thesis is about mental health practices, not mental illness per se, it is apposite to give a brief overview of the way mental illness was constructed leading up to the period under review. The socially structured and socially organised responses and practices which mental illness provokes are an expression of cultural assumptions about the nature of the illness itself.¹¹ In other words, discourses of mental illness are produced by practices and in turn are shaped by practices.

Although in 1880 the typical “lunatic” was a man, by 1940 it was a woman. Discursive shifts, including the medicalisation of insanity, and new discourses of women and madness meant that by the twentieth century, the family was the usual context in which a woman was declared “mad” and transported to a mental hospital. Often there was collaboration between families, the police and the legal and medical fraternities in respect to committal. Moreover, reasons for committal, committal processes, diagnoses, treatment and discharge procedures were different for women and men. Following committal the confinement of women was sometimes regarded as a type of de facto divorce; husbands were often reluctant to reclaim truculent wives. This situation was markedly different when domestic duty was an issue; then men were eager to claim women back, sometimes before they were considered ready. A woman’s neglect of family responsibilities and household chores was recognized by medical authorities as a sign of female madness, and her return to sanity was judged on perceptions of normative female behaviour.¹²

The influence of Darwinian and hereditarian theories which posited that women were genetically weaker, hostage to their reproductive organs, and predisposed to mood-related disorders, meant that increasingly diagnoses became gender specific. Causal theories placed emphasis on the female cycle – puberty, childbirth and menopause – were all implicated in the origins of female insanity. Women’s madness, linked as it was to her biology and reproductive functions, was considered unavoidable. Men’s madness, on the

¹¹ Prior (1993).

¹² See Garton (1988, 2003), Labrum (1990, 1992, 2005), Brookes (1998), Brookes and Thomson (2001), and Coleborne and MacKinnon (2003).

other hand, was regarded as self-induced and brought on by excesses such as the abuse of alcohol and general licentiousness. Jennifer Styles has suggested that the conservative nature of psychiatry in New Zealand may have saved both women and men from extremist eugenic views but in the instance of men, psychiatry's traditional beliefs and practices were responsible for strengthening the perception of the "ideal" New Zealand male as emotionally restrained and invulnerable.¹³

Bronwyn Labrum has suggested that gender roles were perhaps less well circumscribed in nineteenth century New Zealand than they were later. Her assertion is that in the twentieth century, middle-class beliefs about what constituted respectability became progressively more influential and resulted in increased mechanisms for the control of behaviour deemed unsuitable. Theories of sexual difference and the ideology of "separate spheres" defined the function of femininity and masculinity both in everyday life and in women's and men's encounter with psychiatric practices and institutions. For both women and men, the difficulty of the gender role, often aggravated by money, family and marital problems, sometimes exacerbated mental problems. Evidence that some men found it difficult, particularly during the Depression, to live up to incompatible gender roles, such as the independent "man alone" and "bread winner", is found in the files of the Seacliff Mental Hospital for the period 1928-1937.¹⁴ Over time, however, more women than men entered the mental hospital and voluntarily turned into "psychiatric subjects".¹⁵ Warwick Brunton's perusal of extant records shows that from the time of voluntary admission in 1911, female voluntary boarders in New Zealand outnumbered male boarders.¹⁶ This shift of gender in the mental hospital population was indicative of significant changes in perceptions of mentally illness and mirrored changes in the wider cultural and social environment.

¹³ Styles (1994, 1997). See also Labrum (1990) and Blakely (1993). For constructions of the New Zealand male see Phillips (1980, 1996).

¹⁴ Holloway (2001)

¹⁵ See Labrum (1990, 1992), Matthews (1984), Garton (1988), and Coleborne (1997, 2001a).

¹⁶ Brunton (2001).

Legislation and Policy

Initially lunatics were regarded as a law and order problem and placed in gaol but the connection between lunacy and criminality was publicly challenged. In 1846 the Lunatics Ordinance was introduced with the aim of separating the “mad” from the “bad”.¹⁶ Generally, developments in New Zealand followed those of Britain. It was believed that insanity required unique forms of legislation, policy, treatment and care, and the establishment of separate institutions to house the insane. Examination of extant records reveals that legislation and policy were aimed at strictly controlling all aspects of asylum life. The Lunatics Act of 1868, for example, introduced new criteria for committal, and stipulated proceedings for restraint, appointment of officials, keeping of registers and case books, handling of lunatic’s estates, and discharge procedures. Although it was already standard practice, an amendment to the Act in 1882, stipulated that in the asylum the sexes must be kept apart.¹⁷

By linking central state responsibility for the colony’s asylums with the idea of medical management, firm foundations were laid for the legitimisation of the medical profession’s primary role in the care of the insane. The 1911 Mental Defectives Act extended the Mental Hospital Department’s jurisdiction over a range of medico-legal entities constructed around the concept of the “mental defect”. The replacement of the terms “lunatic asylum” and “female attendant” with “hospital” and “nurse” in the Act, indicated a desire to move away from the notion of asylums to a mental hospital model. Provision in the Act was also made for treatment without committal to all who voluntarily sought it, in the hope of changing public attitudes conditioned to regarding committal as shameful and institutions as places of last resort.¹⁸

¹⁶ For discussion of lunacy and criminality see Macdonald (1977, 1989), Williams (1987), Ernst (1991), Brookes (1992) and Adams (2000, 2001).

¹⁷ The Lunatics Act (1868) and Amendment (1882).

¹⁸ The Mental Defectives Act 1911 differentiated between persons of unsound mind, persons mentally infirm, idiots, imbeciles, the feeble minded and epileptics. Self referrals to mental hospitals increased from 2.7 per cent in 1912 to 32.9 per cent in 1947. See Philp (1991) and Brunton (1985, 1997).

What to do about the “unfit”¹⁹ emerged as a major issue for the 1924-1925 Committee of Enquiry into Mental Defectives and Sexual Offenders. It became obvious that the Government was not keen to give legislative effect to all of the committee’s recommendations and clause seven, for example, was amended to establish a new category, the “social defective”. In 1928 the Mental Defectives Amendment Bill was introduced but some of the clauses were still controversial, namely, clauses 21 and 25 which were plainly eugenic in intention.²⁰ Although the controversial clauses were withdrawn, generally eugenists applauded the legal acknowledgement of the “social defective”. The Women’s Division of the New Zealand Farmers Union was one group which wanted the withdrawn clauses reinstated. Their major concern was the cost to society of “unnatural” marriages involving people considered mentally deficient – their union was viewed as responsible for the increased admissions to prisons and mental hospitals. Over time, enthusiasm for eugenic ideas appeared to wane, but vestiges survived and found expression in the language used and provisions made in subsequent legislation. For instance, terminology associated with lunacy was exchanged for the label “mental defective”, and supposedly, in the interests of curtailing reproduction of the “unfit”, sexual intercourse with a female patient became a criminal offence. Additionally, the position which eventually became the Director of Mental Health, was broadened to include jurisdiction over mental defectives both in institutions and in the community.²¹

The law was gendered in that it operated differently for women and men. However, apart from parliamentary debates around issues such as sterilisation, the curtailment of marriage of “unfit” promiscuous women, and venereal disease, (believed to be attributable to feeble-minded women), the female “lunatic” was mainly absent from the actual language of the legislation.²² The exception was in the matter of asylum inspection,

¹⁹ At this time asylum populations consisted of those temporarily unsettled and therefore deemed curable, and those classified as “unfit”. The “unfit” included, the criminal, the insane, the imbecile, the feeble minded, those afflicted by diseases of birth, the deformed, the deaf, the blind etc. See Fleming (1981), and Moore and Tennant (1997).

²⁰ NZPD Vol. 217 July 19 1928 p. 618. Clause 21 made marriage with a person on the Eugenics Board’s list illegal and clause 25 provided for the sterilisation of defectives, provided the “defective” person, their parent or guardian agreed.

²¹ See Mental Defectives Act (1928). Also see *Eugenics Review* (1928) cited in Fleming (1981), Barrer (1933), and Brunton (1985a, 2001).

²² Coleborne (1997).

where it was acknowledged that women's needs were best met by other women. In 1895 Grace Neill was appointed as the first woman Inspector for Charitable Aid, Hospitals and Asylums, and was at one time, the official visitor to both the Porirua and Mount View Lunatic Asylums. The appointment of female visitors was part of a general move toward greater participation of women in more senior positions of all social services. Margaret Tennant has argued, however, that the recruitment of educated middle-class women was part of the social control function of statutory agencies operating at the turn of the century and Neill ended up reinforcing existing sexual stereotypes.²³

Institutional Care, Organisation and Treatment of Patients

Asylums were initially funded by provincial governments but after the provinces were abolished on 12 October 1875, central government established the Lunatic Asylum Department in 1876, as the first social service department in New Zealand.²⁴ Essentially from then onward, institutional care and organisation was predicated on top down policies emanating from a centralised bureaucracy, and medical superintendents, backed by inspectors-general, became recognized as the professional authorities on madness.²⁵ The transformed asylum of the nineteenth century was to be a place of "moral treatment" and gender became a recognized form of asylum organisation. This change of focus put greater emphasis on the role of staff and their moral fitness. Soon after the Dunedin Asylum opened in the 1860s, the lay Keeper, James Hume, said, 'patience, gentle treatment, nourishing diet, cleanliness with light employment or exercise, goes far to recover the lunatic. Good example in the attendants is the greatest guide and gives confidence to the patients'.²⁶ It was expected that attendants would manage inappropriate behaviour and the "insane" would learn to act in accordance with the gender roles

²³ Tennant (1978). See also NZPD Vol. 83 1894 pp.137-138.

²⁴ When the law was revised in 1911 the Lunatic Asylum Departments became the Mental Hospitals Department and then in 1947, became the Mental Hygiene Division of the Department of Health. In just over 30 years after New Zealand was established as a British colony in 1840, a network of state provided lunatic asylums had been established beginning with the development of Karori (Wellington) in 1854 and finishing with Hokitika (later Seaview) in 1872. Institutions were established at Otago and Canterbury in 1863, at Nelson in 1864, and Auckland in 1867. Later came Tokanui in 1911, Kingseat in 1932, and Lake Alice in 1949. See Coleborne (2001a) and Brunton (2001).

²⁵ Philp (2001) and Brunton (2001). Before that, all asylums except the Auckland Asylum, had shared authority between a visiting medical officer and a lay keeper, superintendent or keeper-clerk.

²⁶ Dunedin Asylum Keeper's Journal quoted in Brunton (2001) p. 84.

modelled by female and male attendants respectively. In his report, Hume noted that since female patients had been working in the laundry and kitchen there had been a perceptible change for the better in their temper and habits.²⁷ In 1945, Dr Medicott of Porirua Hospital stated in the nursing journal that the nurse through *her* constant association with the patient, can draw *him* back to “normal” ways of thinking and acting (emphasis added).²⁸

Over half a century after Hume spoke of moral management, Dr Theo Gray, Director-General of Mental Hospitals from 1927-1947, espoused a similar philosophy which promised much, but delivered little, once overcrowding became a problem.²⁹ One consequence of the Great Depression was that the 1929 Rest Homes Act which made provision for state rest-homes to house difficult or frail elderly people, who otherwise might end up in psychiatric institutions, was put on hold. Mental hospitals also held large numbers of so called mentally deficient or mentally retarded children and adults. For a long time, these diverse groups made up the greater proportion of the mental hospital population, putting undue pressure on already overtaxed facilities and staff. In the 1920s and 1930s there was a concerted effort to classify patients, and to separate curable patients from the chronic and incurable, however, over this time, treatment for both short and long term cases lay more in the gamut of work and routine, than in medical intervention. Mental hospitals became synonymous with chronic cases, overcrowding, staff shortages, and poor rates of cure.³⁰

Following World War One, the diagnosis of “shell shock” suggested that hysteria was an illness of emotional rather than of physical origins but Jennifer Styles has argued that in New Zealand ‘gender-specific assumptions of “normal” behaviour denied a psychological

²⁷ Ibid. (2001).

²⁸ Medicott (1945) p.28.

²⁹ Brunton (2001).

³⁰ See Brunton (2001) and Tennant (1989). The term “mentally retarded” was later replaced by “intellectually handicapped”. Currently the nomenclature is a *person* with an intellectual disability with the emphasis on the *person*. Although the female/male divisions were still maintained, institutions in the 20th century, beginning with Tokanui in 1912, were built as detached villas rather than monolithic structures. This was a move to facilitate classification and foster a sense of community. See also Williams (1987) and Thompson (1992).

understanding of the origins of mental disorder in ex-servicemen'.³¹ Generally, psychotherapeutic methods were not highly regarded by New Zealand mental hospital medical authorities. In the late 1930s and 1940s, Insulin Coma Therapy (ICT), Cardiazol Convulsive Therapy (CCT), Electric Convulsive Therapy (ECT), and psychosurgery, all new somatic forms of treatment, were introduced. These therapies meant that nurses' and attendants' roles began to change as they played a more active part in the physical treatment of mental illness. For example, at Porirua in 1949, farm hands were employed to take over from male attendants so the latter could be freed up to assist in the administration of ECT.³² Pictorial representations which show nurses as technicians carrying out doctors' orders, graphically depict the primacy of soma in the diagnosis and treatment of mental illness at this time.³³

A Professional Staff in the Making

Nurses and attendants

Initially, no training was available in New Zealand for staff working in mental hospitals and people learnt on the job.³⁴ In 1890, female and male attendants constituted the main group of mental hospital workers. It was then that the Inspector General, Duncan MacGregor, resolved to transform attendants into a profession fashioned on female hospital nurses. MacGregor hoped 'by systematic lectures on nursing to raise their ideal of their duty, and remove the prejudice which at present exists against this as affording a career for educated young women'.³⁵ Training standards varied from hospital to hospital, and therefore, the systemisation of training became increasingly important. Grace Neill, a Nightingale-trained nurse who was given responsibility for improving training for both female nurses and male attendants, recommended on the advice of the Medico-Psychological Association, that the British publication, Handbook for Attendants on the Insane, become the text book for mental nurses and attendants. Written by a group of medical superintendents it provided precise, if paternalistic instructions for mental

³¹ Styles (1997) p.123.

³² Truman (1984).

³³ Prior (1993).

³⁴ The histories of mental nursing in Britain and New Zealand are similar. See for instance, Peplau (1989) and Nolan (1993).

³⁵ Dept. Lunatic Asylums AJHR 1890 H-12 p.3.

nursing practice and became of ‘canonical importance in mental nursing education for the best part of a century’.³⁷ In New Zealand, the formal national system of training instigated by the Lunatic Asylum Department (later the Mental Hospitals’ Department) in 1905, continued to be based on the Handbook until 1944, when a home-grown version was considered.³⁸ One superintendent stated that nurses needed nothing more than the standard textbook of psychiatry (the Handbook) and the department rule book. Increasingly rule books corresponded to the philosophy of professionalism sought by doctors, and in the 1928 and 1940s editions the female general nurse was presented as the model which mental nurses were to emulate.³⁹ Mental nurse training continued to be carried out in mental hospitals until the 1980s, when it was incorporated into the new comprehensive nursing programmes at technical institutions.

Mental nurse training had a medical focus with lectures on anatomy, physiology and pharmacology given by doctors. Matrons (and later tutor sisters), covered the practical nursing and first aid components of the course. This situation seemed to vary from hospital to hospital depending on availability of staff. Nurses and attendants were prepared first for a junior mental examination, and after three years, successful candidates of a senior examination were awarded their Senior Mental Nurses’ Certificate. Mental nurses, by the end of their training, as examination papers exemplify, were expected to have knowledge of mental nursing practices and the aetiology of mental disorders.⁴⁰ In 1933, in line with the general nurse’s medal, a medallion for registered mental nurses was introduced, although at this time, unlike general nurses, the mental nurse’s qualification was not recognized overseas.⁴¹

In 1944 an amendment to the Nurses and Midwives Act transferred the control of the registration and examination of nurses and attendants from the Mental Hospitals’ Department to the Nurses and Midwives Board. In 1945 psychiatric nursing became a state registerable qualification for both women and men. This meant that the board had

³⁷ Dingwall et al. (1988) p.128.

³⁸ For discussion of the New Zealand text see Chapter Five this thesis.

³⁹ See Brunton (1972, 2001).

⁴⁰ See Appendix A p.123.

⁴¹ See Dept. Mental Hospitals AJHR 1933 H-7 p.3. Reciprocity was achieved with Britain in 1949.

the same powers in respect to mental hospital schools of nursing, and the trainees and graduates of these schools as it exercised in respect to general, midwifery and maternity schools of nursing. The title “psychiatric nurse” replaced the former “mental nurse”, which was seen as more ‘dignified and professional’ and the editor of the nursing journal hoped the changes would ‘go far to removing the feeling of isolation which has long existed between those who care for the mentally sick and those in other spheres of the nursing profession’.⁴² The control of nursing knowledge, however, remained firmly in the hands of the doctors. Nevertheless, involvement of the Nurses and Midwives Board was regarded by some as a major development for mental hospital nursing, improving its standing, and exposing its practices to inspection.

Following the instigation of state registration, the Mental Hygiene Committee of the New Zealand Trained Registered Nurses’ Association (NZTNA) recommended that the 411 eligible males and 291 females registered as psychiatric nurses, be given full membership on the basis that male registered psychiatric nurses, whose training and registration was the same as for female nurses, may form a separate association ‘or even an industrial union’.⁴³ In her address to the twenty-first annual general conference of the Nurses’ Association in 1941, the President Miss McKenny, had stated that ‘nursing is not just a job. Unions, however valuable, with their demands and possible strikes, have no place in nursing’.⁴⁴ A faction of the Nurses’ Association was careful to preserve the professional image of nursing and perhaps the known militant stance of mental hospital staff male attendants, did not fit. In 1932 for instance, at the height of the Depression, the NZTNA would not support nurses taking part in a procession of the unemployed which they opposed on the grounds of ‘lowering the prestige of the profession and ridicule to the uniform’.⁴⁵ Although another faction agitated for a nurses’ union, the Second World War intervened and the issue went into abeyance until after the war. For whatever reason, in 1945 when the constitution of the NZTNA was revised, it was to admit registered female psychiatric nurses only, to full membership. Male nurses continued to be recorded as

⁴² Editorial, “Psychiatric Nurse Training” (1945) p.3.

⁴³ “Mental Hygiene Committee” (1945) p.61.

⁴⁴ McKenny (1941) p.1.

⁴⁵ Standing Committee New Zealand Nurses Association quoted in Carey (1984) p.23.

“other staff” in the annual reports of the Director of Nursing instead of being categorized by sex in the list of registered nurses.⁴⁵

Doctors

According to Theo Gray, the Director-General of Mental Hospitals from 1927-47,

[t]he choice of psychiatry as a career was thought to be evidence of eccentricity ... and the recently qualified man who joined the staff of a mental hospital was regarded as having committed professional hari-kari.⁴⁶

Like nurses and attendants, for some time psychiatrists were regarded as more custodians than doctors, looked down on by their colleagues in general hospitals, and viewed as the “Cinderella’s of medicine”.⁴⁷ The low status of psychiatry, however, meant that it was more accessible to women than the more highly prized medical specialties. Despite this, women medical graduates had trouble finding and keeping work. It was still considered unnatural for women to put a professional career ahead of domestic life and those who did were assumed to have been unlucky in love.⁴⁸ Because in the early days, the appropriate expertise did not exist in New Zealand, several asylum medical superintendents were recruited from overseas, mostly from Britain. Many doctors working in asylums had to learn on the job using overseas models, and outdated ideas were often imported into New Zealand without question. Recruitment and retention of psychiatrists was always a problem and Brunton links this to their position as salaried government officials. Mental hospital medical officer’s remuneration and prospects compared unfavourably with other medical specialties.⁴⁹

The professionalisation of psychiatry was built on the notion of somatic medicine as a branch of scientific medicine and changing social perceptions of insanity. After the late 1930s, it was believed that the new physical therapies would ameliorate all forms of mental disorder. Shayleen Thompson has argued, however, that although the

⁴⁵ Carey (1984) and Stevenson (1997).

⁴⁶ Gray (1958) p.76.

⁴⁷ Gittins (1998) p.3. For reference to Cinderella metaphor in relation to mental nursing see Editorial: “A Point of View” (1944) p.147.

⁴⁸ Cody (2001) and Lunbeck (1994).

⁴⁹ Gray (1958) and Brunton (2001).

professionalisation of psychiatry brought some kudos to psychiatrists, it did not bring changes for the majority of chronic patients.⁵⁰ These people continued to make up most of the mental institutions population. Additionally, despite professional advances, psychiatry remained an unpopular career choice and shortfalls in doctor/patient ratios meant that at best, patients were given cursory attention and at worst, chronic patients did not see a doctor at all. Little happened in New Zealand to develop indigenous training programmes for future psychiatrists until 1946, when psychiatry became established as an academic discipline and the Department of Psychiatry was established at Otago University. From then on, women were more inclined to be attracted to psychiatry in its own right rather than for lack of other choices.⁵¹

Ancillary Staff

From the late 1930s, in addition to nurses, attendants and doctors, ancillary staff began to be employed in mental hospitals. The new positions were deemed to be suitable occupations for women and were often regarded as an adjunct to general nursing. Mary Lambie, the Director of Nursing Services, for example, argued that involving qualified general nurses in social service work would raise the status of the job.⁵² The role of the social service worker (later called social worker), was to undertake investigations according to a doctor's instructions. A social service worker was attached to the psychological clinics in Auckland and Wellington which had been set up under the auspices of the Eugenics Board. A social service worker was also appointed to each of the major mental hospitals but she was not permitted to see patients without first obtaining a doctor's permission. Elizabeth Lunbeck has argued that in being accountable to doctors for their work, social workers reinforced the authority of male doctors to extend their reach beyond the traditional medical realm, and involve themselves in the domestic domain, an area traditionally female.⁵³

Lambie was also anxious to see some form of occupational therapy (OT) available in all hospitals, including mental hospitals, and in 1949 became the first Registrar of the

⁵⁰ Thompson (1992).

⁵¹ Cody (2001).

⁵² Skilton (1981).

⁵³ Lunbeck (1994). Also see Tennant (1989).

Occupational Therapy Board. However, it was male doctors who were given the opportunity to travel overseas to see what was happening elsewhere. Following a trip to England in 1936, where he visited mental hospitals that provided formal occupational therapy classes, Dr Harry Buchanan, then Medical Superintendent of Auckland Mental Hospital, approached the Director General with the idea of instigating OT programmes in New Zealand. In a similar manner to social work, occupational therapy was introduced to mental hospitals as an ancillary service under medical supervision. Margaret Inman, a qualified nurse and trained occupational therapist was brought from Britain to set up occupational therapy in mental hospitals, initially by training nurses to run occupational therapy classes for patients, and then, to set up a specific course to train occupational therapists. Students were required to be at least 21 years of age and Inman said that in the beginning, mature women were deliberately chosen, because she knew they would have to convince mental hospital staff of the need for occupational therapy. The first course began with four female students, three of whom already had some experience in the health field. The second group began early in 1941 and included two female nurses and one male attendant from Seacliff Hospital. Although early on, a three month course was held for male attendants in order to increase the number with OT skills available to work in mental hospitals, like nursing, occupational therapy was viewed as a female occupation.⁵⁴

Male medical officers conducted lectures on anatomy and physiology, and Inman taught and supervised the practical components of the course. In 1945 the first OT school building was opened in the grounds of Oakley Mental Hospital, later Carrington Hospital. In 1946 it was decided to issue a "Certificate of Proficiency" to all who had trained 'prior to the implementation of a settled curriculum'.⁵⁵ However, the candidates were first required to submit a thesis according to a topic set by the Department of Health and it is reported that a few were eliminated because of this requirement. The passing of the Occupational Therapy Act in 1949 made Occupational Therapy more acceptable and in 1950 the first two and a half year course was introduced. Linda Wilson a practicing

⁵⁴ Inman (2007). See also Skilton (1981) and Wilson (2003).

⁵⁵ The Legacy of Occupational Research Group (2007) p.6.

occupational therapist has explored occupational therapy in New Zealand, and concluded that its development is clearly linked to the gender of the majority of its practitioners. She has argued that the ‘femaleness’ of the OT workforce, assumptions about woman’s role, and the association with nursing, have all influenced the developments of professional control over education and practice.⁵⁶ In her socio-historical study of the development of mental health services in the Wellington region from 1945-1978, Katherine Truman makes comparisons between nurses’ and attendants’ conservative management style and custodial role, and the newer groups such as OTs and social workers, who were focused on patient rehabilitation. The inevitable outcome was that although staff were expected to work together, they ended up in competition.⁵⁷

Community Perspectives

Generally there was a fear of, and aversion to, those considered to be of unsound mind. Their place of incarceration was also stigmatised. The building of new asylums in rural areas was as much a retreat from negative public opinion as it was a decision to provide a more conducive environment for recovery.⁵⁸ Institutions such as Porirua and Avondale seem to have been viewed particularly negatively by the public. Name changes were seen as a means of altering public perceptions. For instance, the Auckland Asylum over time became Oakley and then Carrington Hospital.

Perceptions of mental illness and ipso facto those assigned to their care can often be gleaned from newspapers. Sometimes in these publications, mental hospital staff were held responsible for ‘distressing disease’.⁵⁹ In a letter to the *Christchurch Press* in 1938, “Ex-Nurse” questioned this view. Her opinion was that mental problems emanated from poor hereditary and parenting and that ‘[t]he sins of the fathers shall be visited upon the children unto the third and fourth generation’.⁶⁰ As previously mentioned, during the Second World War, there were frequent letters objecting to women being manpowered to work in mental hospitals. A writer to the *New Zealand Herald* wrote, ‘[t]hese young

⁵⁶ Wilson (2003) p.73, 111. See also the Legacy of Occupational Research Group (2007).

⁵⁷ Truman (1984). See also Skilton (2007).

⁵⁸ Brunton (1985b, 2004).

⁵⁹ Ex-Nurse. (1938) p.13.

⁶⁰ Ibid. (1938) p.13.

women are the future mothers of our nation and irremediable harm may be done through compelling them to work where they are physically and temperamentally unsuited'.⁶² "Father of Five" asked in the *New Zealand Truth*, '[w]here is the Freedom from Fear when women are ordered into jobs of which they are terrified?'⁶³ During the war, letters on the topic of "manpowering" also featured in the *New Zealand Nursing Journal*. One nurse wrote that rather than being "manpowered", she wanted "girls" to be actively encouraged to undertake mental nursing as a career. She also suggested that registered general nurses would find it an interesting area in which to work.⁶⁴ In another letter, reprinted from the *Dominion*, a mental nurse said that the problem of mental nursing 'must sit fairly and squarely with the people of New Zealand'. In her opinion, 'the dangers existed in the layman's imagination [and] the unfortunate stigma attached to mental disorders was wickedly wrong'. It was inadequate staffing that made the job so difficult.⁶⁵ Mr G.R. Hart writing in the *New Zealand National Review*, however, castigated the Minister of Health the Rev. A.H. Nordmeyer for suggesting that three months of a general nurse's training should be spent in a mental hospital. His view was that you might just as well send women to work in the mines.⁶⁶

Innovations in psychiatric treatment and promises of cures for mental illness were intended to turn public opinion around. This development contrasted with the previous period when not only was public faith in psychiatrists and psychiatric treatment low, but also notable was the number of campaigns calling for reform. Shayleen Thompson has argued that by the late 1930s, psychiatrists and the general public alike, believed that all forms of mental disorder were amenable to the new somatic forms of treatment.⁶⁷ Nevertheless, a number of individuals and groups continued to be actively involved in campaigns advocating mental hospital reform.⁶⁸

⁶² "Letter to Editor" (1942) p.2.

⁶³ "Father of Five" (1946) p.14.

⁶⁴ McAndrew (1944) p.154.

⁶⁵ Harper (1944) p.155.

⁶⁶ Hart (1943).

⁶⁷ Thompson (1992).

⁶⁸ See for instance, "Medico" (1937), Ridder (1938), Coleridge Farr (1938), Lovell-Smith (1938) and Sainsbury (1947).

Conclusion

The twentieth century marked a period of transition in gender relations and a gendered culture was constructed in the context of social unrest. Validating manhood was particularly important at times of crisis such as the Depression and War. New discourses of femininity and masculinity were overlaid with medical discourses which philosophically adhered to materialism, and a focus on the importance of heredity and the environment. Moral and professional authority and commitment to the practice of somatic medicine were inextricably bound together and ‘anything which served to weaken one would weaken the other’.⁶⁸ Doctors seemed unconcerned with the apparent incompatibility between the conceptualisation of mental illness as a bodily disease and moral imperatives. The underlying *causes* may well have been of a physical nature but the *effects* were moral in character. Legislation also played an important part in constructing patient identity and acted in tandem with psychiatrists to legitimise their authority. The progression of the profession of psychiatry grew expediently along with changing public perceptions of the effectiveness of new radical physical treatments.

Adherence to routines, rules and regulations, was not just because this was the best way of maintaining order in institutions that were severely overcrowded with insufficient staff, but also reflected that mental hospitals were state institutions intent on preserving national identity and the gender order. The transformation of mental attendants into nurses was an important step in the process of hospitalising the asylum and cementing doctors’ dominant position. Yet it was nurses and attendants, not doctors, who coped on a daily basis with patients many of whom were chronic and elderly, epileptic or “mentally retarded”. The perception of mental nursing as domestic work, which any woman could do because she was female, was graphically illustrated in post-war overseas recruitment campaigns. These views were in sharp contrast to ones which represented mental nursing as unsuitable for women and only suitable for certain types of men.

Although new forms of treatment and directions in training signalled a different direction, the absence of its own specific area of knowledge and practice, left mental nursing

⁶⁸ Clarke (1981) p.293. See also Philp (1991).

subservient to the domination of the male medical profession. Female social workers and occupational therapists were also seen as adjuncts to the doctor, albeit social workers ranked higher in the hierarchy, often sharing an office with the medical staff and dining with the matron.⁶⁹ These ancillary groups, however, are also represented as destabilising the nurses' power base. That aside, the manual, domestic and family-type work of the nurse, social worker and occupational therapist, were all identified as female, and differentiated from the intellectual work of the male psychiatrist. Although some women did obtain work in asylums as psychiatrists, their work histories reflected the standing of women in the paid work force, and their positions were usually only temporary until a suitable male candidate was found.⁷⁰

As this chapter has shown, in the first half of the twentieth century, the social and cultural environment, the construction of insanity, legislation and policy, institutional organisation care and treatment of patients, the making of professional staff, and community perceptions were all in their various ways imbued and informed by gender. However, changes over time which led to mental nursing becoming formally aligned with general nursing highlighted the way in which distinctive female and male cultures developed in the mental hospitals. These gender cultures will be further examined in the following chapters.

⁶⁹ For a discussion of how doctors gained control of scientific medicine and dictated the terms of more recently established semi-professions see Belgrave (1991).

⁷⁰ Truman (1984) and Cody (2001).

CHAPTER TWO

THE GENDERING OF NURSING AND ATTENDANT STAFF

As the previous chapter has demonstrated, a number of factors contributed to the development of the mental health service as a system informed by gender constructs. This chapter more closely draws on literature specifically relating to the nursing and attendant staff of mental institutions. It assesses the extent to which discourses concerned with the positioning, responsibilities, and culture of these staff, were informed by gender, and how these findings relate to the present study. Particular attention is paid to literature that draws on first hand accounts from female nurses and male attendants.

Although there has been growing interest in the place of gender in the definition, diagnosis and treatment of those diagnosed as mentally ill,¹ it appears that there has been less attention paid to gender in accounts of those responsible for their day to day care.² Wendy Williams' centennial history of Porirua Hospital *Out of Mind Out of Sight* (1987), supplemented official documents with interviews with ex-staff including nurses and attendants. In the British context, Diana Gittins's (1998) social history of Severalls Hospital from 1913 to 1997 draws on the stories of patients and hospital staff. These two significant histories of mental hospitals, which have drawn extensively on first hand accounts from female nurses and male attendants, are sourced in this chapter along with other relevant texts. Marion Kennedy a former mental hospital nurse, has written a fictionalised autobiography, *The Wrong Side of the Door*, to describe her experience of nursing at Porirua Hospital in the 1940s.³ Narratives such as Kennedy's allow things to be said that may be missing from so-called factual accounts.

¹ In New Zealand, for instance, this interest is given expression through the work of Albrow (1995), Blakeley (1993), Brookes (1992, 1998, 2001), Coleman (2005), Labrum (1990, 1992, 1995, 2005), Styles (1994, 1997), and Willis (1993). In their Australian studies, Coleborne (1997, 2003a, 2007), Coleborne and Mackinnon (2003), and Garton (1988, 2003), have considered gender.

² Thomas Harding's 2005 PhD thesis concerned being a man and a nurse, and Australian nurse P. Warelow's 2003 PhD topic was the significance of gender to Australian psychiatric nursing. English nurse Dean-David Holyoake has looked at the myths of maleness in nursing (2001).

³ Kennedy (1963).

This chapter opens with a discussion of what it was like for nurses and attendants to live and work in a mental institution during the 1920s - 1940s. The transformation from attendant to nurse is then outlined in conjunction with how the Nightingale ethos contributed to the construction of the female mental nurse. This is contrasted with how the male attendant was constructed.

Living and Working in the Mental Institution

Although the men attendants are necessary to maintain order and discipline with the male patients, I feel that an occasional visit by the Matron to this side of the institution might have some really beneficial effect and result in suggestions for the further comfort of the male patients, which would never occur to a man.⁴

As the quote above by Mr Bothamely a hospital visitor indicates, the male side of the mental hospital is represented as being different from the female side. Generally, official visitors' comments reflected the dominant discourses of the reporting period which defined women and men according to their gender positions. Bothamely reiterates this when he takes up the issue of boys living in male wards: 'I think little mites of 4 years could be better under the care of a woman.'⁵ Similarly, in 1897 F.H. Fraser observed, '[t]he management of the kitchen seems to be an improvement instead of the former system when managed by males.'⁶

Official reports note that the nursing care at Porirua for the period between 1925 and 1935 was of a very high standard on the women's side of the hospital. Mental nursing was portrayed as requiring persons with 'high personal qualities such as suitability of temperate and self control'.⁷ In her review of nursing of Sunnyside Hospital, Margaret Harraway also represents nursing care at this time as very good and identifies cleanliness and neatness as the order of the day.⁸ However, a critical counter-point to the official and somewhat benign representation of female nursing as orderly and homely is provided by a woman who nursed at Porirua in 1925. She said that the patients in F. Ward were very

⁴ Official visitor's report 22 May 1934 quoted in Williams (1987) p.96.

⁵ Official visitor's report November 1920 quoted in Williams (1987) p.71.

⁶ Fraser quoted in Williams (1987) p.52.

⁷ Dept. Mental Hospitals AJHR 1933 H-7 p.2.

⁸ Harraway (1992).

violent: '[T]hey were locked in single rooms and you couldn't go near them ... because many of them would tear you to pieces'.⁹ Another female nurse spoke of the routine and time-consuming tasks, such as cleaning, floor polishing, helping in the kitchen and laundry, and tending the coal ranges and open fires, that were needed to keep the hospital running. Contact with patients was described as a never-ending routine as patients were bathed, dressed, fed and supervised. The nurse said 'it was done in the way it was meant to be done ... but it wasn't nursing'.¹⁰ A nurse, who was recruited from the U.K. following the Second World War, suggested that observation was important. She said 'in all the years I was there [Porirua] I never got a knock ... because I saw the signs [but] it was very nerve wracking – you lived with tension all the time'.¹¹

The image of a "home away from home" is carried through in a report on the new nurses' home with descriptions of 'an attractively designed building of handsome dimensions'. The home was 'tastefully furnished' and 'had done much towards promoting the keenness and efficiency of the staff'.¹² Prior to 1928 when the nurses' home was built, nurses at Porirua were required to sleep in the wards. Even after the nurses' home was completed, on their "long day" of duty, nurses were seconded to sleep on wards or villas so they could be available to assist the night staff if necessary.¹³ Although it appears there was less surveillance of male staff, it was mandatory for male attendants to stay in their quarters following their "long day" and like the nurses, they also were required to get approval from the Medical Superintendent if wanting to return late to their quarters on their day off.¹⁴ The 1928 rule book introduced additional rules and regulations for night nurses: '[O]n no pretext whatever shall the male night nurse enter the female division ... nor the female night nurse enter any part of the male division, or permit any nurse or servant belonging to their respective departments to do so'.¹⁵

⁹ Anonymous interview quoted in Williams (1987) p.83.

¹⁰ Anonymous interview quoted in Williams (1987) p.182.

¹¹ Anonymous interview quoted in Williams (1987) p.183, 215.

¹² Dept. Mental Hospital AJHR 1930 H-7 p.5. The first nurses' home was built at Seacliff in 1908 with the intention of emulating general hospital practice (Brunton, 2001 p.339).

¹³ Williams (1987) p.98, 183 and Truman (1984). Duty days consisted of "long days" and "short days". Long days were from 7am – 8pm and short days were from 7am – 5pm.

¹⁴ Interview with James Nolan by Lois Wilson, 3 November, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/124.

¹⁵ Department of Mental Hospitals Rules and Regulations for Nurses (1928) p.11.

Nurses' training was not solely dependent on ward work, but also on 'the influence and discipline in the Nurses' Home – the discipline contingent on community life'.¹⁶ Nurses' homes rules and codes of conduct emphasised professional standards and obedience and respect for doctors and senior nurses. Female mental nurses were permitted to entertain 'lady visitors' only in the communal rooms of the Nurses' Home 'at the times and upon occasions approved by the Medical Superintendent'. Rule four stated that nurses returning to the Nurses' Home by car must leave the car as soon as they arrived home.¹⁷ The rules of conduct which applied to mental nurses were similar to those for general nurses in a similar time period. In *Nurses of Auckland* which explores the history of the general nursing programme in the Auckland School of Nursing, Margaret Brown questions whether many of the rules and regulations were for the benefit of the staff or for the institution. When leaving the nurses' home nurses were required to sign in and out and were not allowed to have visitors in their rooms. Visitors were to wait in the lounge and 'many an unfortunate male was sitting there when crowds of nurses poured out of the dining room, each one peering into the lounge to see if the visitor was for her!'¹⁸

The official descriptions of nurses' homes contrast with those given by male narrators of their quarters.¹⁹ One attendant said, 'if I stretched my arms out, my fingertips could touch the walls on both sides ... Every time the toilet was flushed downstairs, [in my room] there was a whooshing sound of water or air being expressed up a pipe six inches in diameter that went from the ceiling down through the floor'. The same attendant said that when he was in the dayroom of a particular male ward he was reminded of a Western movie, as most of the time staff stood in the middle, 'while the patients milled around us like Indians round the wagon'. When there was a fight, 'we all pitched in to break it up.'²⁰ Female and male staff narratives which described working in some wards as like "bedlam", are aligned more with the negative images that have become associated in many people's minds with mental hospitals in the days before effective medication and

¹⁶ Thurston (1930) p.208.

¹⁷ *Rules for Staff* (1940) cited in Williams (1987) p.183.

¹⁸ Brown (1994) p.89.

¹⁹ Female nurses lived in a "home", male attendants lived in "quarters". Female nurses ate their meals in dining rooms, male attendants dined in the "mess."

²⁰ Anonymous interview quoted in Williams (1987) pp.203-4, 207.

treatment was available, as are portrayals of disturbed patients being given drugs such as paraldehyde, physically restrained, and put in isolation rooms. These representations can usefully be placed alongside those of the nurses and attendants under review in the current study.

Staff lived on the Porirua estate and their lives are depicted as inextricably tied to the institution. Even after working a full day-shift, nurses were still required to attend the evening dances held fortnightly for the “better” patients. Dances were part of the therapeutic regime of asylums, and as Catharine Coleborne has indicated, were not only a reward for patients who assumed gender appropriate behaviour, but also were used to demonstrate to members of the community, the success of the asylum in fostering these behaviours.²¹ A strict hierarchy is shown as operating within the hospital with an aloof, authoritarian male medical superintendent in charge. In her study of mental hospital services in the Wellington area, Katherine Truman emphasises the power of the medical superintendent over hospital affairs, saying that at Porirua, even letters written to the Matron were answered over his signature.²² However, adherence to the rules did not apply just to nurses and attendants, *all* mental hospital staff were regulated to some degree by the dictates of head office.²³

In her study Gittins also represents the mental hospital as a separate community with a highly gendered organisational structure in which female patients were separated from male patients, female nurses from male attendants, and the executive from the hands-on workforce.²⁴ The various groupings within the hospital were physically separated by boundaries, locks and keys, and symbolically by varying degrees of autonomy and belonging. For the people within its confines, whether patients or staff, it became a “protected” place. Gittins uses the metaphor of a family; a family in which relationships

²¹ See Williams (1987) and Coleborne (2003a).

²² Truman (1984).

²³ See Appendix B for Duties of Attendants and Medical Staff 1928 and 1940. An example of the level of control exercised was “condemn day”. This involved each ward charge, once a month, presenting old, broken, or damaged items to a member of the office staff for replacement. Some condemning officers were known to weigh broken pieces of china so that a precise assessment could be made of the amount to be replaced. See Mackie (1981).

²⁴ Gittins (1998).

were governed and guarded by its own laws, clothing regulations, hierarchy, secrecy, space, temporality, and above all, gender. Although the most obvious boundary was between staff and patients, Gittins portrays the division by gender as even stronger. The male medical superintendent was the head of a hierarchical and bureaucratic family in which the matron was a kind of “supreme mother.” The male side of the hospital was run on military lines, while the female side is represented as following Victorian ideals of femininity. Although the matron had absolute power within the “house,” she is shown as being always subservient to the patriarch, the medical superintendent.²⁵ A nurse in Williams’ study spoke of not being encouraged to talk to patients and if asked by a relative for information to answer ‘ask the doctor’. It was, she said, ‘all very secretive’.²⁶

Few accounts of institutional life mention the importance of friendship, in spite of the fact that women and men lived closely in their separate nurses’ homes and quarters, often for years on end. Gittins has indicated that the mental hospital provided a safe place for women, whether patients or staff, particularly those who preferred relationships with other women.²⁷ At a time when some liaisons such as lesbian relationships were frowned upon, staff were accepting of each other and of the patients. We were, a nurse said, ‘tolerant of gay people, drug addicts, alcoholics, whatever. Where better to hide the stigma than in a stigmatized population?’²⁸ Nurse Henderson also represented the mental hospital as a close-knit community in terms of staff sticking together. Early in her career she was told, ‘[e]veryone looks after everyone else around here. It’s the first law of self-preservation’.²⁹ Just as in a family, it was all right to criticize one another and the system, but when outsiders made disparaging remarks, the mental hospital “family” showed solidarity.

The mental hospital “family” also reinforced the dominant gendered expectations in the outside world. Nurse Kennedy spoke of engaged nurses sewing for their glory boxes in the belief that without ‘masses of heavily embroidered linen the marriage could not be

²⁵ Gittins (1998).

²⁶ Anonymous interview quoted in Williams (1987) p.213.

²⁷ Gittins (1998).

²⁸ Anonymous interview quoted in Gittins (1998) p.156.

²⁹ Kennedy (1963) p.160.

consummated', and of nurses' home talk that suggested for women, 'marriage was the only thing that could bring a sense of security in life'.³⁰

From Attendant to Nurse

Warwick Brunton's substantive body of work on mental health policy in New Zealand from 1840 to 1947 traces the history of the transformation of mental hospital attendants into nurses and links nursing reforms in New Zealand with those of Britain. When Theo Gray was appointed Inspector General in the late 1920s, although some progress had been made toward developing the role of the nurse over the attendant, emphasis was still being placed on the nurses' warder functions. The male attendant uniform, introduced in 1898 was not unlike that of a prison warden and consisted of a blue serge jacket and trousers and a peaked cap. In line with the general hospital nurse, the female attendant wore a starched cap, apron, collar and cuffs. Matron and charge nurses like their hospital counterparts, wore a veil. Although the dictates of fashion meant that over time, starched apparel gave way to colour coded uniforms, the style remained similar to the uniform of the general nurse.³¹

It was generally recognised that recruiting women of the right caliber to mental nursing was never going to be easy. At the turn of the century one British medical superintendent complained,

I fear ... that the asylum nurse is rather looked down upon in some places, as if she belonged to an inferior order of the nursing profession ... Certainly, it is true that as yet asylum nursing has not commonly attracted women from the higher classes of society, whereas the hospital has quite often supplied the essential attraction, whatever it may be.³²

³⁰ Kennedy (1963) p.69.

³¹ Brunton (2001). Although in the Depression the brass buttons, braid and caps were done away with, basically the male uniform remained the same up to the 1970s. In the Depression, collars, cuffs and aprons were dispensed with for female staff and in the mid to late 1920s pink and white striped uniforms for probationers and blue for qualified mental nurses were introduced. Matrons and charge nurses continued to wear white.

³² *Asylum News* (1900) quoted in Carpenter (1980) p.136.

The literature suggests that the culture on the male side of the hospital had always been seen as different from that on the female side. For example, Miss McLean, a Porirua official visitor, reported in 1911 that a ward for typhoid patients on the female side, 'was bright and sunny and the patients appeared to be well nursed and cared for generally ...' However, she said that she couldn't speak so favourably of the male ward and considered 'it a pity that female nurses were not put on duty with these cases'.³³ The belief that nursing was women's work meant that there was support for females nursing male patients. An article written by Miss Thyne, Matron of an Edinburgh mental hospital, published in the *New Zealand Nursing Journal* in 1914, indicated that female nursing on the male side of the asylum was happening overseas. In pointing out that physically ill men were nursed by women, she questioned, 'why then because of a mental illness entirely exclude them from the society and acknowledged better nursing of women'? She wrote further that her own preference was to nurse male insane patients rather than female patients: 'The language is bad at times but no worse than that heard on the female side and insults offered to one are less frequent and virulent than those one receives from women'.³⁴

Inspector-General Gray sought to remove the proviso of promotion as of right by insisting that candidates for senior nursing positions be examined and he continued to appoint hospital trained general nurses to senior positions in mental hospitals. In female wards he replaced the titles "charge nurse" and "deputy charge nurse" with "sister" and "staff nurse". Often female general nurses were brought in over other staff which caused resentment, particularly amongst male staff. However, even when female nurses began to work in male wards in some mental hospitals, the chain of command remained sex-specific with female nurses under the command of the matron, and male attendants reporting to male head attendants. Moreover, the gendered nature of the work remained; matrons were responsible for the nurses, nursing care and indoor domestic activities on

³³ McLean (1911) quoted in Williams (1987) p.79.

³⁴ Thyne (1914) p.125.

both sides of the hospital, while head attendants were responsible for the attendants and the outdoor work.³⁵

Ordinary male attendants' salaries remained significantly higher than those of female nurses of similar rank. Moreover, male attendants were able to work in the service until the age of 65, with the expectation of superannuation, while female public servants were required to resign if they married. This meant that although there was a high turnover of female staff, single women who remained in the service were promoted faster than male attendants who often had to wait until older members retired. Matrons were either general hospital trained nurses or had both mental nurse and general nurse qualifications. Senior female nurses were favoured with new career opportunities in the form of supervision of nurses' homes and tutoring. Increases in salaries were used as a means of retaining single women in the service and under Gray's administration the salary gap between females and males at the higher levels narrowed.³⁶

Gray's discriminatory practices toward female nurses and male attendants provide insights into the ways gendered discourses were operating at the time, and how they were used as a strategy in mental hospital doctors' advancement toward professionalism. The success of the doctors' campaign depended on the presence of the nurse "hand-maiden" and as everyone knew, nurses were women. Gray's introduction to the 1940 Mental Hospital Department rule book which emphasised 'a nurse's intelligence, humanity, vocation, service, a sense of nursing professionalism, and hospital pride', was intended to consolidate the move away from a male industrial outlook toward a female professional one.³⁷ The association of mental nursing with general nursing and the female role led to a gender-based dual system. When placed within a wider context, gendered discourses around female nurses and male attendants, can be viewed as indicative of the power-plays and male hierarchies operating within the institutions.

³⁵ Brunton (2001). See also Gittins (1998).

³⁶ See Brunton (2001). By 1947 matrons received 83 per cent of head attendants' pay.

³⁷ Dept. of Mental Hospitals Rules for Staff 1940 p.1.

The Nightingale Ethos and the Construction of the Female Nurse

As indicated by Brunton and others, the model to which female mental nurses were to aspire was the general nurse. In her study of the statutory regulation of nursing in New Zealand from 1901-1997, Patricia French identifies the economic, political and social factors that influenced nursing's development. Florence Nightingale is identified as one of these influences. French posits that the social organisation of society in the mid to late nineteenth century was underscored by gender issues, and identifies Florence Nightingale as one of a small group of British women who fought for women's entitlement to enter education and the working world outside the home. Nightingale capitalised on the wider changes occurring in society and created a structure that ultimately led to the development of modern hospital nursing both in England and in New Zealand. These developments became formalised in legislation, nursing practices, and unwritten laws. After selection, the "ideal nurse" was subjected to a system with explicit codes of conduct on and off duty, uniforms denoting rank, and a specific training regime. Underpinning the Nightingale ethos was the idea that it was woman's nature to care, nurture and be morally good.³⁸

Nightingale's conservative feminist views, with their roots in Christian idealism and nursing as a "calling", placed emphasis on women's abilities for doing rather than thinking. As a result, future generations inherited a profession dominated by medicine and by men. In tracing general nursing's history in America, Susan Reverby found that well into the twentieth century many saw the work-place skills of the nurse as a womanly art and wanted a 'reinfusion into nursing of spirituality and service'.³⁹ In a published address to New Zealand nurses in a 1932 nursing journal, Dr Elizabeth Cole reminded them that women and men had different qualities: '[W]oman has always been the housekeeper and protector of children ... she is more idealistic, more intuitive and more understanding; whereas man is more logical, reasoning, aggressive'.⁴⁰ The publication of

³⁸ See French (2001) and Rodgers (1985). For discussion of the social and historical basis for the ideologies of nursing see Williams (1978).

³⁹ Reverby (1987) p.9.

⁴⁰ Cole (1932) p.282.

views such as these reinforced the Nightingale ethos of nursing and traditional view of women.

French maintains that although nursing directives appeared to originate from the Nurses and Midwives Board, the control exercised by the medical profession, was an influencing and constraining factor in the 'power/knowledge' base of nurses.⁴¹ Unlike her predecessor Grace Neil who maintained nurse training was the role of nurses, Hester Maclean, Assistant Inspector of Hospitals and later Director, of the Division of Nursing, engaged doctors as both teachers and examiners. In her critique of the persistence of the Nightingale ethos, Jan Rodgers has suggested that in declaring that MacLean had 'too lofty opinion of the male', Neil was decrying nursing's dependence on male authority for the production of nursing knowledge.⁴² In dissecting the politics behind nursing, Jane Salvage has argued that the idea that formal training was needed over and above 'women's supposedly instinctive caring attributes' is fairly new and was introduced to meet the needs of doctors for handmaidens to do their bidding rather than a belief in caring as a desirable nursing skill.⁴³

Although French's thesis is primarily concerned with general nursing, she mentions psychiatric nursing as one of the "specialties" which developed within nursing, and the 'power/knowledge relationships within and between them'.⁴⁴ An amendment to the 1939 Nurses and Midwives Act cleared the way for males to register as general nurses and made provision for the recruitment of male nurses for the first time in 38 years.⁴⁵ A further amendment to the Act enabled female mental nurses to sit the general Nurses' State Preliminary Examination after one year's training.⁴⁶ This concession, which was

⁴¹ French (2001) p.43.

⁴² Rodgers (1985) p.98.

⁴³ Salvage (1985) p.2.

⁴⁴ French (2001) p.39. French also uses the New Zealand syllabus for Psychiatric Nurses as an example of outside influences on nursing. Her argument is that the English registration authority asserted power over mental nurse education in New Zealand in terms of curricula content and through the identification of hospitals and training schools where education could be carried out. Before reciprocity was achieved in 1949, the New Zealand syllabus was checked against those of England and Wales.

⁴⁵ Acts pertaining to nursing for the period under review are the Nurses and Midwives Registration Act (1925) (amendments 1926, 1930, 1933, 1939, 1943, 1944) and the Nurses and Midwives Act (1945).

⁴⁶ Successful candidates on the completion of three years' mental nurse training were given one year's

regarded as an important breakthrough in moves toward a closer affiliation between mental and general nursing, did not include male mental attendants.

Just as mental illness was viewed as shameful by the general public and its study a lesser discipline in the medical hierarchy, so too were mental nurses looked down on by their general hospital colleagues. An early article in the nursing journal noted that 'because the nursing of mental cases is not a study worth devoting thought to, by nurses of the best most enlightened and most highly trained class', it is too often left 'to the unskilled, uneducated and unrefined, who only take it up as a means to earn good wages with the least amount of work'.⁴⁷ An editorial which followed emphasised that '[a] nurse must be a woman, working not in the first place for the sake of money-making, but for the good of her fellow creatures'.⁴⁸

Constructing the Male Attendant

It was 1934. We were all unemployed. I got fed up going up and down the line for jobs and then I saw an advertisement [at the mental hospital] for a cricketer. In them days if you were good at cricket or football it didn't matter if you could read or write. I had to take the nearest job.⁴⁹

While, at least in theory, female mental hospital nurses were being constructed in the Nightingale image, as the above quote indicates, male attendants were constructed as good sportsmen. According to Williams 'it was sporting skill which would secure a person a position on the [Porirua] hospital staff'.⁵⁰ Stereotypical gender differences were at play in the selection of staff. Female nurses were expected to be motherly and efficient, and were believed to bring particular feminine qualities to the ward setting, while male attendants were required to have military or penal experience and be proficient in agriculture. Women were also seen as more accepting of authority than men. Not surprisingly, these gender stereotypes reflected the gender order of women and men in the world outside the asylum. A number of disincentives including low wages, long

dispensation in their general training.

⁴⁷ Maclean (1908) p.41.

⁴⁸ Maclean (1909) p.3.

⁴⁹ Anonymous interview quoted in Clarke (1978) p.73.

⁵⁰ Williams (1987) p.141.

hours, and the fear of contamination from the insane, meant asylum work was often seen 'as an occupation of last resort' and, as previously discussed, not suitable for women.⁵¹ Given the stress on order in the asylums, it was inevitable that staff would be recruited more for their brute strength than their benevolence. Because in many instances they came from the same working class section of the population, male staff in particular are represented as exhibiting many of the same characteristics as their patients.⁵²

The development of the asylum "industries" also followed the typical pattern of the division of labour at the time. Tracing the development of occupational therapy in New Zealand, Linda Wilson asserts that there is evidence in the early records that a number of male attendants already had skills in a range of occupations before joining the mental hospital service.⁵³ Male nurses and patients, and to a lesser extent, female nurses and patients, are represented as essential components of the mental hospital's economy and as 'the cornerstone of the hospital'.⁵⁴ Male attendants supervised and participated with patients in the mental hospital "industries" while female nurses worked alongside patients on the "home" front. Patients unable to work were placed in airing courts. A comparatively small number of staff ran hospitals which meant that nurses and attendants were responsible for a range of tasks. As well as some being skilled artisans, attendants (and patients) were also drivers, boiler stokers and chimney sweeps. In her study of nineteenth century asylum work culture in Victoria, Lee-Ann Monk contrasts the different ways female and male staff organised their work spaces. Not only did attendant men signal their difference from the male "lunatic", they also defined and organised their work to denote their sexual difference and masculinity. In this way, 'attendant men were complicit in producing and reproducing the power relations within the asylum'.⁵⁵

Both Williams and Gittins represent the mental hospital as a work place which many valued. Along with first class sports facilities, it provided security, the promise of a pension, and accommodation, particularly for working-class men. It was often a place

⁵¹ Carpenter (1980) p.134.

⁵² Ibid. (1980).

⁵³ Wilson (2003).

⁵⁴ Truman (1984) p.38.

⁵⁵ Monk (2003) p.71.

where several generations of a family would be involved. The relative stability of staff on the male side provided a strong recruitment base for trade unions.⁵⁶ Inspector-General Gray's 1936 report to government suggests that there was certain inevitability about the involvement of male attendants and the Public Service Association (PSA) in hospital affairs. He wrote that, in respect to staff hours, the matter was 'complex' and 'one of our head attendants is co-operating with the Secretary of the Public Service Association to formulate a plan acceptable to every one concerned'.⁵⁷ Gittins has maintained that the different attitude of female nurses and male attendants towards unionism arose from the structural differences between women and men's lives: the marriage clause, family responsibilities, and their often short time in the job, made allegiance to a union hard for women.⁵⁸

Because the turnover rate was comparatively low on the male side, 'there flowed a network of invisible and sometimes secret and interrelated allegiances'.⁵⁹ In his social history of insanity in New South Wales 1880-1940, Stephen Garton represents staff as operating their own unofficial code of behaviour. This prevented them from reporting on each other as those who did were ostracised and punished. Additionally, the custodial nature of the work meant that their actions were governed by institutional norms of efficiency and order rather than the interests of the patients.⁶⁰ A female nurse at Porirua said, '[w]e knew at the time there were lots of things ... there would be the odd one, as in every job, that shouldn't have been on the job'.⁶¹ In Nurse Henderson's narrative, female nurses are represented as dependant on male attendants for information. She instanced a newspaper article on cruelty and neglect at the mental hospital where she was working (Porirua) where a female nurse asked, 'who has a friend among the attendants [so we] can find out more about this business?'.⁶²

⁵⁶ Carpenter (1980) and Brunton (2001).

⁵⁷ Dept. Mental Hospitals AJHR 1936 H-7 p.4.

⁵⁸ Gittins (1998).

⁵⁹ Ibid. (1998) p. 158. See also Carpenter (1980).

⁶⁰ Garton (1988). See also Department of Internal Affairs (2007).

⁶¹ Anonymous interview quoted in Williams (1987) p.182.

⁶² Kennedy (1963) p.175. Nurse Henderson said that it was the male side that was always attacked. However, negative reports in newspapers and the like also impacted on female nurses who felt themselves to be 'socially ostracised' because of the negative associations attached to their work.

The complex gendered hierarchies within the nursing profession meant that generally the female mental nurse was seen as inferior to the general nurse but superior to the male attendant. Gray himself was often at odds with the male attendants, and in believing them only suitable for manual work with outside gangs, exhibited similar prejudice to other Inspectors-General.⁶³ However, he also recognized that male attendants were the backbone of the institutions and he was anxious that they were acknowledged as such. Toward this end he introduced an examination which permitted men to advance to the position of head attendant.⁶⁴ Male attendants zealously guarded their separate but parallel career pathway but in some ways were stymied by the distinctive system of mental nurse registration. Unlike female nurses who had met the registration standards for general nurses, their training was not transferable and there were not many career opportunities beyond the Mental Hospital Department. However, for those who continued to work in mental hospitals, as many did, Brunton hints that there were channels for advancement, albeit often informal.

Discourses around the different ways female nurses and male attendants came to be recognised in the mental hospital system were decidedly gendered. Female mental nurses were actively encouraged to follow the dictates of general nursing in relation to training and professionalism, while male attendants used their membership in the PSA to protect their position as working men with entitlement to a working man's wage.⁶⁵ In Gender Issues and Nursing Practice Margaret Miers has discussed the way in which cultural constructions of femininity have shaped nursing as both profession and practice. She asserts that men in nursing offered a challenge to the 'gendered order in health care'. Male asylum attendants, in line with male workers in the industrial sector, drew on their membership in unions to protect their interests, 'adopting an industrial rather than a domestic view of organisation'.⁶⁶ On the other hand, Thomas Harding has argued that

⁶³ Brunton (2001).

⁶⁴ Most senior nurses and attendants held the senior mental nurses certificate. See Truman (1984).

⁶⁵ Brunton (2001) and Miers (2000).

⁶⁶ Miers (2000) p.88.

men formed or joined unions only because for a long time other avenues within nursing were denied them.⁶⁷

Arising from Gittins point concerning the structural impediments in women's lives as the reason for their low participation in unions, are questions to do with the relative power of women and men both within the mental hospital environment and in wider society. Margaret Harraway's account of the stance taken by male staff at Sunnyside Hospital, when in 1937 they were faced with a female tutor sister, suggests these reflected traditional male work place attitudes toward female workers at the time. Like all mental hospitals, Sunnyside was strictly divided into a female and a male side, which meant that usually women were answerable to women and men answerable to men. Not only did male attendants at Sunnyside express dissatisfaction at a woman having control over them, they also objected to assuming the role of "nurse". In their minds, the role, equated as it was with women, was not sufficiently masculine. Male attendants were often ex-tradesmen and servicemen and 'were tough and uncompromising; they were in control of society'.⁶⁸ The very idea of a woman having power over them was beyond their comprehension. A woman who had nursed at Porirua also spoke about the difficulties she encountered at the time of integration. She said, '[w]e went through quite a rough patch at that time because some of the men didn't like a woman telling them what to do'.⁶⁹

Conclusion

Within the literature there is evidence to suggest that discourses relating to the positioning, responsibilities, and culture of female nurses and male attendants working in mental hospitals for the period under review were informed by gender constructs. The mental hospital was a place in which staff as well as patients were under surveillance and were complicit in the maintenance and perpetuation of normative gendered behaviours. Buildings were designed to keep the sexes, both patients and female nurses and male attendants, apart, and practices reflected dominant social and cultural discourses of

⁶⁷ Harding (2005).

⁶⁸ Harraway (1992) p.17.

⁶⁹ Anonymous interview quoted in Williams (1987) p.215. Here the narrator appears to be talking about female nurses taking charge of male wards.

femininity and masculinity, and reinforced rigid gender roles. Female nurses and female patients did housework while male attendants were employed in industry and worked the land. Male attendants, particularly, are discursively constructed as manual, blue collar workers, in many ways similar to their male patients. They exhibited male solidarity and differentiated themselves from the female work force and are also represented as sportsmen and union men. Implicit in these constructions and representations is the notion that the male side of the mental hospital was different from the female side, and operated according to a different ethos with its own masculine codes of conduct.

For female nurses, double qualifications (registration as both a psychiatric nurse and general nurse) increasingly became the order of the day. Male attendants have been shown to have been resentful of these changes and of having trained general nurses brought in over them. However, male attendants are also represented as valuing unionism over professionalism. Carpenter has suggested that female nurses were more inclined than their male counterparts to embrace the 'culturally sanctioned expectation of self-sacrifice' of general nursing.⁷⁰ Male attendants were not so impressed by the rhetoric of nursing's claims of vocation or profession. Neither was the general nurse hierarchy impressed by the thought of male mental nurses in their midst. Changes in nursing legislation meant that intersecting but competing discourses arose within the mental hospitals, all of which were heavily gendered. As discussed in Chapter One, professionalism, with its connotations of formal training, became associated with the female nurse, while trade unionism, the perceived antithesis of professionalism, became associated with working class male attendants.

It has been suggested in the literature that when changes were afoot to align mental nursing with general nursing, male attendants sought to distance themselves from a role which was subservient to male doctors, and carve a niche for themselves in other ways. Harding has suggested that because they had nowhere else to go, male attendants turned to the PSA as their voice in industrial and professional matters. Yet the question arises as to whether this really signalled a change or if this was a reflection of the way things had

⁷⁰ Carpenter (1980) p.143.

always been. The literature suggests that the nature of mental hospital work meant it had always been more associated with unions and working class male values, rather than with female nursing ones.⁷¹ Conflicting views in the literature has exposed unevenness in the ways in which women and men were relatively advantaged and disadvantaged by discourses of gender.

Although doctor's⁶ contact with patients was often minimal, generally, there is an abundance of material on the role of psychiatrists whether as theorists, social engineers, dispensers of experimental treatments or administrators. The level of attention to male doctors in the literature reflects the relative positioning of women and men vis a vis medicine and nursing, and in society. Much of the nursing literature, primarily focuses on nursing as 'a ghettoized profession relegated to women's sphere',⁷² the power relations between male doctors and female nurses, and critiques of the domination of medical knowledge in the nursing syllabus.⁷³ As discussed, the construction of the female mental nurse in the mode of the general nurse was part of the move by mental hospital doctors to establish themselves as a profession similar to general medicine.

However, the involvement of men in nursing, which Stevenson has described as 'next to motherhood ... perhaps the most archetypal of womanly occupations',⁷⁴ brings another dimension to the analysis and raises issues which do not appear to be adequately addressed in the literature. The rise in status of psychiatrists seemingly also raised the status of female mental nurses and the elevation of the position of the female nurse over the male attendant theoretically meant that the common pattern of women being consistently disadvantaged relative to men was disrupted. Arising from this are questions over and above those relating to the influence of the medical profession. These concern the relative influence and power of female nurses and male attendants. The literature covering the period under study in this thesis, generally, does not explore how gendered

⁷¹ Brunton (2001) asserts that from about 1887 attendants had established links with the embryonic labour movement to further their cause.

⁷² Valentine (1996) p.98. See also Harding (2005) and Gamarnikow (1978).

⁷³ See for instance Rodgers (1985), Salvage (1985), Roberts and Group (1995), Valentine (1996), Papps and Olssen (1997), and Hallam (2000).

⁷⁴ Stevenson (1994) p.6., See also Stevenson (1997).

discourses may have impacted on the culture of the mental hospitals, nor in the main, locate mental nursing discourses historically within a social and cultural context.

Within documents produced to celebrate the milestones of various mental institutions the nursing service is usually but a small part.⁷⁵ One exception is Margaret Harraway's 1987 booklet on the history of nursing education at Sunnyside Hospital. Margaret was also an interviewer for two of the oral histories included in this current project. Another exception is the small publication produced by the Seaview School of Nursing committee to mark the closure of the school in 1992. Much New Zealand research to date at masters and doctoral level, including Brunton's substantive body of work, has not been about psychiatric nursing as such,⁷⁶ but rather about mental illness, the development of policies, institutions and services generally.⁷⁷ Annual returns and reports to government, which purport to present the "facts" of mental illness and institutional life, tell only one side of the story. Often missing from these accounts are the voices of the patients⁷⁸ and those responsible for their day-to-day nursing care. In other published works, both those dedicated to the topic of mental illness and mental institutions, and those of general social history, mental nursing is sometimes given a mention, albeit often brief.⁷⁹ As mentioned, works of fiction also offer valuable insights omitted from descriptive and scholarly accounts.⁸⁰ In my analysis of the oral history tapes, I hope to go beyond the surface of the

⁷⁵ Commemorative publications include Wendy Williams' substantive history of Porirua Hospital (1987), one by the Otago Hospital Board marking the demolition of the Seacliff Hospital buildings (1972), and a history of Tokanui Hospital (1997) compiled by Rodger McLaren as part of the final celebrations of Tokanui's life. Although Tod's 1971 history is about the district of Seacliff, he devotes several chapters to the history of Seacliff Hospital. For instance, past superintendent, Truby King, is given a chapter as is Lionel Terry, a notorious ex-patient. On the occasion of Seaview's one hundredth anniversary, and its one hundred and twenty-fifth anniversary, Warwick Brunton (1972, 1997) produced commemorative documents. M.Hunt (1990) has written a history of Lake Alice Hospital.

⁷⁶ A number of researchers have usefully turned to patient case-books to gain insight into the experience of patients. See for instance: Albrow (1995), Blakeley (1993), Brookes (1992), Coleborne (1997), Labrum (1990, 1992, 1995, 2005), Matthews (1984), Styles (1994, 1997), and Willis (1993).

⁷⁷ An exception is Kate Prebble's (unsighted) recently completed thesis on psychiatric nursing between 1939 and 1972 (personal communication with author).

⁷⁸ Among those who have taken account of patient's voices are Hill (1994) and Gittins (1998). See also Department of Internal Affairs (2007).

⁷⁹ Published works include Barbara Brookes and Jane Thomson (Eds.) (2001) *'Unfortunate Folk'*. General histories include Barbara Brookes, Charlotte Macdonald and Margaret Tennant, (Eds.) (1992) *Women in History 2*, and Linda Bryder and Derek Dow, (Eds.) (1995) *New Countries and Old Medicine*.

⁸⁰ Authors who have written about their own experiences of mental illness both as "fact" or fiction include Americans, Charlotte Gilman (1973), Sylvia Plath (1996) and Kate Millet (1991); English

texts in order to better understand the experiences of female mental nurses and male attendants in their wider social and cultural historical context

CHAPTER THREE

METHODOLOGY

Having looked at how society and various aspects of the mental health system, including the positioning of professionals working within the institutions was informed by constructs of gender, this research seeks to analyse ways in which gender was operating within the oral histories of the nurses and attendants within this profession. The use of oral history raises a number of complex methodological issues which will be discussed in this chapter. These include the use of oral history as text, the influence of poststructuralist thought on understanding oral history, how discourses operate, and the constructed nature of memory and gender. The research process and methods used for the analysis of the oral history texts are also discussed.

Oral History as Text

[T]he past existed, but reconstruction of the past is not possible, leaving only the *representation* of it in texts, for the historian to study.¹

As the above quote implies, only representations of the past can be found in texts. Oral history becomes a particular kind of text through a process of transcribing, indexing and summarising. It starts with ‘the orality of the narrator but is directed (and concluded by) the written text of the historian’.² According to Italian oral historian Alessandro Portelli, oral history ‘is the genre of discourse which orality and writing have developed jointly in order to speak to each other about the past’.³ Megan Hutching argues that few people will have the opportunity to listen to archival interviews; it is only by turning voices into text that people’s stories can be widely distributed. She contends that moving from the often disjointed raw material to a coherent narrative is a complex process, based on the assumption that the finished product ‘remains faithful to the intent and tone of the interview’.⁴ However, understanding the discrepancies in the production of oral histories

¹ Brown (2005) p.169.

² Portelli (1997) p.5.

³ Ibid. (1997) p.5.

⁴ Hutching (2004) p.173.

is possible, only when the interview is regarded as a text rather than as a transparent reproduction of “reality”. In order to make the language of an oral history into a text it has to be “opened” to contain a meaning, but, because there is no closure in a text it is open to multiple meanings.⁵

Women’s oral histories have had a role to play in broader feminist agendas of valuing and recording women’s lives and women’s accounts of their experience. The influence of postmodern theory suggests a move beyond the stage of traditional historiography and the focus on retrieving women’s “truths”, to a more nuanced understanding of the complexities of oral history methodology.⁶ Joan Scott has argued that when meaning is regarded as transparent, critical examination of the workings of the ideological system ‘its categories of representation (homosexual/heterosexual, man/women, black/white as fixed immutable identities) is precluded.⁷ Considering both oral accounts and memory as constructions, gives rise to different modes of studying experience, including the deconstruction of texts. Deconstruction is based on the assumption that within a text there are a multiplicity of signs, discourses and structures which can be “read” from the text. Analysis involves reading against the grain of the surface content, and becoming aware of the assumptions underpinning knowledge claims. Deconstructive practices not only lay bare the tensions which are present in discursive representations, but also provide opportunities for challenging dominant representations.

The Influence of Poststructuralist Thought

Poststructuralism highlights the intertextuality of reading, writing, and oral narratives and the dependence on historical and social specificity.⁸ Intertextuality, the notion of a text borrowing narrative characteristics from other texts, means it is never possible to posit the final definitive meaning of a text because intertextuality is everywhere. A discourse is created in response to other discourses and takes its meaning in relation to other complex systems of meaning. Yet each retrieval creates something new and each repetition

⁵ Brown (2005).

⁶ Gluck and Patai (1991).

⁷ Scott (1992) p.25.

⁸ Ibid. (1992). Also see Scott (1988) and Edwards (1993, 1995).

produces unique meanings and effects.⁹ The texts under study were partial and indexical in nature in that their meaning is not fully contained within them; their meaning is always dependent on reading them in their historic and social context. These texts would already be embedded in political assumptions, for instance, about the gendered nature of labour and mental nursing. In telling their stories, it was envisaged that the nurses and attendants would call on particular cultural representations, and one of my tasks was to look for these representations, for example, the ideal female nurse fashioned in the Nightingale image, and masculine counterpoints to such images. Concentrating on the sets of understandings that were available to the narrators, and putting systems of meaning at the centre of the investigation, enabled analysis of the discursive context in which meanings are and were constructed.

In discussing how poststructural theory can be usefully put into practice, historian Judith Newton has explored how systems of meaning and the material interact. She raises questions concerning the influence public written representation ‘with its complex dream work and contradictions’ has on the way ordinary women and men live their lives and how cultural meaning is transmitted.¹⁰ New Zealand historian Caroline Daley has argued that we cannot regard women and men ‘as disembodied voices, as nothing more than texts for our benefit’.¹¹ In response to Newton’s questions and Daley’s critique, women’s and men’s experiences in relation to their cultural and historic significance, and the way in which they may have been affected by material and other social practices, was a consideration in my analysis. This meant paying attention to the way systems of meaning interacted with material conditions and to the relationship between prescriptions of mental nursing and its practice as constructed by the nurses and attendants during the interview process. Feminist historian Joan Sangster asks, ‘can the interview not be interpreted with a keen materialist and feminist eye to context, and also informed by post-structuralist insights into language?’¹² Sangster’s question is premised on the focus of

⁹ Brown (2005) and Rose (1999).

¹⁰ Newton (1989) p.19.

¹¹ Daley (1998) p.344.

¹² Sangster (1998) p.96.

inquiry still being the cultural construction of memory but set within a framework of economic and social relations.

Studying discursive representations in published books and articles, unpublished theses, government records, pamphlets and newspapers, was an important step in this current research project for understanding how different forms of representation justified particular sets of knowledge. What has been written, for instance, about the organisation of mental hospitals and their staff is not so much a straightforward relaying of the past, but rather, needs to be contextualised and understood in relation to its cultural and historic significance. That is, instead of being seen as undeniable “facts” accounts need to be viewed as particular ways of representing the past. What writers choose to include and exclude, and the way material is presented is equally as important as what is actually said.

Daley has also explored the notion that oral history has a gendered *form* and that female and male narrators construct themselves differently. In oral interviews carried out for a community study investigating the role of gender in a small New Zealand township, she found that the voices of the women shared a lot in common with other women as did the voices of men share in common with other men. For Daley, how a narrator “performed” indicated that memories were shaped by dominant discourses of gender.¹³ Drawing on feminist philosopher Judith Butler’s notion of performativity of gender, Daley concludes that oral histories are ‘aural performances of gender’.¹⁴ Briefly, according to poststructural theory, language, rather than involving factual statements, is a performative group of practices.¹⁵ The notion of performativity intersects with postmodern understandings of identity as performance and is taken up by Butler to conceptualise gender as a discursive effect.¹⁶ Butler’s concept of the performativity of gender has been both embraced and challenged by feminist theorists. Elizabeth Grosz, for instance, has drawn on the notion of ‘bodies and discourses producing one another’, to formulate the idea that the physicality and sexuality of the subject leaves its traces in the texts

¹³ Daley (1998) p.355. See also Daley (1992, 1999).

¹⁴ Daley (1998) p.345.

¹⁵ Andermahr et al.(2000).

¹⁶ For elaboration of “performativity” see Butler (1990, 1993).

produced, just as the ‘processes of textual production also leave their trace or residue on the body of the writer (and reader)’.¹⁷ In discussing what distinguishes a feminist poststructuralist text from other texts, Grosz suggests the possibility of new discursive spaces to contest the limits of common methods of producing and understanding texts.¹⁸ My study, by including both women and men, provides opportunity to explore aural performances of gender and to create a space for the construction of new meanings. The analysis moved away from a merely descriptive account of women and men’s experiences as mental nurses and attendants to one which regarded knowledge as residing in and produced by discourses.

How Discourses Operate

In the work on language of both post-structuralist feminisms and feminist linguistics, there has been a move from the analysis of the decontextualised verbal text to much more theoretical understandings of the making of meanings in complex social and cultural contexts.¹⁹

As touched on in the quote above, discursive practices are understood as meaning-making processes involving not only cultural practices of discourse and signification but also other social practices. Projects which are influenced by Foucauldian ideas, as mine to some extent is, do not make sharp distinctions between the material and the cultural. Social practices are both discursive and material. Michel Foucault’s all-embracing definition of discourse is exemplified in his text The Birth of the Clinic. In this work, Foucault studies the development of medicine and the materialisation of the clinic to advance the notion of discursive formations as far-reaching social strategies with personal, administrative and institutional manifestations. For Foucault, discursive formations not only create groups of people with defined characteristics such as the “madman”, but also the process is personal in that it creates individual subjectivity. He eschews the Marxist idea of the relationship between ideology and social systems as

¹⁷ Grosz (1995) p.21.

¹⁸ Ibid. (1995).

¹⁹ Threadgold (1998) p.179.

consisting of surface and depth, and uses instead the concept of discursive practices, in which knowledge/power is circulated at macro and micro levels.²⁰

Theories of discourse were developed by Foucault in an attempt to understand the relationship between language, social institutions, subjectivity and power.²¹ Discourses have been described as ‘interrelated systems of statements which cohere around common meanings and values’, and as such, represent culturally coded systems of meaning rather than a direct transaction with “reality”.²² It is only ever possible to show versions of “reality” in ‘human-constructed words, sounds, pictures and images’ which are produced in the form of a “text”.²³ Discourses are a product of social and cultural factors rather than individual thoughts and ideas. Chris Weedon explains discursive fields as ‘competing ways of giving meaning to the world and of organising social institutions and processes.’²⁴ It is within these discursive fields that individuals are presented with a range of possible subject positions for constructing meaning. Understanding that individuals are not unified in their subjectivity, but take up different positions on different occasions, or even within the same narrative, was useful when confronted with contradictions in a narrator’s account. Discourse understood as a structuring principle of society, reproduced within ‘modes of thought’, social institutions and individual subjectivity, provided the theoretical framework for analyzing the oral histories of the nurses and attendants under review.²⁵

Discourse theory and practices provided the tools for exploring what it meant to be a female nurse or male attendant in the 1920s - 1940s. The texts produced by the narrators were viewed as discursive representations and examined within the context of the wider discursive fields in operation. My understanding was that the nurses and attendants did not create meanings as autonomous subjects, rather, they were already positioned in multiple and competing discourses. For instance, they would have been positioned within

²⁰ Foucault (1973). Generally, the concepts of ideology and discourses have been retained with critics distinguishing between them. See Andermahr et al. (2000) pp.65-6.

²¹ See Foucault (1980b).

²² Holloway (1983) p.231 quoted in Gavey (1989) p.463. See also Weedon (1987).

²³ Brown (2005) p.7.

²⁴ Weedon (1987) p.35.

²⁵ Ibid. (1987) p.41.

influential discourses of psychiatry, medicine, the economy, education and religion. These discourses, moreover, would not have been disconnected from other discourses, for instance, of nursing, the family, homosexuality and heterosexuality, and femininity and masculinity. Specialist areas such as medicine and psychiatry are formally structured into society and symbolise power and control of knowledge not available to others. Unlike formal bodies of knowledge, discourses such as sexism or racism are not systematically programmed as formal bodies of knowledge, nevertheless, these discourses also function to empower some people at the expense of others.²⁶

From a Foucauldian perspective, power is exercised rather than possessed by an individual, operates in an amorphous fashion from below, and is omnipresent. It can also be productive rather than negative and restrictive. Knowledge and power are inextricably connected. Discourses, since they delineate knowledge, are the form in which the power of a particular group exists and functions. For Foucault ‘there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations’.²⁷ In discussing the notion of dominant and resistant discourses, Teresa de Lauretis refers to spaces which are available on the margins of hegemonic discourses and ‘carved at the interstices of institutions and in the chinks and cracks of the power-knowledge apparatus’.²⁸ This analysis emphasises the continual movement between the discursive space of the positions made possible by hegemonic discourses and the spaces at the margins. These notions of power were useful when thinking about the staff of mental institutions and the possibility of individual agency. The respective meaning that each nurse and attendant gave to her or his mental hospital work experience was understood as resting on the extent and power of discourses, and their positioning within them. In spite of opinions to the contrary, Joan Scott believes that within Foucault’s conception of power there *is* room for agency. This is not the agency of autonomous beings employing free will though, but rather denotes ‘subjects whose agency is created through situations and statuses conferred

²⁶ Layder (2006) p.120.

²⁷ Foucault (1995) p.27. See also Foucault (1980a).

²⁸ De Lauretis (1987) p.25.

on them'.²⁹ In this present study, this meant being aware of the positioning of the nurses and attendants in the hierarchies of power operating in the mental institutions.

Contextualising the oral narratives historically and culturally, enabled consideration of the discourses circulating at the time the narrators were working. These discourses could then be analysed in terms of expressions of power relations and how in the process of reconstructing themselves, the narrators may have either reproduced dominant discourses, or alternatively, produced a counter discourse. Questions arose concerning whose vested interests were served by the ways in which gendered discourses of mental illness and mental nursing operated. How did the narrators reconstruct themselves? How were the practices of mental nursing influenced by the processes of the psychiatric diagnosis which functioned as a sign in decisions in how patients should be treated? In attempting to analyse this, it was important to recognise the historical specificity and the multiplicity of discourses; their relation to what had gone before and how mental health practices were not the product of a single discourse.

Memory as Construction

[Memory] is something that is shared and the activity of remembering can also be collectively and discursively accomplished.³⁰

According to social psychologist Michael Billig, attention should be paid to the ways in which people talk about their memories for when such talk is analysed, remembering, rather than being located in internal mental entities, is found to be embedded in social and discursive activity.³¹ English historian Penny Summerfield has suggested that creating autobiographical stories is a cultural practice in which everyone participates to some degree. The aim of the process is to arrive at an acceptable version of the self. But public memory is not drawn on arbitrarily in the production of personal memory. Rather, the most acceptable version among a number of possibilities is chosen.³² New Zealand oral historian Anna Green describes remembering as a complex business which involves

²⁹ Scott (1992) p.34.

³⁰ Billig (2005) p.213.

³¹ Ibid. (2005).

³² Summerfield (1998).

decisions about what to include and exclude, and in which a narrator will often draw on metaphorical language and cultural myths in order to make sense of the past.³³ What is remembered and retold, and how it is recounted indicates that in the reconstruction, individuals understand the cultural significance of their experiences.³⁴ Experiences are *re-*remembered in the light of changed public meanings, or in poststructuralist terms, according to the range of discourses available to them at particular times. In remembering experiences and making sense of them, private and public memory is constantly negotiated.³⁵ The “popular memory” approach provides insights into the relationship between public and personal accounts.³⁶ The “cultural circuit” suggests that both personal and public accounts are constructed.³⁷ This means that local and particular accounts are unable to escape the effects of the conceptions and definitions of dominant public representations. That is, they are formed from available ways of understanding (through discourses) which fit with a sense of the self and expectations of who the audience is at the moment of telling. Drawing on the theory of “composure”³⁸ Summerfield argues that the version chosen is the one which can best be lived with, but because discourses are multiple, conflicting and splintered, the narrator also needs to find words for what hegemonic discourses marginalise or leave out.³⁹ Because discourses are continually competing for status and power, it was important in my analysis to be aware of the ways in which the narrators, in their reconstructions, may have been drawing on both dominant and marginal discourses. Also, to comprehend how theories, for instance, of biological difference were mobilised not only in the constitution of the mentally ill woman or man,

³³ Green (2004).

³⁴ Daley (1998).

³⁵ Thompson (1988).

³⁶ *Ibid.* (1988). This approach was developed by the Popular Memory Group at the Centre for Contemporary Cultural Studies in Birmingham (United Kingdom). The notion of memory as historical record is rejected in favour of understanding the role of the past in the present, by way of the distortions produced by the effect of “public” upon “private” memories. For further discussion on this concept see Popular Memory Group (1982).

³⁷ The notion that there is a type of feedback loop or cultural circuit between personal accounts and discourse is posited by theorists of popular memory.

³⁸ “Composure” is the term coined by the Popular Memory Group to describe the process of memory-making (Thomson 1994). In using the term Graham Dawson (1994) p.22 plays on the double meaning of the verb ‘to compose’ to explore the twin process of creating accounts of experiences and achieving personal composure or equilibrium through constituting oneself as the subject of the stories.

³⁹ Summerfield (1998).

but may also have been influential in the construction of the female nurse and male attendant to justify their positioning in the gender order.

Personal accounts collected through oral history, whereby a narrator draws on available discourses to construct her or his particular subjectivity, are also inter-subjective in that they are the product of a relationship between a narrator and an audience. Oral history narrators, American feminist Kristina Minister has suggested, assume that what is required of them is 'a public performance ... for a ghostly audience'.⁴⁰ Initially the performance is usually for a single stranger (the interviewer), but ultimately narrators are rendering their stories into the public arena. As part of the process of analysis, Italian philosopher/historian Luisa Passerini argues for the need to listen for silences and contradictions.⁴¹ Interrogation of the tapes in the present study involved paying particular attention to not only what was said, but also to the silences, discrepancies and omissions, on the understanding that meanings are also constructed through exclusions. This allowed for greater insight into what the nurses under study were saying and why they represented themselves as they did.

Gender

Scott suggests that gender may be theorized as the omnipresent ordering of human practices, activities, and social structures. These practices and activities have symbolic meaning, and as Scott has emphasized, gender is an insidious symbol of power.⁴² In Scott's conceptual framework, gender is a process rather than a particular attribute, although the allotment of persons to gender categories is an integral part of the process. Of particular relevance to the present study is the idea that gender is present in the processes, practices, ideologies, symbols, and the production of power in social institutions such as mental hospitals.

⁴⁰ Minister (1991) p.29.

⁴¹ Passerini (1992).

⁴² Scott (1988).

Gender requires an analysis of the discursive relations between women and men particularly because gender is a relational term. Scott has identified four interconnected elements which constitute social relations predicated on sexual difference and signifying relations of power: culturally accessible symbols suggesting multiple (and frequently contradictory) representations; normative concepts which seek to control their metaphoric potential; the restrictive analysis of gender in most historic accounts; and the construction of subjective gender identity.⁴³ Arising from these concepts are particular questions pertinent to the analysis of the oral history interviews in this current project. For instance, what symbolic representations of gender and nursing were available to the female mental nurse and male attendants? To what extent were these symbols limited to normative binary gender representations that fixed the meaning of femininity and masculinity, and thus appeared to be timeless and permanent? For my purposes, a broad view of gender relationships was necessary, particularly one that, rather than resting on the private world of the family as the basis for social organisation, recognised that gender is also constructed in the economy and in social institutions. The organization of sex-segregated labour, for instance, was a consideration in the analysis. Scott's fourth element of the definition of gender, subjective identity, prompts consideration of the ways the nurses' and attendants' gendered identities may have been constructed historically.

Historian Catharine Coleborne has written of how, through oral history and museum collections, past beliefs about mental illness and its practices have been represented.⁴⁴ Using the examples of the Porirua Museum project⁴⁵ and the Tokanui Hospital (1912-1998) oral history project,⁴⁶ she argues that among the motivations to preserve the past, not the least concern is coming to terms with the meaning of closure for both those associated with the institution itself, and the wider community.⁴⁷ The museum at Porirua opened in 1987 to celebrate the centenary of the hospital, and its curators include former

⁴³ Ibid. (1988).

⁴⁴ Catharine Coleborne (2001b) has also curated her own exhibition of asylum artifacts in Australia. She and historian Bronwyn Labrum are conducting a pilot study for a larger project to do with how understandings of the 'past' are both made and circulated through regional history museums (see <http://www.phanza.org.nz/journal/museums.html>).

⁴⁵ Coleborne (2003b).

⁴⁶ Coleborne (2004).

⁴⁷ Tokanui closed in 1998 although Porirua remains partially functional.

mental nursing staff of the hospital. The stated aim is to give visitors ‘a glimpse of how the community has responded to people with mental illness and/or disability since Victorian times’.⁴⁸ The museum is housed in the original female block of the hospital and includes one of the original rooms used to house extremely disturbed women who were isolated from other hospital patients. The space has been restored to how it was in the 1930s. In preserving the collections and keeping particular memories intact, Coleborne suggests the museum curators stake a claim for special knowledge about Porirua’s past.

If, as has been claimed by Scott, agency is created through situations and statuses conferred on particular groups of people, then the authority of the museum’s curators could be said to be legitimised by them having worked at Porirua.⁴⁹ The arrangement of the displays reflects particular constructions of mental illness. For instance, in the seclusion room, past treatment of disturbed patients is represented through artifacts based on confinement, restrictions on the body, surveillance and isolation. Drawing on the work of Susan Vogel, Coleborne argues that what is seen and heard, is not material that ‘speaks for itself’ but material sifted through certain subjectivities at particular times.⁵⁰

The Research Process

The oral history projects

In my initial search for mental nursing sources I consulted Patricia Sargison’s bibliography From Candles to Computers. In this substantial work which she describes as ‘a working tool for the writing of New Zealand nursing in the future’, Sargison has listed eight oral histories concerned with mental nursing.⁵¹ These were recorded with mental nurses and attendants who had worked in mental hospitals including during the 1920s - 1940s, as part of an oral history project undertaken between 1982 and 1984 by the New Zealand Nursing Education and Research Foundation (NERF). When visiting the Alexander Turnbull Library for a first listening of the tapes, my attention was drawn to further tapes related to the same time period. Thus, in addition to the NERF tapes, two

⁴⁸ Quote from a pamphlet (undated) published by the “Friends of Porirua Hospital Museum”.

⁴⁹ Scott (1988). See also Scott (1990).

⁵⁰ Vogel (1990) quoted in Coleborne (2003b) p.110.

⁵¹ Sargison (1986) p.viii.

tapes from a Sunnyside Hospital Oral History Project, one from the Porirua Hospital Resource Centre oral histories, and one from the New Zealand Country Library Service Oral History Project, were accessed. A further tape, recorded by National Oral History of New Zealand in association with the Oral History Centre Alexander Turnbull Library, was located in the Special Collections room of the Auckland City Library. In listening to the interviews with female mental nurses and male attendants, what was of particular interest for this research project were the sections relating to their employment in New Zealand mental institutions in the 1920s - 1940s. In total, nine interviews with female mental nurses and four with male mental attendants were included in the analysis. Twelve of the thirteen interviewees were female.

The NERF (1982 - 1984) project was primarily concerned with recording the experiences of general nurses. Of the 185 interviews undertaken, only about a dozen or so appear to have involved mental nurses. This observation is based on information obtained from the data base at the Alexander Turnbull Library. The difficulty in being precise is because the interviews recorded with nurses who undertook both general and mental nurse training, may have been catalogued under the general nurse rather than the mental nurse category. However, the small number of interviews with other than Pākehā female general nurses in the NERF project was confirmed by the project coordinator Marie Burgess. She wrote, 'when it comes to areas such as psychiatric nursing, the experiences of male and Māori nurses, the oral history collection cannot be of great help'.⁵² Interviews carried out for a later NERF Psychiatric Nurses Oral History Project (1988 - 1989), fell outside the time period of my study. In addition to the oral history tapes, other primary texts provided sources of information on the mental health system for the period under review. Published Government records and archives contained information on legislation and policy, and annual reports for each of the mental hospitals. Journals such as the *New Zealand Nursing Journal* proffered professional opinions including on mental nursing and mental illness, while pamphlets and newspapers offered public views on these matters. Unpublished records, Public Service Association papers for instance, provided insight into workplace issues and the official response to these.

⁵² Burgess, (1984a) p.13 of transcript.

Ethics Committee Approval

In line with the Massey University's "Code of Ethical Conduct for Research, Teaching and Evaluation involving Human Participants", before beginning the project, the screening questionnaire and notification form were completed and forwarded to the Massey University Human Ethics Committee. Accordingly the project was recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Campus Committees.

Accessing the Tapes

As indicated, the oral history tapes of interest are part of the Oral History Collection held at the Alexander Turnbull Library, National Library of New Zealand, Wellington. Although in the interview process the majority of narrators had already given permission for the tapes to be made available for research purposes, according to the protocols of the Turnbull Library, donor permission was still required. Therefore, the first step in accessing the tapes was to write to the donors seeking permission – in most instances, NERF. Additionally, two of the tapes required special permission, one from the person interviewed, and the second from the National Librarian. The criterion was that although note taking while listening to the tapes was acceptable, it was not permissible to transcribe large sections of the recordings. None of the tapes had previously been transcribed as such, although a few had abstracts attached. Photocopying of these summaries, however, was not permitted. The tapes were first listened to at the Oral History Centre of the Turnbull Library;⁵³ thereafter tapes were made available for listening through interlibrary loan, two at a time, at the Auckland City Library Special Collections room under the same criterion. The protocols surrounding the tapes restricted my engagement with them to some extent. However, because my discourse analysis did not require listening for the finer nuances of language as such, but rather, for how the nurses and attendants discursively constructed themselves and mental nursing, it was possible after several times of listening, to identify the sections of the tapes which

⁵³ The exception was the tape which was housed at the Auckland City Library and the two tapes for which special permission was required. These were only listened to in the Special Collections Room at the Auckland City Library.

appeared to best exemplify this. The tapes still contain rich untapped sources of material for future research.

The Interviews

Those interviewed in the 1982 - 1984 NERF oral history project mostly heard of the project by word of mouth, with one elderly nurse contact leading an interviewer to others.⁵⁴ The interviewers who participated in the NERF project were volunteers, and as far as can be ascertained, were female general trained nurses rather than psychiatric nurses.⁵⁵ The nurse who undertook the two Sunnyside interviews, however, was a psychiatric-trained female nurse. The Porirua interview was conducted not by a nurse, but by a female historian who was well versed in conducting oral histories.⁵⁶ The New Zealand Country Library Service interview was conducted by the only male interviewer involved in the projects under review. He had many years experience in conducting interviews, and also trained others in interview techniques, including the nurse interviewers who participated in the NERF project. The nurse interviewers in the NERF project attended a weekend training workshop at which they were given assistance in how to conduct interviews by him and other Radio New Zealand personnel.⁵⁷

The inter-subjective relationship between the interviewer and the interviewee was something to watch for when listening to the tapes. In contrast to some other research which uses discourse analysis, the interview is seen as a 'conversational encounter' in which both the oral narrator *and* the interviewer are a focus of analysis.⁵⁸ This is because the interviewer is not an impartial collector of text but is actively engaged with the narrator in constructing particular historical representations of the past. My final analysis therefore, includes reference to the narrator/interviewer encounter.⁵⁹ Although I was not

⁵⁴ Burgess (1984b) p.22.

⁵⁵ Email communication with the NERF project coordinator Marie Burgess 27 May 2006.

⁵⁶ Email communication with Helen Reilly 13 November 2007.

⁵⁷ Burgess (1984b) p.22.

⁵⁸ Potter and Wetherell (1995) p.85.

⁵⁹ Matters of interest in respect to the interviews which are largely beyond the scope of this present study concern in-depth analysis of the questions asked and the nuances of language. Also of interest, is whether mental nurses and attendants interviewed by general nurses retrospectively represented themselves and mental nursing differently from those interviewed by mental nurses or lay people.

personally involved in conducting the interviews, as researcher I was mindful of my part in constructing the version of the nurses' and attendants' stories presented in this thesis.

Transcribing the Interviews

During the transcription process, my appreciation for the mental nurses and attendants who had been prepared to share their stories grew. Their personal testimonies are not only a valuable historical resource, but bear witness to a workforce that has often been overlooked in the recording of nursing history. As discussed above, protocols associated with the tapes meant that full transcripts were not permitted, nevertheless, my documentation amounted to 105 pages of text. Because the transcription process is dependent on its purpose, there is no definitive way to transcribe and edit interviews.⁶⁰ Oral historian Megan Hutching, argues that it is naïve to suggest that a transcript can fully capture the information and mannerisms transmitted in speech, and ultimately, the way in which interviews are to be used will effect the process.⁶¹

A "thematic" approach was chosen for organising the tape content which meant that excerpts only were used to illustrate particular themes. Although in the process of transcribing the interviews, crutch words, such as 'you know', the 'ums and ahs' and the 'you sees', were included,⁶² in the presentation of the findings, these and transcription notations were kept to a minimum.⁶³ As discussed, my purpose in using oral history as a primary source was not about studying speech patterns as such, but had the wider agenda of exploring how gender constructs may have been operating within the narratives of mental nurses and attendants.

Organising the Data

Decisions about themes, established prior to listening to the tapes, were able to be honed and refined during and after the transcription process. Each theme was then given an

⁶⁰ O'Connell and Kowal (1995) and Green and Hutching (2004).

⁶¹ Hutching (2004).

⁶² Ibid. (2004) pp.168-9.

⁶³ Frisch (1990) cited in Green and Hutching (2004) p.172 recommends that an 'aggressive editorial approach' be adopted in presenting oral history material.

identifier which was noted beside particular relevant quotes in the transcript. These were transferred to a master sheet and every subsequent reading enabled further refining of the process. No major changes were deemed necessary – it was more a matter of regrouping subjects under the chosen themes. For example, union involvement, sport, and friendships, were initially listed as separate themes but later included under the theme of institutional culture. Likewise, marriage and motherhood, and altruism, religion and spiritual beliefs, were incorporated under the theme of wider events. The final themes for grouping the material were: reasons for commencing nursing; mental nurse training; working conditions and institutional culture; perceptions of the mentally ill, mental illness and its treatment; thoughts on general nursing and mental nursing; gender relations and the gender order; and the effect of wider events. In the findings chapter the narrators' words are used selectively to illustrate the chosen themes as are the interviewers' questions and comments.

Introducing the Narrators

By way of introduction to the interviews, each nurse and attendant was asked to tell a little of her/his family of origin. The amount of biographical information relayed by the narrators about themselves was variable. In addition to the information gleaned from listening to the tapes, the record sheet which accompanied each tape provided brief data about each nurse's and attendant's mental nurse history. Brief biographical introductions to each of the narrators are offered below:

Maude Clifton was born in Westland in 1902 and was 81 at time of interview. She trained at Sunnyside Hospital,⁶⁴ registered in 1927, and retired in 1957 having made a career of mental nursing. Maude's maternal grandmother had been matron of a psychiatric hospital in Scotland and her father was an official visitor at Seaview Mental Hospital. Maude said that as a child, she sometimes used to accompany her father on his visits because her father thought it wouldn't hurt her to see 'the other side of life'.⁶⁵

⁶⁴ After this introduction, mental hospitals are referred to in the way that the narrators did, for example, Porirua, Sunnyside, and so on.

⁶⁵ Interview with Maude Clifton by H. Campbell, 7 December, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHIInt-0014/029

David Hill was born in 1902 at Runciman, and was 88 at the time of interview. He worked at the Avondale Asylum and remained in mental nursing until he reached retirement age. Date of registration is unknown. David was born into a large Irish Roman Catholic family and his boyhood revolved around milking the cows, sport, and religion. He said that his mother had managed the farm while his father worked in the mines at Waihi, and 'life was hard'.⁶⁶

Agnes Stuart (nee Stuck and previously Todd) was born in 1907 in Riverton and was 92 at time of interview. She nursed at Sunnyside Hospital in the late thirties and early forties, but did not register. Agnes' paternal grandfather came from England in 1855 and acquired land near Riverton which remained in the family. Her mother came from Ireland and had a Roman Catholic upbringing although Agnes said she was not aware of this until after her mother's death. Agnes had a primary school education.⁶⁷

Archie Lamont was born in 1909 in Northern Island and was 73 at time of interview. He trained at Avondale Asylum and registered in 1932. Archie remained in mental nursing until he reached retirement age. Archie came to New Zealand as a child and his family settled in Mt Albert, Auckland. He said that at the time, his Roman Catholic family of fourteen was the biggest to have arrived in New Zealand. Newspaper reporters were on the wharf to meet them and Archie said that he still found it interesting to look back on the articles printed and photos taken at the time.⁶⁸

Irene Smith (nee Taylor) was born in New Zealand in 1911 and was 72 at time of interview. She trained at Orokaonui and Seacliff hospitals.⁶⁹ Date of registration unknown. Irene returned to mental nursing after completing her general training. During the depression Irene lost her job and went to work as a nurse aid for a Mrs Murray who ran a rest home. The interviewer asked Irene to repeat a story which she had relayed at

⁶⁶ Interview with David Hill by Sarah Dalton, 5 and 12 June, 1990, National Oral History of New Zealand in association with the Oral History Centre, Alexander Turnbull Library 90-OH-067/1-6.

⁶⁷ Interview with Agnes Stuart by Margaret Harraway, 2 and 22 December, 1999, Sunnyside Hospital Oral History Project, Alexander Turnbull Library OHColl-0736.

⁶⁸ Interview with Archie Lamont by Yvonne Shadbolt, 18 July, 1984, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/093.

⁶⁹ Orakaonui was administratively part of Seacliff.

her previous visit. The story concerned Mrs Murray who had been chosen by Truby King on his return from Japan where he had been studying ‘how people lived in their natural state’, to implement ‘his ideals in the preparation of baby food and supervising the mothers’. In 1907 Mrs Muurray became the first Plunket nurse in New Zealand and it was she who encouraged Irene to undertake mental nurse training.⁷⁰

Gwendoline (Gwen) Wilson was born in Gore in 1912 and was 70 at time of interview. She trained at Seacliff Hospital, registered in 1933 and retired in 1972. As well as working at Sunnyside, Gwen also worked at Porirua Hospital and Ashburn Hall where she became Matron. Gwen was brought up on a farm, the third of four children, but during the Great Depression her family had had to walk off the farm. Gwen completed primary school education. She said that she could not pass the physical for general nursing.⁷¹

Thelma McArtney (nee Sutherland) was born in 1912 at Waitati in Otago and was 77 at the time of interview. She nursed at Seacliff and Orakaonui hospitals around the 1930s. Date of registration unknown. On marrying, Thelma left mental nursing and never returned. Thelma’s great grandfather on her maternal side, widowed in Scotland, brought his four children to New Zealand in 1874. Her family on the paternal side came to New Zealand in the late 1850s. Around 1910, Thelma’s father, a “rouseabout” was offered a job at Seacliff Mental Hospital as an attendant by Truby King who had been a friend of his father. When the government bought Larnach’s Castle in Dunedin, as a home for recovering psychiatric patients’ around 1916, Thelma’s father was made superintendent and Thelma spent part of her childhood there. She had three years secondary schooling. After bringing up a family Thelma trained as a librarian and went on to have an illustrious career in the profession.⁷²

⁷⁰ Interview with Irene Smith by W. Lyon, 8 March, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/185.

⁷¹ Interview with Gwen Wilson, by W. Lyon 13 July, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/181.

⁷² Interview with Thelma McArtney by Hugo Manson, 14 April, 1989, New Zealand Oral History Archive, Country Library Service Oral History Project, National Library of New Zealand, OHInt-0058/10.

Donald Graham was born in London in 1912 and was 71 at time of interview. He trained at Tokanui Hospital and registered in 1936. Donald remained in mental nursing until he reached retirement age. Donald had two years secondary schooling in London before coming in 1926, at the age of fourteen, to join his mother who had been in New Zealand since 1919. Donald met and married Esther, another of the narrators, while they were both working at Tokanui.⁷³

May Puch was born in Huntly in 1914 and was 70 at time of interview. She trained at Tokanui Hospital and registered in 1938. May went on to work at both Seacliff and Oakley hospitals and made a career of mental nursing. May's German father came to New Zealand after a ship wreck in the Pacific. Relatives on May's maternal side came to New Zealand on one of the first ships. May attended Hamilton East School and from there she was to have gone on to Hamilton Technical School but became ill and spent many weeks in Waikato Hospital. She said that her poor health disqualified her from entering general nursing.⁷⁴

Margaret (usually known as Eileen) Jones (nee Hyland) was born in New Zealand in 1916 and was 84 at time of interview. She worked at both Seaview and Sunnyside hospitals. Although she nursed through the 1930s and 1940s, it was not until the 1950s that Eileen completed her training and registered. Apart from one three year break, she made mental nursing her career. Prior to her retirement in 1980 she was nursing supervisor at Sunnyside. The eldest of seven siblings, Eileen was brought up in a Catholic farming family near Ashburton. Because of poor health, she missed two years primary schooling but went on to complete four years secondary education.⁷⁵

James Nolan was born in Christchurch in 1916 and was 66 at the time of interview. He trained at Sunnyside Hospital, registering in 1949, and in the course of his career worked

⁷³ Interview with Donald Graham by Lois Wilson, 15 December, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/061.

⁷⁴ Interview with May Puch by Yvonne Shadbolt, 13 July, 1984, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/135.

⁷⁵ Interview with Eileen Jones by Margaret Harraway, 3 and 4 February, 2000, Sunnyside Hospital Oral History Project, Alexander Turnbull Library OHColl-0736.

at Templeton, Lake Alice, and Porirua hospitals. James' father died when he was young and his mother brought up him and his two siblings on her own. He had three years secondary education.⁷⁶

Esther Graham (nee Barton) was born in New Zealand in 1917 and was 65 at the time of interview. Trained at Tokanui Hospital, Esther registered as both a psychiatric nurse and general nurse. Esther returned to mental nursing after 17 years away. It is unclear to which branch of nursing the registration date of 1940 recorded for Esther refers. Esther's sister was also a mental nurse. Esther met and married Donald, another of the narrators, while they both worked at Tokanui.⁷⁷

Ngaere Thompson (nee Pryke) was born in New Zealand in 1919 and was 84 at time of interview. She began nursing at Porirua Hospital in 1936. Date of registration unknown. Ngaere left work when she met and married a head attendant at Porirua. She returned to the hospital after raising a family, and remained there until 1984. On retirement, Ngaere was involved in setting up the Porirua Hospital Museum.⁷⁸

Conclusion

The main aim of the current project was to gain insight into the gendered nature of mental health practice in New Zealand in the 1920s - 1940s. What each nurse and attendant remembered, however, was not viewed as a straightforward accurate record of the past but as a complex social and cultural product. The nurses' and attendants' memories of their mental hospital experiences would have resulted from the interplay between discourses and subjectivity. The notion of discourses as assemblages of meanings which can be called upon in constructing individual subjectivity, allowed for consideration of the different subject positions available to the female nurses and male attendants in constructing their narratives. Ultimately, how an event is remembered, and the

⁷⁶ Interview with James Nolan by Lois Wilson, 3 November, 1983, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/124.

⁷⁷ Interview with Esther Graham by Lois Wilson, 15 March, 1984, New Zealand Nursing Education and Research Foundation, Alexander Turnbull Library OHInt-0014/062.

⁷⁸ Interview with Ngaere Thompson by Helen Reilly, 20 October, 2003, Porirua Hospital Resource Centre Oral Histories, Alexander Turnbull Library OHC 12681.

significance it is given, is dependent on a narrator's relation to power in a particular group or society.⁷⁹

It was only when the tapes were looked at in operation, within their historical and cultural contexts, that it was possible to see what the possibilities were and in whose interests particular discourses were operating at the time. The tapes under study were "read" with the aim of detecting discursive patterns of meaning, ambiguity and inconsistencies. By studying discursive representations through the chosen texts it was hoped to expose how certain forms of representation legitimised and privileged particular kinds of knowledge. Questions arose concerning discursive shifts of meaning, for instance, how in the review period, gendered concepts of mental nursing were interwoven with wider discourses of gender relations in society and in what cultural forms they were represented. Of particular interest was the way in which power was reproduced or challenged, and the fragmentary, contradictory nature of the processes. Underpinning the research process was a focus on revealing the way in which discursive activities helped to construct institutional and social practices in which power and taken-for-granted understandings of gender were embedded. Commitment to a social constructionist epistemology led to the methodology of discourse analysis and allowed for a number of questions to be asked about the constructive effects of language.

⁷⁹ Portelli (1991) p.7.

CHAPTER FOUR

RESEARCH FINDINGS

This chapter presents excerpts from the oral testimonies of nurses and attendants who began mental nurse training, or were working in New Zealand mental hospitals in the 1920s - 1940s. To recap the chosen themes: reasons for commencing nursing; mental nurse training; working conditions and institutional culture; perceptions of the mentally ill, mental illness and its treatment; thoughts on general nursing and mental nursing; gender relations and the gender order; and the effect of wider events. Transcripts were used selectively to illustrate the chosen themes and the interviewers' questions and comments. Analysis is undertaken in the chapter that follows.

How the Interviews Were Conducted

Because the histories were drawn from several oral history projects there was no consistency in the questions interviewers asked. Two of the projects, namely, the Country Library Service, and National Oral History projects obviously had a wider agenda than just mental nursing. The New Zealand Education and Research Foundation (NERF), the Sunnyside Hospital and the Porirua Hospital oral history projects were primarily focused on mental nursing. However, within these, there was considerable variation in the style of questioning adopted by the interviewers. These ranged from straightforward questioning of the narrators about their experiences to more reflective processes which provided space for narrators to talk about issues important to them.

At a training workshop prior to the commencement of the 1982 - 1984 NERF project, to which the majority of tapes under study belong, emphasis was placed on the interviewers obtaining certain basic details, such as, name, date and place of birth at the start of the interview. Although the interviewers had a guide to ensure certain things were covered from there on, they also had the flexibility to draw out information as they went along. By the time they got to the recorded interview they probably had an idea of the questions they wanted to ask because they had already had at least one preliminary interview with

the participant.¹ This was evident when an interviewer introduced a new topic, with phrases such as, ‘now there was something interesting about ... wasn’t there?’ Helen Reilly, the historian who interviewed Ngaere Thompson for the Porirua oral history project had pre-prepared topics to cover, but ‘let Ngaere go’ at times when she was answering questions.² The guidelines, if any, for the Sunnyside Hospital, the Country Library Service, and National Oral History projects, are not known. The dates the interviews took place ranged from 1983 to 2003.³

Reasons for Commencing Mental Nursing

Questions about reasons for entering nursing were along the lines of, ‘what took you into psychiatric nursing’,⁴ and narrators’ replies reflected the few options available at the time. Most were seeking work around the period of the Great Depression, and mental hospitals were one of the few workplaces that had authority to fill staff quotas.⁵ Donald’s response was, ‘I don’t think anyone is ever really head over heels in love with psych nursing, ... nobody could be with the conditions that existed in those times’. Because of the economic downturn, he had lost his previous jobs, first at a dairy company and then on a farm.⁶ For Archie, ‘it wasn’t that you were looking for a career [but were] fortunate if someone told you there was a vacancy’.⁷ Because he lived near Sunnyside, James already ‘had some appreciation of what it was like’. He said that although his mother had high ambitions for him, the Depression meant he had to ‘go out to work early in the piece’.⁸ When the Depression worsened David said he had had to leave the farm. He was ‘in a relief-work gang digging sewage drains in the grounds of Avondale asylum’, when he saw someone he knew and quipped, ‘what working in the nut house?’⁹ On hearing that asylum work offered job security, paid steady money, and provided a uniform, David

¹ Email correspondence 27 May 2006 with Marie Burgess coordinator of the NERF Oral History Project.

² Email correspondence 7 November 2007 with Helen Reilly.

³ For bibliographical details see Chapter Five pp.66-70.

⁴ Generally, I have kept to the term “mental nursing” (the common term used at the time the narrators were training), unless, like in this instance, “psychiatric nursing” was specifically used.

⁵ Interview with May Puch by Yvonne Shadbolt (1984).

⁶ Interview with Donald Graham by Lois Wilson (1983).

⁷ Interview with Archie Lamont by Yvonne Shadbolt (1984).

⁸ Interview with James Nolan by Lois Wilson (1983).

⁹ Interview with David Hill by Sarah Dalton (1990).

‘went home and talked to the wife’. When he began, because he was physically fit, he said, ‘they shoved me straight into the wild ward’.¹⁰

A variety of means including newspaper advertisements, encouragement from peers, knowing of others who had gone into the field including family members, and proximity to home, influenced narrators to commence mental nursing. Gwen commented, ‘there were no other jobs offering [and] when they advertised for psychiatric nurses, somebody said “come along, we may as well apply”’.¹¹ Made redundant from her job in a shop, Irene was working as a nurse aid in a rest home, and the Matron encouraged her to embark on mental nurse training.¹² A friend, who was training at Porirua, suggested to Ngaere that she join her and although Ngaere told her friend she ‘had to be joking’, because she was ‘at a loose end’, decided to ‘have a look’.¹³ Esther, when she heard her older sister had gone nursing at Tokanui, was ‘horrified [because] all we’d heard of those sorts of patients was not very complimentary’.¹⁴ However, a year later, Esther had joined her sister at Tokanui and found that ‘there were some very nice girls there’.¹⁵ For May, mental nursing was only second best. She had wanted to go general nursing but poor health initially prevented her from doing so. Shortly after qualifying as a mental nurse, she again set out to become qualified as a general nurse, but once more ill health intervened. She said the matron of Tokanui told her, ‘I think you had better stay put and do what you do well’.¹⁶ Nursing was something Agnes had wanted to do from childhood and she believed she had been particularly called to mental nursing:

I was working in a bakery, I turned the radio up and here they were pleading for staff for Sunnyside – they were *pleading* for them. I thought that’s what I want to do, [yet] here I am [working] in a cake shop.¹⁷

Following the call, Agnes said she found a housekeeper for her family, took a train to Christchurch and a taxi to Sunnyside where she was given work.

¹⁰ Ibid. (1990).

¹¹ Interview with Gwen Wilson by W. Lyon (1983).

¹² Interview with Irene Smith by W. Lyon (1983).

¹³ Interview with Ngaere Thompson by Helen Reilly (2003).

¹⁴ Interview with Esther Graham by Lois Wilson (1984).

¹⁵ Ibid. (1984).

¹⁶ Interview with May Puch by Yvonne Shadbolt (1984).

¹⁷ Interview with Agnes Stuart by Margaret Harraway (1999).

Mental Nurse Training

As discussed in Chapter One, lectures and examinations were a regular feature of the training programme for mental nurses and attendants, but the gender differences were marked in discussion of these topics. When asked if, when they began mental nursing, they were aware they would have to pass exams, responses from the male respondents indicated that for them it was not too much of an issue. Donald said, ‘it was no big deal as far as I was concerned. I was never particularly scared of exams’;¹⁸ and James answered ‘we didn’t apply ourselves too greatly in those days’.¹⁹ The female respondents were more circumspect. Esther recalled sitting an exam but as far as she could remember, ‘it didn’t deal with any psychiatry [and] there was nothing much on nursing either’.²⁰ Eileen was ‘petrified [of exams] because they were mainly [taken by] doctors high up in the administration part’. She said that although the written questions were set and therefore manageable, ‘when you sat your practical and oral you didn’t know who you were getting [as examiner]’.²¹ Depending on the hospital, lectures were presented either by doctors or registered general nurses. These were fitted between duties, and opinions differed on their value. Lectures were variously described, for example, by Donald, as, ‘taken by a doctor who was particularly bored with the whole thing, [and] just gabbed out of a book’,²² and by May, as ‘beautifully done and taken by a tutor who taught to quite a deep degree’.²³

Lectures closely followed the handbook for attendants of the insane,²⁴ popularly known as “the red book”. The rule books were also significant text which set out clearly the standards expected of staff.²⁵ Narrators remembered undertaking written, oral and practical examinations. They spoke of being examined by the medical superintendent from their own hospital in the junior (oral) hospital exam, and by the medical

¹⁸ Interview with Donald Graham by Lois Wilson (1983).

¹⁹ Interview with James Nolan by Lois Wilson (1983).

²⁰ Interview with Esther Graham by Lois Wilson (1984).

²¹ Interview with Eileen Jones by Margaret Harraway (2000).

²² Interview with Donald Graham by Lois Wilson (1983).

²³ Interview with May Puch by Yvonne Shadbolt (1984).

²⁴ In 1885 a group of Scottish superintendents produced a 64-page text, *Handbook for the Instruction of Attendants on the Insane*. This was revised and expanded by the Medico-Psychological Association in 1893, the additions consisting of material relating to anatomy and physiology and nursing (see Carpenter 1980). This text book was adopted in New Zealand for the training of mental nurses and attendants (Brunton 2001).

²⁵ Brunton (2001) p.327. In 1901 a national code was adopted and was revised in 1910, 1928 and 1940.

superintendent from another hospital in the senior (oral) hospital exam. Hospital matrons were generally responsible for examining the practical components of the course. May said ‘you had to sit an exam just like you do in general nursing [and] you really did have to know the rules’.²⁶ Archie recalled that those who did not pass their exams, ‘were quite useful just the same’.²⁷ This was Agnes’ experience: ‘I was just a nurse aid, [yet], they said I was an excellent nurse’.²⁸ Like Agnes, Eileen worked for a number of years as a nurse aid and when asked about remaining a “pinkie”²⁹ for so long, said, ‘in those days it didn’t seem to matter if you had an exam or not’.³⁰

Working Conditions and the Culture of the Institutions

Narrators responded to the interviewers’ interest in the mental hospital regime. They spoke of the physical layout of the hospitals, the sexual division of labour, the hierarchies in operation, off duty camaraderie and in the case of the male staff, the importance of sport and union membership. The physical environment was described in a variety of ways: Tokanui was ‘open and without fences’,³¹ Seacliff was ‘forbidding and enclosed’,³² and Sunnyside was a ‘prison of a place’.³³ Gwen described the rooms in the nurses’ home as particularly spartan: ‘Sir Truby King decided that fresh air and health were essential and left an opening in the rooms, particularly on the south side. In the winter the rain and snow drifted in’.³⁴ Within the institutional environs, women and men were nursed in separate spaces, for the most part, by female nurses and male attendants respectively. However, Eileen said that try as they might, ‘they couldn’t separate the nurses from the men socially’. At work, however, she said that the only time you used to see a man in those days, was if you got to see them in the kitchen, carving the meat. She said, ‘there was a jostling for position – we all wanted to go to the kitchen to see who the men were –

²⁶ Interview with May Puch by Yvonne Shadbolt (1984).

²⁷ Interview with Archie Lamont by Yvonne Shadbolt (1984).

²⁸ Interview with Agnes Stuart by Margaret Harraway (1999).

²⁹ Female nurses were graded according to seniority. A “pinkie”, so called because of her pink uniform, was at the bottom of the female nursing hierarchy.

³⁰ Interview with Eileen Jones by Margaret Harraway (2000).

³¹ Interview with May Puch by Yvonne Shadbolt (1984).

³² Interview with Gwen Wilson by W. Lyon (1983).

³³ Interview with James Nolan by Lois Wilson (1983).

³⁴ Interview with Gwen Wilson by W. Lyon (1983).

it was our only chance'.³⁵ James described mental hospitals as 'very hierarchical and everybody had their place'.³⁶ At 8 p.m. every day there was a round of each male ward by:

the head attendant, the man in charge of the ward, and his underlings. One of them, depending on seniority, went ahead and unlocked the doors. [Then] the hierarchy – the head attendant and the charge would look in at each dormitory and room – the junior boy (sic) would follow and lock the doors.³⁷

At morning tea time, the junior boy went in last with the patients who made the tea.³⁸

On the female side, at the end of their shift, nurses had to wait until the matron came and 'inspected the place'.³⁹ On his round, 'the doctor would be accompanied by the sister in charge, and others would follow in order of seniority'.⁴⁰ Rank and file of either sex made few decisions and were expected to do as they were told:

From day one, you were literally thrown to the wolves. You looked after the patients – you bathed them, you dressed and fed some of them, and you gradually learnt. Often we had a ward with a hundred and something people, all very, very psychotic, a lot of them violent, [with] a staff of only five, [but] you all pulled together.⁴¹

Nurses described how elderly people, Mongol babies, and hydrocephalic children were 'all lumped together'.⁴² Esther told of how patients, originally admitted with puerperal psychosis,⁴³ 'often looked on the babies as their own, even although many years had gone by [since they themselves had given birth]'.⁴⁴ Female narrators described themselves as 'slave labour'⁴⁵ and 'no better than domestics who polished, scrubbed and cleaned windows'.⁴⁶ 'It was supposed to be nursing', Esther said, '[but] we were maids of all

³⁵ Interview with Eileen Jones by Margaret Harraway (2000).

³⁶ Interview with James Nolan by Lois Wilson (1983).

³⁷ *Ibid.* (1983).

³⁸ *Ibid.* (1983).

³⁹ Interview with May Puch by Yvonne Shadbolt (1984).

⁴⁰ Interview with Eileen Jones by Margaret Harraway (2000).

⁴¹ Interview with Ngaere Thompson by Helen Reilly (2003).

⁴² Interview with Esther Graham by Lois Wilson (1984).

⁴³ Puerperal psychosis is psychosis that appears following childbirth.

⁴⁴ Interview with Esther Graham by Lois Wilson (1984).

⁴⁵ Interview with Irene Smith by W. Lyon (1983).

⁴⁶ Interview with Maude Clifton by H. Campbell (1983).

work'.⁴⁷ When asked if she carried keys all the time, Irene replied, 'yes, it was locking and unlocking doors all the time'. She said that the villas were 'the only places there were no locked doors, they had more of a home atmosphere, and the patients dressed in their own clothes'.⁴⁸ When chosen to work in the villas⁴⁹ she was asked 'nurse, can you make scones'?⁵⁰ Male attendants were 'jack of all trades [and] worked in the "mess",⁵¹ on the farm and on the coal cart'.⁵² They described how every morning, gangs, each with an attendant in charge, would be sent to work on the farms, and in the orchards, greenhouses and gardens. Although female patients 'had nothing to do with the gardens, sometimes female patients and staff were allowed into the gardens to pick gooseberries'.⁵³

Along with the patients, the nurses and attendants wore uniforms. Female patients were dressed alike in wincyette or denim frocks which buttoned down the back, with a belt sewn in the front and tied at the back; the denim ones were navy blue 'with prison stripes down them'.⁵⁴ They also wore 'hard stiff calico bloomers'.⁵⁵ Nurses' uniforms denoted rank with 'sisters in white, staff nurses in blue, and trainees known as "pinkies", [dressed] in pink'. At some hospitals, Seacliff, for example, nurses wore veils.⁵⁶ The nature of the men's clothing, neither patients nor staff, was mentioned by the narrators. According to Ngaere, it was still sometimes hard to know who was who: 'If someone asked to be let out [of the ward], you wouldn't let them, and they could be the doctor'.⁵⁷ (*The narrator and interviewer laughed at this*). When the interviewer suggested that that must have presented problems, Ngaere recanted: 'Well no, a doctor would be dressed as a doctor,

⁴⁷ Interview with Esther Graham by Lois Wilson (1984).

⁴⁸ Interview with Irene Smith by W. Lyon (1983).

⁴⁹ Although the villas did allow for the classification of patients 'they were just as restrictive as a big building. They were smaller and more manageable, but not until the advent of tranquillisers were villas used as they were meant to be, open with self-management and that all sort of thing' (interview with James Nolan by Lois Wilson 1983).

⁵⁰ Interview with Irene Smith by W. Lyon (1983). Irene said the villa patients complained that the only dish the nurses could make was macaroni cheese.

⁵¹ A "mess" is a 'company of persons who take meals together especially in the fighting services' (Oxford University Press 1976 p. 684).

⁵² Interview with James Nolan by Lois Wilson (1983).

⁵³ Interview with Esther Graham by Lois Wilson (1984).

⁵⁴ Interview with Ngaere Thompson by Helen Reilly (2003).

⁵⁵ Interview with Irene Smith by W. Lyon (1983).

⁵⁶ Ibid. (1983).

⁵⁷ Interview with Ngaere Thompson by Helen Reilly (2003).

have a white coat on and have a stethoscope around his neck'.⁵⁸ There was no doubt that the (male) doctors were in charge: 'The doctor's word was final – you wouldn't argue the toss with him and say what do you want to give her that for?'.⁵⁹ And yet, narrators asserted, it was the nurses and attendants who knew the patients best: 'Doctors couldn't get around to see the patients all the time [but] we lived with them 24 hours a day – were very friendly with them – some were very decent people';⁶⁰ 'in those days we knew every patient in every ward – few were discharged so the same people were there all the time';⁶¹ and 'you got to know some of them and developed a warm relationship'.⁶²

Strict hierarchies and rules operated both on and off duty. Off duty, 'all the pinks congregated together, they all lived in, [and] there was great comradeship';⁶³ and, 'although we were not allowed to entertain men in the nurses' home, most of the girls were friendly with the attendants'.⁶⁴ Esther said that the dances held for 'the good or better patients' provided opportunity for the female nurses, 'to sneak a dance' with one of the attendants'.⁶⁵ The nursing sisters were, 'in a class of their own and didn't mix'.⁶⁶ 'They took precedence over everybody – we were scared of them – anything with a veil we gave a wide berth'.⁶⁷ Eileen, however, found that when she herself moved up a level she became quite isolated. She said, 'friends no longer let me into the circle [because] I was [now] a grade higher than they were'.⁶⁸ Meal times at the nurses' home were strictly timetabled and in her off duty time, a nurse had to record in the leave book if she left the hospital grounds: 'There were some strange things written because the [female] nurses resented that the [male] doctor would read [the book] each day'.⁶⁹ Several narrators mentioned that for both female nurses and male attendants there were strict curfews in place for their return to the hospital.

⁵⁸ Ibid. (2003).

⁵⁹ Ibid. (2003).

⁶⁰ Interview with Donald Graham by Lois Wilson (1983).

⁶¹ Interview with Esther Graham by Lois Wilson (1984).

⁶² Interview with Eileen Jones by Margaret Harraway (2000).

⁶³ Ibid. (2000).

⁶⁴ Interview with Irene Smith by W. Lyon (1983).

⁶⁵ Interview with Esther Graham by Lois Wilson (1984).

⁶⁶ Ibid. (1984).

⁶⁷ Interview with Eileen Jones by Margaret Harraway (2000).

⁶⁸ Ibid. (2000).

⁶⁹ Interview with Irene Smith by W. Lyon, (1983).

Ngaere said ‘a male voice in the nurses’ home and everyone went rushing to the top of the stairs to see who it was’, adding, ‘some of the male nurses were permitted to live out and were not so closely guarded’.⁷⁰ Here Ngaere may have been referring to the married male attendants who were permitted to live out except when they were rostered to sleep on the wards so they could be available to assist the night staff if necessary. Both nurses and attendants were locked in at night. Blocks on the windows, to prevent them from sneaking out, made the nurses and attendants more determined: ‘A lot of us were chased by the night watch, but I don’t know if any of us were caught’.⁷¹ Eileen recalled that when she was manpowered (sic) to Sunnyside during the war, even although she was a married woman she was chastised for coming in late to the nurses’ home.⁷² James said, ‘in the male attendants’ quarters, we used to take turns at filing the flange down on the window, so a bottle of beer could just be passed through’.⁷³ At Sunnyside, the attendants’ quarters were attached to the main building and single men lived there. According to James, they ‘would do all sorts of things to get in and out’. Even though the head attendant and the superintendent used to do regular rounds, he said ‘there were ways and means’. He added, ‘today, I think they would probably say I would never have lived under those conditions’.⁷⁴

Some, like Eileen, described their introduction to mental nursing as traumatic. On arrival at Sunnyside there was nobody to greet her or show or tell her anything. She said, ‘when I heard the language of some of the nursing staff, I thought I can’t stand it, [but then] I met a girl I knew and so I stayed’.⁷⁵ Agnes said she did not get to know many of the other nurses at Sunnyside:

We were different sorts of people – I didn’t like the swearing of a lot of them. I think they may have thought me a sissy, [but] I just seemed to have a different outlook. Perhaps they thought they were doing it [nursing] the more professional way, but you didn’t have to speak harshly – it was amazing how they [patients] responded to gentleness.⁷⁶

⁷⁰ Interview with Ngaere Thompson by Helen Reilly (2003).

⁷¹ Interview with Irene Smith by W. Lyon (1983).

⁷² Interview with Eileen Jones by Margaret Harraway (2000).

⁷³ Interview with James Nolan by Lois Wilson (1983).

⁷⁴ Ibid. (1983).

⁷⁵ Interview with Eileen Jones by Margaret Harraway (2000).

⁷⁶ Interview with Agnes Stuart by Margaret Harraway (1999).

Although it was mandatory to leave mental nursing on marriage because ‘that was the policy’,⁷⁷ Thelma was glad to be leaving and said ‘it never occurred to me to go back again’.⁷⁸ Ngaere said she had had to stop work when she married a man who was a charge nurse at Porirua.⁷⁹ She added, ‘they used to say it was a place to meet your husband because you didn’t have to go far to find them’.⁸⁰

For May, ‘the quality of staff at Tokanui was above what it was in some other parts’ because ‘a lot of the girls (sic) were farmer’s daughters’ and the men were ‘already well qualified in other fields of work’. She described Tokanui as ‘like a big family with a very great rapport with the town of Te Awamutu ... We used to have big balls or dances and the town used to give a return ball once a year which was a magnificent do’.⁸¹ When asked if the ball was for staff and patients, May confirmed it was just for staff. She also talked about the magnificent recreation grounds at Tokanui, ‘it was on the circuit for cricket, it [Tokanui] was really part of the town scene’.⁸² Sport was a significant aspect of mental institution culture and sometimes the female nurses would take the ‘better patients’ to watch the men play sport.⁸³ James attributed his entry into an attendant position to his sporting prowess:

When I was offered an attendant position at Sunnyside, I always remember the superintendent saying I’d be a good man for the team and not only for the rugby team.⁸⁴

David said that although mental hospitals had been neglected because ‘there is no profit in mad people’, politically, things began to change in the Depression when ‘New Zealand citizens began applying for jobs [in the mental hospitals]’.⁸⁵ Until then, ‘most of the staff were ‘English-naval types’ who ‘were institutionalised’, and operated a very strict ‘military type’ of discipline:

⁷⁷ Interview with Ngaere Thompson by Helen Reilly (2003).

⁷⁸ Interview with Thelma McArtney by Hugo Manson (1989).

⁷⁹ Donald and Esther Graham also met and married when they were both working at Tokanui.

⁸⁰ Interview with Ngaere Thompson by Helen Reilly (2003).

⁸¹ Interview with May Puch by Yvonne Shadbolt (1984).

⁸² Ibid. (1984).

⁸³ Interview with Esther Graham by Lois Wilson (1984). Thelma said that her ability at sport was always discounted. Although she could outrun others and was a good swimmer, ‘girls were not encouraged to play sport’ (interview with Thelma McArtney by Hugo Manson 1989).

⁸⁴ Interview with James Nolan by Lois Wilson (1983).

⁸⁵ Interview with David Hill by Sarah Dalton (1990).

We New Zealanders looking after [the interests] of New Zealanders didn't altogether approve of [their methods] and we did our best to alter things – be more liberal with the patients, more humane. We made enquiries [but] there was no organized unionism or anything there [at Avondale].⁸⁶

Following a meeting at which he was elected secretary of the Avondale Asylum subsection of the Public Service Association (PSA), David said he went to the Medical Superintendent with documents laying out complaints. As David told it, the Superintendent picked up the papers, tore them through and put them in the waste paper basket.

I went home and said to my wife, I don't know whether I should carry on or not. She said, "you stick with it," and I did. I had meetings with the Medical Superintendent but he refused to do anything. My wife was a good typist and I kept a double copy of everything. In the end, I sent it all to Head Office at Wellington. Oh, the phones were running hot then.⁸⁷

At the time, 'it just wasn't done, as a nurse you weren't allowed to do that sort of thing'.⁸⁸

Perceptions of the Mentally Ill, Mental Illness and its Treatment

In contrast to depictions of patients as not too different from themselves, sometimes narrators represented the patients as second class citizens who engendered revulsion and horror. In general, the nurses favoured biological and hereditary explanations of mental illness for which little could be done. In the process of telling their stories, some narrators reproduced stereotypical views of mental illness and of the mentally ill as figures of amusement. Ngaere, for instance, recalled her first day at Porirua when she had been approached by a patient who introduced herself as Mrs Jonesie and said she knew her (Ngaere's) father. Ngaere said that the next time she went home she told her father she had met Mrs Jonesie in the ward. 'Oh, he said, you're in the right place all right, *her* name is not Jonesie, it's Jones. And it was'. Ngaere also said her father would often tease her saying, 'you know they might never let you out again'.⁸⁹ When patients became

⁸⁶ Ibid. (1990). In 1931 the government had abolished compulsory unionism (see Potter, 1999).

⁸⁷ Interview with David Hill by Sarah Dalton (1990).

⁸⁸ Ibid. (1990). David said that even although at one stage he was 'detested by the administration, banned from the nurses' home, and accused of sedition', he 'won out in the end'.

⁸⁹ Interview with Ngaere Thompson by Helen Reilly (2003).

“manic”, it was thought ‘the moon had something to do with it’.⁹⁰ May said that over time she had come to see a hereditary pattern to mental illness:

From these misalliances you get the schizophrenics, the feeble minded and so on down, with an epileptic slipped in here and there, until you get to the idiots which they reproduce.⁹¹

Asked how patients reacted to their menstrual periods, Esther replied ‘we could tell when they were ready for their period pain, some would get very manic’. She said ‘a lot of times you’d go into a ward and there’d be all these depressed people, [but], everyone loved going into a ward where there was mania, because there were all these happy laughing people’.⁹² She said that one of the things that shocked some of the nurses when they first went into a seclusion room was that they were bare of furniture and personal possessions. This was because the patients could not be trusted with anything.

When the interviewer suggested to Esther, ‘you would have gone in [to mental nursing], ignorant and largely untouched by that kind of life – wouldn’t have met people [like that]’, Esther said the interviewer’s comments ‘brought back the revulsion’ and reminded her of how ‘we’d had to clean them up’, how ‘they weren’t fit to be with other people’.⁹³ Esther at different points in her interview made remarks such as ‘you formed a second skin’, ‘it was like water off a duck’s back’ and ‘although you got hardened to it, deep down inside there was the horror’.⁹⁴ On a lighter note, she recalled a patient calling out, ‘you only came here to clean up filth so you can get your hair permed.’⁹⁵ Essentially, according to Donald, manic patients ‘were shut up and left to their own devices – all you did was go in and change the straw’. A patient in seclusion may have started off with a palliasse filled with straw, but often, he would have ripped the cover to shreds. Patients would have a sail canvas sheet for cover, but no blankets. Although oral Paraldehyde was given to manic patients there was no treatment, ‘management was the thing with

⁹⁰ Interview with Irene Smith by W. Lyon (1983).

⁹¹ Interview with May Puch by Yvonne Shadbolt (1984).

⁹² Interview with Esther Graham by Lois Wilson (1984).

⁹³ Ibid. (1984).

⁹⁴ Ibid. (1984).

⁹⁵ Ibid. (1984).

them'.⁹⁶ James recalled a manic patient who 'cut headlines out of newspapers and then stuck them on the wall; he had a marvellous story stuck all around his room', but, nevertheless, he said 'these patients were faulty'.⁹⁷ Irene described the refractory wards⁹⁸ as 'frightening [and] all very primitive. Sometimes patients became violent,⁹⁹ would attack you, pull your veil off, [and] kick you'.¹⁰⁰

Treatment was 'mainly restraint and custodial care'.¹⁰¹ The only way to manage meal times was to have a grading system: 'Good patients took the top tables and it was graded down to more or less animals – well not animals but their habits were more or less the same as animals'.¹⁰² Patients waited at the end of a meal for the cutlery to be counted. Some were 'just like a little pack rat, they liked to have something'.¹⁰³ (*Here narrator laughed*). The wards were mainly managed by patient labour: 'There were the cleaners, the sweepers and the kitchen hands'. Staff supervised but also 'hopped in and gave a hand'.¹⁰⁴ Basically, Donald said, 'you did the same as the patients, you were one of the team'. Group bathing was described as 'a shambles and like dipping sheep'.¹⁰⁵ Dirty clothes were sent to the laundry and although 'male patients ran the machines, the female nurses used to bring a party of female patients down to hang out the clothes'.¹⁰⁶ Patients' clean clothes were tied in bundles and 'it didn't matter whose they were or whether they fitted or not'.¹⁰⁷ Patients not involved in domestic work, were placed in airing courts. Because 'in those days, we didn't have suitable tranquillisers, the nurse spent all her time

⁹⁶ Interview with Donald Graham by Lois Wilson (1983). Paraldehyde is a quick-acting hypnosedative which was given orally until after the Second World War when an injectable form became available (Department of Internal Affairs 2007 p.23).

⁹⁷ Interview with James Nolan by Lois Wilson (1983).

⁹⁸ Refractory wards housed long-term patients, including patients with an intellectual disability (Department of Internal Affairs 2007 p.23).

⁹⁹ Epileptic patients were considered to be the most dangerous patients (interview with Archie Lamont by Yvonne Shadbolt (1984).

¹⁰⁰ Interview with Irene Smith by W. Lyon (1983).

¹⁰¹ Interview with Gwen Wilson by W. Lyon (1983).

¹⁰² Interview with Donald Graham by Lois Wilson (1983).

¹⁰³ Interview with Irene Smith by W. Lyon (1983).

¹⁰⁴ Interview with Donald Graham by Lois Wilson (1983).

¹⁰⁵ *Ibid.* (1983).

¹⁰⁶ *Ibid.* (1983).

¹⁰⁷ *Ibid.* (1983).

watching – making sure they didn't get into fights – didn't run away – didn't take their lives'.¹⁰⁸

Invited to talk about Electric Convulsive Therapy (ECT),¹⁰⁹ several of the female narrators noticeably paused.¹¹⁰ In a quiet tone Ngaere queried, 'I presume I'm allowed to'.¹¹¹ Assured that she was, she said that although ECT looked frightening and barbaric it was most effective: 'It was mainly used in the beginning on young schizophrenic girls – I'm talking about females because we [female nurses] didn't work with males.'¹¹² Esther said she thought ECT was sometimes a good thing because following a treatment 'some patients forgot what they were depressed about'.¹¹³ However, she also recalled a patient who had been in hospital for years ('it was the menopause you know'), and was just coming right: 'We were hoping she would soon be fit to go home [but] the doctor decided to give her ECT and she went right back'.¹¹⁴ For Donald, 'ECT was a cruel practice, grossly misused, and often wrongly administered and used as a punishment'.¹¹⁵ He cited an incidence of it being used on a paranoid patient who hit a doctor, and said, 'some patients attempted suicide rather than have further ECT'.¹¹⁶ 'In those days', James said, you would have to chase them, drag them, if they knew ECT was coming', [but] 'we literally got rid of droves of people through ECT. In my view, for that purpose, it was well worthwhile'.¹¹⁷

A number recalled the introduction of occupational therapy (OT): 'People they had never bothered with, they got them into this [OT], and they got well enough to leave the

¹⁰⁸ Interview with Eileen Jones by Margaret Harraway (2000).

¹⁰⁹ ECT involves the brief passage of an electric current through the brain via electrodes applied to the scalp to induce a generalized seizure, a fit or convulsion (Department of Internal Affairs 2007 p.23).

¹¹⁰ Presumably people were reluctant to talk about ECT because of the ongoing controversy surrounding its administration.

¹¹¹ Interview with Ngaere Thompson by Helen Reilly (2003).

¹¹² Ibid. (2003)

¹¹³ Interview with Esther Graham by Lois Wilson (1984).

¹¹⁴ Ibid. (1984).

¹¹⁵ Interview with Donald Graham by Lois Wilson (1983).

¹¹⁶ Ibid. (1983).

¹¹⁷ Interview with James Nolan by Lois Wilson (1983). In the early days James said that ECT was "unmodified". Unmodified ECT was ECT administered without an anaesthetic or a muscle relaxant (Department of Internal Affairs 2007 p.23).

hospital eventually';¹¹⁸ 'patients who had previously been ripping their frocks were now unravelling wool'.¹¹⁹ According to Donald, occupational therapists were 'good with handcrafts and that sort of thing', but there was too much emphasis on social workers: 'The nurses were sort of bypassed. Our opinions were never asked for – this was wrong'.¹²⁰ 'When the new disciplines came in', James said, 'to some degree nursing staff lost out'.¹²¹

Although all spoke of the rigidity of the rules, some were prepared to break them. The nurses indicated that the privileges they accorded patients were directed toward domestic tasks and perceptions of appropriate feminine behaviour. In a lowered tone Gwen recounted an incident involving a patient who had attempted suicide. She said she suggested one morning that the woman hang out the tea towels but she was reluctant because she had been told not to leave her room:

[When] I made it quite clear that that was what I wanted, she took the tea towels, rushed out, came in and said, I'll never let you down. Like many other patients, provided they were encouraged and trusted, they never betrayed it.¹²²

Ngaere recalled a young woman, admitted after the birth of her child, who she would allow to sit with her at night, on condition that 'she stopped picking at her finger nails'.¹²³

Thoughts on General Nursing and Mental Nursing

Several narrators spoke of the tensions that existed between general nursing and mental nursing and in a variety of ways, endorsed James' statement that 'mental nursing was the Cinderella of nursing'.¹²⁴ Irene said that people were becoming more aware of the necessity of having trained general nurses on the staff, and as a general trained nurse, she felt she could do more to raise the standards of nursing at the mental hospital. Although she had been led to believe that once 'we sat our state mental exam, we were ... able to

¹¹⁸ Interview with Archie Lamont by Yvonne Shadbolt (1984).

¹¹⁹ Interview with Irene Smith by W. Lyon (1983).

¹²⁰ Interview with Donald Graham by Lois Wilson (1983).

¹²¹ Interview with James Nolan by Lois Wilson (1983).

¹²² Interview with Gwen Wilson by W. Lyon (1983).

¹²³ Interview with Ngaere Thompson by Helen Reilly (2003).

¹²⁴ Interview with James Nolan by Lois Wilson (1983).

do general [nurse training] in two years', when she had commenced her general training, she had 'to start at the bottom'.¹²⁵ When asked if there was a celebration when she finally got her (mental nurse) medal, Irene said that there was not even a presentation ceremony.¹²⁶ Eileen said 'when we got our medals that's all we got'.¹²⁷ According to Gwen, 'mental nursing has always been out of step with general nursing. She said she was 'always on the defensive about the division that's made between mental nursing and general nursing, [about] the condescension [shown] by general trained nurses toward mental nurses'.¹²⁸ Several narrators mentioned that frequently they were required to provide nursing care for a person who had a physical illness as well as a mental illness.

Gender Relations and the Gender Order

In addition to covert allusions, narrators sometimes spoke openly of the gender order and gender relations. Thelma, for instance said, 'I don't like to say this, but my father's attention was on his sons. I often think I made the mistake of being a girl instead of a boy. I say I *chose* to go nursing [but] what else was there to do?'.¹²⁹ When asked about the requisite age for starting mental nursing James said, 'men had to be 21 but I think girls (sic) were able to start at 18'.¹³⁰ He said he did not know why: 'Being a little bit of a male chauvinist I always think the male is just as mature as the girl'.¹³¹ Further, he contended, 'at one stage no men were promoted [and] there was little doubt that the girls were in charge'.¹³² Yet Eileen, when asked about her brother and sister, who had followed her into mental nursing, observed that even though her brother had started after her, and been plagued by ill health, he still managed to be in charge of a ward and become a supervisor at Sunnyside before her. She agreed with the interviewer when she said, 'perhaps it was easier for men'.¹³³

¹²⁵ Interview with Irene Smith by W. Lyon (1983).

¹²⁶ Ibid. (1983).

¹²⁷ Interview with Eileen Jones by Margaret Harraway (2000). This contrasted with the graduation ceremony in the Town Hall and the graduation ball held in honour of graduating general nurses (Brown 1994 p.98).

¹²⁸ Interview with Gwen Wilson by W. Lyon (1983).

¹²⁹ Interview with Thelma McArtney by Hugo Manson (1989).

¹³⁰ Interview with James Nolan by Lois Wilson (1983).

¹³¹ Ibid. (1983).

¹³² Ibid. (1983).

¹³³ Interview with Eileen Jones by Margaret Harraway (2000).

While James was undertaking an occupational therapy course, he received word that he had been promoted to deputy charge at Templeton, a farm for the so called, “mentally deficient”. Previously, he said, ‘it had been rigidly run’ and

the children¹³⁴ sat around with their arms folded and were not allowed to budge – this is not a criticism, but it [Templeton] was under the charge of a matron and there were sisters in charge of all the wards.¹³⁵

James said the system had changed to where ‘a head nurse and a head attendant were appointed, [and] the men were in charge of the boys, and the girls (sic) were in charge of the girls – it was the division of male and females once again’.¹³⁶ When later he was appointed head of the training school at Tokanui, James said, ‘it was unbelievable given that there was a tradition of matrons being heads of training schools, and given that they had more training than me’.¹³⁷ When asked if the job had been advertised, James said he did not think so. When female nurses began to work in the male wards, ‘it wasn’t well received because it was felt we were taking over a man’s domain’.¹³⁸ Eileen clearly remembered entering a male ward when she later became night supervisor and being told by the male attendant, ‘we don’t want you here – get going’.¹³⁹

The Effect of Wider Events

In addition to the Depression, the Second World War was remembered as a time of disruption. Female nurses spoke of women being manpowered (sic) to work in mental hospitals and of nurses who had been forced to leave on marriage being ordered back to work. Esther said that some of those manpowered were quite indignant at being sent to a “nut factory” and would often disappear in the night never to be seen again.¹⁴⁰ During the war there were extreme staff shortages, particularly on the female side.¹⁴¹ Ngaere said

¹³⁴ The term “children” was used, but although a person may have had the mental age of a child, her or his chronological age may have been that of an adult.

¹³⁵ Interview with James Nolan by Lois Wilson (1983).

¹³⁶ Ibid. (1983). James said he was sent to Templeton to start occupational therapy, although ‘they [already] had some system of occupation’. The “boys” would work, ‘making horse and cow covers, boots and shoes, or do upholstery’. He thought the “girls” ‘did some sort of sewing’.

¹³⁷ Ibid. (1983).

¹³⁸ Interview with Eileen Jones by Margaret Harraway (2000). Although the situation differed from hospital to hospital, by the late 1930s, female nurses were in charge of most of the male wards.

¹³⁹ Ibid. (2000).

¹⁴⁰ Interview with Esther Graham by Lois Wilson (1984).

¹⁴¹ Interview with Irene Smith by W. Lyon (1983).

that generally on one day the hours worked were from seven in the morning until eight at night and the next day they were from seven until five. These conditions operated in spite of the eight hour day and 40 hour week becoming law in 1936. When asked if there were returned soldiers admitted to Porirua¹⁴² Ngaere said

they would be on the male side. I don't think many ever came in, but I am only guessing. I wouldn't know if they had a whole army in, just like on the male side, they wouldn't know if on our [female] side, we had a baby born.¹⁴³

Male attendants spoke of mental nursing being a reserved occupation during the war. Attendants working in mental hospitals had to apply for special leave if they wanted to go overseas.¹⁴⁴ Those who remained in New Zealand were manpowered during their days off to unload ships.¹⁴⁵ Donald said, '[w]e were breaking our necks to get away and when we got there, we were breaking our necks to get back'.¹⁴⁶ While away he kept his hand in by doing some mental nursing in the Middle East and working on a hospital ship carrying mental patients home from the war. Unbeknown to Donald, while he was overseas someone applied for military leave on his behalf and also put in applications for any jobs which became available. While in the desert he heard that he had been promoted to charge attendant but said 'there was some bad feeling amongst the staff when I came back to a promotion'. Donald went back to mental nursing on his return from the war, because 'it was the only thing I knew'.¹⁴⁷ James was working at Sunnyside at the outbreak of war and indicated that upon his return, he was fast-tracked through the registration system.¹⁴⁸ After the war, nurses 'were brought over from the UK' to help alleviate the staff shortage. According to Irene 'a lot had no nursing knowledge', were 'very demanding of leave days', and some 'left as soon as their two year bond period was up'.¹⁴⁹ When he talked about the war on a broader front, David reflected both racist cultural constructions of Māori, and constructions of women as sexually available at a price. Māori men, he said, 'were bringing Māori girls from up north and selling them to

¹⁴² According to Deborah Montgomerie (1999) p.169 as a result the war 10,000 men received military pensions for psychiatric disorders.

¹⁴³ Interview with Ngaere Thompson by Helen Reilly (2003).

¹⁴⁴ Interview with Donald Graham by Lois Wilson (1983).

¹⁴⁵ Interview with David Hill by Sarah Dalton (1990).

¹⁴⁶ Interview with Donald Graham by Lois Wilson (1983).

¹⁴⁷ Ibid. (1983).

¹⁴⁸ Interview with James Nolan by Lois Wilson (1983).

¹⁴⁹ Interview with Irene Smith by W. Lyon (1983).

the yanks'. 'You know', he added, 'that's war, the girls were stark staring mad for the yanks 'cause they had money'.¹⁵⁰

Although not always specifically asked about their life outside of nursing, some narrators talked freely about significant incidents. Agnes for example, spoke tearfully of having to marry at seventeen because she was pregnant and of how she still felt badly that she had shamed her father:

I loved my father but he was so indifferent to me. I hated that man but Dad made me marry him. My sister was a very cold person – she never spoke to me because I did such a ... it was a dreadful thing in those days.¹⁵¹

Religious affiliations and what could be called broader spiritual beliefs, were mentioned by some narrators. A number mentioned that they had had a Catholic upbringing.¹⁵² Agnes spoke of wanting to be a missionary nurse from a very young age. When she first heard 'an inner voice' calling her to work at Sunnyside, she thought she 'must be going funny in the head' so visited her doctor:

Girly, he said, you have to go nursing and that's all about it. It was such a joy to hear somebody say that. My sister, refused to see me off at the [train] station [because] she was so *ashamed* of me doing such a thing.¹⁵³

When asked if her sister was ashamed that Agnes was going to leave her family¹⁵⁴ and go to Christchurch to work, Agnes confirmed,

you didn't leave your family in those days [but] it made me realise just how important it was that I go – my family were going to be looked after [while I was gone], but they had no one to look after the people at Sunnyside ... [While there], I wondered where was God – if there was a God.¹⁵⁵

¹⁵⁰ Interview with David Hill by Sarah Dalton (1990).

¹⁵¹ Interview with Agnes Stuart by Margaret Harraway (1999).

¹⁵² One of the many anecdotes that David recounted was about growing up Catholic in a small rural community. Generally, he said, Catholics and Protestants got on well but on St Patrick's Day, Catholic and public school pupils would have 'a real ding dong go' (interview with David Hill by Sarah Dalton 1990).

¹⁵³ Interview with Agnes Stuart by Margaret Harraway (1999). Agnes said that although she wrote to her sister from Sunnyside, her sister did not reply.

¹⁵⁴ By this time Agnes had two sons.

¹⁵⁵ Ibid. (1999).

Agnes said she woke one morning and thought it was time to go home, she had ‘done what I came to do’, [and] ‘didn’t fret about what I had done’.¹⁵⁶ After all, ‘if I’d been a missionary nurse, I would have seen life in the raw like [at Sunnyside], and my boys would [still] have had to be looked after’.¹⁵⁷

Conclusion

For many narrators the ramifications of the Depression affected their decision to take up mental nursing.¹⁵⁸ Later, the advent of World War Two was significant, but its impact was described by the attendants differently from the nurses. Attendants spoke of the war as a time of opportunity, whereas the nurses recalled long hours, staff shortages, and in one instance, being conscripted back to work.¹⁵⁹ Generally, mental nursing was described as ‘fairly rudimentary’, and doing the best you could ‘with talk and warm milk’.¹⁶⁰ For nurse, attendant and patient, conditions were less than ideal and each group, in its own way, was stigmatised and isolated from the rest of the community. As Thelma saw it, ‘mental nursing was a narrow in-grown sort of life’.¹⁶¹

No doubt, the gendered mental hospital organisation and culture in operation would have helped shape the subjectivities of the nurses and attendants, and the way in which they later reconstructed themselves within the interviews. Moreover, their narratives suggest that cultural codes of gender, and institutional hierarchies were in force both on and off duty. Some differences, however, were perceived in the way nurses and attendants respectively, represented themselves. The nurses were more inclined to use their perception of what they considered “nursing” should be, as a bench mark by which to measure their work. Although formal procedures and rituals emulated those of general nursing, they considered the type of nursing they practiced, and the training they received, often fell far short.¹⁶² As Gwen put it, ‘regimentation and cleaning were more

¹⁵⁶ It seems that here Agnes was talking about having left her family to go nursing at Sunnyside.

¹⁵⁷ *Ibid.* (1999).

¹⁵⁸ The biographies indicate that a number had also been influenced by family or friends. Prior familiarity with mental hospitals was also mentioned.

¹⁵⁹ Interview with Eileen Jones by Margaret Harraway (2000).

¹⁶⁰ Interview with Ngaere Thompson by Helen Reilly (2003).

¹⁶¹ Interview with Thelma McArtney by Hugo Manson (1989).

¹⁶² Agnes, for instance, drew parallels between the primitive conditions of missionary nursing and

important than nursing care'.¹⁶³ For the majority, off duty companionship with their colleagues was what kept them going. Additionally, family responsibilities were often to the fore in their narratives. Conversely, the men did not make comparisons with nursing as such, but mentioned working outdoors, sporting and union affiliations, and sharing a beer with a "mate", as important. Although both groups were closely monitored, the perception was that overall, the attendants had greater freedom than the nurses. This reflected societal norms where young males were given more freedom than young females.

Although doctors headed the chain of command, they were perceived as not always knowing what was best for the patients, and it was asserted that the nurses and attendants, who provided the day-to-day care knew the patients better. The women narrators spoke about the doctors and their position of authority. Despite some differences of opinion on the current use of medication, narrators were in general agreement that changes in mental health practices had been for the better. When taken back to Sunnyside for a visit by her interviewer, Agnes commented, 'sometimes you can't really tell the staff from the patients'.¹⁶⁴ In the interview process, the women more so than the men, were inclined to be hesitant about disclosing what they saw as sensitive information. Some in fact, refused to do so on tape.¹⁶⁵ Maude, when asked if she had ever thought about writing a book, replied, 'I think the book would be condemned. My memoirs would be libellous'.¹⁶⁶ The following chapter will analyse how gender was operating within the oral histories of the nurses and attendants.

Sunnyside where she nursed (interview with Agnes Stuart by Margaret Harraway 1999).

¹⁶³ Interview with Gwen Wilson by W. Lyon (1983).

¹⁶⁴ Interview with Agnes Stuart by Margaret Harraway (1999).

¹⁶⁵ Thelma, for example, told the interviewer she would tell her something interesting about Sir Truby King, 'off the record', and Ngaere dropped her voice to a whisper when she described collecting the artifacts for the Porirua Museum. She was also reluctant to repeat on tape details of 'getting rid of the smell' in the building gifted to the museum for its use. It had been a female ward where a number of incontinent former patients had been housed.

¹⁶⁶ Interview with Maude Clifton by H. Campbell (1983).

CHAPTER FIVE

ANALYSIS

This chapter provides an analysis of the findings of the texts and a discussion on how discourses of gender, both overtly and covertly, permeated all aspects of social and cultural life including the mental health system, how these shaped the subjectivities of mental hospital staff, particularly the nursing and attendant staff, and were employed to support particular forms of gendered relations and practices. Selective excerpts from the oral histories and other texts are used to show how different discourses were taken up by the narrators, in reconstituting themselves as mental nurses and attendants. The chapter is structured around the themes of gender and the intersubjective relationship, discourses of marriage and familial obligations, gendered discourses of labour, mental hospitals as gendered workplaces and discourses of knowledge and power.

Gender and the Intersubjective Relationship

The production of oral histories is inter-subjective in that it is the product of a relationship between a narrator and an audience. Oral historians have suggested that through the oral history process, narrators cope with the losses which are inevitable as people age, and as a result, achieve a sense of “composure”.¹ Subjective composure, however, depends on social acknowledgement that the ‘self and world figured in a narrative’ are connected to ‘shared, collective identities and realities’.² As pointed out by British historian Penny Summerfield, those who formulated these theories have not addressed how gender may interface with the process. The feminist awareness of gender as constitutive of social relations in which power is disproportionately distributed, intimates that gender must affect all social communication and socio-linguistic practices. The political goal in social research is to avoid reproducing ‘relations of domination and subordination, of colonisation and disempowerment’.³

¹ See Chapter Three note 38. See also Dawson (1994). For the meaning of reminiscences in later life see Coleman (1991).

² Dawson (1994) p.23.

³ Summerfield (1998) p.24.

As previously indicated, the oral histories under review were part of nursing research and life history projects. For the nurses and attendants, recognition of their shared cultural understandings, of nursing for example, would have influenced the way their narratives were told and the kind of composure possible. Comments such as the work 'wasn't nursing' confirmed shared understandings of the values and practices of nursing. These observations were particularly apparent when female general nurses were interviewing female mental nurses, suggesting that the latter group were aware of the status of mental nursing vis a vis mainstream nursing. A nurse who had made the transition from general nursing to psychiatric nursing said,

I tend to believe that when people talk about nursing, they think and talk about general nursing. It's a bit like the identifier of when you say "he" you're referring to men and women but you're really referring to men. You know, *of course*, women are included in that. It's a bit similar I think.⁴

The extent that people are prepared to share their stories is dependent on the reactions of others. Thus, in the first instance, the relationship between the nurse/attendant and the interviewer was an important part of the process. When the research relationship is based on mutuality it is a process in which, in the words of Summerfield, 'the researcher influences and is influenced by her subjects'.⁵ The interview Margaret conducted with Agnes gave weight to the significance of the intersubjective relationship. When Agnes disclosed details of her life which were painful to her, Margaret, herself a psychiatric nurse, offered encouragement and gave Agnes space to test the validity of her life choices and achieve some form of closure. As asserted above, feminist oral history is not only about the empowerment of the narrator participants; attention must also be turned to the relationship between discourse and the production of memory in order to comprehend the emphasis on the personal and the private in feminist oral history. The question must always be asked: 'Is it mere voyeurism, or is it a political response to the gendered power relations which pervade socio-linguistic exchanges?'⁶

⁴ Interview with Frances Richardson by Yvonne Langridge (2000). This interview was not included in the analysis as such, but was drawn on to provide contextual information pertaining to mental nurses and mental nursing

⁵ Summerfield (1998) p.24.

⁶ Ibid. (1998) p.27.

Several of the female narrators appeared to be aware of the covert requirement that they become the narrative subject of the interview and expressed doubts about whether what they had to say was relevant to the project. May, for example, at one point queried, 'I don't know if this is making sense to you?' When assured by Yvonne, the interviewer, that what she said was very interesting, May said, 'I suppose I digress a bit, you do so at my age'. Yvonne went some way to overcoming the power imbalance which is inevitable between researchers and their subjects by giving May some responsibility for what was discussed. She told May, 'these are the interesting bits, please digress'.⁷ In a few of the interviews the interviewer did not 'let the narrator go' but brought her/him back to answer what appeared to be a pre-prepared set of questions. Although it is not known if any of the interviewers were aware of feminist critiques of conventional science and its inclination to ignore the research relationship in the interests of so called "objective" research, the examples discussed below, suggest there was an understanding of some of the issues of concern for feminists, including reducing the inherent power imbalance between interviewer and interviewee.

The different way in which the nurses and attendants reconstructed themselves and reminisced revealed how their memories were performances of gender. The women narrators were generally more tentative and, in the process of reconstructing themselves, often seemed to be audibly working out the value of their mental nursing experience and trying to resolve any distress which their memories may have caused them. They were more likely at times to talk in a whisper or check out if they were "allowed" to say something. The men appeared more self assured and the heroes of stories of triumphing against the odds. In his narrative, David represented himself as someone who, when he joined the union, 'didn't know anything about it'. He ended up as a union official with responsibility for arranging a national conference for mental division staff to which he 'brought all the remits', and in his dealings with a hostile hospital medical superintendent and head office staff, 'won out in the end'.⁸ As observed by Caroline Daley, '[t]he culture

⁷ Interview with May Puch by Yvonne Shadbolt (1984).

⁸ Interview with David Hill by Sarah Dalton (1990).

... people grew up in has had a profound effect on how they present [and I would add, construct], their memories'.⁹

Discourses of Marriage and Familial Obligations

For the purposes of the oral recording, the interview began when the nurse or attendant was asked to introduce her or himself and tell a little about their family of origin. The narrators' responses varied in the amount of information they gave¹⁰ and some did not refer again to familial relationships. Others, like Agnes, Eileen, Thelma, Ngaere, and David, returned to the topic during the interview. In part, this appeared to be dictated by the interviewers' style, the questions they asked, and the overall purpose of the interview. It was not surprising that the two interviews whose brief was wider than mental nursing, namely those with Thelma and David, would be set within the wider context of the life story. Yet, even within the interviews whose primary purpose was mental nursing there was variation in the way the interview progressed. Whereas David spoke in terms of the "behind the scenes" assistance he received from his wife, generally, the womens' narrations suggest that they were often drawing on gendered discourses of the family in which daughters were constructed as dutiful. Eileen, for instance, spoke of going home on her days off 'to help with other members of the family',¹¹ and so did Ngaere. She said, 'because my mother had little children, I used to go and give her a hand'. At one point she had been required to take a temporary break from mental nursing to help her mother.¹²

For some, Agnes for example, their mental nursing experience could only be explained in the context of the rest of their lives. In positioning herself as someone whose first child was conceived out of wedlock, Agnes drew on discourses in circulation in which reproduction was constructed within the confines of marriage, and unmarried mothers stigmatised. A doctor writing in 1940 in a magazine aimed at mothers and daughters stated:

⁹ Daley (1998) p.356. See also Daley (1992, 1999).

¹⁰ See Chapter Three pp.66-70.

¹¹ Interview with Eileen Jones by Margaret Harraway (2000).

¹² Interview with Ngaere Thompson by Helen Reilly (2003).

It is very terrifying for a girl who has always lived a straight life to find that she is going to be an unmarried mother. She knows ... she will be blamed and probably scorned.¹³

Having conceived pre-nuptially, a woman could redeem herself by marrying and becoming a good mother. Agnes' story demonstrates the power of discourses which constituted women, whether daughters, wives or mothers, as at the mercy of the men in their lives. When speaking of her first pregnancy, Agnes said, 'my mother never spoke of things like that to us'. She told the interviewer,

Margaret, you may not believe it [but] I said to my mother one day, I feel sick in the mornings. ... Then I started wanting lettuce for breakfast. It was sad, sad. I could cry for weeks on end when I think about it. That man got me into trouble and I didn't know it.¹⁴

Forced to marry by a father who 'was so ashamed of me he never forgave me, never forgave me', Agnes described her marriage as unhappy'.¹⁵ Although she was the mother of two boys, what she still wanted was to become a missionary nurse.

A number of authors have emphasised the interplay between the cultural conventions of story telling and personal meaning.¹⁶ According to American oral historian Norman Denzin, at a moment of crisis an epiphany may occur which alters the essential meaning structures in an individual's life, but these stories are always told retrospectively as people re-experience what has occurred.¹⁷ In giving meaning to her abandonment of her husband and family at a time when it was men, not women, who sometimes left their families, Agnes drew on the culturally shared archetypal story of the "call".¹⁸ Since the days when Florence Nightingale defined it as a "calling", secular nursing had been imbued with the "aura" of a religious order.¹⁹ An outward sign was the nurse's uniform which 'represented a non-sexual femininity' and the headgear which resembled the veils

¹³ *Lucky Star* quoted in Tinkler (1995) p.165.

¹⁴ Interview with Agnes Stuart by Margaret Harraway (1999).

¹⁵ *Ibid.* (1999).

¹⁶ See for instance Crawford et al. (1998) and Denzin (1989).

¹⁷ Denzin (1989).

¹⁸ A "call" denotes that a person is chosen and separated from the crowd in order to perform a certain task (Raatikainen 1996).

¹⁹ Bishop and Goldie (1962) p.25. See also Williams (1978) and Welch (1991).

worn by novice nuns, and evoked analogous images of purity and “calling” to a higher ideal.²⁰ Discourses in circulation which associated nursing with religion provided Agnes with a subject position from which to act. She had no option but to respond to the voice that told her to go to work at Sunnyside, especially when her male doctor rather than declaring her “mad”, confirmed that what she had experienced was ‘a spiritual thing’.²¹ In reliving her moment of epiphany, Agnes did not merely reflect the experience, she actively reconstructed it: ‘It made me realise how important it was that I go – my family was going to be looked after but they had no one to look after the people at Sunnyside’.²² In discursively constructing herself as a nurse who left her husband and children because she was called to serve others, Agnes disrupted dominant discourses of the family and normative social relationships between women and men.

Like Agnes, Thelma drew on discourses of the family in which men were represented ‘as the final arbiters of power, ... they established the rules and regulations of the home, which were administered by their wives’.²³ She had really wanted to go to University but knew that for the girls in the family, ‘there was no money for that sort of thing’, and she ‘lost heart’.²⁴ Realising that unlike her brothers, she would have to make her own way in life, when her father told her that they wanted nurses at Seacliff and that they were paid, she went there against her will. Thelma said, ‘the way was to look after your sons’ but questioned ‘why didn’t we [the daughters] get a share of it’?²⁵

Gendered Discourses of Labour

The Great Depression, the period when the majority of the nurses and attendants were seeking work, had the effect of disrupting discourses of family life predicated on the sole male bread winner. Many families were forced to consider alternatives, including women

²⁰ Hallam (2000) p.135. See also Valentine (1996) and Brooks and Rafferty (2007).

²¹ Interview with Agnes Stuart by Margaret Harraway (1999). Interestingly, although hearing voices may be thought of as “mad” it can also be seen as a sign of a particular kind of insight (Tudor 1996).

²² Interview with Agnes Stuart by Margaret Harraway (1999).

²³ Tinkler (1995) p.121.

²⁴ Interview with Thelma McCartney by Hugo Manson (1989).

²⁵ Ibid. (1989).

entering the paid work force.²⁶ Eileen discursively constructed herself as a worker whose wages were an economic necessity for her family. She had worked ‘off and on’ in a hotel for 12 months but was ‘getting sick of [doing] little or nothing.’ As the oldest of seven children, she needed to find paid work. ‘We were poor I don’t mind admitting it [but] in those days you couldn’t get a job’.²⁷ The positioning of women and men in economic discourses in the Depression, when ‘jobs were as scarce as hen’s teeth’,²⁸ was not gender neutral. Labour market policies are never impartial either in their effect or in their fundamental assumptions. Although the 1930 Unemployment Act made provision for employed workers to contribute to an Unemployment Fund, unemployed women were only able to obtain relief through the man of the house. The majority of the female narrators, whose ages ranged from 17 to 21, were single young unemployed or semi-employed women, still living at home. As such, they would have been reliant on the financial support of male relatives. Although it was outside their control, there is evidence that during the Depression women regarded unemployment as degrading. For example, young women belonging to the Auckland branch of the Young Women’s Christian Association (YWCA) spoke of unemployment as ‘a disgrace’.²⁹

In the twentieth century women were entering the paid workforce in greater numbers and asserting their independence but their employment options were limited.³⁰ The work in which the women narrators had previously been involved, (shop, hotel, and domestic work), for example, was commensurate with what would have been expected for working class women of the period. It was standard practice for women to be kept out of so-called “men’s jobs” and to be dismissed or made temporary on marriage. Also, their rates of pay across the board were fixed lower than those of men.³¹ Penny Tinkler has shown through her research on girls’ magazines from 1920 to 1950 that although new opportunities were opening up, girls were still discursively constructed as future wives and mothers rather

²⁶ Frank (1999). See also Simpson (1997)

²⁷ Interview with Eileen Jones by Margaret Harraway (2000).

²⁸ Ibid. (2000).

²⁹ Coney (1986) p.205.

³⁰ See for instance Olssen (1980).

³¹ Olssen (1981) and Shirley et al. (1990).

than as full time career or academic women.³² These imperatives meant that generally the number of women available for work outside the home was variable, and mental hospitals, in particular, were continually short of female staff. Negative public perceptions of mental nursing, and its association with the mentally ill and the work of men, meant that women were reluctant to take it up. As Esther said, ‘it was the last thing a gently brought up girl would do’.³³

Although the Depression limited the male attendants’ job options, the sort of work offered at the mental hospitals was not too far removed from their previous manual labouring/industrial type jobs. They mainly constituted themselves as mental attendants whose work was outdoor physical labour and industrial work rather than nursing. While the duties of some nurses and attendants, such as looking after refractory and debilitated patients, and watching patients placed in airing courts, could be described as nursing, many spent their time supervising the work of patients. James said that because he ‘gravitated to the outside life [he] had no problem fitting in [to Sunnyside]’.³⁴ Even though, according to David, there were 500 on the waiting list for jobs at Avondale Asylum, his past farming experience counted in his favour: ‘They wanted men like me because working parties went out around the farm’.³⁵

In the inter-war years the family became sacrosanct. Discourses of masculinity constructed a male breadwinner who earned a wage sufficient to support a wife and children. The home and family became woman’s sphere; the workplace situated away from the home was that of the man. The suburbs were places to which men returned at the end of the working day for succour.³⁶ On the strength of his job at Avondale Asylum, David said he was able to get a loan from a building society to build a house at Pt Chevalier. In those days, ‘they called it “nappy lane” because of all the young families

³² Tinkler (1995).

³³ Interview with Esther Graham by Lois Wilson (1984).

³⁴ Interview with James Nolan by Lois Wilson (1983).

³⁵ Interview with David Hill by Sarah Dalton (1990). The men under study were all over 21, and it is known that at least two of them, namely Donald and David, were married.

³⁶ Phillips (1996), James and Saville-Smith (1994), and Olssen (2003).

living there'.³⁷ David drew on discourses of the worker as family man who in return for providing a home, turned to his wife for "behind the scenes" support. As indicated in Chapter Four, before taking on the mental hospital job, David had discussed it with his wife, and later, when he became active in the union, she supported him both emotionally and practically by giving him advice and undertaking his secretarial work.

Mental Hospitals as Gendered Workplaces

Although both female nurses and male attendants were employed under the mantle of the mental hospital system, the characteristics of each group reflected the gendered nature of women's and men's employment generally in society. Unlike female nurses, male attendants stayed longer, built careers, were able to set themselves up in powerful positions, and could act collectively to push for material advantages and changes.³⁸ All the men in this present study had been able to make a permanent career out of mental nursing, whereas the women who married, either like Thelma, never returned to nursing, or else like Esther and Ngaere, had broken service. At a time when marriage was regarded as almost compulsory, Maude, Gwen, and May appear to have remained single and pursued a career in mental nursing. Although married, Eileen was mental nursing all her paid working life apart from during the 1940s when she took a three year break due to her deep distress after her second child was stillborn.³⁹ At this time, she took a job at the freezing works, work normally bench-marked "male".⁴⁰

In reconstructing herself as a mental nurse, Eileen struggled to find the words and ended up using language which metaphorically linked mental nursing to men's work. She said, 'you didn't do a lot of nursing ... you did a lot of ... what should I say ... I always said I could work for the council because I had a lot of practical experience like sweeping yards'.⁴¹ A number of female narrators, like Eileen, constructed their work as outside the boundaries of what they considered as nursing, and their work culture more in keeping

³⁷ Interview with David Hill by Sarah Dalton (1990).

³⁸ Gittins (1998).

³⁹ Eileen's first child had been killed in an accident.

⁴⁰ Interview with Eileen Jones by Margaret Harraway (2000).

⁴¹ Ibid. (2000).

with male working class values than female nursing ones. For them, swearing and a certain amount of physical misconduct was not untoward. Ngaere recounted a time when one female nurse physically attacked another female nurse on the ward. She said, 'Maggie was a real hard hard person and of course, we all wanted to hit her at different times'. When the interviewer asked whether the patients had liked Maggie, Ngaere replied that they had no option: 'A lot of them would argue the toss with her and she would give them the works'.⁴²

In their reconstructions, narrators also drew on psychiatric discourses in which the "ideal" female mental nurse was constructed as a semi-professional similar to a general nurse. May stated at the beginning of her interview that she had really wanted to go general nursing but ill health had prevented her. Further into the interview, the interviewer who was a trained general nurse said, 'you told me you wanted to go general nursing. What happened?' May's response was that she could not pass the medical but pointed out, 'we did what we were taught to do in the proper fashion'.⁴³ The interviewer's question and May's slightly defensive response, suggests that she was aware of the marginalised position of mental nursing vis a vis general nursing and its negative image generally. One nurse said,

you can't separate the history [of mental nursing] from the present – where [it] came from in terms of asylums and the working class. Working with mad people means that the people who work with them are a bit sort of suspect as well. So people who went into psych nursing in the early days, were people who were a little bit on the fringe themselves or didn't quite fit in.⁴⁴

Women's Work and Men's Work

Rather than being gender-neutral, occupations are structured with the specific gender of the worker in mind.⁴⁵ Nursing, as a woman's occupation was constituted according to cultural assumptions of women's disposition and their appropriate place in society. Occupations such as nursing were poorly rewarded, not so much because they were not valued, but because of their association with the home and the belief that women gained

⁴² Interview with Ngaere Thompson by Helen Reilly (2003).

⁴³ Interview with May Puch by Yvonne Shadbolt (1984).

⁴⁴ Interview with Frances Richardson by Yvonne Langridge (2000). See also Walsh (2002).

⁴⁵ Williams (1993).

fulfillment in doing what came naturally to them.⁴⁶ As discussed in Chapter Two, the nurse was positioned as “mother” to the doctor positioned as “father”; hospitals became symbolic homes in which male doctors ruled, and gave orders to nurses and ancillary staff. Although mental hospital matrons and ward sisters adopted a subservient position to male doctors, like mothers, they held sway in their own domestic empires.⁴⁷ Esther said, ‘in those days the sisters were such martinets they ruled the roost’.⁴⁸ Yet, although the power of these women differentiated them from other women, it did not make them the equals of men. The metaphoric connection of nursing with the family is used in a number of texts including the oral histories under review. When discussing the male attendants, Eileen said, ‘a lot of them were father figure roles in the place’.⁴⁹ For Agnes, the patients ‘must have thought I was their mother’.⁵⁰

Several writers have highlighted the way in which discourses of domesticity have influenced medical discourse. If a woman doctor was seen as incongruous and going against nature, so was a male nurse an anomaly where “nurse” equates with “mother” and “woman”. It has been argued that men in female-dominated occupations such as nursing, often accentuated their masculinity as a means of legitimising their employment in these occupations, by participating in trade unions, for instance.⁵¹ In the present study, the men, rather than the women, talked about their union involvement. This is consistent with Margaret Bazely’s observation that when she went to work at Sunnyside in the 1950s female staff had very little contact with the PSA.⁵² Despite this, an early example of direct action by public servants took place in 1946 when female nurses at Porirua and Seacliff hospitals refused to work overtime.⁵³ As American sociologist Ava Baron has observed, masculine symbols and the male worker have come to represent unionism even

⁴⁶ See Reverby (1987), Valentine (1996), and James and Saville-Smith (1994).

⁴⁷ See Salvage (1985) and Gamarnikow (1978).

⁴⁸ Interview with Esther Graham by Lois Wilson (1984).

⁴⁹ Interview with Eileen Jones by Margaret Harraway (2000).

⁵⁰ Interview with Agnes Stuart by Margaret Harraway (1999).

⁵¹ See for instance Gamarnikow (1978), and Davies (1980).

⁵² Interview with Margaret Bazely by Margaret Harraway, 14 March, (2000), Sunnyside Hospital Oral History Project, Alexander Turnbull Library OHColl-0736. This interview was not included in the analysis as such, but was drawn on to provide contextual information pertaining to mental nurses and mental nursing. Margaret went on to become matron of Sunnyside Hospital. She also had an illustrious career as a public servant and is often called on to head government inquiries.

⁵³ Roth (1987) pp.117-8.

although women were active in industrial disputes: ‘Women were made invisible even when they were present’.⁵⁴

The construction of masculinities and femininities is always contingent on power but as discussed in Chapter Three, power is unstable. For instance, meanings of manliness emerge out of particular social and institutional practices.⁵⁵ In the inter-war years, women in paid work became symbolic of the supposed rearrangement of power between the sexes, and as such, were targets of male hostility.⁵⁶ One nurse, when speaking of her encounters with male staff said,

they felt very threatened. I’ve had some feedback later on that I was known to be aggressive ... It’s interesting because the same behaviours in men are not seen as aggressive or undesirable characteristics.⁵⁷

Indications are that attempts to turn attendants into nurses were resented by male attendants who feared a female nursing culture encroaching on their masculine domain, blocking their career opportunities and challenging their power. As indicated in Chapter Four, James reconstructed female nurses in a negative way, including dismissing “girls” qualifications as somewhat irrelevant to the practicalities of mental hospital work. When asked what qualifications these girls had, he thought they were not *psychiatrically* trained: ‘There was a mixture of general and psychopaedically trained’. He added, ‘what that meant I’m not sure, as I don’t think that the ... curriculum was developed to the stage it was later’.⁵⁸ Further on in the interview he spoke of being transferred to Templeton farm where previously ‘all the wards were in charge of girls who had some sort of registration’. He and other experienced male attendants from Sunnyside who had psychiatric registration ‘altered the whole outlook of the place’ and set up the male side of the institution as an industrial workplace, in which male attendants taught patients practical skills.⁵⁹ Although the education of male attendants was inferior in quantity and

⁵⁴ Baron (1994) p. 149. For discussion of how the economic preoccupations of trade unions meant that they were unable to adequately deal with the concerns of women see Rowbotham (1979).

⁵⁵ Baron (1994). See also Segal (1990).

⁵⁶ Summerfield (1998).

⁵⁷ Interview with Eileen Jones by Margaret Harraway (2000).

⁵⁸ The term “psychopaedic” was adopted in the 1920s in New Zealand to distinguish between psychopaedic institutions for the education and training of people with intellectual disabilities and psychiatric institutions (Department of Internal Affairs 2007 p.15).

⁵⁹ Interview with James Nolan by Lois Wilson (1983).

quality to that for female nurses, they were positioned to take advantage of leadership roles.⁶⁰

When asked about the male attendants, Eileen said that education-wise they wouldn't have the qualifications, and although 'there is always one rotten apple in a case ... a bit of dead wood, there were some very fine men'.⁶¹ May indicated that male staff at Tokanui 'were a cut above the average'.⁶² Margaret Bazely also spoke positively about male staff. She said, 'those of us working with them have tremendous respect for the way they have adapted from custodians to therapeutic care'.⁶³ The different way in which nurses and attendants reconstructed each other, suggests that each was grounded in cultural suppositions of gender-appropriate behaviour: 'Men are actors, women are emotional support'.⁶⁴ Implicit in the construction of femininity, are assumptions about women's support role both on the home and work front. The dominant ideal of women as nurturers can be at women's expense but, on the other hand, it can be the basis for 'a distinctive women's community organised around [so-called] female values and the primacy of women's relationships'.⁶⁵ In this study, a number of the female nurses spoke of the supportive friendships they formed with other women.⁶⁶

Discourses of Sport and War

Following European settlement in New Zealand, war and sport were two significant factors in defining Pakeha manhood and social equality.⁶⁷ The actualities of economic inequalities were downplayed by blaming innate feminine characteristics as responsible for raising concerns about social status. Thus in the construction of masculinity, inequities, although underpinned by structural mechanisms, were dismissed as predilections arising naturally in the female, and imposed on the male. Participation in sport is necessary to male culture because there, differences are put down to individual

⁶⁰ Dingwall and McIntosh (1978) and Evans (2004).

⁶¹ Interview with Eileen Jones by Margaret Harraway (2000).

⁶² Interview with May Puch by Yvonne Shadbolt (1984).

⁶³ Interview with Margaret Bazely by Margaret Harraway (2000).

⁶⁴ Edley (2001) p.195.

⁶⁵ Taylor (1996) p.174.

⁶⁶ For discussion on the development of women's friendships and culture see Cott (1997), Smith-Rosenberg (1975) and Jeffreys (1985).

⁶⁷ Phillips (1996).

ability rather than deliberate human action.⁶⁸ Both the military and the male world of sport evoke images of teamwork and toughness and are considered valuable training for organisational success.⁶⁹ When talking of sport, David said, ‘[the] thing is you learn to take a hiding ... It gives you a sense of purpose. It did me. ... It’s good character building you know’.⁷⁰

Given the importance of a male sporting culture from which women were excluded, it is not surprising that in a number of oral and written texts, and in photographs of mental hospital staff, men who in their daily working contexts might have opposing interests, are often collectively represented as sportsmen.⁷¹ In the present study, sporting ability was represented as currency for male privilege.⁷² In James’ account of seeking work at Sunnyside he reconstructed himself first and foremost as a sportsman, a position which was endorsed by the medical superintendent. James said, ‘the superintendent recruited people good at rugby. Anyway, that’s how I got into [mental nursing] and stayed for 40 years’.⁷³ In Wendy Williams’ book on Porirua Hospital a chapter is devoted to sport. In the team photos, male attendants sit alongside male doctors and male clerical staff in a performance of male solidarity.⁷⁴ A photo of the bowling club shows a lone woman’s head poking out between the folded arms of two men. Although all the men in the photo are identified by name, she is a “woman unknown”.⁷⁵ Obviously, she was not an active member of the club, as records show that women were not welcome until 1963. The one photo of a women’s sports team is of the 1930 season, “Hospital Ladies Hockey Club”, which was set up because ‘[t]hey [the men] had their soccer but there was no hockey or anything for the nurses’.⁷⁶ Although the matrons at the time were supportive, when they

⁶⁸ James and Saville-Smith (1994) and Phillips (1996).

⁶⁹ Acker (1990).

⁷⁰ Interview with David Hill by Sarah Dalton (1990).

⁷¹ See for instance Gittins (1998) and Williams (1987).

⁷² In a 2004 study, Charlotte Macdonald has shown how women’s marching teams in the post war years, when there were insecurities about the gender order, challenged normative constructions of femininity and masculinity (Macdonald 2004). Caroline Daley has focused on the 1905 All Blacks tour of Great Britain to challenge the notion that rugby, at this time, exemplified New Zealand masculinity and emergent nationalism (Daley 2005).

⁷³ Interview with James Nolan by Lois Wilson (1983).

⁷⁴ See Williams (1987) p. 143, 145, 147.

⁷⁵ *Ibid.* (1987) p.147.

⁷⁶ Anonymous interview quoted in Williams (1987) p.149.

left, the support disappeared and the ladies hockey team's 'brief but brilliant career' at the hospital was over.⁷⁷

War is a situation which epitomises Scott's notion of gender as 'a constitutive element of social relations' and gives recognition to performances and meanings of masculinity denied to women.⁷⁸ The nurses' and attendants' discursive accounts, when set within the wider social context of the construction of war work, suggest that each group was aware of the gender order in operation at the time. Whether, like Donald and James they served overseas, or like David, on the home front, the male narrators positioned themselves within discourses of masculinity, in which men were the key participants in the war effort. Donald indicated that at the outbreak of war many of the attendants were so keen to get overseas, they more or less resigned on the spot: 'We threw our keys on the table and [left]'.⁷⁹ The attendants also drew on postwar discourses of rehabilitation in which ex-servicemen were positioned as having a moral right to special privileges, and employers as having a legal obligation to reinstate them.⁸⁰ James, in reconstructing his postwar nursing self, said:

When I came back, men [like me] who had been overseas, and already started some sort of tutorials were allowed to sit the institution final examination. Providing you passed you were given registration as a psychiatric nurse.⁸¹

David also positioned himself within discourses which privileged men like him who "held the fort" on the home front.⁸² He spoke of the opportunity afforded him by the shortage of trained staff during the war, to take an examination to upgrade to head attendant. At the time, the Medical Superintendent told him he was gifted, '[compared] to the average chap' and that many of the others 'were institutionalized, were robots, just robots'.⁸³ In his 1940 report to government, the Director-General mentioned 'accelerating the promotion of our most promising younger male staff'.⁸⁴

⁷⁷ Williams (1987) p.149.

⁷⁸ Scott (1988) p.42. See also Cooper (1999).

⁷⁹ Interview with Donald Graham by Lois Wilson (1983).

⁸⁰ See Montgomerie (1999, 2001).

⁸¹ Interview with James Nolan by Lois Wilson (1983).

⁸² As mentioned in Chapter Four, David had worked on the wharf unloading ships on his days off.

⁸³ Interview with David Hill by Sarah Dalton (1990).

⁸⁴ Dept. of Mental Hospitals AJHR 1941 H-7 p. 6.

In contrast, the female narrators' reconstructions aligned with the Australian cultural sociologist Bronwyn Davies' description of the 'privation, hardship and namelessness', experienced by women positioned as those who, in war time, patiently wait.⁸⁵ As conveyed in reports of the Mental Hospitals of the Dominion, it was regarded as a point of honour that, by December 1940, over 100 men from the New Zealand mental hospital service had volunteered for service overseas.⁸⁶ Each subsequent war-report updated the number. However, there is no mention in the reports of women like Ngaere, who during the war, sometimes worked 13-hour days:

[On the day] you were supposed to be off, you couldn't be, because they didn't have the staff ... Eventually they had to stop it and you were not allowed to work more than eleven days without a break. The staff were dropping down like flies.⁸⁷

Nor is there mention of those women, who, although forced to leave on marriage, had been ordered back to work without their previous experience being acknowledged. Eileen said,

with so many men overseas you had to fill the vacancies. If you had any qualifications that was the area you were placed in. I finished up at Sunnyside. In those days, I still wasn't registered, so came in at the bottom of the ladder. The two years I'd had [at Seaview] didn't count for anything.⁸⁸

Generally the Second World War did not denote a marked change in the positioning of women and men in the gender order and after the war married women were seen as expendable, with less right to a job than other workers.⁸⁹ The narratives of the nurses and attendants reflect dominant discourses in which men's rather than women's sacrifices in times of war are represented as deserving of recognition.

None of the interviewers specifically brought up the subject of race but both Agnes and David spoke of Māori in the course of their respective interviews.⁹⁰ Agnes said she had

⁸⁵ Davies (1992) p.60. See also Montgomery (1999).

⁸⁶ See for instance Dept. of Mental Hospitals AJHR 1941 H-7 p.2.

⁸⁷ Interview with Ngaere Thompson by Helen Reilly (2003).

⁸⁸ Interview with Eileen Jones by Margaret Harraway (2000).

⁸⁹ Montgomery (1999, 2001) and Summerfield (1998).

⁹⁰ Texts that omit Māori can be seen as part of the project of colonisation (Dalley & Labrum 2000). In-depth discussion of issues pertinent to Māori mental health is beyond the scope of this present study, however, it is obviously an area that needs researching. See Lorelle Burke's masters thesis (unsighted)

only ever nursed one Māori patient. David in recounting his war experiences constructed Māori women as promiscuous. During the Second World War men were warned that a “girl” ‘may look clean but ... you can’t beat the axis if you get VD that may be carried by ‘pick-ups, “good time” girls and prostitutes’.⁹¹ Historically, Māori women have been portrayed as different from Pākehā women. While Māori women were regarded as natural prostitutes, Pākehā women who resorted to prostitution were viewed as having temporarily fallen from grace. Basically, it has been argued that the gendered culture dislodges questions of racism by undercutting socially constructed inequalities and depicting differences as natural. Although beyond the scope of this present study, the term “racism” needs to be deconstructed to expose the mechanisms by which systems of domination reproduce themselves, and the ways in which gender and race are implicit in the process.⁹²

Discourses of Knowledge and Power

Textual representation is never neutral but is always a way of constructing a particular view of the world that furthers the interests of dominant groups. In these representations knowledge production is an exercise in power in which only certain voices are heard.⁹³

Psychiatric Discourses

Critiques of general nursing have shown the way in which male doctors have been instrumental in producing nursing knowledge.⁹⁴ This criticism also applies to mental nursing, where, for a number of years, mental nurse training was reliant on overseas texts produced by British male medical superintendents. Legislative changes discussed in Chapter One, which brought mental nursing under the control of the Nurses and Midwives Board, intimated that the mental nursing curriculum needed to be revised and that a New Zealand text was needed.⁹⁵ The book finally produced, *A Manual of Psychiatry*, was written by Kenneth Stallworthy, a psychiatrist, and covers the ‘New

completed in 2006, which is a study of Māori patients in the Auckland Lunatic Asylum, 1860-1900.

⁹¹ “She May Look Clean” (2006) p. A 24. See also pamphlet *The Shadow over New Zealand* (1942).

⁹² See Eldred-Grigg (1984), James and Saville-Smith (1994) and Ware (1994).

⁹³ Fletcher (1998).

⁹⁴ See for instance Gamarnikow (1978), Rodgers (1985) and French (2001).

⁹⁵ Brunton (2001).

Zealand syllabus for the psychiatric nurse-in-training'.⁹⁶ The discursive representations of mental illness and mental nursing in texts such as Stallworthy's, provide insights into the sets of understanding that were available to the mental nurses and attendants under study. The purpose is not to evaluate the validity of psychiatric diagnoses and treatments, but to analyse what culturally coded systems of gender relations there were; what structurings of power were embedded in these texts. Evaluating the nurses' and attendants' reconstructions contextually and historically, reveals how their mental health practice was influenced by the particular gendered discourses produced by psychiatrists at a time when new somatic remedies, for example, ECT, were being introduced, and the scope of the discipline was expanding. Psychiatrists were 'not merely medical doctors but arbiters of social norms' delving into 'a psychiatry of everyday life' and areas of popular public interest, including sex, concerns about women's nature, and the tenor of relations between the sexes.⁹⁷

Like other medical texts, Stallworthy's book uses the generic "he" and "man" to embrace both women and men.⁹⁸ Following the conventions of the time, male pronouns are used throughout, apart from references to the mental nurse who is constructed female, and in the construction of mental illness in women. Reflecting medical opinion of the day, inherited characteristics are mentioned as important predispositions to mental disorder, and 'a flaw in the make-up of an individual may be unmasked by environmental and emotional difficulties'. Mental illness in women is typically constructed as a dysfunction of the female cycle or as a failure to adjust at certain periods of life, such as puberty, marriage, childbirth and menopause. The nurse is told that women are prone to seizures at the time of menstruation and will need extra medication, painful menstruation (dysmenorrhoea) is sometimes caused by 'resentment at being female' or unhealthy attitudes to sex, and 'sexual aberrations' such as homosexuality, are 'often enough contributory to the illness of the patient'.⁹⁹

⁹⁶ Stallworthy (1950). "Preface".

⁹⁷ Lunbeck (1994) p.49, 308.

⁹⁸ For an explanation of the way in which men have been responsible for creating the structures, categories and meaning of language see Spender (1985). See also Thiele (1992).

⁹⁹ Stallworthy (1950) p. 183, 211, 207, 55-6.

In the section on mental hygiene which ‘applies all the knowledge of man (sic) and his mind, in sickness and in health, to preventing psychiatric disturbance’ the nurse-in-training is told that ‘a happy marriage is a stabilizing influence in the life of an individual’ and that ‘[c]hildbirth is the intended biological destiny of a woman’.¹⁰⁰ For a number of the female nurses under study, their subjectivity was formed in relation to these powerful narratives of women as wives and mothers. Ngaere, for instance, spoke of marriage as something to which many nurses aspired and said that there were a lot of marriages between staff.¹⁰¹ When asked how important in her life her mental nursing had been, Thelma replied that she had been glad to finish it because, ‘I was getting married. I was getting a new life’.¹⁰²

Assumptions about women based on biological imperatives are very powerful in structuring institutional practices.¹⁰³ As discussed in Chapter Four, the female nurses in particular drew on medical discourses of heredity and of women’s biological and emotional vulnerability in their constructions of mental illness. In talking of the theories of mental illness she had developed during her 17 years at Tokanui, May positioned women who ‘used to land up in trouble’ within discourses in which insanity was constructed as a product of heredity. She said, ‘I have seen a woman admitted and her husband asked if there is any other mental instability in the family. [He] would say “no” and the woman’s mother [would be] in the ward I was going to take the woman to’.¹⁰⁴ Others like Esther, discursively constructed women’s mental illness as resulting from an unstable reproductive cycle. Among other things, she spoke of puerperal psychosis patients being warned by doctors not to have any more children.¹⁰⁵

The men did not speculate about mental illness in the same way, suggesting that the cause of men’s mental illness was not subject to the same scrutiny as women’s, nor was it based on biological imperatives. The difference between the nurses’ and attendants’ interest in

¹⁰⁰ Ibid. (1950) p.85.

¹⁰¹ Interview with Ngaere Thompson by Helen Reilly (2003)

¹⁰² Interview with Thelma McArtney by Hugo Manson (1989).

¹⁰³ Weedon (1987).

¹⁰⁴ Interview with May Puch by Yvonne Shadbolt (1984).

¹⁰⁵ Interview with Esther Graham by Lois Wilson (1984).

the aetiology of mental illness also reflects different approaches to their work. Unlike a number of the women, the men were casual about exams and attending lectures. Archie said ‘education doesn’t make them [attendants] really’. He spoke of some attendants as ‘the sort who you wouldn’t give tuppence for [but] who’d walk to the top of the street to give an old fellow a light’. Once he had spoken to the tutor sister about one such attendant telling her, ‘I want you to see this fellow passes his exams ... to give him a pass’. Because he and the tutor had ‘got on pretty well together’ she told him she would.¹⁰⁶

Psychiatry, a practice particularly concerned with the constitution of the individual, mobilized theories of biological difference not only to constitute the mentally ill woman, but also to position the female nurse in the overall network of social power. Prevailing beliefs regarding woman’s biological makeup, nature, and proper sphere could not accord her equal autonomy and expertise with a man. Based on the gendered division of labour, the nurse-doctor relationship emphasized the subordination of nursing to medicine: science and authority was associated with male doctors and ‘caring – putting science into practice – with women’.¹⁰⁷ Stallworthy informed the nurse that if she treated her patient with ‘tact, courtesy and consideration’ she would seldom find him (sic) difficult to handle and if she was to be a credit to her profession she would ‘seldom need formal instruction in ways of handling her patients’. While manic patients may be dangerous, because they are easily distracted, ‘a nurse with a ready tongue [can] avert a threatening situation’. On the other hand, it is the doctor ‘if *he* has the time or patience’ who can be a ‘sympathetic listener’ to the psychiatric patient (emphasis added).¹⁰⁸ In these constructions, nurses could be said to be stereotyped as women who ‘talk too much and listen too little’.¹⁰⁹ Dale Spender has argued that it is necessary to preserve such myths about women for the maintenance of the gender order.¹¹⁰

¹⁰⁶ Interview with Archie Lamont by Yvonne Shadbolt (1984).

¹⁰⁷ Gamamikow (1978) p.114.

¹⁰⁸ Stallworthy (1950) p. 90, 101, 283.

¹⁰⁹ Spender (1985) p.43.

¹¹⁰ Ibid. (1985).

Although implying that a nurse should not need to be told, Stallworthy reminded her that information she may inadvertently find out about the patient in the course of her work, 'must be *secrets* between her, the patient and the doctor' (emphasis added).¹¹¹ A feature of the literature is the depiction of mental hospitals as closed, secretive, communities. A number of the female nurses in this present study questioned whether it was appropriate to talk about particular issues. Comments included, 'I'd love to tell you something about that but I can't'.¹¹² The relationship between doctor and nurse was manifest in their relative power vis a vis the patient. It was not the nurse's place to question the doctor's orders. When asked about medication Ngaere said, 'I'm not the doctor, I don't know why they have them'.¹¹³

Men came to dominate medical and other sciences because of their location in the public sphere of society. Because masculine power and scientific power co-existed, other equally important knowledge, for example, nursing knowledge, was repressed or marginalised. Male knowledge came to represent an authoritative representation of "truth". In this man's world, woman had her (subordinate) place.¹¹⁴ Like general nursing, the division of labour in mental hospitals, emphasised the difference between the intellectual work of the psychiatrist and the manual work of the nurse. British sociologist Lindsay Prior points out that nowhere in nursing texts written in the first half of the twentieth century is any attempt made to develop specific discourses of mental nursing knowledge or therapeutic practices, or to position nurses other than as subordinate to doctors.¹¹⁵

Conclusion

This chapter has analysed the connection between the socially constructed gendered uniqueness of mental nursing and the shaping of this role as a personal and social identity by the women and men who became mental nurses and attendants. The narratives discussed show how individuals navigated the discursive gap between social, cultural and personal perceptions of mental nurse and attendant identity. Although the individual texts

¹¹¹ Stallworthy (1950) p.92.

¹¹² Interview with Thelma McArtney by Hugo Manson (1989).

¹¹³ Interview with Ngaere Thompson by Helen Reilly (2003).

¹¹⁴ Papps and Olssen (1997), Berrey (1991) and Gamarnikow (1978).

¹¹⁵ Prior (1993). See also Gamarnikow (1978).

provided clues to the nature of discourses of mental nursing, it was only through their connection with other relevant texts and discourses on which they drew, that they gained meaning. Powerful discourses of gender relations predicated on the separation of women and men into private and public spheres intersected with a particular gendered knowledge of mental illness and mental nursing. The way in which a number of the narrators subjectively drew on similar narratives indicates that there were distinct ways of thinking and talking about mental nursing operating during the period under focus.

Two opposing narratives were in circulation, each based on cultural assumptions about women and men. Psychiatric discourses constructed those who cared for the mentally ill as para-professionals and female; discourses of labour constructed them as semi-autonomous industrial workers and male. When looking at whose interests were served by the different ways in which gender relations were constructed in these narratives, it is apparent that both psychiatrists, predominantly male, and attendants, also male, benefited. Doctors working in the mental hospital service actively campaigned for psychiatry to be recognized as a bona fide part of the medical system. Properly trained female nurses, subservient to male physicians, were part of this agenda. Biological determinist psychiatric discourses were used to support the subjugation of women to men's authority as both patients and nurses. The power of attendant culture was maintained through discourses of masculinity associated with gendered workplaces. Although medical superintendents may have found militant attendants difficult to deal with, and a threat to their authority, they were essential to the mental hospital's economy and, as such, wielded considerable power. Attendants saw changes on the horizon and lobbied to preserve their male working class culture which they constructed as different from a female nursing culture. Within discourses of masculinity some men also assert control over less powerful men: in the mental hospital environment the power of male medical superintendents vis a vis male attendants was played out within cultural codes of masculinity built on the sports field, union affiliation, the heroics of war and social class.¹¹⁶

¹¹⁶ For discussion of masculinities and social class see Connell (1995) and Brod and Kaufman (1994).

It is, above all, gender relations that are of interest in this thesis. Every statement or idea about women has implications for an understanding of men and vice versa. The categories can only be understood in relation to each other.¹¹⁷ As Scott has proposed, it is the relational aspects of gender that reinforce the binary categories. The constitution of social relations is predicated on sexual difference, supported by culturally available symbols and representations. “Nurse” is a powerful gendered symbol, yet “mental nursing” is paradoxical because although the representation of nursing is symbolic of women, it was men who historically and culturally symbolised *mental* nursing. Within mental institutions these opposing symbols were invoked and interpreted in a way that ‘categorically and unequivocally’¹¹⁸ asserted the meaning of female and male, feminine and masculine. This separate spheres ideology emulated the distinctive female and male cultures dominant in society in the interwar period. It was only, however, in exploring the dependence of the male subject on the female “other” that the foundations for men’s power was able to become known.

Despite the existence of these seemingly straight forward conceptions of power, such as men as dominant and women as oppressed, underlying them, are more complex ideas based on the fluidity of power. The oral testimonies show that the female narrators were situated between the paradigms of powerful competing gendered discourses. They adopted various and changing positions in relation to these discourses, moving between them as different aspects of their lives, including mental nursing, were discussed. What Summerfield has called ‘the lines of fracture’ produced by tensions between competing discourses, reduced the possibility of the female nurses achieving ‘subjective coherence’.¹¹⁹ At different times they discursively constructed themselves as nurses working in ‘well run wards’ and caring for patients whose manic behaviour was ‘easily controlled’,¹²⁰ and at others, as ‘no more a nurse than ... a coal man’,¹²¹ and virtually powerless when confronted with potentially violent patients. The discursive struggle over mental nursing was reflected in the oral histories as the nurses and attendants sought to

¹¹⁷ Alvesson and Billing (2002). See also Scott (1988) and Shapiro (1994).

¹¹⁸ Scott (1988) p.45.

¹¹⁹ Summerfield (1998) p.285.

¹²⁰ Interview with Thelma McCartney by Hugo Manson (1989).

¹²¹ Interview with Ngaere Thompson by Helen Reilly (2003).

represent their vested interests. The implications of the uncertainties and tensions reflected in the two opposing ideas of mental nursing will be considered in the conclusion that follows.

CONCLUSION

This study has asked what insights can be gained from the oral histories of mental nurses and attendants about the gendered nature of mental health practice in New Zealand in the 1920s - 1940s. The question is based on an understanding that constructs of gender can become known through the study of the practices of those who are assigned the duty to care. As Acker has observed, 'practice forever moulds and remoulds the intransitive objects of knowledge in culturally and historically specific ways'.¹

Earlier chapters discussed how, in the first half of the twentieth century, social and cultural practices, the construction of insanity, legislation and policy, institutional organisation care and treatment of patients, the making of professional staff, and community perceptions of mental illness, were all to some extent informed by gender. An analysis of the oral narratives has shown that discourses of gender, premised on perceived differences between the sexes, constituted social relationships in the mental institutions. These discourses shaped the subjectivities of the nurses and attendants and were employed to support particular gendered institutional practices in the period under review. To declare that an organisation is gendered signifies that 'advantage and disadvantage, exploitation and control, action and emotion, meaning and identity', are patterned through distinctive female and male, feminine and masculine cultures.² What feminist educator Celia Davies has called 'gender on the surface',³ was a visible source which structured daily mental hospital organisation. Overt signs of the separate female and male cultures operating included the configuration of the physical space, modes of dress, and the separate organisation of the work and lives of both female and male patients and staff.

A feminist poststructuralist analysis required going beyond the surface of the texts and paying attention to the interconnectedness of the nurses' and attendants' subjectivities, the social organization of the mental health system, and wider social and cultural systems of

¹ Acker (1990) p.146.

² Ibid. (1990).

³ Davies (1995) p.45.

meaning. Locating the construction of femininity and masculinity in a broader social and historical context meant that the oral narrators' memories were understood as the gendered products of the interchange between the practices and discourses of culture and subjectivity. Changes in social relations in the 1930s and 1940s resulted in apprehension about the stability of the population and concern that women were rejecting their maternal and family roles. Cultural expectations of women and men arising from women's and men's position in reproduction and in the labour force, served to reassert and maintain the dominant gender order. Analysis of the texts reveals how in the mental institutions, these gendered discourses were played out in male attendants' attempts to preserve and control the male-ethos of the workplace.

Discourse analysis enabled a more nuanced reading of the texts and provided insights into the gendered nature of mental health practices, often hidden in traditional accounts. Women and men learn that they are constructed or construct themselves as feminine or masculine.⁴ Assumptions about gender were conveyed within discourses in metaphoric and symbolic language and culturally coded systems of meaning, which the nurses and attendants used in constructing their individual subjectivities. The image of nursing, as woman's calling and the projection of the notion of femininity is stereotypical in its gender relations.⁵ Female nurses variously drew on discourses of motherhood, the family, psychiatry and nursing, while male narrators drew on discourses of sport, war, and "men's" work. Embedded within these are social and historical processes by which gender divisions have been constructed. According to American feminist philosopher Jane Flax, gender has become not only 'a central constituting element in each person's sense of self and in a culture's idea of what it means to be a person', but also 'a differentiated and asymmetrical division and attribution of human traits and capacities' and thus of power.⁶

Orientation toward a Foucauldian approach to analysis meant asking what could be talked about, who was allowed to speak, how things could be spoken, what was accepted as

⁴ See for instance, West and Zimmerman (1987).

⁵ For discussion of images of nursing and social change see Hallam (2000).

⁶ Flax (1990a) p.8, 23-25. See also Flax (1990b) and Summerfield (1998).

knowledge, and what rules governed the generation of psychiatric knowledge.⁷ Both knowledge and discourses can be deconstructed to reveal that they are not objective “truths” but discourses produced by people, who hold particular positions. Analysis of the nurses’ oral histories revealed that male discourses of psychiatry prevailed over female discourses of nursing. As medical science became a male gendered endeavour associated with “cure,” behaviours and ideas encoded as female, such as “care,” became marginalised.⁸ The psychiatric diagnosis, linked as it was to theories of the body, acted as a sign to the nurses of how women patients should be treated. The word of male doctors became law and male knowledge came to stand for an authoritative representation of “truth”. Rather than focusing on these so-called “truths”, this analysis identifies some of the ways in which these “truths” were created and circulated. Male doctors’ power to control the psychiatric field resided in their claims to scientific knowledge, embodied not only in medical texts, but also in the organisation of mental hospitals and in social relationships of doctor and patient, and doctor and nurse. At a time when psychiatrists were wanting to forge an alliance with other branches of medicine, psychiatry was constructed as a male profession based on science and mental nursing was constructed as a subordinate position, and like general nursing, linked to women’s domestic role.

Discursive practices operate at an interpersonal, institutional and societal level. Analysis of the oral history testimonies revealed the processes that both constituted the subjectivities of the nurses and attendants and were constituted by them. Subjectivities are formed by the intersection of a number of discourses, some of which may be subordinate or even subversive and include conflicting conceptualisations of identity. In the context of mental nursing, the contradictory character of discourses available to the female mental nurses was clearly apparent. At times the nurses drew on symbols of femininity in constructing themselves as non-masculine, and at others they used masculine metaphors, to describe their work, a coal man and a council labourer, are examples. When gender identity is thought of as fluid and shifting, the voices of the female nurses can be heard sometimes embracing, sometimes resisting, and sometimes

⁷ Foucault (1980a). See also Foucault (1980b) and Motion (1995).

⁸ See Reverby (1987) and Melosh (1982).

transgressing gender norms. In this way, as well as drawing on the discourses of mental nursing in circulation, the narrators were also contributing to them. One reading of the texts suggests that in the 1920s - 1940s, rather than men pursuing a “masculine” career in a female-dominated occupation, in the case of mental nursing, it was women who braved a masculine-dominated environment in the pursuit of employment and, for a few, a meaningful life long career.

To accept oppositional constructions of female nurses and male attendants at face value, serves to perpetuate categorisations of difference premised on socially constructed normative behaviours of women and men, inferred from the fact of bodily difference. It blurs and suppresses the differences *among* the women. Analysis of the oral histories has revealed that for a number of the female nurses, their subjectivities were constructed across gender boundaries. As Scott has argued, the terms “women” and “men” must be open to scrutiny when they are used in particular contexts such as the workplace, and the validity of normative constructions of gender questioned in light of the existence of behaviours that contradict the rules. To maintain that femininity predisposes women to nurturing jobs such as nursing, is to naturalise complex economic and social processes. It also masks the disparities between women’s and men’s work history.⁹ Analysis of the nurses’ and attendants’ narratives in this project has revealed that the organisation of work in mental hospitals during the review period, was accomplished by reference to gender attributes of the worker rather than issues of training, education, or skill.

My own particular interpretation and reconstruction of the nurses’ and attendants’ stories in the form of print is also part of the discourse. The presuppositions I brought to the research process will have affected what has been created here. My interest in women’s mental health, referred to in the Introduction, grew out of my own experience of working with women in the community, some of whom had been diagnosed as having a mental illness. Nothing that has arisen in the course of undertaking this current research has altered my observation that the socially constructed gendered nature of mental health practices reflects the broader cultural values of society in operation at any one time.

⁹ Scott (1990).

The oral histories offer a rich resource whereby the operation of gender can be analysed in historical contexts. These voices from the past raise questions about the gendered nature of contemporary mental health practices. Two possible areas this study opens up for future research are questions of how discourses of the rise of professionalism and the authority of the medical profession (only touched on in this study) intersected with discourses of gender, and how gender operates in contemporary discourses of mental health practices including psychiatric nursing. A “Confidential Forum” recently set up by the Government provided an opportunity for former in-patients of psychiatric hospitals, their families and staff members to formally speak about their experiences of institutional mental health practices.¹⁰ Although the documentation produced by the panel makes moving and interesting reading, regrettably, it does not consider gender as a factor in these practices.

Two further areas of study alluded to in the discussion involve, on the one hand, an investigation into the intersections of colonisation and gender and mental health practices, and on the other hand, a more in-depth examination of the influence of social class. Above all, feminist historical explanations must be attentive to ‘intersecting axes of power – particularly those of ethnicity, race, class, gender, and sexuality.’¹¹

One of these feminist concerns, namely gender, has been focused on in this thesis. When researchers, in the words of Joan Scott, ‘look for the ways in which the concept of gender legitimises and constructs social discourse relationships, they develop insight into the reciprocal nature of gender and society’.¹² Understanding history as a practice which produces and sanctions particular forms of knowledge, meant in this thesis, exploring how history operated as a site for the production of gender knowledge about mental health practices. As such, it contributes to gendered discourses of mental illness.

¹⁰ Department of Internal Affairs (2007).

¹¹ Shapiro (1994) p.20.

¹² Scott (1988) p.46.

APPENDICES

Appendix A: Example of Psychiatric Nurses' Examination

Appendix B: Duties of Attendants and Medical Staff

Appendix A: Example of Psychiatric Nurses' Examination

NURSES AND MIDWIVES BOARD

(Examination) State Preliminary Examination for Pupil Psychiatric Nurses *

(Subject) ELEMENTARY PSYCHIATRY *

*These particulars must be entered on the cover of your answer book

3rd November, 1948

Time allowed: Three Hours

ALL QUESTIONS TO BE ANSWERED

1. State what you know about the causes of mental and nervous disorders. What adjustments are necessary to maintain mental health?
2. Write short notes on the following:
 - a) Instinct
 - b) Orientation
 - c) Flight of ideas
 - d) Negativism
 - e) Stereotype
3. What are the reasons for refusal of food?
Describe the steps you would take to ensure the patient received adequate nourishment.
4. In what type of patient is self mutilation or suicide likely to occur?
Describe :-
 - a) Preventive measures.
 - b) Action to be taken after a definite attempt at suicide.
5. What would you do in the following instances :-
 - a) An escaped patient ?
 - b) Fire in a ward ?
 - c) Sudden impulsiveness ?
 - d) A senile patient who frequently wanders away ?
 - e) Dirty feeding habits ?

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Appendix B:

Duties of Attendants and Medical Staff as outlined in Departmental Rule Books 1928 and 1940

	1928	1940
GENERAL ROLES AND RESPONSIBILITIES OF NURSES/ATTENDANTS		
EXEMPLAR (numbers denote relevant pages in Rule Books)		
Obeys all orders	4	4
Males do not enter female department (and vice versa) without permission)	9	
Remains calm but determined with irritated or difficult patients	28-9	23
Sets an example of work	31	22
Maintains patient and institutional confidentiality	12	6
Does not use patient labour or financial transactions for personal gain	14-15	25
Receives visitors or strangers only with official permission	8	8
Receives no gratuities or consideration from outsiders	14	25
Treats all without fear or favouratism	30	
Keeps a clean and tidy room with dangerous items locked up	11	10
Acts in a spirit of team work	12	11
Uses minimal force for restraint with no dangerous holds	29	38
Official relationships		
Obeys orders	22	22
Communicates with [Medical] Superintendent through Matron/Head Attendant	5	5
Uses formal honorific when addressing other staff	12	11
Is not familiar when addressing patients	12, 32	11, 20
Wears mufti when with patients outside the estate	17	15

	1928	1940
Assists in shaving patients under medical direction		35
Medical Superintendent can authorize shaving by patients	35	35
Bathes patient on admission and weekly thereafter	Bath R.14	41
Properly dresses patients	26	
Maintains order during meals and helps patients who need feeding	36	47
Groups patients at meals according to manners	36	47
Prevents patients leaving meals with food	36	
Uses skills to divert patients from brooding or delusions	31	
Corrects bad habits and language or disgusting tendencies	3, 4, 11	
Ensure that patients wear night attire	34	
Gives patients opportunity for washing and tidying	36	
Ensure paper, envelopes and pens available for patients	37	270
Treats individual patients with appropriate liberty/security	39	26
Does not punish patients	39	23
Observation and Reporting		
Reports illness, examines faeces, diet, delusions	40	
Reports emergency seclusion or restraint	42	
Reports patient deaths to matron/Head Attendant	33	
Reports escapes, accidents, sudden illness	33	17
Reports changes of condition of patient	33	24
Reports improper or disgusting acts	41	

	1928	1940
Institutional Order and Environmental Hygiene		
Directs inquiries about patient care to medical staff	7	7
Does not send/Obtains permission to send patients' correspondence	37	37
Safe Custody	26	
Locks up all medicines	43	32
Prevents violence	29	
Obtains assistance for restraint	29	38
Removes razors from ward	38	
Removes day clothes from patients at night	46	37
Counts and locks up knives, and carving fork and knife after meals	46	37
Locks attendants' rooms, sculleries, bedrooms, stores, cupboards	44	31
Leaves no water in baths or sinks	44	31
Keeps brooms, knives and scissors out of reach	44	31
Searches beds, clothing etc. of suicidal patients and rubbish hoarders	45	34
Aware of duty in event of fire	5	40
Always wears keys secured by strap or chain	40	
Accompanies walking parties at front and rear	26	
Frequently and irregularly counts non-parole patients	26	
Knows patient numbers on walking parties	27	
Signs and accounts for constant observation patients	38	30, 39
Constantly stays with patients on constant observation		39

	1928	1940
Patient Care		
Enjoys and amuses patients as much as possible	28	22
Keeps patients clean	26	
Keeps wards clean and conducted on the lines of a house		21
Professional Development		
Studies diligently towards professional registration	3	4
Knows instructions for dealing with choking		36
Charge Attendants		
Prepares stock sheets	20	
Ensure the safety of all ward stock	20	43
Ward Environment		
Cleanliness of bedding, furniture etc.	20	46
Ensure cleanliness and scrubbing of ward, ventilation, temperature	21	46
Ensure closets- odour free and urinals flushed	21	46
Reports broken windows	44	
Staff Supervision		
Report breaches of discipline to matron/Head Attendant	19	
Formally takes/hands over ward each shift	26	
Patient Care		
Patients tidily and suitably dressed	34	46
Ensure meals served promptly and tastefully		47

	1928	1940
Training Junior Nurses		
Ensure nurses receive sound training		43
Sets example to nurses		43
Reports merits and misconduct of staff to head attendant./matron		43
Matrons and Head Attendants		
Ensures staff carry out their duties		42
Spends time on wards, villas, workshops, occupational centres		42
Reports any allegation of assault to Medical Superintendent		42
Observes bathing to report injuries or disease to medical officer		42
Attends all patients' entertainments		42
Ensure list made of all patient's possessions on admission and how disposed of		42
Ensures all bathing apparatus operating on bath days		42
Ensures all staff receive first aid for choking within one month		42
Ensures institutional hygiene and sanitation, e.g. rubbish, sanitation		42
Reports concerns about quality, quantity and timeliness of meals		42
Encourages wearing of private clothes by patients		42
Monitors size, fit and suitability of institutional clothes and draws attention to slackness		42
Promotes occupational and recreation among patients as part of individual care		42
May inspect quarters occupied by staff		10
Home Sister		
Ensures discipline and good conduct prevail in nurses' home		48
Reports discipline matters to Matron		48

	1928	1940
Medical Officers		
Handles all inquiries from relatives about patients' condition	7	7
Acts on reports of changes of condition, accidents, injury, escape, sudden illness or death	33, 40	17
May censor patient's letters	37	27
Authorises use of single seclusion room by patient under constant supervision	38	39
May place patients under constant observation notice	38	39
May Issue/renew seclusion or restraint order	42	282
May vary temperature of patients' bathe water outside specified range	R 4, 5	
May authorize cold bath	R 10	
Acts on nursing reports of changes in patient's condition		24
May vary patient's privileges		26
May relieve nursing staff from ward duty		30
Authorises male patients to use safety razors		35
May authorize individual patients to bathe/shower privately		41
Undertakes any other duties set by Minister or under Act	Act	Act
Keeps weekly report book, case books, prescription books, registers of seclusion and restraint and post-mortems	Act	Act
May recommend/cancel trial leave	Act	Act
May recommend discharge of committed patients	Act	Act
Medical Superintendents		10
May terminate services of staff on probation	1	2
Deals with staff discipline matters	4, 19	48
Considers complaints and suggestions by staff	5	5

	1928	1940
Sanctions private work done for staff by patients or workshops	14	12
Determines price to be paid for work done by patients for staff	15	25
Authorises alcoholic liquor to be brought onto estate by staff	24	
May relieve nursing staff from ward duty	26	
Acts on reports of accidents, injury, escape, sudden illness or death	33	
Authorises male patients to use safety razors	35	35
May order restrictions on a patient's outward correspondence	37	27
Reviews constant observation notices once each month	38	39
May revoke constant observation notices		8
Approves visiting arrangements for nurses' homes		10
May inspect quarters occupied by staff		17
Ensure that fire safety inspections made twice yearly		40

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