

New Zealand's Karitāne Hospitals and Maternal Mental Health Care, 1907 to 1980

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This article analyses Karitāne hospitals as an unrecognised innovation in maternal mental health care in twentieth-century New Zealand. Leading infant welfare organisation, the Plunket Society, established six Karitāne hospitals between 1907 and 1927, which operated until 1980. Historical scholarship has focused predominantly on the infant welfare functions of the hospitals and the nurses who worked there. As a site of interaction with new mothers, the Karitāne hospitals understood and supported mothers identified with mental illness and emotional problems after birth. This article considers the hospitals' rise and demise through three leaders of the Plunket Society to trace the shifting characterisation of maternal mental illness in New Zealand.

Keywords: Mental illness, Karitāne hospitals, puerperal insanity, infant welfare, motherhood, New Zealand

In 1970 an Otago Medical School student recorded the vital place of the Karitāne hospitals for infant and maternal health care in New Zealand families.¹ They noted the hospitals were 'an exclusively New Zealand institution', which 'carry out such an important role in our New Zealand society, it seems difficult to envisage a society without them'.² The six Karitāne hospitals established from 1907 became a significant feature of the Plunket Society, which reflected the broader infant welfare movement in the western world focused on improving the survival and fitness of citizens.³ Historian Linda Bryder noted that governments historically used infant health data as an 'indicator of the health of a population'.⁴ Indeed, New Zealand received international acclaim for reducing infant mortality, with many nations following suit by establishing versions of the Plunket Society.⁵ But historians have overlooked the role Karitāne hospitals provided in supporting mothers' mental health, particularly given the Plunket Society motto, which begins: 'to help the mothers'.⁶

Much like the wider society, Karitāne hospitals did not publicly discuss maternal mental illnesses in the twentieth century, and Plunket and Karitāne publications remained silent on these illnesses until the 1980s. But an examination of the Karitāne hospital archives reveals unspoken histories of maternal mental illness, medical assistance, and intervention.⁷

Thousands of mothers interacted with Karitāne hospitals between 1907 and 1980; inevitably, some women likely had mental illnesses related to their recent childbirth. Doctors used many phrases to describe women they understood as having a mental illness after birth.⁸ Medical professionals recognised puerperal insanity and mania as the predominant medical diagnoses in the nineteenth and early twentieth centuries.⁹ The public and some doctors increasingly used other terms by the mid-twentieth century, including 'nervous breakdown', 'mental breakdown', 'nerves', and 'worry'. By the late 1960s, 'baby-blues', postnatal depression, and psychoses became accepted medical terms.¹⁰

This article argues that the Karitāne hospitals, designed to help infants thrive and promote breastfeeding, gave tacit support to mothers with psychiatric illnesses and other forms of emotional distress. It charts the rise and demise of the six Karitāne hospitals from 1907 to 1980 through three leaders of the Plunket Society to assess how the hospitals characterised maternal psychiatric problems after birth. In doing so, reflections on broader attitudes toward mental health will also emerge.

Historians have closely studied the Plunket Society as a voluntary social service organisation with its narrative well charted, especially by Linda Bryder in her comprehensive history, *A Voice for Mothers*.¹¹ Until the 1980s, most accounts traced whiggish narratives of the Plunket Society's impact on improving infant health.¹² Many of these histories have not explored maternal mental illness. Bryder, has been effective in complicating the view of the Plunket Society's inflexible dictates, acknowledging more the genuine support it provided to mothers.¹³ She posited that women were not reluctant victims of a male-dominated medical system and argued the widespread popularity of Plunket Society among mothers should be attributed to the help they received.¹⁴

Only a few authors have considered the attitudes of the Plunket Society toward mothers who became mentally unwell after childbirth. Social and feminist historians from the 1960s argued that post-1945, Plunket Society became overbearing towards mothers, which ushered in debates about how motherhood's role contributed to women's emotional distress.¹⁵ Social historian Erik Olssen stated the Plunket Society defined motherhood as women's only legitimate activity and 'constituted a form of imprisonment, a cage from which mental breakdown marked an increasingly common avenue of escape'.¹⁶ Feminist authors in the 1970s and 1980s echoed this rhetoric. This period witnessed a boom of research that examined the Plunket Society's role in promoting domesticity to the broader society but with little attention paid to the support given to those suffering from distress.¹⁷ However, oral histories have generated engaging studies of Karitāne nurses' experiences over time and revealed that some parents received help from Plunket services for postnatal depression in the 1980s.¹⁸

Furthermore, historical debates about the Plunket Society have not usually scrutinised the work of the Karitāne Hospitals. Margaret Tennant and Lesley Courtney explained that the Karitāne nurses were part of a social infrastructure concerned with family support and interventions, yet mention of the specifics of Karitāne nursing is usually regarded as an adjunct to the larger Plunket story, and it is rare that more than a cursory mention is given to the specifics of the work, its importance to Plunket aims, or the nurses' activities after training.¹⁹ Joyce Powell provided a valuable study of Karitāne nurses, and the centenary history offers details about the hospitals.²⁰ In Australia, articles in the late 1980s and early 1990s examined the relationship between the New South Wales Karitane Child and Family Health Units and psychiatric illnesses, as well as support groups for mothers with postnatal depression.²¹ However, the six New Zealand Karitāne hospitals remained unexamined as sites of mental illness support.²²

Rise of the Karitāne Hospital

In the period 1907–38, Plunket Society's founder, Dr Frederic Truby King oversaw the Karitāne hospitals' direction, which served as acute residential care facilities for ailing infants and struggling mothers. King was a psychiatric specialist working as the superintendent at Seacliff Lunatic Asylum (Seacliff), located just north of Dunedin in New Zealand, from 1889–1921.²³ During his tenure, King turned the poorly designed asylum into a workable institution with a productive farm, and his plant and animal husbandry work developed his theories on nutrition.²⁴ King turned to infant welfare after he and his wife, Bella, found it challenging to help their adoptive daughter Mary thrive.²⁵ After experimenting with modifying cow's milk to match human breast milk, King saw the benefits to all infants. He trained a Seacliff nurse Joanna McKinnon in these feeding methods and sent her to Dunedin to advise other mothers.²⁶

The Plunket Society arose from a broader call for legislation to reduce the high infant and maternal mortality rates that plagued New Zealand (and the wider western world).²⁷ Fellow male medical professionals were unenthusiastic about King's intrusion into their domain, so he turned to prominent middle- and upper-class women in the community to take up the preventive cause.²⁸ On 14 May 1907, King addressed a group of citizens in the Dunedin town hall on ways to promote women's and children's health. After the meeting, these women established the Society for the Promotion of the Health of Women and Children.²⁹ The Plunket Society had been one of the only child health initiatives in the early twentieth century until the formal establishment of the Native Health Nursing Scheme in 1911.³⁰ The segregated health system meant Māori mothers received different support than the European-based and middle-class Plunket Society.³¹

The reach of the Plunket Society expanded as rural and larger urban European communities rapidly took up the feeding methods developed by King. Within a short period, networks of volunteer women set up clinics, and nurses were trained to monitor infant health and provide in-home and clinic visits. By 1914 there were seventy-two branches and twenty-seven Plunket nurses interacting with mothers across New Zealand, making 7,534 visits to mainly urban-based parents.³² Mothers made 364,500 Plunket room visits in 1924, and Plunket nurses made 113,052 home visits, with over 35,000 babies in their care.³³

Unpaid labour and intensive fundraising from networks of women throughout the country underpinned the Plunket Society. From the outset, the society was a voluntary organisation, but the government pledged to subsidise the initial four centres and the Dunedin Karitāne Hospital.³⁴ Inevitably, tensions regarding financial viability and duplication of services played out between the state and the voluntary organisation. Frictions occurred as government officials contributed large sums of public money to an organisation they did not control.³⁵ Plunket increasingly relied on subventions from the government to supplement annual budget shortfalls.

The Karitāne hospitals' standard historical narrative records that Nurse Joanna McKinnon alerted King to the plight of neglected infants boarded in licensed baby homes in late 1906.³⁶ King found shocking conditions in many licensed homes and immediately removed the most egregious cases of neglected babies to care for them.³⁷ King 'set about to prove to the community the value and benefit of scientifically correct feeding and handling of those little ones who were unfortunately deprived of "the milk and the heart" of their mothers'.³⁸ These children's illnesses were arguably the consequence of poor management by the licensee of the baby-home and not entirely the result of the parents' ignorance or lack of knowledge. King aligned with a new class of professionals offering childcare advice, which historian Rima Apple suggests called for a scientific, trained motherhood, which insisted that women learn healthful, modern, child-care practices from contemporary experts.³⁹ King felt deeply that the responsibility for an infant's life should remain with the parents and, more specifically, with the mother. King licensed his weekend cottage in Karitāne, north of Dunedin, to care for the babies.⁴⁰ The Dunedin Karitāne-Harris Hospital was officially opened on 13 December 1907, in larger premises in Andersons Bay in Dunedin.⁴¹ Historian Gordon Parry commented it was not the intention of the society to run a hospital for children but the 'success of the Karitane experiment' made it plain that the community needed the facility.⁴²

Dunedin's Karitāne Hospital set the model for such institutions throughout New Zealand. Nurse training took place in Dunedin, with general Plunket nurses receiving four

months of training (typically in addition to previous nursing experience) and Karitāne nurses receiving twelve months of training. Afterwards, they worked in the hospital or the community by attending to families. Plunket and Karitāne nurses interacted with new mothers through either nurse visits to the home or mothers visiting clinics. Women received help from the Karitāne services through admission to one of the hospitals after a referral from a doctor and Plunket nurse or by having a trained Karitāne nurse stay with a family for in-home support. This method was called ‘casing’ and required a family to have economic means to cover the nurse’s travel costs to the home.⁴³ These interactions provided an opportunity to support the mother and identify any emerging problems in the postnatal period.

Plunket Societies opened Karitāne hospitals in other communities in New Zealand, with three eventually in the South Island and three in the North Island. Christchurch opened in 1918, Whānganui in 1919, Wellington in 1923 (1927 officially), Auckland in 1924, and Invercargill in 1925.⁴⁴ Nursing staff and medical advisors provided the bulk of the practical everyday care of babies, toddlers, and pre-schoolers, with the hospitals divided into a premature baby ward (babies under five pounds in weight), a ‘weakling’ ward, normal baby, toddlers’, and pre-schoolers’ areas, mothercraft rooms, milk room, kitchen, and laundry. In 1908, Dunedin Karitāne Hospital cared for 34 babies, 100 babies in 1909, and the hospital case books recorded 128 admissions in 1914.⁴⁵ By 1926, when all six hospitals were open, there were 860 admissions in all the hospitals with around 330 Karitāne nurse trainees working throughout New Zealand.⁴⁶

From 1909 mothers were admitted to a mothercraft section at the Dunedin Karitāne Hospital. In some cases, the mother and child visited for twenty-four hours of observation (which included test-weighing before and after nursing to find out how much milk the baby was getting from the breast), or they could ‘remain in the Institution for days or weeks to establish or re-establish breast-feeding’.⁴⁷ In 1919, the Plunket Committee erected a small house for the reception of up to nineteen nursing mothers, which boasted three bedrooms, a sitting room, and a bathroom.⁴⁸

Karitāne Hospitals and Puerperal Insanity

While King’s contribution to mental health policy is well known, the connection between Karitāne and mental health is less known.⁴⁹ The Karitāne hospitals did not publicly frame their ‘help for mothers’ as mental health support, which aligned with early twentieth-century values. Communities, families, and doctors did not normally openly discuss mental illness. Publications aimed at mothers encouraged women to be ‘ideal’ wives by avoiding excitable or unbalanced behaviours, and self-help books generally did not inform the public about puerperal insanity.⁵⁰ Similarly, Plunket Society publications followed social norms by leaving maternal mental illness out of the narrative. For example, in 1908, when King wrote Plunket’s first advice manual, *Feeding and Care of Baby*, he did not comment directly on the subject.⁵¹ In 1916, the Health Department commissioned a larger edition and, by 1922, sent this book to all married women under thirty-five free of charge.⁵² These books, and others, focussed on behaviour mothers could (or should) be able to control.

Connections between King, the Plunket Society, and maternal mental health can be assessed by exploring the archives. As a superintendent of an asylum for over thirty years, King was aware of puerperal insanity. New Zealand doctors recognised and treated hundreds of women diagnosed with puerperal insanity from the 1860s. For example, in 1915, King noted one mother’s puerperal mania experience, recording the mother ‘admits she “felt different in regard to her baby since she let it fall”. Tells me she lost all affection for it and had no interest in her household duties’.⁵³ This case, recorded only a few years after his book,

reveals that doctors demarcated between private and public experiences of maternal distress: mothers suffered from puerperal insanity, but King and the Plunket Society had no wish, it seems, to associate mental illness with motherhood.⁵⁴

How did King characterise maternal health to the broader public? King focused on aspects of the environment that could be mitigated and improved for mothers, such as birth conditions and home life. He emphasised that mothers were vital in protecting infants and families, and naturally, they required the right environment to succeed. In *Baby's First Month*, King pointed out the need to safeguard the mother and wrote, 'Suckling by the mother is safest and best for the baby, and best for the mother's health too'.⁵⁵ Bella King (using the pseudonym 'Hygeia') also wrote about positive actions that mothers and nurses could take.⁵⁶ For example, 'Hygeia' warned readers in one of the regular Plunket Society columns published in the *New Zealand Woman's Weekly* and over fifty newspapers, 'remember that over-anxiety may defeat its own ends' [for breastfeeding].⁵⁷ She advised that 'the mother who believes in her power to do the natural thing and the nurse who is positive and gives confidence are invariably successful'.⁵⁸ In 1924 King turned his attention to the need to bring the midwifery service up to the highest possible point of efficiency to 'prevent every form of injury or disease that can be avoided'.⁵⁹ Many doctors and childrearing experts advocated for such environmental improvements, so the Plunket Society model did not exist in isolation.

Prevention of illness, both physical and mental, underpinned King's philosophies for supporting mothers in the days after childbirth. He encouraged a household culture that expected the mother received enough sleep, support with meals and cleaning, and emotional support with the responsibilities of motherhood to reduce the new mother's worry. King gave lectures about sleep's importance in infant and maternal health. He stated, 'we have invented that the mother should be disturbed [by night-time breastfeeding], yet the world goes round once every 24 hours, and gives darkness so that we may rest after the activities of the day'.⁶⁰ The Plunket Society placed boundaries to ensure mothers received adequate rest and thus mitigate the risks to the health of infants and mothers.

The Plunket Society model also understood that infants and mothers' nervous systems required careful attention to assuage mental distress and illness and improve the standard of health and fitness of mothers. Plunket and Karitāne nurses were taught

when an apparently healthy woman fails to nurse her child, the nervous factor is most commonly faulty. Either peripheral stimulation is lacking or wrongly applied, the central nervous control is unstable, or the psychological factor is wrong – there is worry, unhappiness, shock, pain, indifference or absence of the mother.⁶¹

The Karitāne hospitals provided early intervention to promote emotional bonding between mother and child. The connection between nerves and emotional health in supporting mothers in their responsibilities differed from other welfare and medical services in the early twentieth century.⁶²

Mental health support is evident in the admission policies of the Karitāne hospitals. If Plunket nurses found their in-home care and treatment advice did not bring about improvement for mothers and babies, they classified such cases as 'special' or 'unsatisfactory'. A pamphlet outlined the admission procedure, which remained unchanged from 1907 to 1980. Admission candidates included premature infants, mothers of twins, inexperienced young or 'geriatric' (aged over thirty) first-time mothers, and a limited number of older children.⁶³ The two most significant mental health care admission reasons were the 'mothercraft' and 'mother's health' sections.

The 'mothercraft' section of the hospitals 'provided the comforts of a home for nursing mothers and practical instruction',⁶⁴ aligning with the 'scientific motherhood' advice model and designed as a site to prevent maternal mental illness. The pamphlet used by doctors and Karitāne staff for admissions stated, 'The overanxious, excitable mother' could be 'helped greatly if given the opportunity and the encouragement to relax in a homely environment where she is assisted with the care of her baby'.⁶⁵ The behaviour listed in the mothercraft category for excitable and anxious mothers included 'not coping', 'sleepless', 'tearful', or stated 'nerves'.⁶⁶ The section provided a socially acceptable framework for mothers identified by nurses, doctors, and family members as needing additional support.

The mother's inability to feed her infant was often a reason for requesting the services of a Karitāne hospital. Admission referrals came from Plunket nurses, family doctors, or the medical advisor of a local Plunket Society. Some referrals came from families directly. For example, one pregnant mother wrote to the Dunedin Karitāne Hospital matron, Annie Campbell, in March 1913. She wrote frankly about her loss:

My children are all born in the winter months, and I have great difficulty in rearing them, having lost one at eight and a half months. Though I have tried with each one, I have never had sufficient milk of my own to feed them, even when lying in bed, and living in the country as I do, it is almost impossible to get cow's milk during winter as the factories are closed.⁶⁷

Both matron and mother understood the broader social and environmental problems in early twentieth-century New Zealand of finding solutions to the high infant mortality rates. The mother sought the Karitāne hospital services to improve the chances of her children surviving infancy which would also alleviate her emotional distress.⁶⁸

'Mother's health' was used as a category for admission in Karitāne hospitals for mental illnesses. This group included women with physical injuries such as childbirth-related haemorrhages and surgery, breast infections, and influenza. Between 1907 and 1937, however, doctors admitted at least twenty-two mothers and their infants to a hospital under 'Mother's Health' where their admission paperwork directly referred to mental illness or distress. In 1911, a woman developed 'puerperal mania', and her baby was admitted to the Dunedin Karitāne Hospital and put on humanised milk while her mother recovered.⁶⁹ A mother in Palmerston was 'neurotic but health good otherwise',⁷⁰ while one baby was admitted as the 'Mother went away for a week and was sent to a mental hospital'.⁷¹ The register also noted that a mother had been on the verge of a nervous breakdown during her pregnancy and her baby remained at Dunedin Karitāne Hospital for a year.⁷² It is unclear whether these mothers received formal diagnoses from a clinician or if the nurses selected the language informally. Still, the characterisation of the behaviours makes it apparent that nurses, doctors, and families believed admission to a Karitāne Hospital provided a respectable alternative to admission to a mental hospital and provided an essential welfare gap in caring for these children and mothers.

Demand for the services offered by Karitāne hospitals increased, and not all parents could access a Karitāne nurse when needed. As Margaret Tennant argued supply was never equal to demand, despite periodic attempts to recruit more Karitāne trainees.⁷³ A Nelson-based mother 'tried unsuccessfully from birth to secure the services of a Karitane Nurse', but her attending Plunket nurse commented that the mother was 'on verge of a nervous breakdown [so] steps were taken to send the baby to Karitane'.⁷⁴ Consequently, five-month-old Joan spent three months at Dunedin Karitāne Hospital from April 1917. This admission publicly appeared to benefit the infant, but in reality, baby Joan's admission enabled her mother to recover her mental stability.

Another mother wrote three letters directly to the hospital requesting admission. She wrote,

I am partly afraid baby will get influenza and partly so worn out... that I feel I must have a rest... if I could get into your institution and have your assistance and guidance while weaning [her baby], I could return in a week or two with baby permanently on his feet.⁷⁵

Her letters reveal the pressures on new mothers and the Karitāne Hospitals' role in filling a welfare gap. Such entries indicate that private philanthropic organisations like the Plunket Society offered parents, mothers, doctors, and nurses an opportunity to negotiate better care privately. There was no apparent stigma attached to mothers and families seeking support from Karitāne hospitals, and this service became increasingly popular.

Karitāne Hospitals during a Baby-Boom

A year after Truby King's death, Dr Helen Deem was appointed medical advisor to the Plunket Society.⁷⁶ This role involved considerable administration and touring Plunket branches, lecturing to, and examining Plunket nurse trainees, and acting as a consultant to the Dunedin Karitāne Hospital. Deem navigated medical and Plunket Society tensions authoritatively throughout her term, which spanned 1939–55, during significant health care and maternity services changes.⁷⁷ The Plunket Society and medical professionals worked hard to fund and promote antenatal programmes for expectant mothers.⁷⁸ Extensive development of postnatal examination and treatment was recommended in the mid-1930s after a Department of Health maternity services inquiry noted that the medical profession had 'come to recognise that the supervision of patients for some weeks after confinement is equal in importance to ante-natal supervision'.⁷⁹ The inquiry recommended rest and convalescent homes for women after they left the maternity hospital or a system of domestic assistance.⁸⁰ In part response, the first Labour government introduced the *Social Security Act* in 1938. This act significantly altered maternity services by giving all women free maternal health care during the antenatal and labour periods and fourteen days of postnatal hospital care.⁸¹

Due to these legislative changes, hospitals gradually became the preferred location for childbirth.⁸² Increased medical interaction during maternity care in the early postnatal period exposed more doctors and nursing staff to mothers experiencing the 'baby blues' and a more comprehensive range of mood disorders. Doctors likely 'prescribed' admission to a Karitāne hospital to mothers they identified as 'at risk' and needing support with motherhood adjustments. Mothers were encouraged to stay for one to two weeks in the mothercraft section of the Karitāne hospitals following their discharge from maternity homes, especially if they had more than one child at home. The number of Karitāne trainees rose from 714 in the 1930s, to 1056 in the 1950s, reflecting the baby-boom.⁸³ Similarly, the admissions registers recorded 1,373 entries across all six hospitals in 1944 which expanded by 1950, to 2,100 admissions.⁸⁴ The postwar generation of mothers had larger families than previous generations, which may have contributed to physical and mental risks. They were also the first generation to bring up children without domestic help or the traditional extended family support when the 'nuclear' family moved into single suburban houses.⁸⁵

Another watershed moment in western maternity and mental health care services was the end of the Second World War. In response to increasing patient numbers in mental hospitals, the United States enacted the *National Mental Health Act of 1946*, which formed the National Institute of Mental Health.⁸⁶ Diplomats also established the United Nations in 1946 and the World Health Organisation, which placed 'health' at the centre of international policies.⁸⁷ Reforming its mental health legislation in response to these global changes, New

Zealand repealed the *Mental Defectives Act 1911* in favour of the *Mental Health Act 1954*.⁸⁸ Furthermore, the therapeutic landscape shifted with the introduction of new pharmaceutical products.⁸⁹ Hope and optimism saw changes in language from viewing mental illness as hereditary and incurable to treatable and even preventable.

Postwar childcare experts debated the importance of the mother–child relationship, which invariably led to mother blaming.⁹⁰ Child psychologists reacted against the mothering techniques taught by the Plunket Society, deemed psychologically damaging through the practices of rigid feeding routines.⁹¹ In Britain, Donald Winnicott promoted the ‘good enough’ mother, and John Bowlby emphasised the importance of mothers to the development of the child’s psychological well-being.⁹² The idea that something was wrong with the mother rather than motherhood itself pervaded the literature, and rarely did these experts challenge the assumption that motherhood and distress should not mix.⁹³

Deem weighed in on balancing the mother–infant bond in this context. Deem stressed a ‘common sense’ approach to infant feeding, which permitted women, in a limited fashion, to put their needs first. Appealing to the medical community, she wrote in 1949, ‘we as general practitioners, obstetricians, and paediatricians should be concerned ... with the fitness and happiness of the mother and baby’.⁹⁴ In the revised Plunket Society publication, *Modern Mothercraft*, Deem reflected on the tensions between developing psychological ideas about the importance of the mother supporting the infant’s mental health. She acknowledged the difficulty some mothers had in breastfeeding and advised mothers who found it difficult to wean. ‘How should the mother cope?’, Deem asked when considering ‘difficult weaning’ situations.⁹⁵ She advised that a mother ‘must make up her mind to control her feelings and not give way to expressions of anger or anxiety. She must assume a “don’t care” attitude’.⁹⁶ In this respect, the mother was encouraged not to worry about prolonged psychological damage for their child but to consider their own needs. However, this model may not have provided room to accept alternative emotions in motherhood.⁹⁷ Deem acknowledged that motherhood’s responsibilities are ‘extremely wearing’ and recommended mothers have the baby admitted to a Karitāne hospital to overcome the problem and improve the relationship between mother and child.⁹⁸

The Karitāne Hospitals Special Case Books (KSCB) indicate shifting language regarding maternal mental illness frameworks in the mid-twentieth century. Mothers were no longer described as having puerperal insanity. For example, Dunedin Karitāne Hospital admitted baby Janice from Alexandra in 1941 because of her mother’s ‘mental condition’.⁹⁹ In 1950, Invercargill Karitāne Hospital admitted a two-week-old baby from Edendale because of the mother’s ‘mental depression’.¹⁰⁰ Another mother was described as on the ‘verge of a nervous breakdown’.¹⁰¹ Karitāne and Plunket nurses continued to provide urgent postnatal assistance to mothers and families on the verge of crisis. This support was privately negotiated to protect and maintain the bonds between mother and child.

There were limits to the hospitals’ innovation for maternal mental health care. Tennant and Courtney commented that Karitāne nurses’ sphere of competence was restricted to infants, and evidence points to Plunket and Karitāne nurses being ill-trained to support mentally unwell mothers.¹⁰² One Karitāne Nurse said, ‘We weren’t trained to deal with difficult people’.¹⁰³ Ernest Beaglehole, head of the Mental Health Association, criticised the Plunket Society in 1950 for having no infant and child psychology training as part of the training programme for Plunket or Karitāne nurses.¹⁰⁴ However, he did not extend his criticism to maternal mental health. Some Karitāne nurses realised the hurtful and strange behaviour they were subjected to whilst ‘casing’ with families could have been due to postnatal depression. Nurses recalled experiencing mothers’ conduct which included

tearfulness, inability to cope, rage, violent outbursts, and negative feelings towards the baby, father, and nurse. For example, one Karitāne nurse recalled, 'I didn't know what was going on ... The mother seemed to resent me'.¹⁰⁵ Another Karitāne nurse cared for five children under five, one a premature baby, for three months. The mother could not help and sat on the sofa all day: 'In hindsight, she may have had post-natal depression'.¹⁰⁶ Such evidence suggests many nurses were not trained to recognise symptoms suggestive of mental illness, exposing the service to criticism and caused miscommunication between the mothers and various care providers.

Social pressure to internalise mental health concerns also played a role in limiting Plunket and Karitāne support. Nurses thought women were reluctant to discuss their problems openly, for few women would admit that motherhood fell short of their expectations. Former Plunket nurse Jacinta Creagh felt that postnatal depression had always been present in New Zealand, but it was not discussed: 'Women would hide their problems and keep their depression to themselves. They didn't want to be labelled as "mental"'.¹⁰⁷ Creagh also noted that 'old-fashioned Plunket nurses, not trained in counselling skills, did not encourage women to share such "secrets"'.¹⁰⁸ Helen Moriarty recalled she experienced 'bad depression' after her first birth in 1950, 'but it wasn't recognised, by me, or anyone else, didn't have a name and wasn't acceptable'.¹⁰⁹ Nurses, mothers, families, and communities all participated in this silencing of the broad spectrum of maternal distress and illness. In reality, Plunket and Karitāne nurses worked within the socially accepted framework to encourage women to behave in ways they believed would promote the robust mental health of the mother to protect and support their infant.

The Demise of the Karitāne Hospitals

The Plunket Society appointed Dr Neil Begg as the director of Medical Services after Dr Deem's premature death in 1955, a position he held until his retirement in 1977.¹¹⁰ Begg took over the Plunket Society's leadership during intense government scrutiny over the financial contributions toward the Karitāne hospitals, which were 'draining the Plunket funds'.¹¹¹ Plunket president Jocelyn Ryburn applied pressure on the government to investigate the funding issues, which became the Finlay Commission.¹¹² The report, published in 1959, supported maintaining the Karitāne hospital system in New Zealand, emphasising excellent work in helping mothers.¹¹³ The authors argued that more funding should be available to 'train a further 150 nurses a year so they could be employed to help mothers who were really hard pressed'.¹¹⁴

Medical doctors continued to use 'Mother's health' as a discretionary admission category for the Karitāne hospitals in the 1960s and 1970s. Wellington Karitāne Hospital accepted thirty-three admissions for 'mother's health' between 1958 and 1961.¹¹⁵ One mother of Tawa Flat was admitted for her 'mental breakdown' in April 1959, while another mother weaned her baby owing to her failing milk supply and 'nervous condition'.¹¹⁶

Begg brought new understandings of maternal mental illness, noting that 'a mother who is not getting on with her child or a child making her mother's life a misery is not so easily defined in terms of a sickness', with maternal problems possibly stemming from social, personal, or behavioural factors.¹¹⁷ He spent time in the directorship before revising the parental reference book, *The New Zealand Child and his Family*, which acknowledged motherhood responsibilities could contribute to poor maternal mental health.¹¹⁸ Begg noted that

following pregnancy and childbirth is a period of emotional instability for some mothers. There is a sudden realisation of her position when she sees the utter dependence of the new little person... it may be a short step to the miseries of self-reproach if things are not going well.¹¹⁹

Plunket acknowledged that environmental and social factors played a role in supporting or threatening the bond between mother and child.

Social rather than health problems were at the heart of Karitāne admissions by the 1970s, with the boundaries between 'health' and 'social welfare' becoming more permeable.¹²⁰ Robyn, a former Karitāne nurse, noted the referrals changed dramatically, with many families considered 'at risk' due to the lack of parenting skills or money, and cases included 'a mother with mental health problems', and respite care for others, such as an overburdened mother with many children under five.¹²¹ One commentator noted in 1970 that 'seven of the twenty-five babies and three of the mothers are more social problems than feeding problems'.¹²² Furthermore, the ratio of mothers and babies admitted to the hospitals changed. In 1958 there were 573 mothers admitted to Karitāne Hospitals, yet by 1977, in the first six months alone, 575 mothers were admitted, along with a further 537 outpatients.¹²³ This shift was partly due to women having fewer children and partly to improvements in neonatal units attached to public hospitals.¹²⁴

Plunket Society and Karitāne publications remained silent on childbirth-related mental illnesses, but the archives reveal the increasing need for maternal mental health support. J.H. McMillan, director of Plunket Nursing Services, reported the 'mentally disturbed, the wrist-slashing patient is not unknown in a Karitane Hospital'.¹²⁵ McMillan recommended urgent staff training to care for the significant numbers of patients with social and emotional problems, including fifty-eight mothers identified with 'psychiatric problems'.¹²⁶ The deputy director of Medical Services for Plunket, Dr Ian Hassell, also showed concern about maternal mental illness rates. He reported in 1977 that eight of the thirty case studies he selected from Auckland Karitāne Hospital were related to maternal depression.¹²⁷ The Dunedin Karitāne Hospital matron described one mother as very depressed and withdrawn, denying knowledge of a son in the Karitāne hospital.¹²⁸ Another mother was 'emotionally volatile and was on the verge of tears for no apparent reason'.¹²⁹

Government policy challenged the already stretched hospital funding. Over the 1970s the hospitals struggled with a shortage of qualified staff. Plunket Society president, Joyce Andrews, confirmed the hospitals had been partially staffed by solo mothers who came with their babies to the hospital and worked for low wages.¹³⁰ From 1973, the Domestic Purposes Benefit (DPB) 'dried up what had been the main source of unpaid domestic help in New Zealand', wrote Sue Kedgely, and 'institutions like Karitane hospitals ... suffered financially when it was introduced'.¹³¹ In an attempt to increase nursing enrolments and counter the loss of domestic workers to the DPB, the Plunket Society announced in 1974 that solo mothers could keep their babies with them when they trained as Karitāne nurses. There was also concern that 'there was a duplication of services with District Health nurses'.¹³² Furthermore, the hospitals were increasingly used for ex-nuptial babies awaiting adoption or Department of Social Welfare foster care.¹³³ However, funding for the necessary domestic help did not eventuate and contributed to pressures in all six hospitals' budgets and the volunteer labour crisis.¹³⁴

Several psychologists favoured the Karitāne hospital model to improve mothers' and children's mental health outcomes. In 1968, under the leadership of Dr P. Lewis and Professor W. Ironside, the University of Otago Psychological Department collaborated with Dunedin Karitāne Hospital to research infant and maternal relationships. They studied 104 mothers who 'failed to cope' with parenthood and published their results in the *New Zealand Medical Journal* in 1974. The study, called 'The Karitane Project', found that poor bonding between mother and child could be remedied by eight days in the mothercraft section and showed strong connections between maternal mental health support that the Karitāne hospitals provided to women. Seventy-seven mothers in the study (eighty percent) showed psychological ill-health when their infant was admitted. Of these seventy-seven women, the authors described three mothers as presenting with psychotic illness, two with schizophrenia, and one with bipolar manic-depression. Six mothers had personality disorders, including hysteria and aggression. The remaining sixty-eight (eighty-eight percent) had 'affective disturbances that were neither transient nor mild', with mood changes, dysfunctional eating habits, and sleep disturbances.¹³⁵ The authors noted that 'admission to hospital acts as an ameliorating therapeutic manoeuvre highlighting a hospital role that could have important preventive effects if more was known about it'.¹³⁶

Financial tensions between the government and Plunket services came to a head in the late 1970s. Begg maintained that the hospitals' maternal mental health support aspects were 'not well understood by the authorities', and that 'some of the most important work of the Karitane Hospital was regarded with a great deal of suspicion by the Social Security authorities who were handing out money'.¹³⁷ Ultimately financing the hospital model with intense community fundraising became 'intolerable' in a climate of deinstitutionalisation.¹³⁸ After Begg's retirement, David Geddis, the newly appointed medical director, wrote the report that led to hospital closures in 1977.¹³⁹ Five hospitals were closed by 1978, and after a drawn-out dispute in Invercargill, their doors closed in 1980.¹⁴⁰ Plunket Karitāne Family Support Units replaced the hospitals, which did not provide 24-hour care and considerably less nursing recruits.¹⁴¹

Conclusions

In New Zealand, all six Karitāne hospitals were permanently closed by 1980 and are now a distant memory in the early twenty-first century.¹⁴² This article has demonstrated that Karitāne hospitals were a valuable site of postnatal care and mental health support for mothers in New Zealand throughout the twentieth century. Mothers used the hospitals to aid their physical and psychological recovery and gain respite from family responsibilities. This care was relatively discrete and did not carry the stigma of being admitted to a mental hospital. The hospitals provided a publicly acceptable residential facility for women to privately negotiate emotions about infant care and childrearing.

The hospitals held a unique position to provide interventions for women and families that other institutions did not and could not achieve in twentieth-century New Zealand. By encouraging women to seek support for breastfeeding in a 24-hour care model, the hospitals provided a socially acceptable scaffolded system to care for these women while they improved their 'mothercraft'. Such admissions provided an alternative care option and likely mitigated referrals to mental hospitals and psychiatrists.

A shifting terrain of social values regarding mental illness and health provides the background to the rise and demise of the Karitāne Hospitals. Three leaders demonstrate

changing values in society. In the Truby King era, the community understood that mothers required a supportive environment for successful relationships and motherhood. In the second leadership era, Helen Deem emphasised sympathetic and pragmatic advice on breastfeeding and highlighted international thinking about achieving ‘mental health’. Mid-twentieth-century social values, however, understood the failure to meet standards of behaviour as ‘failed motherhood’ rather than associating such behaviour with mental illness. More work is needed to re-examine mothers’ resistance to medical or nursing advice and care, particularly regarding broader mental health conversations in New Zealand.

The third leadership era saw an increased awareness of the social issues facing many families and a trend in declining stigma around mental illness. The Plunket Society's dependency on donations, subventions from the state, and unpaid labour made the welfare society vulnerable to shifts in public and government mood. Consequently, funding pressures and the changing scope of care provided in the hospitals overrode the critical work for improving relationships between mothers and their babies. Begg commented that ‘it would be a retrograde step if there were nowhere for mothers and children to go’.¹⁴³ Yet, such a step occurred when financing the institutions became unfeasible.

The ‘Karitane Project’ article ended by noting, ‘it is still a difficult problem within our culture to provide effective long-term supportive and therapeutic services for the nursing couple [the mother and infant], especially in terms of their mental health’.¹⁴⁴ Devoted initially to infant feeding, the hospitals became an innovation in maternal mental health care. Forty years after their closure, no unified government organisation oversees maternal mental health.¹⁴⁵ In May 2022, a report by the Helen Clark Foundation highlighted that current New Zealand policies and services are insufficient to meet current and likely future maternal mental health needs, with particularly dire outcomes for Māori, Pacific Island, and Asian mothers.¹⁴⁶ It seems critical to consider the historical lessons of the New Zealand Karitāne hospitals concerning mental health policies for mothers and families.

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¹ Throughout the article the macron over long vowels is used in Māori words. Within quotes, the macron is not used, to reflect contemporary spelling.

² The Australian Mothercraft Society commenced in Sydney 1922 which established a Karitane Mothercraft Hospital, but this article focuses only on the New Zealand hospitals: M. R. Chalmers, “‘Karitane Babies’ and Their Families”, (Preventive and Social Medicine (PSM) Dissertation, University of Otago, Dunedin, 1970), 1.

³ The group were named the ‘Society for the Promotion of Health for Women and Children’. Since 1907, it had been more popularly known as the ‘Plunket Society’, after the Patrons, Lord and Lady Plunket, which is the name used hereafter. Linda Bryder, *A Voice for Mothers: The Plunket Society and Infant Welfare, 1907–2000* (Auckland, NZ: Auckland University Press, 2003), 9.

⁴ Linda Bryder, “New Zealand’s Infant Welfare Services and Maori, 1907–60”, *Health and History* 3, no. 1 (2001): 65.

⁵ See Philippa Mein Smith, “Truby King’s Women: Four Australian Case Studies”, *Social History of Medicine* 32, no. 2 (1 May 2019): 357–76; Philippa Mein Smith, *Mothers and King Baby: Infant Survival and Welfare in an Imperial World: Australia 1880–1950* (London, UK: Macmillan Press Ltd, 1997); Raymond K. Richards, *Closing the Door to Destitution: The Shaping of the Social Security Acts of the United States and New Zealand* (Pennsylvania: Pennsylvania State University Press, 1994), 38, 55; R.M. Woodbury, *Infant Mortality and Preventive Work in New Zealand* (Washington, USA: US Department of Labor, Children’s Bureau, 1922), 53.

⁶ The full motto ‘to help the mothers and save the babies’ was included on most letterheads of Plunket Society until the 1970s.

⁷ I am grateful to Chief Executive Officer Amanda Malu and former Chief Nurse Jane O'Malley for granting access to the Plunket Society archives and allowing publication rights.

⁸ The vast medical literature on postpartum psychiatric disorders mostly distinguishes between three categories: the 'third-day blues' (or the 'baby-blues'), postpartum depression, and postpartum psychosis. At the mild end of the spectrum is the baby blues, affecting up to seventy-five percent of new mothers. At the other end is postpartum psychosis, a rare psychotic reaction (one in 500 women) following childbirth. In between these extremes is postpartum depression, estimated to affect between ten and twenty-two percent of new mothers. More recently, other categories have been added to recognised psychiatric childbirth complications, including Postpartum Obsessive Compulsive Disorder and Postpartum Post Traumatic Stress Disorder: Sara Weeks, *Mothers Cry Too: Recognising and Coping with Postnatal Depression* (Auckland, NZ: Penguin Books New Zealand, 2013); Jenny Phillips, *Mothers Matter Too* (Auckland: A.H. & A.W. Reed Ltd, 1983); I.F. Brockington and R. Kumar, eds, *Motherhood and Mental Illness* (London, UK: Academic Press Inc. Ltd, 1982); Max Abbott, *Postnatal Depression* (Auckland, NZ: Mental Health Foundation of New Zealand, 1982); James Alexander Hamilton, *Postpartum Psychiatric Problems* (Saint Louis, USA: The C.V. Mosby Company, 1962).

⁹ Gillian White, "A Comparison of the Postpartum Depression Screening Scale with the Edinburgh Postnatal Depression Scale", *New Zealand College of Midwives Journal* 39 (2008): 28; Ian Brockington, "Postpartum Psychiatric Disorders", *The Lancet* 363, no. 9405 (2004): 303–10; Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2004); Nancy Theriot, "Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and 'Puerperal Insanity'", *American Studies* 30, no. 2 (1989): 69–88; Irvine Loudon, "Puerperal Insanity in the Nineteenth Century", *Journal of the Royal Society of Medicine* 81 (February 1988): 76–9.

¹⁰ Lisa Held and Alexandra Rutherford, "Can't a Mother Sing the Blues?: Postpartum Depression and the Construction of Motherhood in Late 20th-Century America", *History of Psychology* 15, no. 2 (May 2012): 107–23.

¹¹ Margaret Tennant and Lesley Courtney, "'The Karitane': The Rise and Fall of a Semi-Profession for Women", *New Zealand Journal of History* 51, no. 1 (2017): 114.

¹² Mary Truby King, *Truby King, the Man: A Biography* (London, UK: George Allen & Unwin, 1948); Helen F. Salkeld, "The New Zealand Plunket Society: Its Origin and Development" (PSM Dissertation, University of Otago, Dunedin, 1948); Gordon Parry, *A Fence at the Top: The First 75 Years of the Plunket Society* (Dunedin: The Society, 1982); Lloyd Chapman, *In a Strange Garden: The Life and Times of Truby King* (Auckland, NZ: Penguin Books Ltd, 2003); Jim Sullivan, *I Was a Plunket Baby: 100 Years of the Royal New Zealand Plunket Society (Inc)* (Random House New Zealand Ltd, 2007).

¹³ Tennant and Courtney, "'The Karitane'", 128.

¹⁴ Bryder, *A Voice for Mothers*, 260–75. See also, Philippa Mein Smith, "Infant Welfare Services and Infant Mortality: A Historian's View", *Australian Economic Review* 24, no. 1 (1991): 22–34.

¹⁵ Margot Roth took aim at the Plunket mothercraft system with 'railway timetable rules': Margot Roth, "Housewives or Human Beings?", *New Zealand Listener* (20 November 1959), 6–7, 26.

¹⁶ Erik Olssen, "Truby King and the Plunket Society: An Analysis of a Prescriptive Ideology", *New Zealand Journal of History* 15, no. 1 (1981): 21–2.

¹⁷ Maureen Hickey, "Negotiating Infant Welfare: The Plunket Society in the Interwar Period" (MA thesis, University of Otago, Dunedin, 1999); Belinda Hitchman, "Gender and Health: The Feminist Challenge to the Traditional Medical System" (MA thesis, University of Auckland, 1987); Lynne S. Milne, "The Plunket Society: An Experiment in Infant Welfare" (BA (Hons) dissertation, University of Otago, 1976).

¹⁸ Eight of sixteen mothers self-identified as having experienced postnatal depression, and all of them spoke about the supportive role of Plunket nurses. Margaret E. Favell, "Plunket Nursing in a Social, Political and Historical Context: Clients' Perspective of Mothering and Nursing", (Master of Health Sciences thesis, University of Otago, 1997), 93; Bryder, *A Voice for Mothers*, 188–201; Sullivan, 142–6; Sue Kedgley, *Mum's the Word: The Untold Story of Motherhood in New Zealand* (Auckland, NZ: Random House New Zealand Ltd, 1996), 152–66, 298–302.

¹⁹ Tennant and Courtney, "'The Karitane'": 114–; and Lesley Courtney, "'An Excellent Preparation for Marriage and Families of Their Own': Karitane Nursing in New Zealand, 1959–1979" (MA Thesis, Massey University, 2001).

²⁰ Joyce Powell, "Our Nursing History Must Be Documented", *Kai Tiaki: Nursing New Zealand* 10, no. 3 (1 April 2004): 3–5; Joyce Powell, *'A Suitable Job for Young Ladies': The Karitane Story, 1907 to 2007* (Palmerston North: Heritage Press Ltd, 2007); Sullivan, 116–47.

²¹ Mary McLelland and F.W. Clements, "Maternal Understanding and the Physical Health of Babies", *Medical Journal of Australia* 2, no. 5 (1956): 173–81; M. J. Harris, M. D. Hawley, and C. Harris, "The Karitane Mothercraft Hospital Current and Future Activities", *Medical Journal of Australia* 1, no. 24 (1972): 1261–5.

Thanks to Clare Ashton for drawing my attention to Australian support groups for postnatal depression in Karitane Mothercraft Societies. Kerry C. Lockhart, “Karitane Mothers’ Post Partum Support Group”, *The Lamp* (August 1988): 11–12; Kerry C. Lockhart, “Life after Postnatal Depression”, *Patient Management* 15, no. 2 (1991): 39–41; Karolyn Vaughan, “Mother, Baby Residential Admission: The Mother’s Experience”, (Master of Nursing thesis, University of Western Sydney, 2000).

²² Connections and divergences between Australia and New Zealand are an important untapped area of research: Linda Bryder, “The Plunket Society: Part of the New Zealand Way of Life?”, *Australian Historical Studies* 39, no. 2 (1 June 2008): 183–98.

²³ Barbara Brookes, “King, Frederic Truby”, in *Te Ara Dictionary of New Zealand* (New Zealand Ministry for Culture and Heritage Te Manatu, 1993), <https://teara.govt.nz/en/biographies/2k8/king-frederic-truby> (accessed 9 October 2019).

²⁴ Brookes, “King, Frederic Truby”.

²⁵ Bryder, *A Voice for Mothers*, 9.

²⁶ *Ibid.*, 17; Brookes, “King, Frederic Truby”.

²⁷ The Department of Public Health (DPH) had been set up in 1901, which aimed to reduce infant mortality rates. It was renamed the Department of Health in 1920. See Derek A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington, NZ: Victoria University Press, 1995), 9; Bryder, “New Zealand’s Infant Welfare Services and Maori”; Sullivan, 26.

²⁸ Brookes, “King, Frederic Truby”.

²⁹ *Ibid.*

³⁰ The Plunket Society was predominantly European focused until 1960, with Bryder explaining the exclusion of Māori from Plunket’s coverage was a result of a territorial dispute between Plunket and the DPH. This department initiated its own ‘backblock’ nursing scheme in 1909, providing district nurses for rural areas, and introduced a ‘Native Health Nursing Scheme’ in 1911. See A. McKegg, “The Maori Health Nursing Scheme: An Experiment in Autonomous Health Care”, *New Zealand Journal of History* 26, no. 2 (1992): 145–60.

³¹ Deem explained in 1952 ‘The Plunket Society ... must not visit Maori paha [“pa” or “settlements”] or give advice to those living in Maori fashion as work amongst the real Maoris is undertaken by the Department of Health’. H. Deem to S. Ludbrook, 10 December 1952, Plunket Society, 581, Hocken Library (HL), quoted in Bryder, “New Zealand’s Infant Welfare Services and Maori”, 69–70.

³² Sullivan, 23.

³³ Bryder, “New Zealand’s Infant Welfare Services and Maori”, 69–70; Sullivan, 57.

³⁴ J. Millar to Kathleen Hosking, 19 December 1907, quoted in Bryder, *A Voice for Mothers*, 31–2.

³⁵ In 1924 Plunket was allocated £26,831 of the government health budget; in contrast to this Māori health attracted £10,689. *Appendices to the Journals of the House of Representatives (AJHR)*, 1925, B-1 Part iv, 27, quoted in Bryder, “New Zealand’s Infant Welfare Services and Maori”, 70.

³⁶ As a Justice of the Peace, King had a right to enter homes which the government licensed for the boarding out of unwanted babies: Sullivan, 116.

³⁷ *Ibid.*

³⁸ King, *Truby King, the Man*, 159–60.

³⁹ Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (Piscataway, USA: Rutgers University Press, 2006), 25.

⁴⁰ Nurse McKinnon and A.M. O’Shea, plus other ‘helpers’, cared for the babies who arrived on May 20, 1907. These helpers have typically been unnamed by historians, but anecdotally are believed to be Kāi Tahu and Kāti Huirapa Māori midwives and healers. Mere Harper and Ria Tikini: “Our History”, Plunket New Zealand, <https://www.plunket.org.nz/plunket/about-plunket/who-we-are/our-history/> (accessed 27 April 2022).

⁴¹ For simplicity, each hospital will be referred to with its location. Parry, *A Fence at the Top*, 39–40.

⁴² *Ibid.*

⁴³ Joyce Powell, *Plunket Pioneers: Recollections of Plunket Nurses from 1940 to 2000* (Auckland: Heritage Press, 2003).

⁴⁴ Sullivan, 116–47.

⁴⁵ *Ibid.*, 125.

⁴⁶ *Ibid.*; Tennant and Courtney, 116.

⁴⁷ Publications relating to Plunket Rules, 1907, AG-007-008-022, HL.

⁴⁸ 1919 Minutes of Report for the Central Council of Royal Society for the Health of Women and Children, HL, 25.

⁴⁹ Linda Bryder, “Challenging New Zealand’s Icon, Sir Frederic Truby King”, *Social History of Medicine* 33, no. 1 (2020): 201–23; Barbara Brookes, “Papering over Madness: Accountability and Resistance in Colonial Asylum Files: A New Zealand Case Study”, *Rethinking History* 22, no. 3 (3 July 2018): 356–74.

⁵⁰ Mary Ries Melendy, *Viviflore: The Pathway to Mental and Physical Perfection, the Twentieth Century Book for Every Woman* (Chicago, USA; Auckland, New Zealand: William Gribble & Co, 1904); Mary Ries Melendy, *The Ideal Woman: For Maidens, Wives, Mothers* (Auckland: W.M. Gribble & Co, 1913).

⁵¹ This book sold 20,000 copies in five years.

⁵² Bryder, *A Voice for Mothers*, 47; Linda Bryder, *Not Just Weighing Babies: Plunket in Auckland, 1908–1998* (Auckland, NZ: Pyramid Press, 1998), 23.

⁵³ F. Truby King, Medical note for Florence M., 22 December 1915, Statutory Papers DAHI D266 19851 Box 60, Dunedin, Archives New Zealand.

⁵⁴ Women continued to be admitted to mental hospitals for puerperal insanity until the late 1940s. J.T. Watts, *Annual Report of the Director-General of Health* (Wellington, NZ: R.E. Owen, Government Printer, 1950).

⁵⁵ *Baby's First Month*, Public Health Department and Truby King, 1913, HL, 4.

⁵⁶ Brookes, "King, Frederic Truby".

⁵⁷ Hygeia, "Natural Feeding", *New Zealand Woman's Weekly*, 12 January 1933, 42.

⁵⁸ *Ibid.*

⁵⁹ Letter from FTK to Miss Morgan, 14 May 1924, Maternal Mortality and Ante-natal, part one, J.M. Munro Kerr, Glasgow University, 1925, Series of lectures and notes on midwifery, AG-007-005/014, HL.

⁶⁰ Truby King, "Two Lectures by Dr Truby King", 18 and 19 December 1919, 10, AG-007-008/025, HL.

⁶¹ Dot Gillet, Karitane Nurses' notebook, 1930, Misc-MS-1737, HL.

⁶² *Ibid.*, 102, 104.

⁶³ "Karitane Hospitals: Admissible and Non-admissible Cases, 1907", Publications relating to Plunket Rules, AG-007-008-022, HL.

⁶⁴ *Ibid.*, 1.

⁶⁵ *Ibid.*, 2.

⁶⁶ Data collated from the Karitane Special Case Books (hereafter KSCB) held in the HL, including KSCB 1911–1912, AG-038/015; 1912–1913, AG-038/016; 1913–1914, AG-038/017; and 1915–1922, AG-038/018.

⁶⁷ Letter from Mary A. to Annie Campbell, 27 March 1913, Matron's correspondence, AG-038/052, HL.

⁶⁸ Letter from Annie Campbell to Mary A., 27 March 1913, Matron's correspondence, AG-038/052, HL.

⁶⁹ KSCB 1911–1912, 49, AG-038/015, HL.

⁷⁰ 22 June 1914, KSCB 1913–1914, AG-038/017, HL.

⁷¹ 11 October 1914, Admission Register 1914–1915, Dunedin Karitane Hospital, AG-038/067, HL.

⁷² 4 January 1914, KSCB 1913–1914, 33–35, AG-038/017, HL.

⁷³ Tennant and Courtney, 125.

⁷⁴ KSCB 1915–1922, KSCB, AG-038/018, HL, 110.

⁷⁵ 21 June 1913, KSCB 1912–1913, AG-038/016, HL.

⁷⁶ Deem spent a year as a house surgeon at Whangānui Hospital and was appointed lecturer and honorary physician to the Whangānui Stewart Karitāne Home. In 1933 she became a member of the inaugural Plunket Society Medical Advisory Committee. Linda Bryder, "Deem, Muriel Helen", *Dictionary of New Zealand Biography*, first published in 2000, Te Ara – the Encyclopaedia of New Zealand, <https://teara.govt.nz/en/biographies/5d14/deem-muriel-helen> (accessed 18 September 2020).

⁷⁷ Many English-speaking countries made maternity reforms in the 1930s, including Title V of the Social Security Act in 1935, United States, and Maternal and Child Health Services in Australia. Philippa Mein Smith, "Mortality in Childbirth in the 1920s and 1930s", in *Women in History: Essays on European Women in New Zealand*, edited by Barbara Brookes, Charlotte Macdonald, and Margaret Tennant (Wellington, NZ: Allen & Unwin/Port Nicolson Press, 1986), 137–55; Philippa Mein Smith, *Maternity in Dispute: New Zealand, 1920–1939* (Wellington, NZ: Historical Publications Branch, Department of Internal Affairs, Government Printer, 1986).

⁷⁸ Salkeld.

⁷⁹ D.G. McMillan and T.L. Paget, "Committee of Inquiry into Maternity Services" (Wellington, NZ: Ministry of Health, 1938), 86–8.

⁸⁰ McMillan and Paget, 78.

⁸¹ The act stated women would receive 'all necessary medical and nursing attendance, maintenance, and care at her confinement and for fourteen days succeeding the date of the birth of her child'. New Zealand Parliament, *Social Security Act 1938*, Part III, sections 95–100, 119–122, 119.

⁸² Helen Mountain Harte, "Home Births to Hospital Births: Interviews with Maori Women Who Had Their Babies in the 1930s", *Health and History* 3, no. 1 (2001): 87–108.

⁸³ Tennant and Courtney, 116.

⁸⁴ All six hospitals recorded 2,257 maternal admissions in 1975. Sullivan, 125.

⁸⁵ Kedgley, 155.

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- ⁸⁶ See Gerald N. Grob, "The Reorganization of Psychiatry", in his *From Asylum to Community, Mental Health Policy in Modern America* (Princeton, NJ: Princeton University Press, 1991), 24–43.
- ⁸⁷ The terms declared 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. "Constitution of the World Health Organization", <https://www.who.int/about/governance/constitution> (accessed 29 April 2022).
- ⁸⁸ The United Kingdom repealed its *Mental Deficiency Act 1913* with the *Mental Health Act 1959*, which sparked a shift toward community care and the deinstitutionalisation of larger mental hospitals. See Warwick Brunton, "The Origins of Deinstitutionalisation in New Zealand", *Health and History* 5, no. 2 (2003): 75–103.
- ⁸⁹ K. R. Stallworthy, *A Manual of Psychiatry* (New Zealand: N. M. Peryer Limited, 1963), 293–310.
- ⁹⁰ Helene Deutsch declared that for women to be good and normal they must sacrifice themselves to their children. Helene Deutsch, *The Psychology of Women: A Psychoanalytic Interpretation*, vols 1–2 (New York: Grune & Stratton, 1944); Anne Harrington, "Mother Love and Mental Illness: An Emotional History", *Osiris* 31, no. 1 (1 July 2016): 94–115.
- ⁹¹ Maurice Bevan-Brown, *Mental Health and Personality Disorder: A Selection of Essays* (Christchurch, NZ: Dunford Publications Ltd, 1961); Maurice Bevan-Brown, *The Sources of Love and Fear*, 3rd ed. (Christchurch, NZ: The Raven Press Co. Ltd., 1960); Grantly Dick-Read, *Childbirth without Fear: Being the Eleventh Impression of Revelation of Childbirth*, 2nd ed. (London: Heinemann Medical, 1943).
- ⁹² John Bowlby, *Maternal Care and Mental Health* (World Health Organization, 1952); D.W. Winnicott, *The Child and the Family: First Relationships* (London: Tavistock Publications, 1957).
- ⁹³ Held and Rutherford, 109, 119.
- ⁹⁴ *Ibid*; Helen Deem and Harold Silverstone, "The Growth of the New Zealand Infants during the First Year of Life", *New Zealand Medical Journal* (February 1944), AG-007-008/025, HL; Helen Deem, "The Management of the New-born", *New Zealand Medical Journal* (February 1949), AG-007-008/025, HL; Helen Deem, "Care of the Premature Baby", *New Zealand Medical Journal* (June 1949), AG-007-008/025, HL.
- ⁹⁵ Helen Deem and Nora FitzGibbon, *Modern Mothercraft: A Guide to Parents*, 9th edition (Dunedin, NZ: Coulls Somerville Wilkie Ltd, 1955), 71.
- ⁹⁶ Deem and FitzGibbon, 71.
- ⁹⁷ Resistance from some mothers to this advice likely came from the need to address difficult emotions, including why a mother did not enjoy mothering.
- ⁹⁸ Deem and FitzGibbon, 71.
- ⁹⁹ Plunket Nurse Elsie Mareo to Dr Deem, 5 December 1941, Unsatisfactory Cases to Dr Deem, AG-007-004/049, HL.
- ¹⁰⁰ The baby was weaned as part of the mother's recovery, but the mother and baby remained together. Invercargill Karitane Hospital Admission Register, 11 June 1950, AG-168-01, HL.
- ¹⁰¹ Unsatisfactory Cases to Dr Deem, Johnsonville, March 1952, AG-007-004/048, HL.
- ¹⁰² Tennant and Courtney, 122.
- ¹⁰³ Powell, "A Suitable Job for Young Ladies", 68.
- ¹⁰⁴ Ernest Beaglehole, *Mental Health in New Zealand* (Wellington, NZ: New Zealand University Press, 1950), quoted in Kedgley, 174.
- ¹⁰⁵ Powell, "A Suitable Job for Young Ladies", 68.
- ¹⁰⁶ *Ibid*, 69.
- ¹⁰⁷ Kedgley, 299.
- ¹⁰⁸ *Ibid*.
- ¹⁰⁹ *Ibid.*, 155.
- ¹¹⁰ Neil Colquhoun Begg (1915–95) served as a paediatrician to Dunedin Hospital, the Karitāne hospital, and Queen Mary Maternity Hospital. Linda Bryder, "Begg, Alexander Charles and Begg, Neil Colquhoun", *Dictionary of New Zealand Biography*, Te Ara - the Encyclopaedia of New Zealand, <https://teara.govt.nz/en/biographies/5b18/begg-alexander-charles> (accessed 28 April 2022).
- ¹¹¹ Bryder, *A Voice for Mothers*, 112.
- ¹¹² *Ibid.*; Sullivan, 68.
- ¹¹³ *Report of the Consultative Committee on Infant and Pre-School Health Services* (Wellington, NZ: Government Printer, 1960), 112.
- ¹¹⁴ Dr Neil Begg, interview with Jim Sullivan, 31 August 1992, Royal New Zealand Plunket Society Oral History Project, OHInt-0314/05, Alexander Turnbull Library, Wellington, NZ.
- ¹¹⁵ Wellington Karitane Hospital Admission Register 1958–1961, AG-782-3/1, HL.
- ¹¹⁶ *Ibid.*, 14 April 1959 and date unknown.
- ¹¹⁷ Begg, interview with Jim Sullivan.
- ¹¹⁸ Bryder, "Begg, Alexander Charles and Begg, Neil Colquhoun".

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- ¹¹⁹ Neil Begg, *The New Zealand Child and His Family* (Christchurch, NZ: Whitcombe & Tombs for the New Zealand Plunket Society, 1972), 135.
- ¹²⁰ Tennant and Courtney, “‘The Karitane’”, 114.
- ¹²¹ Powell, “*A Suitable Job for Young Ladies*”, 70.
- ¹²² Chalmers, 39.
- ¹²³ Peter K. Cressey, “Plunket-Karitane Hospital Report”, 1977, MS-2974/0806, 1, HL.
- ¹²⁴ This was partly due to the availability of oral contraceptives by the 1960s. Helen Smyth, *Rocking the Cradle: Contraception, Sex and Politics in New Zealand* (Wellington, NZ: Steele Roberts, 2000).
- ¹²⁵ J.H. McMillan, Director of Nursing Services Assessment of Karitane Hospitals, 1977, MS-2974/0351, 1–4, HL.
- ¹²⁶ *Ibid.*
- ¹²⁷ Hassell described one woman with a two-week-old infant as an ‘immature depressed mother’: Ian Hassell, Plunket-Karitane Hospital Report, 1977, MS-2974/0353, HL.
- ¹²⁸ The referring doctor feared the mother might harm her baby when he asked Karitāne to take the baby into care: Chalmers, 36–7.
- ¹²⁹ She attributed her breastfeeding challenges to her using the antidepressant, Mandrex. Chalmers, 29–31.
- ¹³⁰ When the DPB came in, many mothers could afford to live elsewhere on the higher DPB payments. Bryder, *A Voice for Mothers*, 192.
- ¹³¹ The DPB officially recognised the right of women to care for their children when no other financial provider was available and allowed single mothers, widows, and divorced women to claim maintenance for their children from 1973. Kedgley, 274; Christine Dann, *Up from Under: Women and Liberation in New Zealand, 1970–1985* (Wellington, NZ: Allen & Unwin/Port Nicholson Press, 1985), 28–50.
- ¹³² Begg, interview with Jim Sullivan.
- ¹³³ Tennant and Courtney, 117.
- ¹³⁴ Sullivan, 146.
- ¹³⁵ P.J.E. Lewis et al., “The Karitane Project: Psychological Ill-Health, Infant Distress and the Postpartum Period”, *New Zealand Medical Journal* 79, no. 517 (12 June 1974): 1005–9.
- ¹³⁶ *Ibid.*, 1009.
- ¹³⁷ Begg, interview with Jim Sullivan.
- ¹³⁸ Annual government grants ranged from \$59,000 (\$850,000) in 1972 to \$220,000 (\$2.5 million) in 1975. Sullivan, 144; Begg, interview with Jim Sullivan; Brunton.
- ¹³⁹ Sullivan, 145–6.
- ¹⁴⁰ Bryder, *A Voice for Mothers*, 188–201; Sullivan, 146.
- ¹⁴¹ Graduates were later called ‘Community Karitanes’. Over the 1980s only 55 Community Karitanes were trained; the number increasing to 102 in the 1990s, still well below the heyday of Karitāne hospital-based training: Leigh Whale, Secretary Plunket Society Ethics Committee to Lesley Courtney, 20 November 2002 quoted in Tennant and Courtney, “‘The Karitane’”, 118. Plunket kaiāwhina were also trained from the 1990s to assist Māori families: Lesley Courtney, ‘An Excellent Preparation for marriage and families of their own: Karitane nursing in New Zealand, 1959-1979 (MA in History, Massey University, 2001), 143-6, quoted in Tennant and Courtney, “‘The Karitane’”, 118.
- ¹⁴² Vaughan’s 1998 study showed the benefits of the Australian Karitane Child and Family Units for mothers’ mental health through decreases to sixteen women’s Edinburgh Postnatal Depression Scale scores over their admission duration.
- ¹⁴³ Begg, interview with Jim Sullivan.
- ¹⁴⁴ Lewis, 1009.
- ¹⁴⁵ A variety of non-government organisations support mothers and families: Perinatal Anxiety Depression Aotearoa, <https://pada.nz/> and Mental Health Foundation, <https://mentalhealth.org.nz/>.
- ¹⁴⁶ Holly Walker, “Āhurutia Te Rito; It Takes a Village”, *The Helen Clark Foundation* (May 2022), <https://helenclark.foundation/publications-and-media/ahurutia-te-rito-it-takes-a-village/> (accessed 5 May 2022).