THE PATIENTS' WORLD: BRITISH COLUMBIA'S MENTAL HEALTH FACILITIES, *1910-1935*

by

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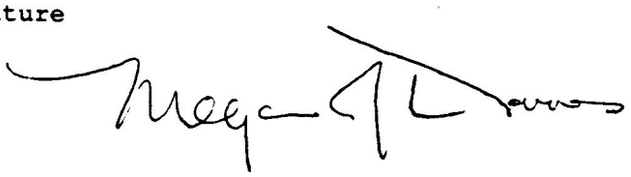

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INTRODUCTION

Photographs in the 1916 annual report of British Columbia's New Westminster Insane Asylum show an imposing edifice rising behind tailored lawns and tidy flower beds, images that strike a jarring note when juxtaposed against the purpose of the institution. Patients for whom the institution was built in 1877 and the staff who ministered to their needs are conspicuously absent from these official photographs of the province's primary mental health care facility. Nor do we see the concerned faces of government officials and the public, peering in through the asylum gates.

Much of the history of mental health care in the western world, like the photographic image described above, reveals little of what really motivated the individuals who created, worked inside or made use of institutions such as these. The initial Whig historiography of the rise of mental health care charted a heroic tale of reform, humanism and progress, ignoring both the ambivalent aspects of asylum development and the reality of patient existence. British historians like Kathleen Jones, in her early work on mental health policy, A History of Mental Health Services, considered social policy to be something that existed primarily in the minds of influential figures and found expression in major events and ~amous cases.[1] Similarly, across the Atlantic, American historians wrote in positive terms of the development of moral

1. Kathleen Jones, Mental Health and Social Policy (London: Routledge and Keagan Paul, 1960).

treatment and humanitarian care facilities during the early nineteenth century. Albert Deutsch, for example, interpreted moral treatment, non-restraint, lunacy law reform and mental hygiene as successive and progressive steps from the original lunatic asylums and the incarceration of the mentally ill in jails and poorhouses.[2]

It is clear that this early body of literature had limitations. Jones never considered the impact policy had on asylum patients and staff. Indeed, the underlying assumption within her work *is* that the state has the right to legislate the lives of those people deemed mentally ill. Deutsch's reliance on published material means that he, too, was seldom able to look behind the public face of asylums. And perhaps more importantly, Deutsch's work, like Jones', revealed a parallel belief in the "rightness" of one group in society imposing its definition of sanity upon others. Psychiatry, Deutsch told us, is the "noblest branch" of medicine.]

While acknowledging the limitations of this early body of work, one must also point to some of its strengths. The tendency of this group of historians to focus on individuals may have limited their scope, but it also meant that they produced some useful biographical material about key individuals in the historical development of mental health policy. Deutsch's work, for example, includes a Chapter on

2. Albert Deutsch, The Mentally III in America: A History of Their Care and Treatment from Colonial Times (New York: Columbia University Press, 1949.)

3. Ibid, p.272.

Dorthea Dix, a lay reformer in the field of American mental health who deserves a full-scale biography which incorporates contemporary historiography in the field. Moreover, detailed works which chronicle the development of legal policy, like Jones' British work, provide a starting point for more analytical work like that of Harvey Simmons on the English Mental Deficiency Act of 1913.[4]

The publication in English of Michel Foucault's Madness and Civilization in 1965 challenged the work of historians such as Jones and Deutsch.[5] Widely read by the new social historians and exceedingly influential, Foucault's work cast doubt on the fundamental tenets of Whig historiography. The development of institutionalized mental health care facilities was not, Foucault argued, a humanitarian gesture. Rather, the asylum had less to do with the humane treatment of the insane and everything to do with marking vagabonds, criminals and the insane as "the other" and, under the guise of humanism, incarcerating them in huge institutions of eighteenth and nineteenth century France. In this new regime, insanity became synonymous with immorality and was something that required "correction". Hence, the psychiatrist became the priest of madness, an individual who had the power to measure sanity.

4. Harvey Simmons, "Explaining Social Policy: The English Mental Deficiency Act of 1913," Journal of Social Policy, vol 11 no 3 (1978), pp.387-403.

5. Michel Foucault, Madness and Civilization, trans. by Richard Howard, (New York: Vintage Books, 1965.)

Foucault's perspective was quickly adopted by a number of social historians. David Rothman, in his 1971 book The Discovery of the Asylum, argued that the development of American public asylums, poorhouses and penitentiaries during the Jacksonian period was in fact a form of "social control".' The real purpose of these new institutions was to rehabilitate deviant members of society. Those who would not work, the slovenly and the imbecilic, would be taught the merits of the work ethic and, hence, the asylum would become a model for American society.

Andrew Scull's Museums of Madness, a study of nineteenth-century English asylums utilized an approach similar to Rothman. As Scull stated in his introduction, his work was an attempt to move "away from the rhetoric of intentions and to consider instead the actual facts about the establishment and operation of the new apparatus for the social control of the mad."7 Consequently, Scull focused his attention on how the mentally ill, now considered a unique social group, became the impetus behind the creation of a state-run and highly bureaucratic asylum system. Parallel to the development of this institutional network was the emergence of a new professional class of asylum physicians and administrators. For Scull, these changes were only one facet, albeit an important one, of the wider shift in the social

6. David Rothman, The Discovery of the Asylum (Boston: Little, Brown and Company, 1971),p.xix.

7. Andrew Scull, Museums of Madness (Harmondsworth, England: Penguin Books, 1979),p.15.

organization of deviance. Such controls, he argued, were most often imposed on the poor. Moreover, the development of the asylum meant that families and communities now had a convenient and socially acceptable place for individuals whose behaviour was troublesome or intolerable.

Rothman and SCull's early work shared several important themes. They saw the state as a coercive monolith rather than a benevolent parent. Most importantly, they argued that any study of asylums must take into account the class interests of those who built and ran these vast institutions. This interest in the power dynamics of asylum policy has informed much of the subsequent scholarship in this field, regardless of whether historians agree or disagree with the basic arguments put forth by Rothman, Scull and others of the "social control" school.

Yet holders of social control theory have done much more than simply facilitate interest in how class and professional interests informed public policy regarding mental health care. The whole notion of whether asylums really were a form of social control and, if so, whether one can consider this in a conspiratorial framework, has engendered considerable debate. Michael Ignatieff, who was himself responsible for an important early work on the history of penal reform, has criticized the early social control literature for its interpretation of the state as all powerful and therefore the sole

arbiter in moral and social issues.' Moreover, Ignatieff points out that this perspective paints asylum keepers and policy makers as inevitably conspiratorial figures who sought only to label and confine deviance.

Certainly, a somewhat simplistic analysis of power is a fundamental weakness of the early work of Scull and Rothman. These scholars, while no longer ignoring patients like Jones and Deutsch do, still see them as powerless pawns. We are left with no sense of what motivated patients nor how they perceived their own mental health or the treatment which they received in the asylum. Furthermore, as Tom Brown points out, the role played by families in incarcerating their kin is not dealt with adequately in the early literature.'

The question of power is also somewhat distorted by Rothman and Scull's penchant for arguing that policy makers and asylum keepers represented the interests of the emergent middle class. However, Scull's own argument that asylums brought the establishment of a professional group of asylum superintendents with their own set of aspirations calls this premise into question. As well, we must acknowledge that the emerging institutions themselves, because of their

8. Michael Ignatieff, "State, Civil Society, and Total Institutions: A Critique of Recent Social Histories of Punishment," in M. Tunry and N. Morris, eds., Crime and Justice: An Annual Review of Research (Chicago: University of Chicago, 1981), 153-192.

9. Thomas Brown, "Foucault Plus Twenty: On Writing the History of Canadian Psychiatry in the 1980's," Canadian Bulletin of Medical History 2, 1 (Summer, 1985): 23-49.

monolithic nature, likely developed a set of values, rules and rationales that were different from the rest of society. Indeed, as Brown has observed, it is this "inner world of the asylum" that is most neglected by early social control historians. For example, Scull's Museums of Madness has a chapter which deals specifically with asylums, yet he does not consider such topics as daily patient life, asylum attendants and patient subculture.

Challenging the work of Rothman and Scull, there have been other scholars in the field whose intellectual heritage harkens back to the earlier Whig historiography. Among this group Gerald Grob unquestionably offers the most substantial critique of those who see the institution as a form of social control. Grob's two volumes, Mental Institutions in America: Social Policy to 1875 and Mental Illness and American Society, 1875-1940, do much to illuminate the contours of the asylum world by outlining in detail the emergence of asylum bureaucracy and professional interests. [10]

However, Grob's work shares a fundamental weakness with that of Scull and Rothman - a lack of gender analysis. Given the dramatic surge of feminist scholarship during the late 1970's and 1980's, this is both surprising and disappointing. In the case of Scull and Rothman's early work this shortcoming is rather problematic. The use of a social control model by implication presents a romanticized picture of care

10. Gerald Grob, Mental Institutions in America: Social Policy to 1875 (New York: Free Press, 1973) and Mental Illness and American Society, 1875-1940 (Princeton: Princeton University Press), 1983.

given by the family to those deemed mentally ill. Yet, as we know today, the family can be an extremely dangerous place for women.[11] There is no reason to suppose that this situation was any different in the past: in some cases an asylum may have been the safest place for a woman.

Grob notes the preponderance of women in the new psychiatric professions that emerged during the late nineteenth and early twentieth century (psychologists, occupational therapists and social workers) and considers the implications of power struggles between "male" and "female" professionals in the psychiatric field. Yet, like the social controlists he criticises, he largely ignores the ways in which gender differences shaped the experiences of male and female patients.

But as more recent work illustrates, gender analysis can bring new insights to bear on the history of psychiatry.12 Furthermore, feminist scholars have made important contributions to discussions of power and to the treatment of women by the medical profession.[u] It is disappointing that Scull, Rothman and Grob, working at the time that this renaissance of feminist scholarship was occurring, chose to ignore

11. Anne Oakley, Subject Women (Oxford: Fontana Paperbacks, 1982).

12. See, for example, Elaine Showalter, The Female Malady, (Harmondsworth, England: Penguin Books, 1983).

13. For feminist analysis that deals specifically with women and psychiatry see P. Susan Penfold and Gillian A. Walker, Women and the Psychiatric Paradox (Montreal: Eden Press, 1983) and Dorthy E. Smith and Sara J. David, eds., Women Look at Psychiatry, (Vancouver: Press Gang Publishers, 1975).

what it had to offer.

However, other recent work in this field has gone a long way both to address these shortcomings of the neo-Whig and social control historiography and to explore new ways of interpreting the history of psychiatric care. Richard Fox described his work, So Far Disordered in Mind, as an analysis of the "social and cultural meaning of insanity in California" during the latter nineteenth and early twentieth centuries.[14] Fox looks at a period similar to Grob's 1983 work, yet he is more interested in seeing how new theories about the nature and treatment of mental illnesses actually affected patients than in charting the professional development of the field. After careful scrutiny of committal records Fox argues that class and ethnicity did have an impact on whether or not an individual was committed. However, he modifies older notions of social control: while committal procedures were undoubtedly used by the medical profession to enhance their own status, they were also employed for other reasons by both families and local authorities. Thus, we begin to see the asylum as serving the interests of several different groups.

But FOX'S work is limited by the fact that his source material is confined to the committal records and therefore does not consider the experience of patients once inside the asylum. In contrast, Nancy Tomes' A Generous Confidence: Thomas Kirkbride and the Art of Asylum-

14. Richard Fox, So Far Disordered in Mind (Berkeley: University of California Press, 1978.)

Keeping is an attempt to see how asylums actually worked and to render visible both patients and their families.[15] Tomes' book is both the study of the nineteenth-century Pennsylvania Hospital and its chief physician, Thomas Kirkbride.

Like Fox, Tornes sees the asylum as an institution that met needs perceived by society as a whole rather than simply enhancing the professional aspirations of the medical ranks. Tomes argues that families used the institution as a last resort, when all other means of treating difficult family members had been unsuccessful, or in response to a specific crisis. Moreover, she illustrates how family members made their own demands on the institution. This line of investigation is flawed by the fact that she implies that Pennysylvania Hospital, a private asylum, was a typical institution. It is difficult to imagine that non-paying families would have the same amount of control in public institutions. Yet Tomes does manage to illuminate the complex motivations behind family committals to Pennsylvania Hospital during Kirkbride'S tenure.

Tomes' book is more disappointing when it shifts to patients inside the asylum. In her descriptions of diagnosis, treatment and daily asylum life, Tomes almost invariably considers patient routine and behaviour as it was interpreted by the asylum staff, thereby rendering patients passive. Even patient friendships are interpreted through

15. Nancy Tomes, A Generous Confidence: Thomas Kirkbride and the Art of Asylum-Keeping (New York: Cambridge University Press, 1984.)

Kirkbride's own words. Hence, beyond an extensive portrait of Eliza Kirkbride (a patient and later Kirkbride's second wife) we are left with little idea of either patient motivation or of the manner in which patients themselves shaped the asylum environment.

Anne Digby's work Madness, Morality and Medicine is similar to Generous Confidence in that Digby chose to focus on one institution - in this case the Quakers' York Retreat in England.[15] Digby's time frame, however, is considerably longer than most historical work in this field: her study encompasses the years between 1796 and 1914. As Digby acknowledges, the religious nature of the York Retreat makes its history somewhat unique. However, the value of this work lies in the use Digby has made of the extensive collections of records made available to her. In chapter seven of the book, for example, Digby employs institutional records and the private papers of one asylum attendant to reconstruct the working lives of institutional attendants - a key group of asylum personal about whom very little has been written to date. Similarly, her exploration of patient subculture, set within the institutional framework of asylum life, allows us to appreciate both the individual and institutional nature of asylum life.

Because they take us inside the walls of the asylum Digby and Tomes serve as important correctives to the earlier historiography of mental health. Ultimately, Digby's greater sensitivity to her material,

16. Anne Digby, Madness, Morality and Medicine (New York: Cambridge University Press, 1985.)

and perhaps better sources, mean that she is more successful *in* recreating the inner world of the asylum. Nonetheless, while Digby and Tomes look at differences between male and female patients, neither uses gender as a major tool of analysis.

Elaine Showalter is the only recent scholar to produce an extensive work that utilizes both a feminist analysis and a social control perspective *in* the history of mental health.[17] Showalter's The Female Malady considers the gender implications of cultural meanings of insanity between 1830 and 1980. Working from secondary material _ treatises, novels and personal accounts - Showalter argues that, by the beginning of her period, the "cultural imagery" of an insane person had shifted from the dangerous male to the female victim. This change *in* popular thought, Showalter maintains, is linked to the asylum reforms of the nineteenth century and to the growing percentages of incarcerated women.

Showalter is interested in seeing how notions of femininity have been used to create male defined stereotypes of "mad" women. Yet her work *is* most insightful when she turns to the epidemic of "shell-shock" cases amongst male veterans of World War I. Showalter argues that the refusal of many psychiatrists to acknowledge the mental torment of veterans was linked to a fear of the "feminine" manifestations of shellshock, and her discussion of the portrayal of such veterans *in* fictional literature of the period illustrates the usefulness of gender

17. Elaine Showalter, The Female Malady.

analysis for understanding men as well as women.

But work which brings together historical theory and feminist analysis of psychiatry is still rare. In Canada, Wendy Mitchinson has written a number of articles which compare the experience and treatment of men and women in-nineteenth-century Ontario asylums. In her study of gynaecological operations performed on female patients at the London, Ontario asylum, Mitchinson illustrates that abstract theory about the nature of femininity did affect the medical treatment which women received in very concrete ways.lI Moreover, as *is* shown by the work of Grob and Tomes, Mitchinson's description of the debate over such surgery shows that the medical profession can scarcely be perceived as a monolithic entity - a point which serves as a necessary corrective to early social control theory.

Mitchinson's more recent work on the history of mental health care has turned from psychiatric theory to the patients and families who made use of the institutiollS.[lt] Again, her work critiques social control theory by arguing the nineteenth century asylums did not serve as places to "hide away" those who could or would not work or whose behaviour was socially unacceptable. Istead, Mitchinson sees the asylum as serving a

18. Wendy Mitchinson, "Gynaecological Operations on Insane Women: London, Ontario, 1895-1901," Journal of Social History, 15, 4: 467-484.

19. Wendy Mitchinson, "Gender and Insanity **as** Characteristics of the Insane: A Nineteenth-Century Case," Canadian Bulletin of Medical History, **4**, 2, (1987): 99-117 and "Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum: The Case of Toronto," in eds., Janice Dickin McGinnis and Wendy Mitchinson, Essays in the History of Canadian Medicine (Toronto: McClelland and Stewart, 1988.), pp.88-109.

custodial purpose in its care of the elderly and those who were too *ill* to support themselves. Here again, Mitchinson's gender analysis is useful for she clearly illustrates the linkages between female committals and the family: kin appear to have been more ready to commit female members than male.

The work of S.E.D. Shortt is another important addition to the historiography of Canadian psychiatry. Shortt's Victorian Lunacy looks at the London Ontario asylum during the late nineteenth century and specifically at Richard M. Bucke, the institution's medical superintendent during the period.[20] In a book which does much to illuminate the personal world of a late nineteenth century psychiatrist, his tendency to downplay gender differences - specifically regarding the gynaecological operations performed on women of which Mitchinson has written - is disappointing. Moreover, Shortt's discussion of patient subculture is initially exciting but ultimately unfruitful. Here again, source material limits just how much of the inner world of patient life can be explored.

Harvey Simmons' work differs dramatically from that of Mitchinson and Shortt in two important respects. First, Simmons is primarily interested in mental health policy and its formulation. Furthermore, his major work in the field to date, From Asylum to Welfare looks at the

20. S.E.D. Shortt, Victorian Lunacy: Richard M. Burke and the Practice of Late Nineteenth-Century Psychiatry, (Cambridge: Cambridge University Press, 1986).

treatment of the mentally handicapped rather than the insane.[21] This book, which covers the period from 1831 to 1980, provides a detailed summary of events and individuals that shaped the development of social policy for Ontario's mentally handicapped residents. It *is* not Simmons' mandate to explore the effect which this policy had on patients and family members.

In this way, recent scholarship on the history of psychiatry, both inside and outside .Canada, can be seen as following some general trends.[22] For the most part historians have chosen to study a specific institution, at times shaping their work around a discussion of key individuals. Such work is informed by the analysis of power, class and professional privilege first outlined by Foucault, Scull and Rothman. And finally, we can see the beginnings of an analysis which includes gender as a variable and looks at those individuals who had remained hidden from history - patients, the families of those incarcerated and the asylum attendants.

Yet in many ways the history of mental health care during the

21. Harvey Simmons, From Asylum to Welfare (Downsview, Ontario: National Institute on Mental Retardation, 1982.)

22. Other Canadian work not covered in this discussion include: Rayner Baehre, "The Ill-Regulated Mind: A Study of the Making of Psychiatry in Ontario, 1830-1921," Ph D Thesis, York University, 1985; Thomas E. Brown, "Living With God's Afflicted: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911," Ph D Thesis, Queen's University, 1981; and Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," in S.E.D. Shortt, ed., Medicine in Canadian Society: Historical Perspectives, (Montreal: McGill-Queen's University Press, 1981), pp.93-114.

crucial post-World War I years remains a static photographic image like that which was depicted *in* the 1913 New Westminster annual report. Historians, with the exception of Tom Brown, have chosen to end their studies at or before 1914, thereby avoiding the influx of "shell-shocked" men who returned from the trenches *in* need of psychiatric care.[23] We still know less than we should about how the public hygiene movement, the professionalization of nursing, the birth of social work and the economic twists of the post-war period influenced government policy and actual patient experience. An analysis that incorporates gender, professional interests, the needs of family and institutional concerns will help explain how the development of the more scientific twentieth century mental health hospital affected those who entered as patients.

In the case of the history of psychiatry *in* Canada, work has been limited by geography as well as time period. There is only a small amount of published work that looks at asylums outside central Canada.[24] Tom Brown's article about the period which Freud's disciple, Dr. Ernest Jones spent *in* Canada, suggested that Freudian thought was introduced to Toronto's medical elite from 1908-1913, but we have no idea of whether

23. See Tom Brown, "Shell-Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War," in ed. Charles Roland, Health, Disease and Medicine: Essays in Canadian History, (Toronto: Hannah Institute for the History of Medicine, 1984), pp.308-332.

24. See, for example, Daniel Francis, "The Development of Lunatic Asylums in the Atlantic Provinces."

such debates spread to medical establishments outside Toronto and Montreal.[25] We need to know more about variations between treatment between different regions of Canada.

This thesis both builds upon and shifts away from work that *is* currently been done on the history of psychiatry *in* Canada. In my study of British Columbia's two premier mental health care facilities, New Westminster and Essondale, between 1910 and 1935, I am interested, like Tomes, Shortt and Digby, *in* reconstructing patient experience and the institutional community. My use of gender as a primary tool of analysis reflects the concerns of Mitchinson and Showalter. And I am indebted to Grob's analysis of professional development, both within the institutional setting and *in* the fields of mental hygiene and community mental health care. However, my work also tries to adopt a patient centred perspective. This is made possible by utilizing twentieth century patient case files, which are significantly more detailed than those of the previous century. Greater sensitivity to such material can allow a measured interpretation of how patients experienced asylum life. In short, I suggest that historians must avoid categorizing mental health patients **as** insane or victims.

Scull, *in* a recent review of Roy Porter's book, A Social History of Madness: Stories of the Insane, indicates that this kind of approach

25. Thomas E.Brown, "Dr. Ernest Jones, Psychoanalysis, and the Canadian Medical Profession, 1908-1913," *in* Medicine in Canadian Society, pp.315-353.

may only serve to romanticise the mad.[26] I do not see the patients at New Westminster or Essondale as the keepers of truth or powerless victims: clearly, either interpretation is simplistic. However, the case histories which I have studied show that men and women entered the asylum for any number of reasons: emotional distress was somewhat gender differentiated but nonetheless highly individualistic. It is difficult and probably less than useful to look backward and pass judgement on the "sanity" of mental health patients. My choice, therefore, has been to accept, whenever possible, the concerns and motivations of the patients I study as genuine. Furthermore, I try to consider how policy, treatment and institutional change shaped the experience of patients.

The asylum can best be perceived as a negotiated space. Asylum superintendents and doctors struggled to make their professional realm appear relevant to the society of which it was part. Government bureaucrats balanced public opinion against fiscal accountability. And these administrative concerns and professional demands did much to define the contours of patient experience within the gates of New Westminster and Essondale.

Gender was an important variable within this process for it is clear that men and women had very different experiences as patients. Moreover, the ways in which male and female patients negotiated some sense of individuality within the "inner world" of the asylum were also

26. Andrew Scull, "Keepers," London Review of Books, vol 10 no 17, (September 29, 1988), pp.21-25.

gender differentiated. Men and women took rather different routes to the asylum and brought elements of male and female cultures into the institution and shaped their new world accordingly. As this thesis will illustrate, patients, doctors, bureaucrats and family all played roles in the institutionalization process.

CHAPTER 1: PATIEN'I' CULTURE AND ASYLUM CULTURE

The subculture of New Westminster and Essondale asylums was a curious amalgamation of the rational and the irrational, an institutional order constantly threatened by the uncertainties of patient behaviour. For the patients, some things were simply givens - power and order imposed from above in the physical spaces set out for various kinds of patients and daily routine enforced through institutional discipline. Sanity, the ultimate code of judgement, was based on their ability to confor.m to asylum routine.

There is much in the character of large institutions such as Essondale and New Westminster that denies the individuality of those for whom they exist. Yet, within this ordered sphere, the men and women who were patients affir.med their individuality and personal power through the creation of other, less "rational", facets of patient subculture. The case histories of patients at the two institutions under study provide indications of how the institutionalized made personal their surroundings and underline the importance of looking at how the weak create their own systems of order and power.[1] In the stories of those who were patients at New Westminster and Essondale between 1910 and 1935 we find that both men and women imposed a more personalized character on the asylum community through the friendships they made and the work they

1. See Elizabeth Janeway's, Powers of the Weak, an insightful discussion of power as a relationship between unequal partners and also of the tools available to those deemed "powerless". (New York: Morrow Quill Paperbacks, 1981).

performed.[2] As well, there are suggestions that patients themselves created codes of patient behaviour. In this patient world, however, gender was the great divide. An analysis of the variant experiences of male and female patients serves to illuminate differences between the male and female milieus that existed within the asylum.

In contrast to eastern Canada and most American states which had built mental health institutions by the 1850's, British Columbia's first provincial asylum was not established until 1872.[3] The asylum remained in Victoria until 1878, when a total of thirty-seven patients, accompanied by the asylum staff, were moved to a new facility in New Westminster, on the north bank of the Fraser River. The period up to 1910 was a time of steadily increasing public use of New Westminster: the institution's patient population grew from a yearly average of forty-five patients in 1880 to 563 in 1910. The growth of the two institutions between 1910 and 1935 was dynamic: one small institution, housing 595 patients was transformed by 1935 into two complexes which

2. We must remember, however, to approach case histories with a measure of caution for this kind of data may reflect a gender bias in the way in which patient behaviour was reported. Asylum doctors, throughout the period, were exclusively male.

3. For a discussion of the history of Maritime asylums see, Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces." S.E.D. Shortt's Victorian Lunacy is an excellent study of London asylum in Ontario in the late nineteenth-century. Important histories of nineteenth-century American asylums include: Nancy Tomes, A Generous Confidence, Richard W.Fox, So Far Disordered in Mind.

held a total of 2823 patients.[4]

Under the jurisdiction of the Provincial Secretary's department from 1872, by 1910 the government of B.C. believed it had a modern, efficient mental health care institution. Dr. Charles Doherty, then asylum superintendent, outlined an optimistic agenda to fellow members of his profession at the 1912 American Medico-psychological Association in Atlantic City. Doherty's presentation was a detailed description of Essondale, the new asylum then under construction. Essondale's facilities for recreation and manual arts and crafts, Doherty told the meeting, would greatly assist in the care of acute patients.[5] Based on a design chosen by Franklin B. Ware, State Architect of New York, the new buildings would be fireproof, well-ventilated, and allow in a maximum amount of sunlight.' Essondale, Doherty reported, would be composed of a central administrative building, with acute, chronic and other buildings grouped around it in a horseshoe.[7]

4. These figures are based on statistics culled from the Annual Reports of the medical superintendent in the B.C.Sessional Papers. They represent the number of patients in residence at the close of the year. The cumulative total of patients treated for 1910 **was** 843, and for the 1934/35 fiscal year 3,721.

5. C.E.Doherty, "Treatment of the Insane in British Columbia," printed in "The Annual Report of the Public Hospital for the Insane," (Hereafter "Annual Report,"), 1912, Sessional Papers, 1913, (Victoria: King's Printers, 1913) p.G37. Note that each annual report **was** published in the following year's sessional papers. Whenever I refer to annual reports, I cite the actual year which they catalogue.

6. Ibid, p.G38.

7. Ibid.

Doherty's optimism was, however, somewhat misplaced. The first building at Essondale opened on April 1, 1913. But the First World War began one year later and, for the most part, put an end to development of the asylum for its duration. Indeed, by 1916 Dr. McKay, acting medical superintendent, reported that the new institution was filled and suggested that a new building with 150 beds for acute cases was needed.' But new construction was slow in coming. While a small building for the feeble-minded was opened in 1919, the second major building at Essondale, a new facility for acute patients, was not constructed until 1924.' Despite the Great Depression of the 1930's, there was significantly more expansion at New Westminster and Essondale than in the previous decade. In 1930 the third major building of the Essondale complex, a residence for women, was completed. At the same time initial remodelling began on the older facilities at New Westminster for use in the care of the mentally handicapped. Another new unit, known as the Vet's Wing, was constructed at Essondale in 1934 for longterm patients, many of whom were war veterans. One year later a number of small cottages at Essondale were set aside to be residences for aged patients.

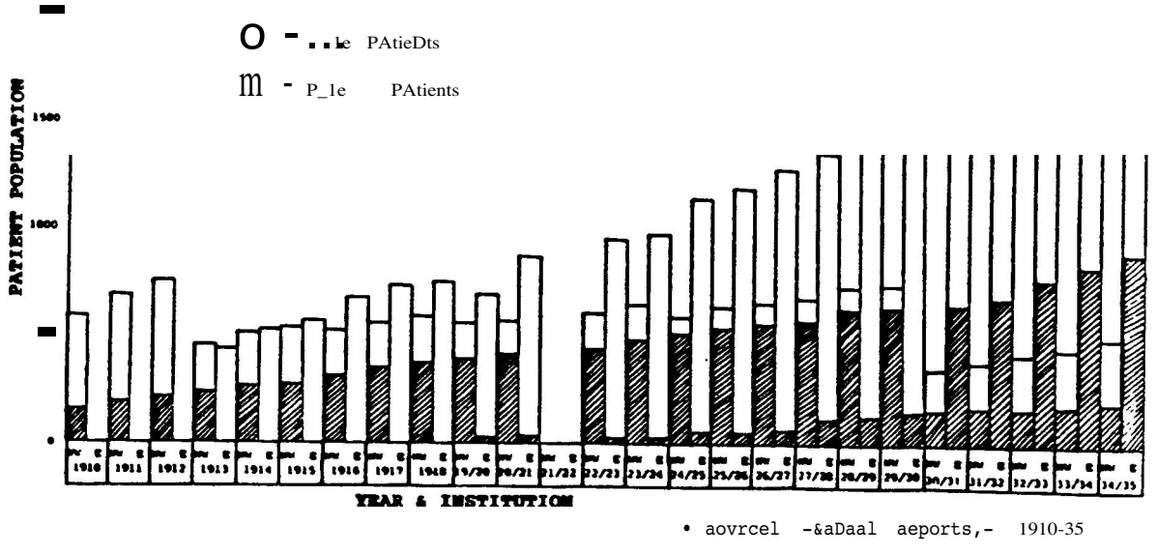
This slow building schedule shaped patient life. Repeated complaints concerning overpopulation at both institutions, particularly during the 1920's and 1930's, indicate that living conditions within the asylums were crowded. Medical superintendent, Dr. H.G. Steeves, argued

8. "Annual Report," 1917, p.I10.

9. "Annual Report," 1921, p.Y8 and "Annual Report," 1924, p.P11.

in both the 1922/23 and 1924/25 annual reports that a building programme was urgently needed.[10] In 1928 the medical superintendent, Dr. A.L. Crease, noted that the female side of the institution was particularly overcrowded, adding that he was looking forward to the completion of the new female chronic Quilding." And even after the new female facility was completed *in* 1930, Crease continued to warn that overcrowded conditions increased the number of acute and chronic cases and created a potentially dangerous situation *in* New Westminster's older non-fireproofed buildings. [12] Figure A shows that admissions increased steadily throughout the period.

PIGURE A: GENDER • PATIENT POPtJLll.TIOIl AT IIDf ~I.S'!'ER • BSSOIIDALE



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10. "Annual Report," 1923, p.Vll-12 and "Annual Report," 1925, p.R14.

11. "Annual Report," 1928, p.X10.

12. "Annual Report," 1934, 010-11.

The written reports of the medical superintendents do not illuminate the gender dynamics of institutional development. Figure A shows that from 1913 to 1930, when the female chronic building at Essondale was ready for occupation, New Westminster was primarily occupied by women and Essondale by men. Although the gender separation between the two institutions was not total, it did create two separate spaces - one male and one female. Female patients at New Westminster lived *in* what was primarily a female world, their contact with men limited to physicians and the occasional visitor or staff members.

S.E.D. Shortt, looking at the London Asylum during an earlier period, writes of an asylum subculture born out of the close, daily contact between attendants and patients, "a relationship doubtless woven of rules broken, punishments dispensed, food *denied* or allocated, or liberties permitted."11 Large numbers of patients meant that routine and organization became crucial to the smooth functioning of the institution.[14] Patients' daily lives, therefore, were circumscribed by a set of institutional codes, implicit and explicit, that related specifically to the internal workings of the asylum community. As I shall illustrate, doctors at New Westminster and Essondale equated mental wellbeing with the ability to cooperate with asylum routine. Thus, asylum routine was as much a means of establishing the authority held by staffpersons as it was a policy of effective and efficient

13. Shortt, Victorian Lunacy, p.49.

14. See Francis, "The Development of the Lunatic Asylum," p.110.

asylum management.

Initiation into asylum routine and a corresponding loss of individuality and freedom began when a patient first entered the asylum. Personal items, such as jewellery and letters, which the patient had brought with him or-her were catalogued and put away, a patient number was assigned, and the patient examined for any bruises or marking - thus absolving the asylum of responsibility for injuries acquired previous to committal. Patients were also given institutional clothing to wear, much of which was made and mended by female patients. The women, we are told in a 1921 letter from the superintendent were "dressed in plain, serviceable, one piece gingham dresses and also ...fully clothed in respect to underclothing."15 Wearing institutional clothing, stripped of any personal belongings and a number rather than a name (for the purposes of the institutional bureaucracy) men and women became patients.

In the last step of the admission process the patient was bathed and put to bed under observation. A quiet, cooperative patient, like Mr. Shannon in 1920, would be "allowed up on the ward," the same day they arrived, while other patients might remain in bed for their first week at the asylum.[16] For instance, Mr. Morgan, who entered the asylum

15. File 5-6, Box 13, B.C. Mental Health Services (Hereafter BCMH) GR 542, Provincial Archives of British Columbia (Hereafter PABC) .

16. Patient '6465, Box 84, Riverview Collection (Hereafter RC), G 042, PABC. All patients' names are fictional and were selected to reflect the ethnic background of the individual named.

in January of 1920, was closeted in a single room and given repeated cabinet baths for three weeks until his behaviour was considered quiet enough for the ward.[17]

The case histories show that the admission routine remained unaltered throughout the period. The process served to begin the institutionalization of patients by taking away individual personal belongings and est~blishing the authority roles of staff and physicians. But, in addition to admittance procedures, there were codes of behaviour particular to the institutional community with which the new patient had to become familiar. New patients learned the importance of complying with the daily routine of the institution, the correct manner of addressing staffpersons, and how to gain the special privileges that would give them more individual freedom. They also discovered that confining patients to their beds was one means of discipline. A series of chart notations, relating to Mr. Morgan tell us that this troublesome patient was allowed to get out of bed only when he ceased being "restless and destructive."[18] Good health, it would appear, was equated with good behaviour: "bad" patients were "sick". Hence, they belonged in bed.

Routine and disciplinary measures served both to maintain order and to affirm the power and authority of staff on the ward. And, as Shortt points out, this process may also have served the important

17. Patient '6209, Box 79, RC, PABC.

18. Patient '6209, Box 79, RC, PABC.

function of differentiating between patients and attendants, two groups of people who shared both the experience of institutional routine and, often, a similar social background.[19] As such, privileges given to cooperative patients or punishments doled out to patients considered "difficult", had an-importance which was only meaningful *in* the context of the asylum subculture. For example, Mrs. Petch's chart notes that "she was demanding certain privileges such as leaving cups *in* her room against the nurse's instruction which accounted for this trouble [tension between the patient and the nursing staff] ."20 Clearly, *in* this case, the cups left where they should not be were less important than disobeying a nurse's instructions: such small rules likely served to underscore *lines* of authority and power within the asylum. Mrs. Wardock was considered a difficult case throughout her stay *in* the asylum because, as her physician noted at one point, "[she] *is* not conforming any better to ward routine, discipline and self control."21

Ward routine was a daily ritual of *rising,* dressing, eating and working, broken on Sunday by church services and visitors. Patients who cooperated with the routine were rewarded by extra privileges which included working off the ward or the freedom to walk in the grounds

19. Shortt, Victorian Lunacy, p.49. Shortt also notes that staff uniforms served to differentiate between staff and patients.

20. Patient '6712, Box 88, RC, PABC.

21. Patient '61964, Box 79, RC, PABC.

alone in the evening or with a party in the afternoon.[22] The common denominator of such privileges was a symbolic or real granting of freedom, privacy and individuality. Such a code of privilege is, of course, a common means of maintaining order in institutions designed to punish or reform inhabitants. Toronto's Mercer Reformatory for women employed similar tactics to those outlined above during the late nineteenth century: good behaviour was rewarded by a transfer to a larger, more comfortable cell.[23] In New Westminster and Essondale the end result of privileged patient status was most often discharge.[24]

By 1920 part of the procedure for disciplining patients had become formalized into what was known as the parole system. Patients, throughout the period, had been released on a probationary system whereby they were discharged into the care of a relative or friend. Under this new set of regulations trusted patients were allowed out of the asylum for limited periods of t~e - an afternoon or a weekend. Thus, Mr. Wright, after one year in Essondale, was allowed to go out on

22. For example, Patient *16209,* Box 79, RC, PABC.

23. Carolyn Strange, wThe Criminal and Fallen of Their Sex: The Establishment of Canada's First Women's Prison, 1874-1907," Canadian Journal of Women and the Law, 1, 1 (1985), p.84.

24. But not always. The best example of this is Patient *12501,* a Chinese immigrant who, although apparently healthy, remained at Essondale from 1910 until 1935 when the Canadian government managed to ship h~ and a number of other Chinese patients back to China in 1936. Throughout this period this patient worked in the asylum laundry. Patient *12501,* Box 25, RC, PABC.

weekends to visit his sister-in-law *in* Vancouver.[25] His wife, who lived *in* Victoria, travelled over from the island each week to visit him.

The case histories suggest that personal space and the freedom to move and make one's own choices were used by asylum staff and physicians to elicit good behaviour among patients. The documents also allow us glimpses into how patients felt when they were thrust into the asylum community. Gerald Grob argues that admission to a mental hospital of this period was a frightening experience:[26] certainly, a sense of disorientation *is* strongly suggested by several of the case histories. An elderly woman, Mrs. Farnom, said after being admitted that "it [the asylum] is all so strange to her."[27] For some patients, the asylum would eventually become a place that approximated home, but many continued to express their dissatisfaction with the asylum. Five months after her admission it was noted that Mrs. Farnom "mixes agreeably with her associates," yet she continued to ask to be released.

New patients likely found the asylum a noisy, busy and rather confusing place. Certainly, many patients were loud. Mrs. Cassini, for instance, sang constantly throughout the day for several months.[28] Similarly, Mr. Little was described as "frequently noisy, destructive,

25. Patient *111222,* Box 170, RC, PABC.

26. Gerald Grob, Mental Illness and American Society, 1875-1940, p.15.

27. Patient *111051,* Box 166, RC, PABC.

28. Patient *16330,* Box 26, RC, PABC.

violent and abusive."[2] Patient responses to the asylum environment varied. Mrs. Petch, after campaigning for months to get released, wrote back to tell her doctor that she missed "all the noise and company" of the asylum.[30] In contrast, Miss Elbridge, a young woman, wrote a letter to one of the asylum doctors while she was a patient, telling him that "This afternoon my nerves were all on edge, and for the racket that was going on in one corner of the room and another, by talking, piano-strumming, and what not, I could have knocked their heads off!"[31]

An initial sense of disorientation may have been resolved when a patient began to establish a place for him/herself within the asylum community. Here, however, the case histories suggest subtle gender differences in adaptation to the asylum subculture. New friendships with other patients, for instance, probably helped both men and women feel at home *in* the asylum. There are, however, considerably more references to female friendship in the documents, likely a reflection of the important role same sex friendships have played in female culture."[32] Mrs. Todd, for example, wrote to tell her husband that she had a new friend "There *is* a little girl here I love very dearly she is the image

29. Patient '2265, Box 26, RC, PABC.

30. Patient '2265, Box 88, RC, PABC.

31. Patient '10700, Box *160*, RC, PABC.

32. Lorettee Woolsey, "Bonds Between Women and Between Men," Atlantis vol 13 no 1 (Fall/automne 1987), pp.116-136.

of my sister v."]) Perhaps, by finding a stand-in for a beloved sister, Mrs. Todd sought to recreate within the asylum a sense of kin and family. [34]

The importance of female friendship is underscored by evidence that such friendships could last beyond the confines of the asylum. In 1931, more than a year after she left the asylum, Mrs. Whitherspoon wrote to a female friend who remained in the institution to say "when you get well enough to go home I want you to come and see us. I have been thinking about you all so much and the happy times we had together. You sure are good company."]~ However, male case histories include no direct references to patient friendships like those of Mrs. Todd or Mrs. Whitherspoon. Onl~ in one case does a doctor note of Mr. Stockton, his patient, that "He *is* a great friend of the other workmen."]'

But the asylum patients did not always come together as friends. On the overcrowded and noisy wards tension could erupt into violence among patients. This kind of behaviour was more common on the male wards, a reflection of the prevalence of violence within male culture. Dr. E.J. Ryan, First Assistant Physician at Essondale, on making his

33. Patient 110746, Box 161, RC, PABC.

34. See Margaret Conrad, "Sundays Always Make Me Think of Home": Time and Place in Canadian Women's History," in B. Latham and R. Pazdro, eds., Not Just Pin Money: Selected Essays on the History of Women's Work in British Columbia, (Victoria: Camosun College Press, 1984), pp.12-13.

35. Patient *111228,* Box 170, RC, PABC.

36. Patient *16247,* Box 80, RC, PABC.

morning rounds in March 1921, discovered that Mr. Boyd had attacked another patient with a broom. Nor was this an isolated occurrence, the doctor noted, for this same patient had previously attacked other patients, "with brooms and anything he can get hands on."3?

A second incident of patient violence is similarly documented. A letter to Dr.Crease, written by a Mr. Fisher, illustrates how tension could escalate on a ward. Throughout one evening, Mr. Green refused to comply with Mr. Fisher's requests for quiet. Mr. Fisher explained that the next morning "he [Green] made a few remarks about me and it led to an argument in which he called me a foul name. We started to scuffle."" This pattern of violence suggests that tension grew as men sought to adapt to an interior, domestic routine which was culturally unfamiliar. Elaine Showalter points out that the atmosphere of mental institutions of this period was emasculating.[39] In the world of the asylum, male privilege was replaced by the kind of powerlessness more common to women than men.

Work was another facet of patient life within New Westminster and Essondale. Dr. Doherty, in his 1912 speech to the American Medico-Psychological Association spoke of the role patients had played in the construction of Essondale. The doctor told his audience that throughout 1908 and 1909 between twenty and sixty-five patients worked to clear the

37. Patient '6117, Box 88, RC, PABC.

38. Patient '6442, Box 83, RC, PABC.

39. Showalter, The Female Malady, p.18S.

Essondale site for building, and stated that "The manner in which our patients took hold of this work surprised me, one patient alone during one month handling 17 tons of blasting-powder."40 And in his annual report of the same year Doherty said that patients were encouraged to work in asylum shops, gardens and at the farm.[41] Dr. C.K. Clarke of the Canadian National Committee for Mental Hygiene and Dr. Farrar of the Dominion Soldier's Re-Establishment Commission (SCR) who visited Essondale and New Westminster in December 1918 on behalf of the SCR found this utilization of patient labour admirable. The two doctors commented in their final report that "The entire history of this institution, brief as it *is*, presents a continuous story of the uses to which patient labour can legitimately be turned."42

Nor was B.C. the only province that used patients as an internal, unpaid labour force. Harvey Simmons argues that by 1900 patient work had become an essential part of the economy of Ontario asylums.[43] In 1925, for example, mentally handicapped men and women at Orillia Asylum supplied other provincial institutions with shoes and clothing made by patients.[44] We do not know what percentage of New Westminster and

40. Doherty, "Treatment of the Insane, "Annual Report," 1913, p.G38.

41. "Annual Report," 1912, G8.

42. File 8384, Vol 217, Inspection Reports of Mental Hospitals, 1918-1920, RG 38, Public Archives of Canada.

43. Harvey Simmons, From Asylum to Welfare, p.103.

44 Ibid, p.105.

Essondale patients worked, but Figure B shows that patient labour brought a significant amount of revenue. Indeed, in 1910 $25,000. in patient-generated revenue is recorded, a quarter of the entire maintenance expenditure for that year. Perhaps this is one reason for the comparatively optimistic tone of the earliest reports of the period for at no later date did revenue from patient labour constitute such a significant proportion of the total costs of running the institution.

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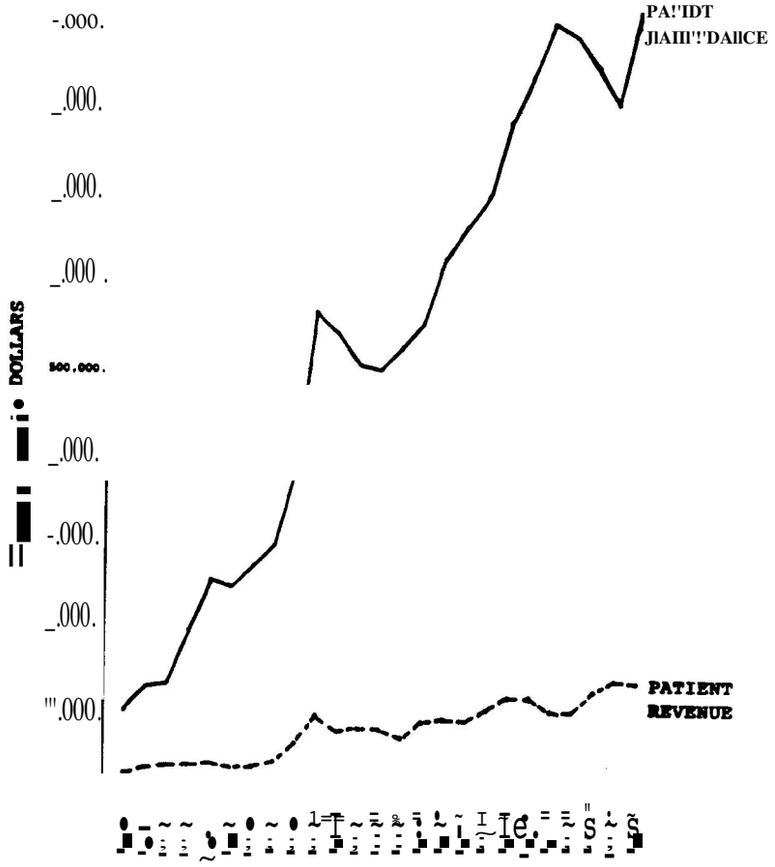

-Source: -AaDual ••porta,- 1934/35, pp. X42-43. %56-57.

The fiscal possibilities of patient labour found a convenient echo in the medical belief that work itself constituted the best kind of therapy for the majority of patients. The idea that work was therapeutic was scarcely revolutionary or particular to B.C. Dr. Richard Bucke of London asylum in Ontario had argued in support of work as a form of treatment since 1876.[45] In B.C., sentiments which brought together medical thought and the belief that those in public institutions should, whenever possible, work for their keep found ready supporters amongst the asylum superintendents and the government administrators. In his 1912 annual report Doherty wrote that both amusement and work were key to the successful treatment of patients.[46]

Yet there wa~ clearly a darker side to the benevolence which Doherty expressed in the 1912 report. Three years later Dr. McKay, the acting superintendent, presented the argument that, in his opinion, most patients did not need medical treatment but "reeducation" through work and amusement.[47] McKay's sentiments were, in fact, an underlying premise of institutionalization. Indeed, English asylums of the earlier period saw it as their mandate to make those who were unable to work functional members of society once again.[41]

But whether Doherty or McKay's articulation of asylum policy most

45. Shortt, Victorian Lunacy, p.131.

46. "Annual Report," 1912,

47. "Annual Report," 1915,

48. Scull, Museums of Madness, pp.40-42, 69.

closely matched the real attitudes of physicians and staff toward patients is moot, for it is clear that, in a fundamental sense, the ability to be a cooperative, industrious worker was equated with good mental health. Mr. Stockton, a returned soldier who entered the asylum in 1920 is one example of how notions of health and industry were entwined.[49] When Mr. Stockton proved to be quiet and cooperative on his ward, he was given a "try-out" with the carpenter. Two months later he was working on a daily basis with the asylum carpenter and, his chart states, "doing very excellent work." By May 1922 Mr. Stockton was allowed to go out to games with Mr. Hall, the carpenter, and he was out on probation the following autumn.

Similarly, the case notes of Miss Peterson, aged fifteen, show that her willingness to work was taken as an indication of improved mental health.[50] Miss Peterson, who was admitted to the asylum by her mother in 1930, worked at the Nurse's Home on the grounds of Essondale until she "told another patient that it would be a very easy place to escape from." She was immediately moved back to work on the ward. One month later, however, we find Miss Peterson at work in the asylum laundry and in another four weeks she was discharged in the care of her mother. Thus, work was seen as part of a patient's progress toward good health.

Certainly, work may have been useful therapy for some patients.

49. Patient '6247, Box 167, RC, PABC.

50. Patient '11206, Box 170, RC, PABC.

Indeed, the short respite from the confinement of the ward which work offered might well have had its own therapeutic value.[51] The case record of Mr. Neillson provides a good illustration of a patient who used his work in the asylum garden as a means of personalizing the institutional environment.[52] Mr. Neillson,a Finnish labourer, entered the asylum in August of 1910 and remained there until his death at age 75 in 1927. Although his physicians continually noted that this patient was suspicious and delusional, a more positive theme within the ward notes is his work as a gardener. On November 13th, 1919 Dr. McAllister wrote that Mr. Neillson "treats the garden as if it were his own place, and makes the most of his tools. He is a good planner." Dr. McAllister clearly perceived this patient's ability and willingness to work as a sign of mental health. More significantly, the ward notes imply that his work in the asylum's grounds gave Mr. Neillson the freedom to plan and direct an activity that was recognizably his own and, hence, provided him with a sense of place and personal responsibility within the institutional community.

Although Doherty, in his 1912 lecture, did not mention if the patient who handled 17 tons of blasting powder was male, it appears that the patient work experience at the asylum was gender-differentiated. In fact, throughout the period under study, descriptions of patient work contained in the annual reports indicate a rigid gender separation

51. Shortt, Victorian Lunacy, p.132.

52. Patient 12705, Box 27, RC, PABC.

within the asylum community, based on male and female labour.[53] While more attention was generally given to work done by men in the annual reports, particularly the activities of the Colony Farm at Essondale, the 1923 report provides a good description of the variety of work done by female patients.

> The lady patients have also been occupied in productive occupations. Some have worked in the vegetable gardens and small fruits. The finishing room in the laundry occupies twenty. The tailor shop provides occupation for a score more, while the occupational room finds from eighty to ninety-five busily engaged everyday. Here much useful work is done ...Nearly 10,000 sheets were made, 100 table cloths, over 1,500 articles of clothing for free patients ...~

Similarly, the annual reports indicate that male patients worked at tasks which would have been considered appropriate for their sex: caring for crops and livestock at Colony Farm and doing maintenance on institutional buildings.

A study of the patient case histories, however, modifies this picture in an interesting fashion. In fact, we find that both men and women often began their work career within the institution by performing domestic work on their own wards.[55] The patient files suggest that those male patients who were either labelled "troublesome" or "seriously

53. Shortt makes this same point about the earlier period at London Asylum in Ontario. His source for this information *is* also the annual reports of the medical superintendent. See Shortt, Victorian Lunacy, p.132.

54. "Annual Report," 1923-24, P12.

55. See Patient *12670,* Box 26, RC, PABC, for an example of a female patient who began working on the ward and then was moved to the tailor's shop. See Patient *16209,* Box 79, RC, PABC for a similar male example.

disturbed" were initially assigned domestic tasks on their wards, work traditionally done by women. Mr. Boyd, for example, who had a reputation for violence on the ward, did ward work during the first four years of his stay at the asylum. By 1925, however, the chart notations of "restless" and "indolent" had been replaced by "content" and "little trouble", and he was working in the laundry.56 Male patients, therefore, were "punished" for difficult behaviour by being made to perform traditionally female work.

Once a patient had proved to be a reliable and trusted worker, he or she was moved off the ward, thereby gaining more physical freedom, a chance to do different kinds of work and new opportunities to meet patients from other wards. It was at this point that gender became a significant variable in deciding what kind of work a patient would perform. Typically, able-bodied and reliable men were sent to work as labourers at the Colony Farm while women performed a variety of domestic chores.

Patient case histories indicate that patient work within the asylum may have had different meanings for men and women. It has been argued that women have historically used familiar domestic rituals to comfort themselves *in* a strange, unknown environment, and it is likely that women at New Westminster and Essondale found solace *in* performing household tasks.[57] Similarly, one would expect male patients like Mr.

56. Patient *16117,* Box 88, RC, PABC.

57. Conrad, "Sundays Always Make Me Think of Home," p.9.

Levesque, who had worked in logging and construction camps in different parts of B.C., to have found comfort through the work he *did* with the "outdoor gang" at Essondale.[58]

Male patients who were not as "quiet and cooperative" as Mr. Levesque and were therefore confined to their wards might, however, have felt very differently about the work which they performed. Certainly, the fact that patient labour was unwaged would not have seemed unfamiliar to most female patients. And perhaps more significantly, the work which male patients at New Westminster and Essondale *did* on the wards, the bedmaking, dusting and cleaning, coupled with the interior, domesticated surroundings and routine of the institution would have been alien and, in all probability, somewhat humiliating for male patients. Gender differentiated patient work *did,* however, serve to reinforce the physical boundaries of the male and female communities at the two institutions. Men, as the case of Mr. Leveque indicates, if they proved to be co-operative patients and were not likely to try and escape, were offered the opportunity of working at masculine occupations outside the asylum buildings - in the grounds or at Colony Farm, the institution's agricultural unit. There was even room for a small number of privileged male patients to live at the farm itself. Outdoor work, therefore, not only gave male patients a chance to work at an appropriately masculine occupation, but it also provided male patients with a greater degree of freedom, even if that only meant temporary liberty from the physical

58. Patient *111238,* Box 170~ RC, PABC.

restrictions of ward life. The work set for female patients, however, restricted their movements to inside the institution or to the close proximity of the asylum fruit and vegetable gardens.

Yet the kinds of work which women performed as seamstresses, canners and laundresses, while limiting their sphere of activity, would also have allowed more frequent and extended opportunities for patient interaction than the work performed by men. Female friendships like the one between Mrs. Whitherspoon and Mrs. Craven who were, the former's chart tells us, "constant companions" likely grew over hours spent hemming sheets and mending clothes.[59]

Thus, we find that the institution was, in part, a replica of the larger society that surrounded it: female patient culture within New Westminster was both bound and shaped by the work which women performed. Margaret Conrad, in her discussion of female culture in the Maritimes, tells us that home, family and gender roles assigned to daughters, mothers, and widows together shaped the female work experience.~ A discussion of the gender divisions of patient labour within New Westminster and Essondale suggests that when home and family were no longer variables, the state served to institute the female gender

59. Patient *111228,* Box 170, RC, PABC.

60. Margaret Conrad, "Sundays Always Make Me Think of Home," p.13.

rOle.[51] What *is* interesting, however, *is* the suggestion that, while female work was static, male defined work was a reward for "wellness", as it was defined by staff and physicians.

Racial stereotypes and individual work experience also had an impact on the kind of work patients were assigned. For example, Mr. Lin, a Chinese immigrant, hospitalized in 1910 and discharged when repatriated to China in 1935, spent twenty-four years working in the asylum laundry, a rather typical occupation for a Chinese immigrant to Canada during the period.~ And, somewhat ironically, Mr. Boyd, who had been a cook at the Vancouver General Hospital until he attacked a maid with a knife, was put to work in the asylum's kitchen.[53]

We are left with an image of an institutional community which had both an evolving physical structure and a lively patient subculture. The growth of the two institutions throughout the period, both in the physical size and in the patient population, likely meant that both communities became more impersonal and routine and discipline more important, and administrators were increasingly removed from the daily lives of the patients. We also know that maleness and femaleness had different meanings within the context of asylum codes of discipline and

61. For a parallel discussion of state inVOlvement in the development of feminine ideology through public education see Barbara Riley, "*Six* Saucepans to One: Domestic Science vs. the Horne in British Columbia, 1900-1930," in Not Just Pin Honey, pp. 159-181.

62. Patient *12501,* Box 25, RC, PABC.

63. Patient *16117,* Box 88, RC, PABC.

privilege and that the experience of women as patients cannot be directly equated with that of men. Central as well to the character of this asylum community was the tension between those in authority who sought to impose order, and the asylum patients whose very presence within the institution was testimony to the irrationality of human behaviour. The following chapter will add a new dimension to this picture by considering the roles played by government administrators, medical superintendents, physicians, attendants and nurses within the asylum community.

CHAPTER 2: STAFF, ADMINISTRATION AND CARE

An analysis of patient life and the process of institutional development provides a framework within which we can conceptualize the experiences of patients at New Westminster and Essondale between 1910 and 1935. But underpinning the lives of patients and the evolution of the two institutions was the work performed by asylum staff and administrators. A discussion of the different roles played by attendants, physicians and government bureaucrats within the internal asylum world is crucial to an understanding of how the patient experience within B.C.'s mental health facilities evolved throughout the period.

The early twentieth-century was a period of significant change for New Westminster and Essondale. The interest of policy makers and psychiatrists became focused on new kinds of patients - those deemed feeble-minded, children, and the families of those incarcerated *in* the asylum. There were moves to create new ~tandards of professionalism *in* the mental health field and to present the twentieth-century asylum as a modern scientific medical facility ~taffed by trained professionals. And, within the asylum, a somewhat paternalistic and flexible ~taff/adrninistrative relationship became more alienated and rigid.

All these changes appear to have made the asylum a more impersonal environment for patients. As this chapter illustrates, the professionalization and medicalization of the twentieth-century asylum and the new policy directions followed by the asylum superintendents and

the Provincial Secretary'~ office meant that individuality, always denied by the very nature of large public institutions, became an even rarer commodity within the growing institutional community.

The office of the Provincial Secretary, across the Strait of Georgia in Victoria; was both a weathervane of public opinion and the ultimate voice *in* policy decisions concerning New Westminster and Essondale. Government administrators responsible for the two institutions had to balance professional advances against public sentiment and fiscal concerns. Indeed, the office of the provincial secretary and the asylum administration had received an early warning of the importance of public opinion when the asylum came under the scandalized scrutiny of the public *in* 1894. Suggestions that patients at the asylum were being mistreated resulted *in* a prolonged inspection of the institutions during October and November of that year by Drs. Edward Suter Hasell and Charles Frederick Newcombe.[1]

In their report the two commissioners roundly condemned the staff of the asylum, and most particularly, Dr. R.I. Bentley, the medical superintendent. Their criticism centred on the extensive use of mechanical restraints and the lack of patient documentation: no record

1. In fact, a second series of visits was necessary because, as the physicians wrote in their report, "the official stenographer who took down in writing the evidence presented at our first examination having disappeared, together with his notes." On each visit the entire premises were inspected and patients and staff interviewed, making the report an invaluable historical document. See C.F.Newcombe and Edward h'asell, The Report of the Commissioners Appointed to Enquire into Cl~rtain Matters in Connection with the Provincial Lunatic Asylum at New Westminster, B.C., File 1, Box 1, GR 482, PABC.

of daily patient care was kept, making it easier for cruelty to pass unnoticed. Although the 1894 commission, and Bentley's subsequent resignation are passed over in most accounts of the institution's history, it *is* likely that a local legacy of distrust and scandal continued to hover over the institution into the twentieth century.2

The provincial secretary's office and the medical superintendents tried to counter this public perception of provincial mental health facilities as antiquated and unhealthy with their presentation of the mental hospital, as it came to be called, as a modern health facility that operated on scientific, medical guidelines. Letters from the provincial secretary's office to the medical superintendent of the asylum show that the former passed on public concerns about the standard of care within the institutions. Although the source of the complaint *is* not always identified, it appears that queries from a member of the Legislative Assembly or from influential public figures were given priority in the provincial secretary's office. For instance, when Captain I.A. MacKenzie, an M.L.A., inquired about an incident of staff-

2. Historical accounts of mental health care in B.C. include Chapter 23 in T.F. Rose, From Shaman to Modern Medicine: A Century of the Healing Arts in British Columbia (Vancouver: Mitchell Press, 1972), and two unpublished papers: Richard Foulkes, "British Columbia Mental Health Services, Historical Perspective to 1961," n.d., Griffin/Greenland Archives, Toronto and B.C. Mental Health Branch, Department of Health Services and Hospital Insurance, "A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia, 1850-1970," 1972, PABC.

Bentley, in his letter of resignation contained in the 1894-95 Sessional Papers (p.659) makes reference to "all the erroneous and damaging statements that have gone broadcast through the country," suggesting that news of the commission was widespread.

patient violence in 1923 and the subsequent dismissal of the attendant, Steeves was requested to, and did, send a full explanation of the incident to the provincial secretary.' Similarly, in 1930 Walker, deputy provincial secretary, commented to Crease on interest shown in the asylum by Dr. Ernest Winch, a C.C.F. member of the Legislative Assembly, "It *is* just as well to let him (Winch) know that we are wide-awake, and constantly conferring, and deciding upon extensions and improvements to the Mental Hospitals and the treatments given therein.,,4 Clearly, Walker wanted to present a positive public image to concerned, and especially influential, citizens.

But how did the government's preoccupation with public opinion influence patient care and treatment within the asylum? Certainly, mental health policy within the province, throughout the period, can be interpreted as a response to broader public sentiment and to events in the external community which altered the public perception of mental health. In an attempt to illustrate that Essondale and New Westminster were scientific, modern mental hospitals, the provincial government shaped asylum policy to address public concerns.

Immigrants, and, more specifically, the mental capabilities of these newcomers were matters which concerned the public and government administrators alike. The two decades prior to World War I brought

3. File 1, Box 14, BCMH, GR 542, PABC.

4. File 7, Box 15, BCMH, GR 542, PABC.

unprecedented numbers of immigrants to Canada.[5] Although new immigrants meant larger markets for Canadian goods, new settlement movements to the west and a larger work force, their presence also created racial tension, both because of job displacement and cultural differences.' Hostility to non-English speaking immigrants, particularly those who came across the Pacific from Asian countries, was especially acute in British Columbia.' Indeed, women's groups in Vancouver during the period expressed their concern over the large numbers of feeble-minded immigrants they believed were entering Canada.'

Medical Superintendent Doherty's annual report for the 1912 calendar year articulated a concern about the mental health of Canada's immigrants which no doubt played into the worst fears of the province's populace. The failure of immigration officials to hire experienced medical personnel to inspect new immigrants at ports of entry was resulting, Doherty wrote, in a "tremendous number" of new Canadians who

5. Immigration totals were 49,000 in 1901 and 146,000 in 1905. The record year was, however, 1913, with 402,000 immigrants entering Canada. Immigration figures are cited from, Robert Craig Brown and Ramsay Cook, Canada, 1896-1921: A Nation Transformed, (Toronto: McClelland and Stewart, 1974), p.179.

6. Donald Avery, "Canadian Immigration Policy and the "Foreign" Navvy, 1896-1914," in M. Cross and G. Kealey, eds., The Consolidation of Capitalism, 189-1929, (Toronto: McClelland and Stewart, 1983), pp.45-73.

7. Brown and Cook, Canada, 1896-1921, p.69. See also W.P.Ward, White Canada Forever, (Montreal: McGill-Queen's Press, 1978).

8. Angus McLaren, "The Creation of a Haven for Human Thoroughbreds: The Sterilization of the Feeble-Minded and the Mentally III in British Columbia," Canadian Historical Review, LXVII, 2, (1986), pp.133-134.

comprised "idiots, lunatics and those suffering from incurable disease."' Furthermore, the 1912 report noted that fully 72% of those incarcerated in New Westminster asylum were born outside Canada and that the province annually paid out $72,800 on this group of the mentally ill.[10]

By 1915, however, the annual reports were focusing on the danger, not just of mentally ill and mentally handicapped immigrants, but of the problems caused by the offspring of such people. The influence of eugenicist and social darwinist thought is clearly apparent in the argument articulated by the then superintendent that, if more care were not taken

> we will have an unlimited number of mentally deficient entering our midst. These will not only be a burden, but their offspring must necessarily be weaklings, as it is as true in the higher as well as the lower animal kingdoms that "like begets like".ll

Significantly, notions of heredity meant that mental illness or mental handicap now called into question the sanity not just of the individual immigrant but also the mental health of his or her entire family.

In addition to trumpeting the danger of allowing mentally *ill* or mentally handicap~d immigrants into the country, the administration kept a keen watch on the racial composition of the asylum population.[12]

9. "Annual Report," 1913, p.G6.

10. Ibid.

11. "Annual Report," 1916, p.L8.

12. Angus McLaren, in his work on the campaign to sterilize B.C.'s feeble-minded, argues that fears of the ethnic vulnerability of Canada's Anglo-Saxon populace was a component of eugenicist concerns. See

took care to specify numbers of patients from the British Empire, the Orient, those born in Canada and "other".11 Cataloguing the racial origin of patients continued to be a feature of the superintendent's annual reports until the onset of the Depression, although from 1925 onwards the reports began to take a less strident tone concerning immigration and mental health.

New immigrants who entered the asylum *also* risked deportation if they had been in Canada less than five years. In 1906 federal legislation was passed to amend the Immigration Act to allow deportation of insane, feeble-minded and epileptic ~igrants. The next year the rate of deportations doubled, seventy-five percent of them based on medical grounds.[14] From the provincial government's perspective, deportation was cheaper than a lengthy institutional stay. In 1923 Dr. Steeves noted that the average time it took to deport a patient was three months, at a cost of approximately $100.00 per patient.15

The patient database, which contains information relating to all patients who came into New Westminster and Essondale during the calendar year of 1910 and the fiscal years of *1919/20* and *1929/30* shows that III

McLaren, "The Creation of a Haven for Human Thoroughbreds, p.134.

13."Annual Report," 1925, p.R9.

14. Henry Drystek, "The Simplest and Cheapest Mode of Dealing with Them: Deportation from Canada before World War II," Histoire sociale-Social History vol xv, no 30 (1982): pp.413-415.

15. "Annual Reports," 1923, p.V9.

patients, among a total of 1375, were deported.[16] Mental health policy concerning Canada's immigrant population, therefore, provided a means by which the asylum staff and the government bureaucracy could demonstrate the important social role played by both asylums and asylum doctors. Institutional physicians like Doherty were able to use public unease over new immigrants to enhance their own professional credentials: only qualified men like themselves would be able to ensure that immigrants were mentally fit. Moreover, by acting as a filter to "catch" and deport those immigrants deemed psychologically unfit, the asylum was able to help ensure that only hard working and productive immigrants remained in Canada.

As has been noted, the post-war annual reports indicate a new and growing focus on the hereditary aspects of mental health and, in particular, a concern about those deemed "feeble-minded". Here again, we find that asylum policy dovetailed with public opinion. Concern over the feeble-minded in Britain dated, in fact, from the turn of the century and Canadian activists such as Ontario's Helen MacMurchy had been campaigning for increased awareness about the feeble-minded since the early years of the twentieth century.17 In B.C. action appears to

16. The deportation of mentally ill immigrants was not, of course, particular to this period. Dr. T.F.Rose in From Shaman to Modern Medicine, p.145 notes that Dr. Bodington was responsible for the deportation of a number of Chinese patients and "on one [undated) occasion even personally escorted a party of twenty-two half-witted ne-er-do-wells, back to their prosperous families in England."

17. Harvey G.Simmons, From Asylum to Welfare, p. 67-71.

have corne somewhat later: in 1914, for example, The Champion, a suffragist newspaper, argued for the sterilization of the mentally unfit.lI It is not entirely surprising, therefore, to see that the first plea for construction of a separate facility for the feeble-minded appears in the 1916 "annual report of Essondale and New Westminster's medical superintendent.[1] Even more striking is the government's response: by 1919, notwithstanding the war and overcrowding among the general patient population, a small building for sixty feeble-minded children had been opened at Essondale and a site selected for a school for "subnormal" boys.~

In this way, early policy development at New Westminster and Essondale concerning the feeble-minded appears to have been directed toward children rather than adults. This focus was in keeping with other developments in social policy during the period, a Provincial Industrial Horne for Girls was established in Vancouver in 1914.[21] Mothers' pensions legislation was brought into effect in B.C. in 1920,

18. Cited in McLaren, "The Creation of a Haven for Human Thoroughbreds," p.133.

19. "Annual Report," 1917, p.I8.

20. "Annual Report," 1920, p.Y8.

21. Indiana Matters, "Sinners or Sinned Against?: Historical Aspects of Female Juvenile Delinquency in British Columbia," in Not Just Pin Money, pp.265-277.

allowing widowed mothers to remain at home with their children.[22] And in Eastern Canada the St. George School for Child Study at the University of Toronto and the McGill University's Day Nursery and Child Laboratory in Montreal were in the forefront of national research in child psychology during the 1920's.[23]

Although they were a secondary rather than a primary focus of concern, adult patients as well were affected by this new focus on the feeble-minded. Because patients considered feeble minded were not always identified as such on their case files it is difficult to assess whether or not larger numbers of mentally handicapped patients were actually coming into the institutions. However, administrators clearly believed that they were dealing with a growing problem. In 1923 the medical superintendent reported that there were one hundred and twenty-five feeble-minded cases in the asylum among a total of approximately 1500 patients.[24] By 1930 the number of patients recognized as feeble-minded had risen to four hundred among 2000 resident patients.[25] For patients, the shifting focus of public interest from immigrants to the

22. Megan J.Davies, "Services Rendered, Rearing Children for the State: Mothers' Pensions in British Columbia, 1919-1931," in Not Just Pin Money, pp.249-263.

23. Veronica Strong Boag, "Intruders in the Nursery: Childcare Professionals Reshape the Years One to Five, 1920-1940," in Joy Parr, ed., Childhood and Family in Canadian History, (Toronto: McClelland and Stewart, 1982), pp.167-173.

24. "Annual Report," 1922/23, p.V12.

25. "Annual Report," 1929/30, p.BB10.

feeble minded to children meant that, if individuals were not included *in* one of these categories, their mental health was largely ignored by policy makers and the pUblic. Geriatric mental health patients and war veterans suffering from "shell-shock", for example, were virtually ignored by the administration throughout the period, whereas patients with drug related problems or venereal disease received sporadic attention. [26] Only a small number of people, most notably Dr. Winch, M.L.A., concerned themselves with the wellbeing of the general patient populace. This kind of public policy may, however, have been crucial to both continued government support and the professional status of the doctors who held medical positions in the two institutions. At a time during which older institutions like New Westminster must have seemed outdated, shaping provincial mental health policy to address the growing national concern with the mental and moral wellbeing of children, immigrants and the feeble-minded likely helped demonstrate the social validity of the two institutions.

By 1930, perhaps *in* response to both the rising statistics of feebleminded patients and concerns about the wellbeing of local children, the asylum had made an even more dramatic entry into the field of mental hygiene. Under the supervision of Dr.Crease, Miss Josephine Kilburn opened the Social Service Department in 1929. Kilburn, a

26. For a discussion of government policy and the mental health of veterans see Desmond Morton and Glenn Wright, Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930 (Toronto: University of Toronto Press, 1987), pp.97-100.

graduate of the new social science course at the University of British Columbia and a former children's psychiatric social worker in Toronto, was responsible for the wellbeing of Vancouver patients who had left, or were leaving, New Westminster and Essondale. But, as she stated in her 1932/33 Annual Report, her primary focus was those patients who were part of a family unit. "Of most vital importance," Kilburn wrote, *"is* the reconstruction of the family along normative home lines, as in making contacts with the remaining members of the family we are touching the larger field of preventative psychiatry."27 Kilburn's assertion of traditional domestic ideology was by no means unique among social workers of the period, for the importance and necessity for maintaining the family unit had been a cornerstone of the profession since the 1920' s.21

Thus, after 1929, patients who were both from the Vancouver area and members of a traditional nuclear family would have had contact with the social services department. For example, Mr. Wright was visited at home by *Miss* Kilburn one month after he was released on probation in

27. "Annual Report," 1932/33, p.L15. This new department expanded rapidly. In 1932 an affiliated child guidance clinic was opened in Vancouver and another in Victoria two years later. The stated purpose of these clinics was to slow the numbers of children entering the provincial mental health facilities by providing physical and psychiatric testing and professional guidance to parents. In fact, of the 129 cases handled in the Vancouver clinic during its first year of operation, only seven came in on a voluntary basis.

28. James Struthers, "Lord Give Us Men: Women and Social Work in English Canada, 1918 to 1953," unpublished paper presented at the Canadian Historical Association, Vancouver, 1983, p.8.

1931. Miss Kilburn's report of her visit indicates that the entire family and their style of living came under the scrutiny of the *social* worker: she took care to note that the family lived in a respectable part of town, had "well kept good furniture" and that the patient's wife was "nicely dressed in a summer dress, clean and well-groomed.[21] The inauguration of the *social* service department meant that the state now had a greater opportunity to influence the course of a patient's post-asylum life than had previously been the case. For patients of the social service department or the child guidance clinic the result may have been intrusive.

But the establishment of the social service department and its offspring, the child guidance clinic, did more than merely prop up the nuclear family. An equally significant aspect of this new kind of care was the fact that eugenicist theory and community mental health fostered the idea that all people, because of a~ost incalculable hereditary factors, were vulnerable to mental illness and that mental illness was more likely to be ongoing than easily cured. These attitudinal changes had two important results. Where before patients had been treated as individuals with particular concerns, they now became the weak link in the eugenic chain and brought suspicion on both their forebears and offspring. Second, and equally Significantly, such manifestations of the mental hygiene movement brought to social workers and psychiatrists renewed professional status and many more potential patients.

29. Patient *111222,* Box 170, RC, PABC.

The significant developments regarding mental health in B.C. _ both in policy and in public opinion - were accompanied by a parallel development in terms of patient and staff experience: the growth of the bureaucratic infrastructure within the asylum. The staff list included in the asylum's 1910 annual report shows that the institution had already developed two lines of staff - administrative and medical - both of which were ultimately responsible to Dr. C.E. Doherty, the medical superintendent. On the medical side, in addition to the medical superintendent, there was an assistant medical superintendent, a matron, a chief female attendant, chief male attendant and an analyst.[30]

The staff listings indicate the importance of non-medical staff within the institution: in 1910, of the nineteen staff listed, only six were medical personnel. Some of these non-medical positions clearly served administrative functions: the bursar and his assistant, the steward and store-keeper. The remainder of the asylum staff were those whose particular craft or skill served a dual purpose within the institution. This group of men, which in 1910 included an engineer, carpenter, plasterer and mason, farmer, gardener, tailor, laundryman and shoemaker, were used both as resident craftspeople and as co-ordinators of patient labour within the institution.

This staff structure remained fundamentally unaltered between 1910 and 1935, although staff lists from the latter portion of the period list new professionals including a social worker, an instructress of

30. See "Annual Report," 1910, p.G4.

nurses, a clinical clerk and an occupational therapist. When Essondale opened in 1913 a duplicate staff was created with Doherty and McKay, then his assistant medical superintendent, overseeing the operation of both institutions. By the 1920's the institutional hierarchy had developed clear lines of command and responsibility. Daily patient care and treatment at this point appears to have rested with the matron and assistant matron or the chief attendant and his assistant. Staff responsibilities show clear gender differentiations with the matron, the female staff member with the highest position in the staff hierarchy, taking charge of food, clothing and other traditionally female work, while male staff were responsible for mechanical chores, the farm and interventionist therapy.

At New Westminster, as in other asylums of the period, the major administrative and medical roles were fused into one position in 1885 when Dr. R.I. Bentley was made medical superintendent. These joint medical and administrative responsibilities meant that, for the medical superintendent of the late nineteenth century, the care of patients came after the administrative concerns of his institution and the asylum farm. Detailed knowledge of patients rested with the assistant physicians and attendants.[31] Nancy Tomes' study of Thomas Kirkbride's tenure as medical superintendent at Pennsylvania Hospital from 1840 to 1883, however, suggests that Kirkbride did maintain a personal interest

31. S.E.D. Shortt, Victorian Lunacy, p.34.

in his patients.[32] But this may simply reflect the difference between care at public and private institutions. At New Westminster and Essondale we can gauge the involvement of medical superintendents with patients by examining the initials of attending physicians on patient casefiles that marked periOdic observations of patients. Physicians began initialling their observations of patients in 1913.[33] Among the sixty-three case files surveyed, there are only three cases, all of them women, in which the medical superintendent personally examined asylum patients - a ratio which is particularly striking when assessed in the light of continuing staff shortages. Thus, we can assume that patients would rarely have had contact with the medical superintendent, although, like Dr. Bucke at the London asylum, it is likely that the medical superintendent made periodic visits to the wards and workplaces of the institutions. Nevertheless, the assistant medical superintendent and assistant and junior physicians wielded considerable power both over the logistical affairs of the institution and over the area of patient care. Certainly, for patients the junior physicians would have been the most accessible.

Each of the three men who served as medical superintendent during the period would, therefore, have been a distant figure of power and

32. Nancy Tomes, A Generous Confidence, p.213-222.

33. Apparently asylum physicians in B.C. began this practice three years after their Ontario colleagues began initialling comments written on patient files. A personal communication from Lykke de la Cour to the author, May 1988.

authority. However, longterrn patients and junior staff would have become familiar, albeit from a distance, with the medical superintendents for each remained with the asylum for a considerable period of time. Dr. Doherty occupied the position from 1905 until his death in 1920. Dr. H.G. Steeves took over in 1920 and ran the two hospitals until December 1926 when he himself died. At that time Dr. A.L. Crease, who had come to the hospital in 1916 to work as pathologist and third physician, took over: Crease was to remain in charge of the two institutions until his retirement in 1950. All three men had been educated in Central Canada, the only place in Canada where it was possible to receive medical training during the *period.*[34] Doherty received his medical education at Trinity College, Toronto, while the other two men were both educated at McGill University in Montreal. Only Crease had done specialist graduate training, spending four years studying medicine and pathology in the United States.

Although it was Doherty's predecessor, Dr. George Herbert Manchestor, who had suggested the establishment of a modern mental hospital, Doherty was responsible for seeing that the land was cleared and the first buildings constructed. This activity, coupled with his presence as a speaker at the 1912 American Medico-psychological Association Annual Meeting, suggest that, if World War I had not

34. The Faculty of Medicine at the University of British Columbia was not, in fact, opened until 1950. See Rose, From Shaman to Modern Medicine, p.164.

intervened, Doherty's personal drive might have brought substantive changes to mental health care in the Province.[35] Nor was a determined character Doherty's only attribute: his lengthy tenure as medical superintendent is likely an indication of the good relationship he enjoyed with government bureaucrats."

Certainly, the provincial government's habit of recruiting medical superintendents from the ranks of those already in their employ meant that government bureaucrats would have had an opportunity to assess the character and capabilities of a potential candidate. Indeed, the ability to administer an institution, rather than skill as a physician, may have been of premier importance to the provincial government. The medical superintendent chosen was inevitably the most senior physician at the institution, never an outsider. In 1920 Steeves, then assistant medical superintendent and with experience running Resthaven Sanitarium for returned soldiers in Sidney, B.C., was chosen over Crease, who had post-graduate training, as superintendent. Both men had joined New Westminster's staff in 1914 and were in their mid-thirties at the time. In 1926, Crease, then assistant medical superintendent, in turn succeeded Steeves.

35. This is also suggested by Rose in From Shaman to Modern Medicine, p.146.

36. Dr.Manchestor, it has been suggested, resigned after four years as medical superintendent because of poor relations with both government and staff, but remained in B.C. as the province's first private psychiatrist and was from 1919 to 1926 psychiatric officer at Shaughnessy Military Hospital in Vancouver.

The fact that medical superintendents were chosen for their administrative rather than medical abilities would clearly have had implications regarding patient care within the two institutions. Promoting from within the institutional hierarchy likely resulted in a stagnation in fo~ of treatment used. Moreover, a corresponding focus on institutional efficiency, rather than treatment and care, would have helped to make their stay in the asylum an alienating experience for patients.

While the provincial secretary stressed the asylum's accountability to the public, the medical superintendent's loyalties were more divided. As chief asylum physician, the superintendent was concerned both with patient care and the status of medical professionals linked to his institution. But, as an administrator, he was responsible to the provincial government for supervising his staff and for the ongoing maintenance of two institutions.[37] The medical superintendent had to meet a whole series of demands. His desire to increase the professional stature of his staff had to be balanced against budgetary constraints and occasional requests for patronage appointments. The majority of the latter demands came from the provincial secretary. For example, in July 1924 Provincial Secretary J.D. MacLean wrote to Superintendent Steeves asking that Dr. Gee, the son of a good friend, be

37. Officially, the Provincial Secretary gave the superintendent full control over his staff - an authority that Dr.Doherty, in 1913, stressed, arguing that it was important for medical superintendent's to be able to dismiss nurses without permission from the Provincial Secretary. See "Annual Report," 1914, p.H7.

taken on staff. Dr. Gee was duly hired.[31] Moreover, the stature of the psychiatric field *in* Canada must have worried the various medical superintendents. During the early years of the twentieth century the field was perceived as marginal and somewhat questionable by many medical practitione~s." Between 1910 and 1935, the medical profession, increasingly regarded as scientific and prestigious, rose *in* status. In contrast, psychiatrists, as they began to call themselves, were tied to institutions that were perceived as archaic and seemingly unable to cure their patients.[40] Consequently, *in* an attempt to increase their professional stature, psychiatrists moved into the new field of mental hygiene. Inevitably, this meant an abandonment of the asylum and its patients.[41]

The story of psychiatry at New Westminster and Essondale throughout the period echoes these wider themes. During the late nineteenth century, *in* spite of the 1894 commission, the asylum superintendent would likely have been a respected figure *in* the West Coast medical community. Certainly, the presence of Dr. G.F. Bodington, who was to become asylum superintendent *in* 1895 at the foun~ing meeting of the Vancouver Medical Association *in* 1886, suggests an image of

38. See File 3, Box 14, BCMH, GR 542, PABC.

39. Grob, Mental Hospitals, p.267.

40. Ibid, p.185-186.

41. Ibid, chapter 10.

respectability.42 By the close of World War I, however, the status of the medical superintendent at New Westminster and Essondale and of his fellow psychiatrists, appears to have become more tenuous. The fact that the parents of an eight year old boy who had come to the asylum for treatment in 1920~ removed their son to take him to Dr. Price, a popular local faith healer, suggests that the psychiatric profession did not enjoy a complete monopoly in the field of mental health at this time.[43] Psychiatrists appear to bave been in a position where they had to demonstrate their relevance to twentieth-century Canadians.

Thus, while they s~ remained linked to the asylum, the institutional physicians appear to have increasingly sought to link themselves with issues that the broader public identified as important. Major policy innovations aIter World War I, such as the development of community mental health programs in the late 1920's, took place beyond the gates of the asylum and likely had little impact on the health and wellbeing of patients themselves. Institutionalized patients ceased to be top priority. Instead. Crease, medical superintendent during the last decade under study, appears to have purposefully promoted both himself and the psychiatLic profession as community psychiatrists. By 1936 Crease was able to present himself as a community expert on the

42. Rose, Shaman to Modern Medicine, pp.101-102.

43. Patient '6388, Box 82, RC, PASCo For a brief reference to the "Reverend Doctor Price" see ~obert E. McKechnie, Strong Medicine, (Vancouver: J.J.Douglas Ltd, 1972), p.1S1. Apparently Price's meetings drew over a thousand believers during the early 1920's.

mental health of children: along with *Miss* Kilburn, Crease was a member of the Committee on Juvenile Delinquency. His report stressed the importance of psychological testing for delinquents.[44]

The dubious status of psychiatry *in* early twentieth-century British Columbia also manifested itself in a continued shortage of asylum physicians. The problem of finding suitable medical staff was of special concern to the medical superintendents, and became particularly acute during and after World War I. In fact, Drs. Clarke and Farrar's 1918 report for the Dominion Soldier'S Re-Establishment Commission (SCR), noted that each of the two institutions, which at that time housed 596 and 751 patients respectively, was being staffed by only two physicians, a ratio of approximately 336 patients per doctor.[45] And *in* 1923 Steeves complained to MacLean about the difficulty of finding young doctors to fill junior assistant physician postings: only men too old for general practice were applying for the job. Steeves suggested that a salary raise to $200.00 a month (likely a raise from $150.00/month) might attract more suitable applicants.[46]

Certainly, for an ambitious young psychiatrist, British Columbia's asylums were not a desirable place to be in 1923. As Gerald Grob notes, by the twentieth-century, psychiatrists were turning away from

44. File 4, Box 9, BCMH, GR 542, PABC.

45. File 8384, Vol 217, Inspection of Mental Hospitals, RG 38, Public Archives of Canada.

46. File 1, Box 14, BCMH, Gr 542, PABC.

traditional asylum work and becoming more interested in studying mental disease in a scientific, medical context - a move which would enhance their professional status by linking them more closely with the medical establishment.[47] B.C.'s mental hospitals, short on staff and space, could hardly be expected to attract the best of McGill and Toronto's medical graduates. Moreover, although the Vancouver medical profession was active throughout the period in public education and was responsible for founding a medical library, the West Coast would not have provided a particularly stimulating professional environment for physicians.[41] Drs. Clarke and Farrar, in their 1918 SCR report, lamented the lack of staff, space and equipment which stifled the development of scientific study at Essondale, and suggested staff be given opportunities to go east to study.4g Subsequent reports from the superintendent show no indication that this suggestion was made into policy.

The transiency of many of the physicians employed by the asylum may also be an indication of the low status of psychiatry during the period. While the war drew several members of the asylum medical staff away, other physicians left to pursue various related career opportunities. The 1915 annual report tells us that Doherty was overseas with the army and Dr. McKay in the position of acting medical

47. Gerald Grob, The Inner World of American Psychiatry, 1890-1940, (New Brunswick, New Jersey: Rutgers University Press, 1985), p.8.

48. Rose, From Shaman to Modern Medicine, pp.101-105.

49. File 8384, Vol 217, Inspection of Mental Hospitals, RG 38, PAC.

superintendent. During 1914, McKay reported, Dr. Steeves had resigned to do similar work.in a private sanitarium. He was replaced by Dr. F.W. Wittich, previously of the Tranquille tuberculosis sanitarium, who left on December 1st to take charge of a private TB facility. McKay then hired Dr. Crease whom, he noted, had spent four years doing research work at Providence Hospital, Rhode Island.[50] McKay himself left New Westminster and Essondale at the close of the war and set up a private asylum, called Hollywood Sanitarium, on Sixth Street in New Westminster. [51] Diagnosis and treatment by physicians at New Westminster and Essondale during the period was also linked to the struggle for a more professional approach to mental health care. Increasingly, the asylum doctors perceived mental illness as pathological in origin, thereby aligning themselves more closely with scientific branches of medicine. What this shift meant, however, is that asylum physicians increasingly ignored the environmental and emotive factors that lay behind the mental illness of their patients. This change is best illustrated by the causes of mental illness listed in the annual reports of the asylum superintendent. In 1910, at the beginning of the period under study, among the thirty-eight causes

50. ftAnnual Report," 1915, p.G7.

51. For a brief history of this facility see Frank Ogden, ftHistorical Outline: Hollywood Hospital, New Westminster,ft unpublished paper, 1964. Millicent Lindo Collection, Add. Mss. 1037, PABC. By the later twentieth-century Hollywood Hospital had become a private care facility for alcohol abusers and was located on the Saanich Peninsula. The buildings and grounds were recently purchased by the University of Victoria.

listed by the superintendent, thirteen related specifically to emotional states or life-situations which could lead to emotional instability. As well, this early report lists a wide range of causes within the emotive range, including bu~iness worry, childbirth, death of husband, solitude and "women", When the causes listed in the 1910 report are translated in percentages of the patients admitted during the year, we find a significant gender difference with seven percent of the male patients listed under emotive causes and twenty percent of the women in s~ilar categories." In the 1920 report, while the percentages of patients listed in similar categories remained constant, the number of factors and situations was reduced to two - traumatic and worry.S]

This trend became more pronounced from the mid-twenties onward when we find that mental illness was rarely linked to emotional wellbeing *in* the eyes of asylum bureaucracy. In 1930, for example, only 1.5 percent of the men and three percent of the women admitted were listed as having an emotional "cause of attack". [54] Instead, mental illness was more frequently perceived as a pathological condition, with cause listed as "constitutional" or "heredity". [5b] While the case histories illustrate that not all patients received an entirely unsympathetic response from asylum doctors, this new focus on the

52. "Annual Report," 1910, p.G45.

53. "Annual Report," 1920/21, p.W24.

54. "Annual Report," 1929/30, p.BB22.

55. "Annual Report," 1934/35, p.X29.

pathological factors behind mental illness likely meant that the emotional concerns of patients were less often acknowledged.

Nor did New Westminster have an historic tradition of the more humane "moral treatment" like asylums elsewhere in Canada and the United States.[5] Richard Fox notes in his study of California asylums between 1870 and 1930, that by the end of the nineteenth-century the large numbers and ethnic diversity of patients made moral treatment impossible.[51] In fact, it was under the management of Dr. Bentley, supposedly a proponent of the moral treatment, that severe abuses of patients took place.[51] The report of two commissioners, Dr. Edward Hasell and Dr. Charles F. Newcombe, who were sent to New Westminster in 1894 to investigate tales of cruelty to patients, shows that even in a smaller institution of the period mechanical restraint, rather than moral treatment, was employed. In their report Hasell and Newcombe stated that "Having on the first day of our visit been info~ed by Dr.Bentley [the then medical superintendent] that ...mechanical restraint was only used by special order and after proper enquiry, we were astounded at hearing patient after patient telling ...of their being tortured to semi-s~rangulation by means of the straight jacket, and of one man having a hand crippled for life by the prolonged use of a

56. Shortt, Victorian Lunacy, pp.128-129.

57. Richard Fox, So Far Disordered in Mind, p.14.

58. George Young, "Perceptions of Insanity: New Westminster Asylum, 1890-1905," Unpublished undergraduate paper, University of Victoria, 1988.

leather "mit". "Si

While the use of both mechanical restraint and moral persuasion as forms of treatment had largely disappeared from B.C.'s asylums by 1910, there was little besides work therapy to replace them. Indeed, although the annual reports of the superintendent outline various forms of treatment used over the time period, the case histories suggest that few patients received any form of interventionist treatment throughout the period. For example, during the pre-war period hydrotherapy was touted as the most successful form of therapy available: over 8000 treatments, or approximately four per patient, were administered in 1911.~ Yet when we turn to the patient case files for an illustration of a patient who experienced hydrotherapy, we can find only one such patient.'l

Similarly, malaria fever therapy, based on the work done by the Austrian psychiatrist Julius Wagner-Jauregg and used frequently in the United States during the 1920's and 1930's, while mentioned in the 1927/1928 annual r~port as a possible, although problematic form of treatment, was not used on one of the sixty-three patients who were

59. Dr.Edward Hasell and Dr.Charles F.Newcombe, The Report of the Commissioners Appointed to Enquire into Certain Matters in Connection with the Provincial Lunatic Asylum at New Westminster, B.C., 1894, p.3.

60. "Annual Report," 1911, p.G10.

61. Patient *16209* (admitted 1920) received cabinet baths following periods of nervous excitement.

studied in detail.[u] There is one intriguing case of a female patient being given an early form of electric shock treatment in 1929, but no mention is made of such therapy in the annual reports of the period.[u]

But for most patients at New Westminster and Essondale the professional evolution of psychiatry likely meant few changes in the way they experienced life in the asylum. With psychiatrists looking outside the asylum for new frontiers for their profession, few mental health patients in B.C. appear to have encountered innovative or interventionist forms of treatment during their time in the asylum. Indeed, while the 1910 to 1935 period, was a time of consolidation and readjustment within the psychiatric profession as a whole - for institutionalized patients of psychiatrists, physicians were custodians of their mental illness rather than a key to wellbeing.

Doctors were .not the only paid asylum staff that underwent an evolution during the period. Due to the inaccessibility of the New Westminster and Essondale administrative records and the dearth of secondary material on asylum attendants, conclusions drawn at this point must necessarily be tentative in nature. But we can, however, see that significant changes took place in the administration's attitude toward, and expectations of, asylum attendants. Professionally educated caregivers, and most particularly nurses, were considered the

62. ftAnnual Report,ft 1911, p.G10. For a detailed history of malaria fever therapy see Gerald Grob, The Inner World of American Psychiatry, pp.104-105.

63. See Patient *110695,* Box 160, RC, PABC.

appropriate people to staff a modern mental health care facility. For attendants, however, the key issues were not education and a professional image but wages and quality of work. It is not entirely clear at what point the shift occurred from the older job of attendant to the modern profession of psychiatric nurse but as these two positions solidified in the postwar period, the earlier employer/employee relationship, which suggests degrees of flexibility and paternalism, was at least partially replaced by a new, more confrontational relationship.

It should be noted, however, that neither collective action on the part of asylum attendants nor administrative attempts to upgrade the status and abilities of attendants were particular to B.C. asylums during the 1920's. Dr. Richard Bucke of the London Asylum, for one, had worked throughout the latter nineteenth-century to promote a new professional standard among his asylum attendants.~ It is reasonable to assume that, in the critical climate that followed the 1894 Commission Report, a similar process occurred in B.C., for the report did focus on staff shortcomings.'s Certainly, Doherty was anxious to stress that attendants of his era were a different breed than those who had previously found employment at the asylum. In 1913 he proudly stated that "the ignorant, shiftless, lazy, eye-serving and sometimes drunken attendant of former days is unknown in this hospital.""

64. Shortt, Victorian Lunacy, pp.43-44.

65. Hasell and Newcombe, The Report of the Commissioners, p. 80.

66. "Annual Report," 1914, p.H7.

Although there is no official record of collective action by asylum attendants before 1919 we can assume that staff at New Westminster and Essondale would have heard that British asylum attendants were beginning to organize in the pre-war period.'1 Indeed, the issues raised by the local branch of the Civil Servant's Association in 1919 and New Westminster and Essondale's local 35 of the Mental Hospital Attendants Federal Union in 1923 were similar to those raised by Britain'S National Asylum Workers Union in 1911." In 1919 the attendants wanted an eight-hour workday while *in* 1923 the New Westminster and Essondale attendants asked for a "living wage" of $125.00 per month and safer working conditions. A union was necessary, they argued in 1923, so that they would be able to present their grievances collectively to the superintendent. Furthermore, the authors of the letter pointed out, a better paid staff would benefit the entire institution, arguing that happy employees "will not only take a much keener interest in their work, but they will in every way possible help the officers of the institution to make it a model one, thus benefiting the patients. n"

67. For a description of early organizational activity among attendants *in* British asylums see Mick Carpenter, "Asylum Nursing Before 1914: A Chapter in the History of Labour," in Celia Davies, ed., Rewriting Nursing History, (London: Croom HeLm, 1978) , pp.123-146 and F.R.Adams, "From Association to Union:Professional Organization of Asylum Attendants, 1869-1919," British Journal of Sociology, 20, (1969), p.11-26.

68. File 3, Box 13 and File 2, Box 14, BCMH, GR 542, PASCo

69. File 2, Box 20, BCMH$_r$ GR 542, PASCo

The administration's response to *union* activity on the part of asylum attendants was less than positive. In 1919, the administration stated that their goal was an eight hour day, yet *in* 1924 attendants were still working at least ten and a half hour shifts.'o In 1923, however, the response was much more dramatic. Two months after Steeves had written to tell MacLean about the demands which his attendants had made, the Provincial Secretary replied. There would be no wage hikes, MacLean told the superintendent. Furthermore, MacLean was convinced that the institution was overstaffed and expected to see a ten percent reduction *in* asylum staff *in* the near future.[71] Seven employees were subsequently laid off. This response may have been the reason why *in* 1929, when Essondale attendants organized once more, they chose to call themselves the Essondale Employees Association, a title less likely to provoke a negative reaction from the asylum bureaucracy.72

Yet the asylum administration cannot simply be portrayed as anti-employee. Indeed, there *is* evidence that, particularly *in* the early years of the period, the bureaucratic arm of the asylum took a paternalistic concern *in* the welfare of their employees. For example, when an employee was killed in a non-work related accident in 1910, three months salary was paid out to his widOW." Similarly, when one of

70. File 5, Box 13, BCMH, GR 542, PABC.

71. File 2, Box 14, BCMH, GR 542, PABC.

72. File 10, Box 20, BCMH, GR 542, PABC.

73. File 5, Box 12, BCMH, GR 542, PABC.

the institutional chaplains retired in poor health in 1922 he was given a "small retiring allowance."[74] A paternalistic employer/employee relationship continued, to some degree, throughout the period. However, there are suggestions that as the institutions grew relations between the administration and staff became more impersonal and less flexible. One illustration of this change is "Campbell's Store", a small convenience store at Essondale which sold cigarettes and other small items. An employee had been permitted to establish the store, probably sometime in the 1910's or 1920's, to raise money to pay for his son's illness. In 1929, with that employee now deceased, staff offered to run the store collectively and put aside profits to help asylum staff in needy circumstances. This informal system of charity which had been acceptable previously was no longer considered appropriate and their request was denied.[75]

In addition to allowing their paid staff less flexibility, we also find that the administration increasingly equated professionalism with education and appearance: an ideal attendant or nurse was schooled in the skills of scientific medical care and presented a professional image whieh echoed that of the general nursing profession. Thus, in 1921 both male and female "nursing staff" were issued with uniforms, which likely served both to reinforce

74. File 6, Box 13, BCMH, GR 542, PABC.

75. File 10, Box 20, BCMH, GR 542, PABC.

staff authority and present an image of a modern medical hospital.[16]

It is interesting, as well, to note the use of the term "nurse" to describe both male and female attendants in the piece of 1921 correspondence previously cited. Probably, as in the United Kingdom, this was an attempt-to link attendants with the increasingly prestigious and dynamic nursing profession.[17] In B.C., the Graduate Nurse's Association won thier campaign for registration in 1918, and by 1924 women wanting to become nurses in B.C. had to have completed two years of high school and taken training at an accredited school of nursing before they could be certified. The professionalization of nurses was also taking place on a national scale. Between 1929 and 1931, Professor George Weir of the University of British Columbia conducted a landmark survey of nursing education across the country. The published results of Weir's work, which dealt with training, professional standards and curriculum, did much to establish nursing as a creditable profession in Canada." In keeping with developments at other provincial asylums,

76. File 2, Box 13, BCMH, GR 542, PABC.

77. Carpenter, "Asylum Nursing Before 1914," pp.135-137 argues that British asylum attendants sought to associate the~elves with the larger nursing profession.

In B.C., the Graduate Nurses's Association won their campaign for registration in 1918, and by 1924 women wanting to become nurses in B.C. had to have completed two years of high school and taken training at an accredited school of nursing before they could be certified. For more information about this process see Jo Ann Whittaker, "The Search for Legitimacy: Nurses' Registration in British Columbia, 1913-1935," Not Just Pin Money, pp.320-321.

78. See George M. Weir, Survey of Nursing Education in Canada, (Toronto: University of Toronto Press, 1932).

Essondale established its own diploma program for nurses in 1930." Under the direction of Miss Hicks, the Supervisor of Nurses, the institution offered a three year course with intensive instruction in mental health nursing and another six month post-graduate program for nurses trained at a general hospital. [80]

For both female nurses and male attendants at New Westminster and Essondale moves by the a~~nistration to create a more professional staff brought new pressure to conform with the administration's idea of professional, and therefore appropriate, staff behaviour. While education was increasingly seen as important, so too was a more nebulous criteria of "professional conduct". Steeves, in a 1923 letter to MacLean, then Provincial Secretary, explained that M.R. Lehoux, a holiday relief attendant, had not been kept on permanently because he was "altogether too uneducated and uncouth to be a satisfactory attendant."[81] Similarly, asylum nurses were also expected to behave in a manner in keeping with their new professional status. When Miss Jane Russell was relieved of her duties in 1929 it was the result of "conduct unbecoming to a nurse," perhaps an indication of the new expectation

79. Similar programs had been started elsewhere in Canada by this time. For example, the School of Nursing affiliated with Brandon Mental Hospital in Manitoba began giving lectures in mental health nursing in 1921. At Ponoka, Alberta, instruction began in 1930. See John Murray Gibbon and Mary S. Mathewson, Three Centuries of Canadian Nursing (Toronto: MacMillan, 1947): 387-417.

80. "Annual Report," 1930/31, p.LI0.

81. File 1, Box 14, BCMH, GR 542, PABC.

placed on asylum nurses.[12]

However, the records note few dismissals similar to Miss Russell's. More frequently, women left the employ of the asylum for marriage, indicating that New Westminster and Essondale were sources of employment for young, unmarried women.13 What is less clear is whether, in a bid for a more professional nursing staff, the asylum administrators sought or were able to employ middle class, rather than working class, women as nurses. As Jo Ann Whittaker notes in her study of nursing registration in B.C., after 1924 the new provincial requirement of two years' high school education for nurses would have made nursing a difficult profession for working class women to enter.[14] Yet if Canadian asylum nursing had the same low status among the general nursing profession as did British asylum nursing, it is possible that New Westminster and Essondale continued to hire working class women as nurses throughout the period.

Nevertheless, the administrators at Essondale and New Westminster probably looked for staff who were young, educated, professional and committed to their work. Crease wrote to the Provincial Secretary in 1924 that it was customary to employ staff aged thirty-five or

82. File 10, Box 20, BCMH, GR 542, PABC.

83. This also appears to have been the case with nurses at the Vancouver General Hospital. See Nora Kelly, Quest for a Profession: A History of the Vancouver General Hospital School of Nursing (Vancouver: Evergreen Press, 1973), p.16.

84. Whittaker, "The Search for Legitimacy," p.320.

younger.'S An application form used in 1927 shows that prospective employees were asked to provide details about their educational background and work history and to give two character references." As well, the administration was interested in whether the applicant was a British subject, either by birth or naturalization and if *slhe* had served in the First World War." It appears that the administration had a policy of hiring attendants who were ethnically British, perhaps because of the province's close ties with the United Kingdom: a 1924 list of male and female attendants shows that, among the 142 listed, less than a handful did not possess Irish, English, Scottish or Welsh surnames. ''

Yet in spite of administrative attempts to hire well educated, professional caregivers, studies of British asylum attendants of the period tell us asylum work was neither financially remunerative nor satisfying and therefore attracted many who simply could not find jobs elsewhere." Yet even given the low status of asylum work and the poor job conditions, men at New Westminster and Essondale were able to make considerably more money than their female co-workers. Documents available from New Westminster and Essondale tell us that there were

85. File 7, Box 14, BCMH, GR 542, PABC.

86. Ibid.

87. Ibid.

88. Ibid.

89. Carpenter, "Asylum Nursing before 1914," pp.134-136.

large differences in the salaries paid to male and female staff. A 1921 report states that male nurses earned a monthly salary that ranged between $68.00 and $85.00.~ Female nurses earned considerably less, from $40.00 to $60.00 per month.'l In addition, no woman was allowed to continue working as an asylum nurse if she was married: even widows were not considered suitable employees.

For unmarried staff, life at the asylum must have been fairly cloistered. A 1924 report states that both female nurses and single male staff were required to live in the hospital and, unless they had special permission, were expected to be in the building by 10:30 p.m. at night.'2 AS well, we find that working hours for all staff were long in 1924: day staff worked from 6:30 a.m. until 6:30 p.m. with one and three quarter hours off for meals, while the night shift lasted from seven p.m. to 6:30 a.m.[n] All employees worked a forty-eight hour week, with two weeks annual paid vacation.

While the lack of administrative records makes it impossible to ascertain whether these rules remained consistent throughout the period, long hours, living in, and the geographic isolation of the two

90. File 1, Box 13, BCMH, GR 542, PABC.

91. Ibid.

92. File 3, Box 13, BCMH, GR 542, PABC.

93. These hours of work are comparable to the hours of student nurses at the Vancouver General Hospital during the same period. In 1917 student nurses at that institution worked from seven a.m. to seven p.m. with one or two hours off during the day for meals. Kelly, Quest for a Profession, p.35.

institutions would have meant that nurses and attendants at Essondale and New Westminster were as isolated from the wider society as the patients for whom they cared. The sense of frustration that this kind of confinement likely created *is* reflected in one story of patient/staff violence which occurred in 1923. Steeves reported to the Provincial Secretary that a sixty-three year old male patient had "attempted to force his way past the attendant while he was standing at the ward door," and had received a blow to his jaw and a fractured rib.[M] The other attendant on duty, Steeves wrote, "claims he was attending another patient ... and saw very little"'5 Notwithstanding this gesture of staff solidarity, and taking into account the testimony of an old and trusted patient, the attendant in question was dismissed.

This tale of ward violence harkens back to the era of Dr. Bentley and the 1894 Commission of Inquiry. Yet the world of the asylum had undergone considerable change in the nearly thirty years which separated the two incidents. Government administrators and the new mental health professionals expanded the horizons of psychiatric medicine well beyond the gates of the asylum and redefined mental health **as** pathological rather than emotional or environmental in origin. The elements of flexibility and paternalistic individuality which had previously characterized the relationship between staff and administers had been replaced by a more impersonalized situation. For patients at New

94. File 1, Box 14, BCMH, GR 542, PABC.

95. Ibid.

Westminster and Essondale, the full impact of these changes would not begin to be felt for another decade or more, when electric shock treatment, the frontal lobotomy and psychosomatic medication would become, in the hands of the psychiatric profession, the ultimate tools of impersonal alienation.

CHAPTER 3: ZNTERrNG AND LEAVJ:NG THE ASYLUM

The sixty-six patient case histories garnered from the archival collection of Easondale and New Westminster papers present a kaleidoscope of personal circumstance: men and women entered the asylum for a multitude of reasons, stayed for varying periods of time, and died or left the asylum. We find, however, that these tales, colourful or pathetic, take on a more comprehensive structure when set within the context of information compiled from a database of patient information. Statistical findings, used along with the patient case histories, show that gender, education, occupation and the region of the province which patients came from all influenced the circumstances under which patients entered the two institutions, how long they stayed and how, and if, they left the asylum. Equal numbers of patient case files, totalling sixty-six in number, were selected at random from each of the years studied. When a patient entered the asylum, an effort was made to obtain a brief life history and a more detailed summary of events which had occurred just prior to committal. Of course, the kind of information gathered in both these instances was highly coloured by the asylum staff's own opinions concerning mental health and patient lifestyles. Nonetheless, this biographical information can be used to flesh out the statistical information provided by the patient database which I have constructed.

For the patient database, three target years were selected, the calendar year of 1910 and the fiscal years of 1919-1920 and 1929-1930, and every patient who entered the asylum during those years was included

in the database. In total, information was entered concerning 406 women and 963 men, enabling me to run statistical tests relating to duration of stay, death and recovery rates, and committal and discharge patterns.

Historians who study patients in mental health facilities have generally noted the ·familial context of mental illness.[1] The case histories of the women who entered New Westminster and Essondale support this interpretation: the links between the emotional distress of women and their family situations are well documented, as is the crucial role played by the family in both committal and release. The male case histories, however, show that male committals were more closely linked to the workplace and other public settings. Yet gender was not the only factor influencing the committal and confinement patterns of mental health patients in B.C. Well educated men and women stayed in the asylum for shorter periods of time and were less likely to die when resident in New Westminster or Essondale. Occupation level appears to have been less significant. The statistical data indicates that occupation did not have a dramatic impact on release patterns, although seasonally or marginally employed men did tend to spend longer periods in the asylum and were most likely to be committed by an agent of the state. This chapter will move from an exploration of the gender dynamics of mental health care to a discussion of how educational and

1. See Wendy Mitchinson, wGender and Insanity as Characteristics of the Insane: A Nineteenth-Century Case," p.114. See also J.K. Walton, "Casting out and bringing back in Victorian England: pauper lunatics, 1840-70," in W. F. Bynum, Roy Porter and M. Shepherd, eds., The Anatomy of Madness, Vol. II, (London: Tavistock Publications, 1985), p.139.

occupational status may have affected length of stay and circumstances of committal.

Although there is little difference in the ages at which men and women entered New Westminster and Essondale, the case histories suggest that gender was the -major factor in shaping the circumstances under which patients entered Essondale and New Westminster. Emotional conflicts experienced by male patients often appear to have direct links with poverty and public misbehaviour. Male case histories indicate that male emotional disturbances can only be linked to one specific transitional point in the male life cycle - old age and retirement from the paid workforce. In contrast, we find that women's emotional wellbeing a~ost invariably centred around the family and that female emotional distress was linked to particular points in the female life-cycle - childbirth and old age, for example. This phenomenon underlines the need for historians to visualize women's lives as a series of "roles" or phases.[2]

Young, unmarried women who were unhappy at home, women who had just given birth, depressed or disadvantaged middle-aged women, and

2. See Gerda Lerner, "New Approaches to the Study of Women in American History," in Bernice A. Carroll, ed. Liberating Women's History: Theoretical and Critical Essays (Urbana: University of Illinois Press, 1976), pp. 349-356. For a Canadian example of the lifecycle approach see Gail Cuthbert Brandt, "Weaving It Together: Life Cycle and the Industrial Experience of Female Cotton Workers in Quebec, 1910-1950," in A. Prentice and S.Trofimenkoff, eds., The Neglected Majority, Vol. II. Contemporary feminist scholars have written more Sf.H_™: ifically about health and the female life cycle, see Maggie Scarf, Unfirished Business: Pressure Points in the Lives of Women (New York: Dour :~day, 1980.)

older women who had no one to care for them all comprise typical female committals throughout the period. Miss Elbridge, a woman of twenty-seven years of age *is* one example of a young unmarried woman whose homelife appears to have been fraught with tension and emotional stress.[3] Her case notes tell us that there was animosity between *Miss* Elbridge and her brothers and sister and that the relationship between the patient and her mother was particularly difficult. *Miss* Elbridge's doctor's notes claim, that *Miss* Elbridge "at times wants to kill them [her family]." Indeed, three days before she entered the asylum, Miss Elbridge had written to her doctor suggesting that what she really needed was time away from her family. "Would it be a good idea," Miss Elbridge wrote, "and could it be done, to take a room in some quiet hotel, apartment, or house , and endeavour to sleep for a week or two?"

The case of Miss Peterson, a young woman of fifteen, suggests several parallels to Miss Elbridge's case.[4] With the patient's father ill with tuberculosis and absent at Tranquille Sanitarium in the interior of the province, tension appears to have focused on the mother-daughter relationship. Miss Peterson's mother told the doctor that "she can do nothing with the patient for she is very indifferent and sullen to commands. At times (she) has been destructive at home - throwing articles about the room in a purposeless manner." Yet in spite of the

3. Patient '10700, Box 160, RC, PABC.

4. Patient '11206, Box 170, RC, PABC.

difficulties posed by an absent husband and an adolescent daughter, it does not appear that committing her daughter was an easy decision for Mrs. Peterson. Three months after Miss Peterson had entered Essondale her mother wrote a letter to the superintendent saying "It was a great blow to myself and husband to put my Daughter at Essondale."

Compared to Miss Peterson's situation, Miss Elliot's case history provides an illustration of how emotional distress experienced by young women within the family setting might be expressed through withdrawal rather than anger. This young woman was eighteen years old at the time of her committal and had lived in Lethbridge, Alberta until her parents moved to Victoria "on account of her [their daughter's] mental condition."[5] Miss Elliot's doctor noted that "about the beginning of the new year, her mother first noticed that she did not have any interest in her usual work and that she was very moody, and would cry at the least little thing ..." A failed suicide attempt appears to have convinced her family that Miss Elliot had to be committed: she remained in the asylum for seven months.

There are both similarities and differences between the emotional distress suffered by the women whose lives are outlined above. The articulate, rather analytical explanations of what troubled her that Miss Elbridge offered to her doctor are very different from the sullen rage of Miss Peterson or the tearful despair of Miss Elliot. Yet all three case histories suggest that the period between adolescence and

5. Patient *12595*, Box 26, RC, PABC.

independent womanhood (marriage for most women of the period) could be a time of considerable emotional distress for many women and tell us that the setting for this drama was most often the family home.

Single women, however, were a minority group among the female asylum population. Throughout the period only 29.9 percent of the women who entered the asylum were unmarried.' In contrast, we find that fully 55.1 percent of female patients were married at the time they became residents.' Certainly, these figures indicate that marriage in the early twentieth-century was often less than ideal for women. Veronica Strong-Boag argues that, for housewives, this was a period of growing isolation in the home, fatiguing housework and increased responsibility for maintaining their family's emotional equilibrium.' Added to these general factors were the demands made on wives and mothers by specific events - immigration to a new land, the care of mentally unstable World War I veterans and the economic devastation of the Depression years. In such cases we can assume that women played a significant role in holding

6. Source: Patient Database.

7. Source: Patient Database. These figures are consistent with Mitchinson's work on patients at the Toronto Asylum during the nineteenth century: Mitchinson found that 39.7 percent of the women she studied were single while 51.4 percent were married.

8. Veronica Strong Boag, The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939 (Toronto: Copp Clark pitman, 1988), pp. 92-95. See also Meg Luxton, More Than a Labour of Love, (Toronto: Women's Press, 1980), pp. 46-49.

their families together.' And in British Columbia the resource-based, seasonal nature of the workplace also made stable relationships difficult to maintain .10

The case histories of married women at New Westminster and Essondale reflect both wider themes of isolation, bad marriages, hard work and poverty and more specific incidents that are clearly linked to post-partum depression." Today, motherhood is regarded as a major and potentially traumatic time of transition for women. Contemporary researchers now acknowledge that the new burden of responsibility and the stress of giving birth and coping with a new baby, often in an isolated setting, can lead to postpartum depression among new mothers.[12] Although historical literature on this subject is very rare, it is clear from the considerable numbers of women who entered the asylum following the birth of a child that the onset of motherhood was also a time of

9. See Strong Boag, The New Day Recalled, p.93 and John Herd Thompson with Allan Seager, Canada,1922-1939: Decade of Discord (Toronto: McClelland and Stewart, 1985) p.211-213.

10. See Rolf Knight, A Very Ordinary Life, (Vancouver: New Star Books, 1974), an autobiographical account of a woman who was married to a transient worker in B.C. during the period. Knight often lived apart from her husband or in makeshift accommodation: they were not able to purchase a home until 1942.

11. See, for example, the letters from Daisy Phillips, a newly married Englishwoman who settled in southeastern B.C. just before World War I. R. Cole Harris and Elizabeth Phillips (eds), Letters From Windermere, 1912-1914 (Vancouver: University of British Columbia Press, 1984) .

12. See Jean A. Ball, Reactions to Motherhood: The Role of Post-Natal Care (Cambridge: Cambridge University Press, 1987).

emotional stress for Canadian women in the early twentieth-century.13

Mrs. Todd provides one example of a postpartum patient who entered the asylum during the period under study.14 Age twenty-one, Mrs. Todd had just given birth to her first baby in the Vancouver General Hospital. Mrs. Todd appears to have had a painful and perhaps difficult childbirth for her case notes tell us that she had twelve stitches at the birth. Following her baby's birth, Mrs. Todd, according to her doctor, "escaped from bed - ran to window with a mere sheet around her" and tried to throw herself out of the hospital window.

The case history of Mrs. Marland, who had come to Canada as a warbride eighteen months previously, shows how stress relating to the new responsibilities of motherhood could be compounded by isolation from kin and friends. 15 When she entered the asylum Mrs. Marland told the doctor that "I was .very nervous when my baby was born; worried a good deal ... When I went home I was very nervous. The baby was small and I thought I could not handle him very well."16 Mrs. Marland remained in the asylum for nine months and then returned to her home.

13. Charlotte MacKenzie notes that one patient at the Ticehurst Asylum in England during an earlier period suffered mental breakdowns following childbirth or miscarriage. See "Social Factors in the admission, discharge and continuing stay of patients at Ticehurst Asylum, 1845-1917" in The Anatomy of Madness, vol. II, p.156.

14. Patient '10746, Box 161, RC, PABC.

15. Georgina Taylor, "Shall I Drown Myself Now or Later?" in Kathleen Storrie, ed., Women, Isolation and Bonding, (Toronto: Methuen, 1982), pp. 79-100.

16. Patient '6445, Box 84, RC, PABC.

The number of women who entered the asylum following the birth of a child is noteworthy. Among the twenty-two case histories of women who were in their child bearing years which I collected, eight suggest that postpartum depression may have led to committal. The fact that childbirth often took place within the first year following marriage means that some post partum patients may also have been responding to the new demands of marriage.

But new mothers were not the only women to feel emotional stress relating to their maternal role. We find that married women of any age found themselves unable to cope with the emotional and physical demands placed on them, a situation that was often compounded by the loneliness of their lives.17 The case of the thirty-eight year old Mrs. Otter, the wife of a barrister and mother of one thirteen-year-old child who entered the asylum in November 1929, provides one example of how wives and mothers could find their role as emotional caregivers unbearable.lI Mrs. Otter's doctor wrote on her chart that his patient "tells me that for some time past she has had a strange feeling at times which frightens her in that her love for her family and especially her daughter, seems to have left her. At othertimes she feels impelled to do them bodily harm and for this reason, she felt that she must get away

17. See Taylor, "Shall I Drown Myself .." and Rolf Knight, A Very Ordinary Life.

18. Patient *111054,* Box 167, RC, PABC.

from her family.n[19] Mrs. Otter's husband informed the admitting doctor that his wife had not been well since early in the year and that her mental illness had manifested itself in a loss of identity, depression, threatened suicide and running away from home. The words of Mrs. Otter suggest that middle aged women like her may have found the maternal role a difficult burden.

The female case histories show that marriage could also bring women money worries, marital problems and exhaustion from household labour - any of which could lead to them being institutionalized. The economic vulnerability of women at this period in their lives is illustrated by a number of cases. Mrs. Roberts, for example, entered the asylum three times.[20] Her case history suggests that on each occasion her committal was directly linked to the fact that she had either been abused or abandoned by a husband who had several times left her and their children destitute. It is, of course, difficult to tell how common such abuses were. Strong-Boag notes that women of this period were under considerable societal pressure to continue to stay within their marriages, no matter how brutal their circumstances.[21]

In addition, the case histories of married female patients frequently indicate that they were simply weary of performing housework. Mrs. Mallet,age forty-six and married with three children, told the

19. Ibid.

20. Patient '6384, Box 82, RC, PABC.

21. Strong Boag, The New Day Recalled, p.97-99.

doctor who signed her committal forms in 1910 that, "she was badly run down and that she thought it best to return here for awhile." [n22] Mrs. Turkington, three years her junior, who was committed in 1910 had simply refused to perform any cooking or cleaning for the past month. Signed in by her undoubtediy hungry son, she would remain in the asylum for two months.[23]

The sixteen case histories for married female patients in or approaching middle ·age, therefore, suggest that emotional stress for women of their age group was rooted in their familial roles as emotional caregivers and domestic workers and exacerbated by their financial dependence on the family's male wage earner. As such, entry into the asylum can be seen as an opportunity to escape the physical and emotional demands of home or as a punishment for failing to meet the expectations of their husbands and families.

The tales of the elderly women who carne into the asylum as patients illustrate how, in a period preceding the development of specific homes for the aged, the asylum served to accommodate the elderly who had no other place to live." Strong-Boag notes that, before 1915, one of the few places for Vancouver's indigent aged were

22. Patient '2778, Box 27, RC, PABC.

23. Patient '2675, Box 26, RC, PABC.

24. Although the admission records do not show a drop in committal rates of the elderly after provincial Old Age Pensions were in introduced in 1928, this state support must have eased the living situations of elderly people. See Strong Boag, The New Day Recalled, pp. 186-188.

the public wards of Vancouver General Hospital.[25] After 1915 the city established a home for the aged which offered dormitory accommodation.[26] Nonetheless, throughout the period under study Essondale and New Westminster continued to care for the elderly.

As the case histories illustrate, the family played a crucial role in maintaining aged women in their home.[27] Mrs. Farnom, for example, was approximately sixty years old when she entered the asylum in November, 1929.[21] A resident of a small town in the interior of the province, Mrs. Farnom had emigrated from Scotland twenty years previously and come with her husband to farm in B.C. Mr. Farnom was still alive when his wife entered the asylum but told the authorities that, with no children or kin to assist him, he could no longer take care of his wife. Although Mrs. Farnom was diagnosed in 1930 by asylum doctors as "not insane", she had to wait until 1936 until arrangements could be made to transfer her to a home for the aged.

Mrs. Petch's case provides another example of the crucial role that family played in providing shelter for elderly women in early

25. Strong-Boag, "Living," in The Working Lives Collective, Working Lives: Vancouver, 1886-1986 (Vancouver: New Star Press, 1986), p.89.

26. Ibid.

27. See Jane Synge, "Work and Family Support Patterns of the Aged in the Early Twentieth Century," in Victor Marshall, ed., Aging in Canada: Social Perspectives (Don Mills: Fitzhenry and Whiteside, 1980), pp. 135-144.

28. Patient t11051, Box 166, RC, PABC.

twentieth century B.C.[29] In January of 1921 Mrs. Petch's daughter was out of town and her niece tired of dealing with her aunt's extravagant propensity for buying dry goods and items of furniture at various Vancouver shops, and then forgetting about her purchases. Somehow Mrs. Petch ended up in jail and from there was committed. She spent fifteen months in the asylum, but unlike Mrs. Farnom had family who were willing to sign her out and provide her with a home.

Elderly women who came into the asylum throughout the period shared similar characteristics. Without exception, they became patients when their familial support system ceased to function. Moreover, the differences between the two cases show that we can perceive the asylum as playing two roles in the lives of elderly British Columbians during the period: the institution could provide a temporary place of refuge during a time of crisis, as in the case of Mrs. Petch or, for women like Mrs. Farnom, entry into the asylum might mean that the elderly individual would be forced to spend the rest of his or her life in an institution. Furthermore, although there is little mention of financial matters in the case histories of these women, it is fair to assume that elderly women who lacked the financial resources to maintain themselves in their own dwellings would be vulnerable to institutionalization.

The fate of destitute or unsupported elderly women who entered the asylum is perhaps the most stark illustration of female vulnerability provided by the women who were patients at New Westminster and

29. Patient t6712, Box 88, RC, PABC.

Essondale. Certainly, articulation of emotional distress was most often the reserve of the middle-aged, the young mothers and the unmarried. Yet the common characteristic that is shared by the majority of the case histories of women who entered the asylum during the years under study is the key role played by family. We see that the family was a catalyst for the emotional distress experienced by women and the home the setting for this drama.

Male patients who came into New Westminster and Essondale between 1910 and 1935 contrast sharply with their female counterparts. Few men entered the asylum because of family conflicts. Instead, the case histories tell tales of business worries, violence, incidents at work, public mischief and poverty. Moreover, apart from the fact that old age often meant economic hardship, and hence a reliance on public institutions for labouring men, there appears to be no evidence to suggest that male committals were linked to specific life stages.

The case histories of male patients are illustrative of a male culture in the western province that was centred on the public world of business, the workplace and the beer parlour. Indeed, married men rarely entered the asylum as patients: only 28 percent of the total male population ~urveyed were married, a figure significantly lower than Mitchinson's figure of 41.6 percent for the earlier period in Ontario.[30] The B.C. ~tatistics may reflect the resource-based nature of the provincial economy and the fact that Vancouver and New Westminster were

30. Mitchinson, "Gender and Insanity," p. 106.

port cities with transient work forces.[31] Therefore, instead of being linked to family-centred conflicts, we find that incidents which brought men into New Westminster and Essondale were strongly symptomatic of male culture and the structure of the British Columbia economy.

The case of Mr. McAllister, for instance, provides an illustration of the significant roles played by money and power in the construction of male self identity.32 Mr. McAllister was 58 years old and had worked in the construction and wood processing industries. In January 1910, however, police in Hedley reported that Mr. McAllister had been acting strangely." First, he hired a team of horses and followed an imaginary criminal to Princeton, twenty-five miles distant. Next, acting as agent for an eyeglasses company, Mr. McAllister "gave away 20 pairs of spectacles in the district after having paid $80. for the output." Such irresponsible behaviour would likely have been difficult for the local community to accept, yet it also reflects links between money, power and male identity.

Work-centred incidents were also common. Mr. Boyd was sixty-nine years old and a kitchen worker at Vancouver General Hospital in 1920.[34]

31. Robert McDonald, "Working," in Working Lives, p.25-26.

32. Some historical material has been written about the links between waged work and male self image. See Ava Baron, "Acquiring a Manly Competence: The Demise of Apprenticeship and the Re-Masculinization of Printers' Work," unpublished paper presented at the American Studies Association Meeting, Miami, 1988, pp. 1-3.

33. Patient t2551, Box 25, RC, PABC.

34. Patient t6695, Box 88, RC, PABC.

Believing that "he was being systematically persecuted," by his co-workers Boyd retaliated by attacking one of the kitchen maids with a butcher knife. Committal to the asylum and a trial on charges of attempted murder followed.

Indeed, incidents of actual physical violence, such as the knife-wielding Mr. Boyd, while virtually unknown among the case histories of female patients, were a secondary theme of male committals. Clearly, in early twentieth century B.C., physical violence was both an outlet for emotional distress and a facet of male culture. Mr. Green, a thirty-nine year old veteran who entered the asylum in 1920, provides one illustration of the link between violence and male mental distress.[35] Mr. Green's father, who committed his son to the asylum, told the admitting physician a tale of escalating violence. The physician in question wrote that "On June 28th patient took a loaded gun and threatened to blow his (own) brains out." This incident was followed the next day by another violent struggle in which it took three men (including Mr. Green's brother and a policeman) to control the patient. Mr. Green retaliated by informing his brother that "he would settle with him later." Both Mr. Green and Mr. Boyd illustrate how elements of violence formed part of the way men in early twentieth-century B.C. dealt with personal or work-related problems.

The case histories of elderly men who entered the asylum bear the most similarity to their female counterparts. Like women, men in this

35. Patient *16442,* Box 83, RC, PABC.

age group came into the asylum when they were homeless. However, in the case of men we find that the emphasis was placed on their inability to function in the job market, rather than the fact that there was nobody to care for them. Mr. MacLean, for instance, was a seventy year old widower when he -became a patient in 1910.[36] Originally from Scotland, Mr. MacLean had worked allover the world as a ship's carpenter. By 1910 , however, he was stranded in Vancouver and having difficulty securing employment because of ill health. Hungry and without money, he was unlucky enough to ask a "detective" for food money and, after nine days in jail, was brought to New Westminster. Mr. MacLean died in the asylum thirteen years later.

The case of a veteran, Mr. Lodge, shows an interweaving of the themes of violence, work and poverty that are characteristic of male committals. " Mr. Lodge was forty years old and unmarried when he became a patient in 1929. He told the doctor who examined him at the asylum that he had contracted syphilis during World War I and had spent most of the ensuing years worrying about the disease and spending considerable amounts of money on useless cures. Anger and frustration eventually were directed at a doctor, whom he had paid well for an unsuccessful treatment. Significantly, the stress appears to have become unbearable at Christmas when, as Mr. Lodge informed the asylum physician,

36. Patient t2656, Box 25, RC, PABC.

37. Patient tll15, Box 168, RC, PABC.

> I had to work overtime and I lost that job and got broke. I had nothing to eat for four days. I went and told him (his doctor) that it was his fault and he rang up the police.

In several ways, the incidents surrounding Mr. Lodge's committal bring together themes whi~h are common to many of the male case histories. Anger over work and concern about money are dealt with by a hostile and potentially violent confrontation. And, while old age brought poverty and dependence to both men and women, the case histories studied for this chapter show that male and female patients had different emotional concerns and responded to these concerns in gender specific ways.

Thus, we see that male patients entered the asylum for very different reasons than did women. Often members of a resource-based transient workforce, the men of B.C. during this period were vulnerable to institutionalization if their ability to work, and hence support themselves, was impaired. Moreover, it is clear that male emotional distress was centred around the workplace and financial concerns, rather than the female world of kin and home.

Although a provision for voluntary self-committal was established in 1920, patients rarely chose to sign themselves into New Westminster and Essondale. Release from the asylum was gender differentiated for it appears that favoured male patients were often released on their own recognizance. Women, in contrast, always had to be signed out by a family member or friend. An analysis of which individuals took responsibility for committing or releasing the men and women who were institutionalized during the period reveals much about the larger

community or family dramas that surrounded an individual's entry into, or release from, the asylum.

The committal patterns of the men and women who entered New Westminster and Essondale reinforces the argument that conflict, either overt or internal, took place most frequently for women within the sphere of home and family. Male patients were most often signed into New Westminster or Essondale by the police while women were usually committed by a member of their own family. Mitchinson notes that this pattern holds true for committals to the Toronto Asylum during the nineteenth-century: women generally entered the asylum through family committal while men were more often admitted by use of the warrant system."

Let us begin by looking more closely at how women came into the asylum. Male family members dominated the committal process for all women, fully 67.4% of female patients were signed in by male family members compared to the 15.3% committed by female family members. The largest single category, however, were women who were signed in by their husbands: a total of 45% of female patients are in this category. [see Table A)

38. Mitchinson, "Gender and Insanity," p.104.

DBLJ: A: COIdKI'1"l'AL PATTEIUiS, 1'10, 1'1'/20, 1'2g/30

	Woman	Men
epoua.	t5.3%	g.5%
J'ath.r	8.3%	5.5%
Moth.r	5.5%	2.n
:t..cliat. J'amily (_1.)	13.8%	g.2%
Immecliat. J'amily (femal.)	g.8%	.8%
~her J'amily	2.U	2.5%
Doctor	3.5%	11.n
Polio.	g.U	U.O%
I'riend(a)	0%	4.8%
other (including auf)	.U	1.0%

The listing of who signed female patients out of the asylum, however, shows an interesting variation in this pattern. [See Table B] Again, husbands comprise the largest single category: 41.4% of female patients. But what is different is the role played by female family members in signing release forms for their sisters, daughters, nieces and cousins. While 22.1% of female patients were signed in by male family members other than their husbands, only 10.2% returned to sign out these women. Female family members, however, appear to have played a consistent role in signing their female relatives both in and out of the asylum: 15.2% of female patients were committed by female kin while 16.6% of these women were signed out by female family members.

DBLE B: UT LSZ PA'l'"lI:RIIS, 1810, 1818/20, U2g/30

	Woman	Men
apoua.	41.n	12.n
J'ather	0%	8.8%
Mother	7.0%	t.n
Immecliai. J'amily (mal.)	10.2%	12.8%
Immecliat. J'amily (femal.)	g.n	t.U
other J'amily	1.2%	5.7%
Doctor	.n	.n
Polio.	0%	.3%
J'denc! (a)	7.n	6.U
IIlatitution	g.5%	4.U
IaDigratioD	8.n	28.U
Zacapec!	0%	10.8%
~r (including auf)	0%	.n

These findings suggest several things. First, that families who committed female members believed that it was appropriate for men to make the initial contact with the institutional staff and to fulfil the legal rites of committal. Signing a patient out, however, implied that the signer would take care of the patient and this was, in all likelihood, considered a female task. So, while 8.3% (twenty-one) of female patients were signed in by their fathers, we find not one instance of a father signing papers so that his daughter might leave the asylum. Furthermore, as Table A illustrates, slightly more mothers came to sign their daughters out than signed them in: 5.5% of women were committed by their mothers while 7% of the female release forms were signed by mothers.

The case histories show that the committal of a daughter or sister was often a strategy used when other kinds of treatment had failed. Committal of a family member was both a traumatic and difficult decision. For example, Miss. Elliot's parents first moved from Lethbridge, Alberta to Victoria in the hope that the city would be more favourable to Miss. Elliot's mental health.[39] When their daughter's severe depression continued, they committed her to the asylum.

Accessibilit~ to the asylum played a major role in determining whether families saw the asylum as an option for dealing with a troublesome or unproductive female family member. We find that 85.9% of women, as compared to 64.9% of male patients, came from the Lower

39. Patient t2595, Box 26, RC, PABC.

Mainland and Vancouver Island regions. That convenience was a motivation behind choosing a provincial institution is illustrated by the fact that women were more likely to be signed in by their families if they came from either of the regions listed above.

That there are pronounced regional differences in the committal patterns of women but not in the case of men may be explained by two factors. First, because men were often committed by law enforcement agencies, transportation to the asylum was not the economic and logistical problem it may have been for many families of female patients. In the latter case the transportation costs of sending both patient and family member, and the cost of the return fare and accommodation for accompanying kin would have to be added the wages lost by the family member who went with the patient. Thus, we can expect to see a lower committal rate for female patients from outlying areas.

In a manner reminiscent of the use of orphanages, women who were left to raise children alone appear to have used the asylum when an adolescent or adult offspring proved too disruptive within the family circle.[co] Such parental attempts to control insubordinate adolescents, it has been noted, are also reflective of the lengthening period of

40. See Bettina Bradbury, "The Fragmented Family: Family Strategies in the Face of Death, Illness and Poverty, Montreal, 1860-1885," in Joy Parr, ed., Childhood and Family in Canadian History, pp.109-128.

adolescence.[41] For instance, Miss Peterson, age fourteen, was signed in by her mother while her father was a tuberculosis patient at Tranquille Sanatorium in the interior of the province. Her case history suggests that Mrs. Peterson used the asylum as a temporary home for a difficult child for whom she could not care. Furthermore, in this case there would have been little that was unfamiliar or frightening about the asylum, as the patient's father had been employed at Essondale before he became ill.

We have some idea of the coping strategies used by families with a member who was considered dysfunctional. But it is more difficult to know how to interpret the major role played by male spouses in the committal process. Are we looking at a way in which husbands were able to police wives and define what was appropriate behaviour for wives or mothers? Or is this perhaps an indication of the difficulty husbands may have had caring for wives who were sick and unable to participate in household chores or childcare?

The patient case histories can be utilized at this juncture to provide some indication of the spouse's agenda when husbands signed in their wives. What the histories of married women who entered the asylum suggest is that the motives behind a husband's committing of his wife were often highly individualistic. In some cases husbands were likely acting on the advice of the attending physician or participating in a

41. Cheryl Krasnick Warsh, "The First Mrs. Rochester," Unpublished paper presented at the Canadian Historical Association, Windsor, 1988. p.7.

mutual decision with their wives. However, it is clear that some men used the threat of committal to punish or manipulate their wives.

Mrs. Roberts is an example of a woman whose husband fits into the latter category. Mrs. Roberts entered the asylum for the first time in 1915, apparently following the birth of a child. She was signed in by her husband and told her doctor that he had been abusive. She was released on special probation into the care of her husband who left her, without money, to find work on the prairies. In 1920 when Mrs. Roberts was committed for the third time, apparently once more because of her husband, she told a similar story "He [Mr. Roberts] is the cause of me being here He said the best thing was to go back to New Westminster why he could kill me. He is a way bigger than I am." Mr. Roberts appears to have found the asylum a useful place in which to put a troublesome wife.[42]

The case history of Mrs. Otter, in contrast, suggest that, among some couples, a woman's committal was the result of a mutual decision between husband and wife. Mrs. Otter, age thirty-eight and mother of one thirteen year old child, was signed in by her husband after a lengthy depression.[u] Yet she told the asylum doctor that, because she believed that she might become physically abusive, "she felt that she must get away from her family." Mrs. Otter stayed in the asylum for eight months, leaving with her feelings toward her family apparently

42. Patient t6384, Box 82, RC, PABC.

43. Patient t11054, Box 167, RC, PABC.

resolved. She was signed out by her husband, who told the admitting physicians that his wife had, in the time previous to her committal, suffered from loss of memory, threatened to commit suicide and had run away from home. This testimony indicates how family life could be fragmented when a member who nurtured and cared for her spouse and children withdrew emotionally and physically, demanding instead that she receive care.

It is also evident that some husbands, confused and frightened by their wives' emotional distress, were quick to follow medical opinion and commit their wives. Mr. Marland, for instance, may have been following the advice of the private nurse he had hired to care for his wife and baby when he signed Mrs. Marland into the asylum in 1920.[44] However, the fact that Mrs. Marland, an Englishwoman with whom he had married and returned to Canada only eighteen months previously, was unable to leave the house, perform household tasks or care for her child must have been extremely frightening for Mr. Marland. Indeed, for men who were unable to hire a replacement for their wives, the task of providing care for children and performing household tasks in addition to their duties as breadwinner must have been an a1most impossible burden.

Gender differences emerge more clearly when we turn to male patients who entered the asylum in 1910, 1920 and 1930. [See Table A] As has been previOUSly mentioned, police played a major role in committing

44. Patient t6445, Box 84, RC, PABC.

male patients. Fully 46% of the male patients on the database entered the asylum through the action of the RCMP or the British Columbia Provincial Police. ' Family, including spouses, parents and extended family members, signed in a total of 33.4% of men committed. When we look more closely at this figure, we find that few married male patients were committed by their wives: only 17% of the committal papers of married male patients were signed by wives. What is similar to the committal patterns of female patients, however, is the role played by male family members in committing their male kin. Indeed, when we take into account the numbers of women who were signed in by their husbands, the figure of male patients being committed by male family members is actually higher at 30.2%.

Male release patterns show a greater similarity to those of female patients than do committals. [See Table B] Cumulatively, more family members came to release men than committed them. Indeed, 53.6% of those male patients for whom we have this information were released into the care of a family member. This process, in contrast to female patients, was dominated by male kin: while 17 percent of the married men were signed out by their wives, 22.9% of all male patients included in the sample were signed out by fathers, brothers, uncles and male cousins. However, it is also clear that the state continued to play an important role in regard to male patients, deporting fully 28.4% of male patients committed during the target years. [See Table B]

The fact that male kin were active in signing out male relatives suggests that male .patients were seen as too dangerous for women to take responsibility for and therefore male kin were sent to the asylum to bring home their sons, brothers and nephews. Or this data may simply reflect that it was easier for men than women to leave home and travel during the period under study. But what do these statistics tell us about gender differences? The fact that police were so often involved in committing men and the high male deportation rates indicates that the state did use the asylum as a tool for social control and that this occurred more frequently in the case of male patients. However, it should also be noted that the higher percentages of single men, coupled with the transient nature of B.C.'s male labour market, would mean that it is logical to find more male committals taking place in the public realm. What might be suggested is that the state, in early twentieth century B.C., used the asylum to contain the "disorderly [and male] poor" who were seen as posing a threat to "property, decorum, and the "social order. ".4 We find that the RCMP or the Provincial Police committed men whose public behaviour was socially disruptive and therefore unacceptable. Thus, Mr. Lim, a middle-aged Chinese labourer, was arrested and committed when, "hiding behind a shed in a private home - [he] dressed in the owner's clothes - having taken off his own clothes

44. J.K. Walton, "Casting out and bringing back in Victorian England; pauper lunatics, *1840-70,"* in The Anatomy of Madness, Vol. II, p.138.

and laid them aside. "[45]

The story of ,Mr. Stevson, a forty-three year old Norwegian miner, is similar, albeit slightly more dramatic than Mr. Lim's.[46] A patient in the Whitehorse hospital in *1910,* Mr. Stevson "escaped from the hospital and ran down the town in his night shirt and ... into the Yukon River." The behaviour of Mr. Stevson and Mr. Lim, while it posed no obvious danger to society, nonetheless attracted the interest of the police and was likely a matter of concern within the local community. Thus, the asylum served a social purpose insofar as it was a place to contain men who were undesirable members of the larger community. Moreover, this pOlicing of men underlines once again the fact that men of this period, in contrast to women, spent much of their lives in a public world where they were more lik~ly to come into direct contact with the policing arm of the state.

Duration of stay provides another illustration of gender differences between male and female patients at New Westminster and Essondale. [See Tables C and DJ We find that working men between twenty and forty-five years of age stayed in the shortest period of time, while generally men stayed in for a slightly shorter period of time than did women. But for women length of stay does not appear to have been influenced by age: Table C shows that the duration of stay remained relatively constant for women of all age groups. The idea that male

45. Patient '2501, Box 25, RC, PABC.

46. Patient '2748, Box ,RC, PABC.

patients were seen as more capable of coping outside the asylum is more strongly suggested by figures which list patient prognoses on leaving. Higher percentages of men are listed in the improved and unimproved categories, indicating that, generally speaking, women had to be seen as recovered in order to leave the asylum.

~ c: AGE , LENGTH or 8~Y FOR WOMEN, 1910, 1919/20, 1929/30

Ag.	l-lg	20-30	31-45	45-60	61+
Stay					
l••• than 1 yr	64.3%	51.7%	52.8%	52.5%	51.2%
1-5 yr.	28.6%	30.0%	28.2%	25.1%	30.3%
IIIOre than 5 yr.	7.1%	18.3%	18.n	22.5%	18.6%

~ D: AGE , LENGTH OF 8~Y FOR MEN, 1910, 1919/20, 1929/30

Ag.	l-U	20-30	31-45	45-60	61+
Stay					
1... than 1 yr	41.2%	60.8%	62.8%	56.8%	48.3%
1-5 yr.	44.1%	28.0%	23.7%	23.7%	n.2%
IIIOre than 5 yr.	14.7%	11.7%	13.6%	U.5%	22.5%

Certainly, gender played a major role in determining the ways in which patients came to and left the asylum. However, an exploration of the roles played by occupational status and educational background in influencing the same facets of patient experience show that class, as determined by occupation and education, is also a significant variable in reconstructing the lives of mental health patients in early twentieth century British Columbia. In this instance, each patient in the database was assigned an occupational and educational ranking. Using a basic, three-tier system of ranking educational level I was able to assign an educational level to 400 of the 406 women in the sample and 880 of the 963 male patients included in the database. A modification of

the ranking system developed by Michael Katz et al in their collaborative work on ethnicity and occupation in nineteenth-century cities was employed to assign an occupational rating to patients.[41] This latter form of classification was more problematic than the former. As might be expected, few women were listed as having an occupation beyond "housewife". Nor does the Katz classification system list a single specifically female occupation. In some cases, however, it was possible to ascertain occupational level by noting the occupation of a female patient's husband or father. In total, I was able to assign an occupational classification to 113 of the 406 female patients and to 864 of the 963 male patients. The fact that very small numbers of women could be classified under occupation made it necessary to discard the female patients and look solely at men at this point.

occupation does not appear to have had a measurable impact on whether men left the asylum or died when resident. However, occupation does appear to have influenced length of stay. As shown by Table E, professional men or those who owned their own business, on average stayed in the asylum for a shorter period of time. In contrast, seasonally or marginally employed men were more likely to remain patients for longer than men in the other two cateqories.[41]

47. Michael Katz et aI, "Occupation and Ethnicity in Five Nineteenth-Century Cities: A Collaborative Inquiry," Historical Methods Newsletter, 7, (1974),p.l74-216.

48. Richard Fox argues that blue-collar workers in California were overrepresented in the patient populations in that state's mental health facilities. See Fox, 50 Far Disordered in Mind, p.llO. However, since we do not know the percentage of blue-collar workers in the general B.C.

~ E: OCCOP~ION , LENGTH OF STAY rOR KEN, 1910, 1919/20, 129/30

Occupational Itanlt Stay	Prof •••ionu/ Own au.in •••	Craft.per.on/ Skill.d	..a.onally/ ..-inally
1••• than 1 yr	70.2%	61.7%	53.5%
1-5 yr.	2C.U	26.3%	25.7%
~J:e than 5 yr.	5.5%	12.0%	20.9'11

Interestingly, education appears to have played a much more significant role in determining the length of time a patient spent in the asylum, his or her chances of leaving the institution and the prognosis a patient received on discharge. Although gender alters the pattern considerably, both male and female patients who were moderately or well educated were more likely to be discharged from the asylum. [See Table F] Patients with little or no education, and most particularly women in this category, stood a much higher chance of dying while institutionalized. Table F serves to clarify this point: fully 58.3% of the female patients with little or no education died in the asylum, while death rates among the women who were classified as moderately educated or well educated were 37.2% and 38.3% respectively. Yet the male pattern, while also suggesting that patients with little or no education were more likely to die in the asylum, is much less polarized: death rates among male patients with little or no education comprised 46.6% of the popul~tion, 37% of men with moderate education and 33.1% of those who were well educated did not survive incarceration.[4]

population it is not possible to speculate on this point.

49. These death rates, while high, were nonetheless lower than at Tecehurst Asylum, England during the 1845-1917 period which had a death rate of between sixty to ninety percent. See Charlotte MacKenzie,

~ F: ZDUCATION LEVEL, DISCHARGE VB DEATH, 1910, 1919/20, 1929/30

ZducatioD Level	Well Zelucated	80_ ZducatioD	Little/No ZducatioD
Women			
Diac:harqed	61.n	62.8%	u.n
Died	38.3%	37.2%	58.3%
~			
Diac:harqed	fifi.n	63.0%	53.4%
Died	33.1%	37.0%	Ci.n

Educational background also appears to have been influential in determining how long patients stayed in the asylum. As illustrated by Table F, patients, whether male or female, tended to stay in the asylum longer if they were poorly educated. Here again, it is difficult to know how to interpret these statistics. A more educated patient might have received more sympathetic care from doctors who could share his or her intellectual concerns. Or education might provide a patient with an intellectual and imaginative life that would take them beyond the often depressing world of the asylum. At this point we can do no more than speculate as to the meaning of this particular group of statistics.

The paths that led men and women into B.C.'s asylum during the early decades of the twentieth-century were defined by both gender and class. Female committals reflect the economic and cultural bonds which linked women to the family unit. In contrast, male emotional distress was more often rooted *in* conflict with extra-familial authority and set in the public realms of the workplace, the beer parlour or the street.

"Social Factors in admission, discharge and continuing stay," The Anatomy of Madness, Vol. II, p.149.

Yet underlying gender defined circumstances was the more subtle manner in which educational and occupational factors influenced both the ways men and women became patients and how their time of discharge was determined.

This chapter suggests that class, gender and family life were crucial factors in what determined the fate of the mentally ill in early twentieth century British Columbia. Clearly, men and women were most vulnerable to committal when they were socially disruptive, either in the home or the community, and also economically vulnerable. Length of stay, and whether a patient died while resident, also appears to have been linked to numerous variables - age, educational level and occupation. In order to discuss the social purpose served by the asylum during this period, therefore, we must build an analysis that makes allowance for the complexities of both the committal process and the lives of patients and their families.

CHAPTER 4: IDEALS OF MENTAL WELLBEING

We now have an understanding of the life circumstances that brought male and female patients within the gates of New Westminster and Essondale and have charted the contours of their experience as patients. But what was the ideal of mental health which was presented to patients by the institutional physicians and how did patients themselves feel about their own emotional wellbeing? Moreover, what forums existed within the asylum for patients to negotiate with their doctors or express dissatisfaction with the care they received?

To varying degrees, doctors and patients alike subscribed to gender stereotypes in their perceptions of mental wellbeing. Asylum doctors expected patients to conform to the notion that men were workers and women nurturers. An analysis of patient case files suggests that patients whose lifestyles most closely matched those of their doctors were likely both to share their physicians' ideas about mental health or, in fact, to elucidate their own circumstances to fit their doctor's interpretation. In contrast, patients who did not share the belief systems or the class background of their physicians tended to express their disbelief in, and dissatisfaction with, the medical model of mental health by gender differentiated kinds of rebellion.

This chapter is an exploration of these themes, a conversation with some of the patients who entered New Westminster and Essondale between 1910 and 1935 and the doctors who cared for them. After a brief discussion of sources I shall consider what patient characteristics were

considered "ideal" or preferable by asylum physicians. I shall then turn to the patients themselves and look at how they responded to institutionalization. Clearly, patients do not fall into tidy subgroups - personal attitudes and agendas of patients are often highly individualistic - yet by charting the nuances of patient attitude and behaviour we can structure a tentative analysis of how asylum patients may have felt about their own mental health.

As historians of women have noted, it is a difficult task to discover what women have felt and thought in the past. When we turn to mental health patients, however, we find that, beyond the occasional expose or fictional account of an asylum experience, both male and female patients have found little voice in the historical documentation of the period.[1] In our search to discover more about the attitudes of mental health patients we are fortunate to have on hand sixty-six randomly selected patient case histories from Essondale and New Westminster. Particularly in the post-war period, when patient case files became much more comprehensive, the case histories of patients at B.C.'s mental health facilities are an invaluable source of information about patients. Throughout the period, asylum physicians periodically wrote brief observations on patient health and behaviour. And by 1920

1. One fictional account of an American women's incarceration during this period, Emily Holmes Coleman's The Shutter of Snow, (London: Virago, 1981) shows how one female patient experienced life within an American asylum during the 1920s. Emily Coleman entered the asylum in 1924 following the birth of her son and a bout of puerperal fever. The protagonist in this novel, a woman suffering from post-partum depression, is clearly modeled on Coleman's own life experiences.

it was customary for a physician to interview patients after they had been in the asylum for a few days. These interviews, recorded verbatim, comprise a rich source of information. AS well, a smaller number of patients wrote letters to their doctors, either after they left the asylum or while they were still at Essondale or New Westminster.

Each part of a patient case file described above can be used to ascertain patient attitudes. The patients' charts are clearly information that has been filtered through a medical perspective. Yet the patient behaviour described by asylum physicians would be, in part, a reflection of the patient's own attitude toward the asylum and an indication of their belief in the healing process at the asylum. In addition, while questions asked in patient interviews were set by the asylum psychiatrists, the answers given by patients can provide suggestions of patient attitudes and expectations. Similarly, what limited amount of patient correspondence exists is useful in determining the role that physicians and the institution played in the lives of men and women who passed under their care.

Just what comprised an ideal patient, from the asylum doctors' point of view, was never explicitly stated. However, the sources do provide some idea of what standards patients were expected to match. In addition we find that the manner in which a patient presented him or herself, coupled with a nebulous blend of gender and class expectations, influenced the kind of response patients received from physicians.

Patient interviews usually took place a short time after a patient had been admitted. The transcripts of these interviews strongly suggest that appearing mentally healthy implied reflecting Anglo-Saxon, middle-class sensibilities and adhering to a set of gender specific guidelines regarding behaviour-and aspirations.[2] Thus, in a manner not unlike the pardon tales used by sixteenth-century French prisoners, the patient interview allowed mental health patients of twentieth-century British Columbia to "retell' or "re-vision" their circumstances in a fashion that conformed with the asylum physicians' perception of their wellbeing.[3]

Key to a successful "re-visioning" of patient experience was the patient's willingness to place his or her account within the context of compliance with, and respect for, the asylum's medical staff. One illustration of how compliance was seen as a sign of good health was Mr. Shannon who entered the asylum voluntarily in 1920 at the suggestion of the judge who officiated at his trial for cocaine possession. His interview provides us with an example of a patient who meekly agreed with his doctors's interpretation of the circumstances which had brought

2. This process continues to be a facet of the contemporary psychiatric experience. Jerome Frank, in his study of psychiatrist/patient relationships tells us that, "middle class patients appear to offer better prospects for therapy because their values are closer to those of the psychiatrists,W Jerome D.Frank, wThe Dynamics of the Psychotherapeutic Relationship,w in Thomas J.Scheff, ed., Mental Illness and Social Processes, (New York: Harper and Row, 1967), p.174.

3. Natalie Zemon Davis, Fiction in the Archives: Pardon Tales and Their Tellers in Sixteenth-Century France, (Stanford, California: Stanford University Press, 1987), p.11.

him into Essondale.

Q. [Doctor] Do you appreciate the danger you have run?
A. [Patient] I know it now.
Q. [Doctor] Do you know where it will lead you?
A. [Patient] I know it all now.
Q. [Doctor] Have you learned your lesson?
A. [Patient] I have, I know it all now.
Q. [Doctor] Your wisest plan is to get out of the city of Vancouver.
A. [Patient] I know it now.
Q. [Doctor] Yes, they know you in Vancouver and will have an eye on you.
A. [Patient] I will get on a boat pretty soon.[4]

Mr. Shannon was willing, at least momentarily, to adopt his physician's interpretation of his own mental health. And, like the French king who gave absolution to those who carefully constructed pardon tales, showed remorse and rehabilitation, the asylum physicians accepted Mr. Shannon's penance and declared him "recovered."

Evidence that a patient believed in and was grateful for the medical attention s/he had received was also interpreted as a measure of sanity. Mr. Lodge, for example, was a male labourer who entered the asylum in December and remained there for just over one year. This man was broke and believed that, because he had syphilis, he would never be able to work again.[5] However, the malaria treatment which he underwent while a patient at the asylum and his subsequent good health, made him a

4. Patient '6465, Box 84, RC, PABC.

5. Patient '11115, Box 168, RC, PABC.

grateful and cooperative patient.' For this man, then, the asylum experience appears to have been positive. Mr. Lodge's ward notes show that his doctors interpreted his gratitude as a sign that he had gained "insight" into his condition and was therefore cured. Certainly, patients were wise to present appropriate expressions of gratitude and respect toward the asylum doctors. After all, physicians had the power to grant both freedom and absolution.

For B.C. mental health patients who were able to use the patient/doctor interview as a forum for negotiation, the presentation of his or her personal circumstances was key to being released from the asylum. Mr. Shannon's interview hints that patients were aware that they had to express agreement with views of the asylum doctors in order to be released. A letter written by Mrs. Todd to her husband tells us that one patient, at any rate, perceived her relationship with the asylum physicians as a kind of charade.

> I could say alot but I me (sic) here to control my tongue and tears ...besides it pays to act a bit green sometimes ...I am to (sic) slick for these doctors I have a secret but they are beating me. Only one brain to a dozen doctors."1

Naivete, silence and emotional stability were seen by this woman as the elements of an ide~l female patient.

6. Malaria treatment was introduced as a cure for syphilis in the late 1920'5. Developed by Julius Wagner von Jauregg, an Austrian, it was used throughout Europe and North America until the 1940'5. See Elliot Valenstein,Great and Desperate Cures (New York: Basic Books, 1982), pp.30-31.

7. Patient 110746, Box 161, RC, PABC.

But was Mrs. Todd right in thinking that she had to be quiet and passive in order to be seen as "well" by the asylum doctors? Undoubtably, medical attitudes toward gender differences were an important factor in the "re-visioning" process. An ideal female patient was rather different than an ideal male patient. Men's wellbeing was linked to work (their ability to work and their belief in the work ethic), while women were expected to become wives and mothers and conform to a domestic vision of womanhood.' Patients who were most successful in "re-visioning" were those whose articulated aspirations most closely matched the middle class, gender specific attitudes held by their doctors.

Mrs. Otter provides one illustration of how this process worked for female patients. Mrs. Otter was a member of the middle-class and had completed high school, a respectable educational level for the 1920s.' During her interview she presented her own solution to her dilemma, that she should return to her husband and son and take care of them.

Q. [Doctor) And how do you feel ...?
A. [patient) I feel that if he [her husband) would like to go back tomorrow, I could take up my job [as a homemaker) and make a good job of it. I feel that my family need me and I should not be here.

8. See Mary Vipond, "The Image of Women in Mass Circulation Magazines in the 1920s," in A. Prentice and S. Mann Trofimenkoff, eds. The Neglected Majority, Vol.1, (Toronto: McClelland and Stewart, 1977), p.117-118 and Strong-Boag, The New Day Recalled, p.137.

9. Veronica Strong Boag, The New Day Recalled, p.21.

The medical response to this suggestion was positive: following the interview her doctor wrote that Mrs. Otter's "attitude towards her family is resuming its normal status."[10]

But not all female patients found it so easy to demonstrate compliance with their doctors. The contrast between the case histories of Mrs. Otter and of Mrs. Roberts, a working class woman, is striking. Mrs. Roberts was married and the mother of five children when she entered the asylum for the third t~e in May, 1920. The interviews which Mrs. Roberts had with three different doctors when she was committed in 1920 show clearly that she believed that her mental condition was directly related to poor living conditions, a brutal husband and the fact that her children were in the Catholic Orphanage. Yet the asylum physicians were less than sympathetic, describing Mrs. Roberts at different times as "slovenly", "troublesome" and "surly".11 In their eyes she was an unco-operative patient and a poor parent. Furthe~ore, the doctors dismissed her stories of mistreatment by her husband as delusions.

But what elicited such an unsympathetic response toward Mrs. Roberts from the medical profession? Certainly, Mrs. Roberts was not a model patient: she complained about her treatment by nurses and constantly asked for discharge so she might go home. But it is also likely that Mrs. Roberts's lifestyle, which she refused to reinterpret

10. Patient 111054, Box 167, RC, PABC.

11. Patient 16384, Box 82, RC, PABC.

to suit her doctors, would have been unacceptable to the middle class physicians who cared for her.[12] A woman who had a violent, fragmented relationship with her husband and whose children had been in the care of the Children's Aid, would have had a difficult time eliciting a sympathetic response from the asylum doctors.[13] Similarly, it was taken as a sign of mental instability that Mrs. Wardock (a widow) could not recall the date of her marriage.[14] Doctors were not alone in their seeming inability to provide sympathetic care for women whose home lives contradicted the domestic ideal. When ex-patient Mrs. Whitherspoon went to see Miss Kilburn, the social worker with the Family Welfare Bureau of Greater Vancouver, in April, 1932, Miss Kilburn wrote to Dr. Crease (then superintendent at New Westminster and Essondale). Mrs. Whitherspoon, she said, had come to the bureau complaining about her husband. Kilburn concluded by stating that, "we suspect that her condition is responsible for her complaints."15 Female patients whose lives did not conform to the domestic ideal, it would appear, continued

12. Jerome Frank notes that, "behaviour of patients which does not conform to his (the psychiatrist's) position is apt to be characterized as "resistance" or "manipulation,", "The Dynamics of the Psychotherapeutic Relationship," p.183.

13. Certainly, Nellie's husband was unsuccessful in trying to gain a sympathetic hearing from New Westminster. In December 1917 he wrote to the Provincial Inspector of Municipalities in Victoria, asking that his wife be released for Christmas for, "she longs to get back to her children; which is quite natural ••" However, New Westminster refused to release their patient. Patient *16384,* Box 82, RC, PASCo

14. Patient *16196,* Box 79, RC, PASCo

15. Patient *111228,* Box 170, RC, PASCo

to be viewed as mentally unstable while their fellow patients who embraced domesticity were more often able to discard the stigma of insanity. Women were perceived by the medical profession as "well" when they expressed a desire to marry or stay within their marriage, have children and create a home.

In contrast, it was anticipated that male patients would respond to treatment by illustrating that they were capable of becoming a functional part of the labour force once more. Asylum doctors who cared for male patients undoubtably had practical reasons for ascertaining whether or not men would be able to support themselves once they left the asylum. Yet beyond the pragmatics of whether a patient would be able to support hi~elf outside the asylum, it is clear that a male patient who was capable of working efficiently and was eager to work was seen to be on the road to good health.[16] Thus, if in the course of his interview, a male patient was able to reaffirm an image of himself as a well-motivated working man, the doctor might be convinced that this was indeed true. A conversation between an English labourer and his doctor provides an illustration of one such interchange.

Q. [Doctor] How do you feel recently?
A.[Patient] I feel as though I would like to go back and start over again.
Q. [Doctor] Are you feeling better now?
A. [Patient] I feel better.
Q. [Doctor] You think you would be alright kept on at work?

16. Andrew Scull, in his work on the development of asylums in England, notes that asylums, like workhouses, were intended to teach the unemployed how to work and to appreciate the intrinsic value of work. Scull, Museums of Madness, pp.40-42, 69.

A. [Patient} Yes.

The connection between good mental health and a desire to work is clear. Most male patients, it appears, had to demonstrate, either through rhetoric or labour, their willingness to resume a place in outside society as a prOductive member of the working populace.

In the case of married men, the work ethic was linked to what was seen as a moral obligation to provide for their family. The ward notes for Mr. Green, for instance, indicate that a patient who expressed concern for his family and told the doctor that he wanted to provide, " a proper home for them," could expect a sympathetic response.[17] In this particular case, doctors continued to be supportive until the patient withdrew from asylum activities and began to create his own language.

This perception of the "ideal" male patient, as opposed to that of the female counterpart, emphasized the role played by men in the public realms of waged work and community - and in the case of married men their role as provider of material goods in the home. In contrast, the "ideal" female patient was one who subscribed to the prevalent middle class notions that women were best suited to the roles of wife and mother and whose behaviour showed elements of passivity and naivete. Yet, **as** other aspects of behaviour which constituted the "ideal" patient illustrate, it was anticipated that both men and women would demonstrate what were in fact "classic" female characteristics. In the world of the asylum, patients were expected to be grateful and to agree with their

17. Patient *16442,* Box 83, RC, PABC.

doctor's interpretation of their own lives and circumstances.

Contemporary gender ideology, the expediency of expressing views that were acceptable to the medical staff at the asylum and the cultural and class backgrounds of patients all served to define patient attitudes toward their mental health and shape the doctor/patient relationship. But just what purpose did the patient see being served by the asylum and its doctors? Did they think that the asylum really helped to heal them, and what did patients themselves equate with mental health? It is difficult to answer these questions in any comprehensive sense, for only a small number of case histories contain fragments of this kind of information. However, it is clear that gender served to inform patient concepts of wellbeing and to shape the response of female patients to their male doctors.

As Joy Parr has noted, masculine identities have traditionally been located in paid employment." It is not surprising, therefore, to find that many male patients shared their doctors' belief that good mental health was to be equated with the ability to work. For one example of this attitude we can turn to the case history of Mr. Frank, an elderly British labourer who entered the asylum in 1920." During his patient/doctor interview this patient was asked

Q.[Doctor) Where are you now?

18. Joy Parr, lecture at York University, March 1988.

19. Patient t6692, Box ee, RC, PABC.

A. [Patient] Where am I now? Well to tell you the truth I don't know where I am; I'm supposed to be in the asylum: but I don't know why, I worked up until Christmas.

For Mr. Frank, it appeared to be inconceivable that, having been able to perform waged labour a short time before he was now a patient in an asylum.

Similarly, the case histories show that many female patients themselves expressed the belief that good mental health for women lay in traditional domestic forms. Indeed, we find that, in the minds of many female patients, the image of mental health was most closely linked, not to the ideal of domesticity, but to their physical ability to perform housework. Mrs. Whitherspoon illustrated this tendency to link work and health in her interview when describing her homelife.

Q. [Doctor) And you got worse at home, eh?
A. [Patient) Yes. I seemed ...well, I tried to get around the house, you know, to do my work but it didn't seem as if I could get ahead at all. I used to be a good worker and it seems now as if I can't get around to it at all.~

This patient's husband agreed with his wife's perception of good health. In a letter written to the asylum doctor after his wife's release he said "Everything going fine. Mrs. [Whitherspoon) taken hold of household duties fine." For female patient and family, then, the link between mental wellbeing and domestic labour **was** defined in very practical terms. In essence, many male and female patients saw themselves as sick because they were no longer able to perform·the

20. Patient 111228, Box 170, RC, PABC.

physical tasks demanded by their gender roles.

It is not possible, due to the lack of source material, to discuss how male patients viewed their doctors at the asylum. However, the case histories which provide information about the relationship between female patients and 'their doctors suggest that a number of women attempted to recreate the gender dynamics of the nuclear family, placing their doctors in the position of the dominant, all-important male. Certainly, female patients were cognizant of the role played by gender in the relationship which they had with their doctors. The case histories chosen for this thesis suggest that they expressed this awareness in a number of ways.

For some women, it appears that their attitude toward asylum doctors was highlighted by a sense that these men could also be part of the ideal of heterosexual romance. Miss Elbridge, for example, believed that personal validation would come through marriage. The fact that she turned to the main male presence in her world to fulfil the role of a husband is not surprising. For instance, in one of the copious letters which she wrote to her doctor Miss Elbridge said "Housework. It will become lovable when I have my own man and my own home .••And of all the classes of men I like none better than doctors."21 This kind of transference is scarcely unusual. The psychiatrist as an a~ost mystical figure of male authority and knowledge is a common characterization in female accounts of psychiatric treatment. As the

21. Patient '10700, Box 160, RC, PABC.

editor of Emily Holmes Coleman's fictionalized account of her own stay in an American asylum during the 1920s reports "Fathers, Husbands, Doctors, Gods emerge as enormous figures in her (Coleman's) mad world ..".22 Certainly, many female patients acknowledged that the power held by other figures of male authority in their lives. Mrs. Roberts, for example, several times referred to the asylum doctor as her "husband," while Mrs. Fraser believed that her husband and doctor were conspiring against her. 23

Some female patients may have found it useful to cater to their doctor's sense of superiority and power. Mrs. Todd used female flattery and deference to male authority in what was likely an attempt to improve her standing with her doctor. In a letter to the asylum physician a month after she had been committed she wrote "really Doctor I have never met a man of your type before. You just won't be vamped and that is what I like about yoU."24 This patient is unique amongst those studied for an apparently deliberate attempt to make use of the male/female dichotomy. For all female patients, however, their relationship with their doctors was defined by both gender and power differences.

22. See Carmen Callil, introduction to The Shutter of Snow, p.3. Similarly, Judi Chamberlin and Barbara Findlay's personal accounts of their experiences as psychiatric patients demonstrate that male therapists often have considerable power over the lives of their female patients, at times assuming the roles of father, husband or lover. Judi Chamberlin, "Struggling To Be Born," pp.53-57, and Barbara Findlay, "Shrink! Shrank! S~riek!," pp.59-71, in I'm Not Mad I'm Angry.

23. Patients 46384 and 46444, Box 82, RC, PABC.

24. Patient 410746, Box 161, RC, PABC.

Yet patient responses to medical care cannot be so neatly boxed into gender divisions. The voices that emerge from the patient case histories of Essondale and New Westminster express a wide range of expectations and responses. We find patients asking for help, expecting to receive assistance or, in some cases, documenting their disappointment when, after all, the asylum does not bring them peace of mind. That some patients came into the asylum believing that they would be healed is clear. Mr. Leveque interrupted his interview to ask nAre you going to help me though?n[25] Mrs. Harwood's rather agitated query "Have I said the wrong thing again? Have I? Everyone is trying to help me,n[26] suggests that she felt that the asylum staff were attempting to assist her: it was her own instability that was impeding her progress to mental health. Mrs. Marland indicates that, for some patients, the healing properties of the asylum grew during their stay "I didn't think it would do me any good at first, but I think it done me a lot of good coming here. Well, I am feeling much better now: I feel more like myself.n21 For this woman, then, the results of her asylum experience were positive: she was able to return to her family and resume the life which she had left.

Not all patients expressed such positive perspectives on their asylum experience .. Mrs. Fraser, for example, told her doctor "I don't

25. Patient *111238,* Box 170, RC, PABC.

26. Patient *111234,* Box 170, RC, PABC.

27. Patient *16445,* Box 84, RC, PABC.

understand the way they treat the patients here. I got a wrong impression all together. I am no better since I came here. I am getting worse."[28] It is worth adding that this woman's assessment of her ability to retain her mental health in the asylum was correct: her mental condition worsened over the fifteen years she remained as a patient and she eventually died of what was termed "exhaustion of dementia praecox."

For some patients, too, it was likely that the asylum was more of a lesson learnt than a healing experience. Mrs. Otter's conversation with her doctor shows that she made use of her asylum experience to learn that life outside was preferable to being a patient.

> A. [Patient) When I see what I have seen since I came in here and realize how far it can go if it [emotional illness) is let run ...
> Q. [Doctor] You get a bird's eye view of it.
> A. [Patient) You see some pretty tragic things here.[29]

One can assume that this patient was not the only one who had this reaction to committal. It is likely that many patients whose mental health was unstable or whose personal circumstances had brought them within the asylum, viewed their experience as both a punishment and a warning.

Such vignettes are merely fragments of how mental health patients viewed their stay in the asylum. We can see, however, that patient responses and attitudes varied. Gender informed patient perspectives on

28. Patient *16444,* Box 83, RC, PABC.

29. Patient 111054, Box 167, RC, PABC.

mental health and shaped their relationships with asylum physicians, yet patient attitudes toward medical treatment were also highly individualistic.

Men and women could also impose a kind of individuality on the asylum environment by becoming either a "good" or a "bad" patient. Gerald Grob notes in his study of similar institutions in the United States, the behaviour of patients was often simply un-cooperative, even anarchistic. [30] Thus, forums for negative expression were found in the daily patterns of asylum life. Patients might refuse to work or eat, remain mute for lengths of time or rebel in a whole variety of ways. Some patients, however, chose more dramatic forms of resistance - escape and suicide. We find that forms of patient protest tended to reflect patterns which were gender specific.

One kind of protest frequently employed by female patients was the refusal of food.[31] A 1927 menu indicates that food at the asylum was adequate but mundane and repetitive.[32] Patients who refused to eat would first be spoon-fed and then, if that failed, tube-fed. One illustration of this process is Mrs. Fraser who believed that her food at the asylum was poisoned. In 1923 and again the following year she

30. Grob, Mental Hospitals, p.16.

31. Interestingly, hunger strikes were also used by suffragettes imprisoned in England before World War I. Elaine Showalter, The Female Malady, p.162.

32. GR 542, Box 14, File 7.

refused to eat and was tube-fed.[33] Elaine Showalter's work on women and madness suggests that, because women have a traditional link with food, women like Mrs. Fraser may have sought to express their anger through actions centred around the preparation and consumption of food.

In contrast, we find that escape was almost exclusively used as a male form of resistance. Between 1910 and 1935 a total of 112 men and four women escaped from New Westminster and Essondale: among the patients who entered the asylum in 1910, 1920 and 1930 no women escaped, but thirty-seven of the 464 men who left the asylum were escapees.]· Mr. Lutz, an example of a male escapee, was living at Farm Cottage when he successfully completed a classic escape. Mr. Lutz removed the window of the room where he was sleeping, tied a rope to the bed and thus managed to free himself. The fact that he used for rope a kind of window cord not seen around the asylum, suggests that he had been plotting his escape for some time.[35] Patient escapes were not always so dramatic. Mr. Campbell simply walked away from the dining room where he was at work and was never seen again."

These pronounced gender difference between male and female escapees may well have been related to opportunity. Female patients

33. Patient f6444, Box 83, RC, PABC.

34. Statistics compiled from annual reports, 1910-1935 and from the patient database.

35. PABC, Box 160, RC, PABC.

36. Patient f2680, Box 26, RC, PABC.

generally worked inside the asylum and, hence, would have had little opportunity to elude staff and attendants. Nor would it have been easy for female escapees to quickly secure employment and vanish into the larger populace. It is also possible that this gender difference in the number of escapees related to differing male and female attitudes towards the atmosphere of the asylum. The interior, domesticated surroundings of the institution, coupled with the fact that all patient labour was unwaged, would not have seemed unfamiliar to most female patients. For the men, it may have often seemed intolerable.]1

Patient suicides occurred less frequently than did escapes. The patient database lists a total of six suicides among the patients who entered in 1910, 19.20 and 1930. Of these six patients, only one was a woman, indicating that suicide, like escape, was primarily a male form of protest." The information which is available through annual reports and case histories suggests that, while many of the patients who entered the asylum were considered suicidal, few actually committed suicide while incarcerated. Suicide, therefore, can be viewed as the most extreme form of patient resistance at New westminster and Essondale. Patients were more likely to express frustration, anger or

37. Elissa Gelfand in her work on women's writings from French prisons, makes a similar suggestion, arguing that female prisoners are more likely to conform to the expectation that prisoners be passive. Men, however, tend to refuse this identification and are therefore more rebellious. Imagination in Confinement: Women's Writings from French Prisons, (Ithaca, New York: Cornell University Press, 1983), p.7.

38. Patient database.

disappointment by simply refusing to comply with asylum standards of "good" patient behaviour. And, as we have seen, while resistance to asylum conditions found a variety of forums within the institutional setting, gender informed a patient's choice of modes of protest.

This chapter has been a tentative discussion of the images of standards of mental health presented by patients and physicians and of patient attitudes toward their own mental health and the asylum experience. It is my hope that what emerges is a sense of the individuality of patients at New Westminster and Essondale. For beyond the confines set by gender and class, these people were individuals whose pain and circumstances brought them inside the institution. Some sought help. Others tried to cooperate in order to secure their release or chose to resist by whatever means were at their disposal. In any discussion of the social history of mental health it is important to keep in mind the individualism of the patients whom we study.

Clearly, asylum physicians had specific gender stereotypes which they linked to notions of mental health. Patients whose lives and attitudes did not conform to their doctor's ideology were considered suspect. However, qender stereotyping was not only exhibited by the medical profession. Many patients, both men and women, appear to have measured their own sanity against their ability to conform to traditional gender roles. It is also apparent that a facet of patient subculture was the resistance of patients. Modes of resistance and patient protest reflect both the institutional setting and elements of

male and female culture.

Therefore, we find that the attitudes of both patients and doctors were, to a large degree, reflective of ideas concerning health and gender that were prevalent in Canadian society of the period. Yet it is also true that the institutional community of the asylum also served to shape how physicians and patients regarded one another. Asylum doctors had the power to pass judgement on the sanity of patients, while patients themselves had limited avenues through which to express what they thought and felt. Thus, we see that patient attitudes and responses, like physicians' expectations of patients, were a product of both the institutional world and the larger British Columbian community.

CONCLUSION

Let us turn once again to the 1916 photograph of the New Westminster in the Superintendent's annual report. Here we have the public face of the asylum, the image conveys a sense of pride and accomplishment. Throughout the period under study, new buildings, a larger medical staff, a focus on the mental wellbeing of children and the feebleminded, and the beginnings of community mental health care were seen as steps which would place New Westminster and Essondale in the vanguard of twentieth-century mental health care. Although budgetary constraints, overcrowding and a shortage of qualified medical personnel occasionally served to check this optimistic vision, the mood of the period was generally positive.

Yet, when we look within the asylum community, this image shifts considerably. For asylum attendants, patients and the families of those committed, institutional growth appears to have meant that a more impersonal environment was created. Certainly, the administrative records that are available indicate that working relations between administration and staff became increasingly alienated during the years under study. And within this asylum world, the lives of patients were set within the context of an institutional routine which prescribed gender specific codes of discipline and privilege. It is clear that men and women had different patient experiences. Public image and policy directives, then, were often far removed from the actual experience of those who lived and worked in the asylum.

Gender was significant in other contexts. Women tended to enter the asylum through family related conflicts while male emotional distress was most often located in the public realms of the workplace, the beer parlour and the local community. violence was often a sub-theme in stories of male committals. And once patients entered the asylum, both doctors and patients used gender stereotypes to define mental wellbeing. As well, patients imposed a kind of individuality upon the asylum environment by recreating aspects of male and female culture. We can perceive friendships with other patients, work habits and types of patient protest as forms of gender defined patient culture. In this sense the institutional community reflected the norms of the larger Canadian society.

The asylum community was a kind of negotiated space with different measures of power and responsibility being allotted to various participants. The medical superintendent had to balance professional allegiances, fiscal constraints and patients' wellbeing. Within the institutions themselves, administrative power could only be checked by the state or public opinion. Asylum attendants, too, were scarcely powerless: as the intermediary between administrative policy and patient experience, attendants e»ercised considerable control over the daily lives of patients. Nor were patients insignificant players within the world of the asylum. As we have seen, patients often had their own agendas. The asylum might Btmply provide shelter and food, or be viewed as a respite from a troubled nomelife, a punishment or salvation from a

disturbed psyche. Certainly, the fact that patient behaviour was sometimes "irrational" does not mean we can dismiss the impact which patients themselves had on the asylum, for the tension that existed between patient irrationality and asylum routine indicates that patients did, to a degree, impose their own culture upon the asylum world.

Insufficient sources may limit historical discussions of patient subculture and the asylum community. However, if we are to understand the social purpose served by asylums like New westminster and Essondale, we must try to view the asylum world through the eyes of those who were patients within it. Contemporary writing and activism of ex-psychiatric patients demonstrates that those who have been institutionalized perceive their experience in a way which is different from that of doctors, nursing staff or even their own families." As this thesis demonstrates, a greater sensitivity to the archival material available allows a measured analysis of how patients constructed and viewed the world within the walls of the asylum.

39. For example, see Bonnie Burstow and Don Weitz, Shrink Resistant: The Struggle Against psychiatry in Canada, (Vancouver: New Star Books, 1988.)

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