

Psychiatry and Eugenics: The Classification and Diagnosis of Female Patients in British
Columbia's Psychiatric Institutions, 1918-1933

by

Paige Fehr
B.A., Vancouver Island University, 2015

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Supervisory Committee

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Dr. Lynne Marks (Department of History)
Supervisor

Dr. Annalee Lepp (Department of Gender Studies)
Outside Member

Abstract

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Outside Member

Between 1918 and 1933, the eugenic notion of “defective heredity” was central to psychiatric practice in British Columbia. Public and medical professionals’ concerns were heightened by an apparent increase in “insane” and “mentally deficient” individuals in the province. Using the annual reports for the asylums and the case files of women who were admitted to the Public Hospital for the Insane and to Essondale between 1918 and 1933, this thesis examines the relationship between psychiatric practice and eugenics, specifically how eugenically-minded asylum physicians classified and diagnosed female patients. Asylum physicians used admissions forms, patient interviews, observation, and inference to make diagnoses. Often, despite a lack of evidence, they concluded that patients had inherited a predisposition to mental disease. Women admitted to B.C.’s Public Hospital for the Insane and to Essondale were more likely than their male counterparts to have their mental condition linked to heredity. Any “eccentric” or “abnormal” behaviour or personality in the patient or their family was considered by asylum physicians to be evidence of a predisposition to mental disorder. Within the population of female asylum patients, racialized women were the most likely to be labeled as having “defective heredity.” Widespread racial discrimination in the province, combined with the fact that eugenic discourse targeted non-white citizens as being biologically and culturally inferior, shaped and influenced the asylum physicians’ classification and diagnoses of mental illness among racialized women. The experiences of these women during their incarceration were also shaped by racialized discourse and their behaviour was negatively stereotyped by asylum staff.

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Introduction

In April 1926, Dr. J.G McKay appeared before the British Columbia Royal Commission on Mental Hygiene and when asked what he believed was the cause of insanity, he declared that “heredity is paramount.” He was then probed about what percentage of asylum patients were insane due to heredity and he replied that it was between 60 percent and 70 percent.¹ McKay’s response was typical for a Canadian asylum physician during this period. From the late nineteenth century through the first few decades of the twentieth century, the eugenic discourse of “defective heredity,” which promoted the notion that individuals were inheriting predispositions to mental disorders at an unprecedented rate, became a major concern in British Columbia’s medical and lay communities. Asylum physicians in this period were strong supporters of eugenic programs that promoted restricting marriage, reproduction, and immigration among those with “defective heredity,” specifically the insane and feeble-minded. During the 1920s, a significant percentage of patients in B.C.’s mental asylums were classified as having inherited a predisposition to mental disease. This strong eugenic discourse led to the passing of the Sexual Sterilization Act in 1933 under which approximately 350 individuals, the majority of whom were women, underwent sexual sterilization. While historians have studied the relationship between eugenics and psychiatric practice, they have focused on the sexual sterilization of patients and the period prior to the passing of the Act has largely been overlooked. In this thesis, I am interested in investigating the

¹Dr. McKay was the assistant medical superintendent of the Public Hospital for the Insane from 1907 until 1918 and founder of the private Hollywood Sanitarium in New Westminster. British Columbia Archives, Royal Commission on Mental Hygiene, GR 0865, Box 1 File 7, Report of the Mental Hygiene Commission held in Vancouver 13-14 April 1926, and in Victoria 16 April 1926, 19.

ways in which the discourse of “defective heredity” was used in the institutional context prior to the passing of the Act, specifically in the classification and diagnosis of female asylum patients.

Prior to 1872, individuals deemed insane in British Columbia were looked after by friends or family, held in the local jails, or returned to their country of birth.² In 1872, lay reformers protested that the confinement of the insane in jails was an act of “heartless inhumanity” and an asylum was established across the harbour from Victoria on the Songhees Reserve.³ Conditions at this small asylum were poor. The building was dilapidated and the management was inadequate.⁴ The asylum remained in Victoria for five years until a larger facility, the Public Hospital for the Insane (PHI), was established in New Westminster. The PHI opened its doors to patients in May 1878 and within a year it had filled all of its 41 beds.⁵ By the turn of the century, many extensions had been added and improvements were made to the building. As the number of available beds increased, so did the number of new admissions. By the early 1900s, there were almost 250 patients in the asylum and overcrowding, and its associated problems, was increasingly becoming a major issue. A new facility was desperately needed and, in April 1913, the Provincial Hospital for the Insane, also called Essondale, opened in Coquitlam and 525 male patients were transferred there. Although the sexes were not completely separated between the two facilities, female patients were generally not incarcerated

² For a detailed account of the care of the insane prior to the establishment of an asylum and the creation of the psychiatric hospital system in B.C., see Gary Ferguson, “Control of the Insane in British Columbia, 1849-78: Care, Cure, or Confinement?” in *Regulating Lives: Historical Essays on the State, Society, the Individual, and the Law*, edited by John McLaren, Dorothy Chunn, and Robert Menzies (Vancouver: UBC Press, 2002), 63-96.

³ Ferguson, “Control of the Insane in British Columbia,” 64, 68, 82; Val Adolf, *In the Context of its Time: A History of Woodlands* (Victoria, B.C.: Ministry of Social Services), 16.

⁴ Ferguson, “Control of the Insane in British Columbia,” 84.

⁵ Adolf, *In the Context of Its Time*, 30.

long-term at Essondale until 1931 when the female ward opened.⁶ Shortly after Essdonale opened, a third psychiatric facility was established in Colquitz. In 1919, the Provincial Mental Home was created to exclusively house “criminally insane” men.⁷

From its inception until the development of psychotherapeutic drugs and electroshock therapy in the mid-twentieth century, the primary method of asylum treatment was moral therapy. Moral therapy was a strictly scheduled behavioural approach to treatment that sought to avoid the use of physical restraint and decrease the manifestation of mental illness by engaging the patient in regular activities and labour, offering a simple diet, and ensuring plenty of rest.⁸ However, overcrowding and underfunding made it difficult to fully carry out this program. In 1951, the PHI was renamed Woodlands School and became an institution for the developmentally disabled until its closure in 1996. Essondale was renamed Riverview Hospital in the 1960s and remained open until 2012.⁹

This thesis focuses on the relationship between eugenics and psychiatric practice in British Columbia. Between 1918 and 1933, the eugenic notion of “defective heredity” heightened public and medical professionals’ concern over the apparent increase of “insane” and “mentally deficient” individuals in the province. Using the asylums’ annual reports and case files of women who were admitted to the Public Hospital for the Insane and Essondale, this thesis examines how eugenically minded asylum physicians classified and diagnosed patients and frequently used heredity as an explanation for mental illness.

⁶ Adolf, *In the Context of its Time*, 23-46, 75.

⁷ Legislative Library of B.C., “Mental Health Policies: Historical Overview,” Background Paper, January 2008, 3.

⁸ Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen’s University Press, 1989), 197.

⁹ Adolf, *In the Context of its Time*, 87; Legislative Library of B.C., “Mental Health Policies: Historical Overview,” 3-11.

Overall, this study is concerned with how contemporary ideas of mental illness and mental deficiency, gender, race, and eugenics played out in B.C.'s psychiatric institutions in the early twentieth century.

Historiography

Prior to the rise of social history in the 1970s and 1980s, historians of nineteenth- and early twentieth-century psychiatric asylums tended to focus on the administrators and physicians. These historians viewed the pre-asylum period as a nightmare for the insane while the asylum was seen as a progressive humanitarian innovation that offered great therapeutic benefits.¹⁰ In 1961, Michel Foucault published *Madness and Civilization* and argued that the creation of asylums in the Western world ushered in an era of unprecedented oppression of those classified as mad.¹¹ Foucault saw the use of moral therapy as a subtle, repressive form of psychological control and a mechanism designed to coerce the insane to conform to the moral views of those in power (i.e. the physicians, administrators, and the middle and upper classes).¹² Building on Foucault's work, many historians approached their analyses of the asylum through the lens of social control over the deviant and unproductive. One component of the asylum that these historians neglected to address was the patients themselves. Following the shift to social history, scholarship on the asylum began to explore the "patient perspective." This approach has focused on the experiences of patients and has questioned assumptions about the primacy

¹⁰ James E. Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000), 6.

¹¹ Moran, *Committed to the State Asylum*, 7.

¹² See Michel Foucault, "The Birth of the Asylum," in *Madness and Civilization: A History of Insanity in the Age of Reason*, translated by Richard Howard (New York: Pantheon Books, 1965); Ferguson, "Control of the Insane in British Columbia," 67; Moran, *Committed to the State Asylum*, 7.

of the institutions and their psychiatric professionals. Most recently, historians have been interested in understanding the role and power patients and their families had in challenging the asylums' authority.¹³

Many historians have agreed that the asylum in the nineteenth and early twentieth century was an institution of social control used to segregate the deviant and unproductive and to reform behaviour. Daniel Francis describes the asylum as a “self-enclosed, tightly organized institution, the aim of which was the reformation of its inmates into socially conventional patterns.”¹⁴ Thomas E. Brown and James Moran link the creation of the asylum in Upper Canada to both a form of social control and the emergence of a new set of capitalist social relations, specifically the development of a generalized market wage economy that created a new middle class and a class of propertyless wage labourers.¹⁵ Brown explains that the former established hegemony over the latter through a number of strategies, such as creating institutions like the asylum for the purposes of social control. The middle class sought to render the unproductive in society productive through institutionalization.¹⁶ Similarly, Moran describes the asylum

¹³ Moran, *Committed to the State Asylum*, 9-11. For studies concerned about the role and power families played in admissions and care, see Andre Cellard and Marie-Claude Thifault, “The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-Century Quebec,” in *Mental Health and Canadian Society: Historical Perspectives*, ed. James Moran and David Wright (Montreal: McGill-Queen’s University Press, 2006), 97-116; Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen’s University Press, 1989), 63-100; and Mary-Ellen Kelm, “The only place likely to do her any good: The Admission of Women to B.C.’s Provincial Hospital for the Insane, 1905-1915,” *B.C. Studies* 96 (1992/1993): 66-89 and “Women, Families, and the Provincial Hospital for the Insane, British Columbia, 1905-1915,” *Journal of Family History* 19, 2 (1994): 177-193.

¹⁴ Daniel Francis, “The Development of the Lunatic Asylum in the Maritime Provinces,” *Acadiensis* 6, 2 (1977): 32-33.

¹⁵ Thomas E. Brown, “The Origins of the Asylum in Upper Canada, 1830-1839: Towards an Interpretation,” *Canadian Bulletin of Medical History* 1, 1 (1984): 46.

¹⁶ Brown, “The Origins of the Asylum,” 45-46.

as an “embod[iment] of the ideals of Bourgeois society”; a focus on order and control was seen in the asylum’s design and management with the goal of making irrational minds rational again.¹⁷ These historians agree that the asylum functioned as a way for the emerging middle class, and an already established upper class, to manage and socially control the lower/working class insane.

Historians have nuanced the theory of social control, arguing that the asylum suited the needs of a number of different groups and were not just single-purpose institutions with the goal of social control. S.E.D. Shortt argues that, for legislators, the asylum performed a useful role as a welfare institution. It served the needy and demonstrated government benevolence, which in turn legitimated its political authority.¹⁸ More recently, both Wendy Mitchinson and Geoffrey Reaume agree that asylums did act as a form of social control, but they also performed the functions of care and custody. They argue that, for some patients, the asylum was a place of refuge from unenviable treatments and conditions imposed on them by a largely unsympathetic society or a shelter for those who had nowhere else to turn.¹⁹

In measuring the “success” of the asylum in this period, Canadian historians have come to similar conclusions. Most concur that Canadian asylums failed to live up to their founders’ expectations: the carrying out of a moral therapy regime. Gary Ferguson, David Shephard, and Mitchinson all point to overcrowding and the issues that came along with

¹⁷ Moran, *Committed to the State Asylum*, 71, 168.

¹⁸ S.E.D Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry* (New York: Cambridge University Press, 1986), 26, 40-41, 61.

¹⁹ Mitchinson explains that, before many patients entered the asylum, they had experienced some form of restraint such as isolation. Many also had their heads shaved and blistered and were given purgatives and drugs. Wendy Mitchinson, “The Toronto and Gladesville Asylums: Humane Alternatives for the Insane in Canada and Australia?” *Bulletin of the History of Medicine* 63, 1 (1989): 57-58. Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2000), 20-21.

it as the main reason for the “failure” of asylums. Too many patients meant that moral therapy was difficult to dispense. These historians maintain that, as a result, the asylums inevitably became impersonal custodial facilities and poor ones at that.²⁰ Economic factors also played a role in the failure of the asylums. They were chronically underfunded or, in B.C.’s case, the government was reluctant to expend any money on proper facilities, and the asylums had to compete for resources with other projects, such as road building, that were often given a higher priority.²¹ Overall, historians’ assessment of the asylums’ success as curative facilities suggests that, while the intentions may have been positive, asylum were unable to live up to expectations due to lack of resources.

Since the 1980s, the “patient perspective” has become a common methodological approach among historians of Canada’s asylums. This methodology generally involves using quantitative data on age, gender, class, and diagnoses along with qualitative data obtained from patient case files and admission registers. When historians have taken a patient-centered approach, they have analyzed various aspects of the patient experience with the goal of moving away from the “top down” approach that has focused on the asylum and its administrators. Studies of psychiatric history in Canada that have used patient case files have added significantly to our understanding of the lives and experiences of individuals who were incarcerated within institutions. Using case files, historians have investigated the initial admission process, patient relationships with each other and their physicians, daily routines, treatments, patient culture, patient labour, resistance to institutionalization, and patient abuse. As Reaume explains, the goal of

²⁰ Ferguson, “Control of the Insane in B.C.,” 86; David A.E. Shephard, *Island Doctor: John Mackieson and Medicine in Nineteenth-Century Prince Edward Island* (Montreal: McGill-Queen’s University Press, 2003), 90, 96-97; Mitchinson, “The Toronto and Gladesville Asylums,” 58, 65; Francis, “The Development of the Lunatic Asylum,” 37.

²¹ Ferguson, “Control of the Insane in B.C.,” 83, 86; Shephard, *Island Doctor*, 99.

using a patient-centered approach is to “uncover stories about people who were patients and to take their views and experiences seriously as the lives of individual humans who lived in large mental institutions.”²² However, there are limitations to the patient focused approach. First, most of the information within case files was recorded by medical staff for a specific purpose and therefore offers little insight into what the patients themselves thought of their incarceration. Second, case files have to be selected, either randomly or intentionally, and when a sample is established, information can be lost.²³

In patient-centered asylum studies, historians have used gender as a category of analysis. Using quantitative methods, historians have compared the age, occupation, socio-economic status, committal patterns, length of stay, and civil status of men and women admitted to asylums and have found significant differences. As Megan Davies explains, men and women had very different experiences as patients within the institutions. The ways in which patients negotiated a sense of individuality within the asylum was differentiated by gender. They also brought elements of male and female culture into the asylum and shaped their new world accordingly.²⁴ As historians have found, the wider social patterns of gender were further reflected and reinforced in the asylums’ workplaces and work assignments.²⁵ Women performed labour that benefitted the inner economy of the asylum, such as doing laundry and sewing with their living

²² Reaume, *Remembrance of Patients Past*, 5.

²³ For example, Warsh employs a statistical framework that randomly selected case files while Reaume selected case files that he considered the most rich in information. Warsh, *Moments of Unreason*, 5; Reaume, *Remembrance of Patients Past*, 4.

²⁴ Megan Jean Davies, “The Patients’ World: British Columbia’s Mental Health Facilities, 1910-1935” (MA Thesis, University of Waterloo, 1989), 18-19.

²⁵ Cheryl Krasnick Warsh, “In Charge of the Loons: A Portrait of the London Asylum for the Insane in the Nineteenth Century,” *Ontario History* 74 (1982): 167-168; Reaume, *Remembrance of Patients Past*, 146-153; Ken Scott, “Society, Place, Work: the B.C. Public Hospital for the Insane, 1872-1902,” *BC Studies* 171 (2011): 93-110; Moran, *Committed to the State Asylum*, 92-95.

spaces often doubling as their working spaces, and they rarely worked outdoors. Ken Scott explains that the women's ward was a "distinctly female domestic living space" where middle-class ideas about gender roles and "home" were replicated. Men performed outdoor labour and their work primarily contributed to the external economy of the asylum. The fact that women's work was part of the internal economy and male work brought income into the asylum reflected gendered conceptions of economic activity that was made up of separate yet complementary spheres.²⁶

A gender-focused perspective has also been used to understand how physician knowledge and perspectives impacted the care and treatment of female patients. Mary-ellen Kelm, in "A Life Apart: The Experience of Women and the Asylum Practice of Charles Doherty at B.C.'s Provincial Hospital for the Insane," uses the tenure of superintendent Doherty as the time frame (1905-1915) for her study, and argues that this period offers a unique opportunity to examine the lives of institutionalized women. Doherty was concerned with modernizing the Provincial Hospital for the Insane, and the improvement of male treatment and institutional conditions were integral to his plans. Female patients were excluded from the reforms that characterized his tenure.²⁷ For example, Doherty introduced hydrotherapy and agricultural work treatments, but neither of these were of benefit to female patients. When the new institution opened in 1913, only men were transferred while women remained in the underfunded and overcrowded older facility.²⁸ Kelm argues that, because of official disinterest in female patients, these

²⁶ Scott, "Society, Place, Work," 101-104.

²⁷ Mary-ellen Kelm, "A Life Apart: The Experience of Women and the Asylum Practice of Charles Doherty at British Columbia's Provincial Hospital for the Insane, 1905-1915," *Canadian Bulletin of Medical History* 11 (1994): 336.

²⁸ Kelm points out that hydrotherapy equipment was installed in the male wards in 1906, but it was not until 1911 that the equipment was added to the women's ward and then it was only to the

women developed enhanced control over the tone of and activities on the wards. Since psychiatric therapy in this period required patient cooperation, women had to choose, or be able to choose, to participate in their own recovery. Kelm suggests that, in this way, female patients had significant control over their institutional lives. Following the First World War, the eugenics movement generated a renewed interest in female patients, primarily as feeble-minded threats to the gene pool.²⁹

In examining the asylum patient experience, historians have also been concerned with looking at the role that race and ethnicity played in shaping admissions and institutionalization.³⁰ It is important to note that in B.C. during this period, there was widespread racial discrimination against Asian immigrants and Indigenous peoples. Historians have documented how anti-Asian discrimination was based on a combination of biological, social, and economic concerns.³¹ In the case of Indigenous peoples in B.C., they had been segregated on reserves and assimilationist programs were well underway by the 1920s. These populations did not have access to the privileges of full citizenship

refractory ward. Kelm, "A Life Apart," 338.

²⁹ Kelm, "A Life Apart," 336.

³⁰ For a study of ethnicity in Ontario's asylums in the nineteenth century, see David Wright and Tom Themeles, "Migration, Madness, and the Celtic Fringe: A Comparison of Irish and Scottish Admissions to Four Canadian Mental Hospitals, c. 1841-91," in *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*, edited by Angela McCarthy and Catharine Coleborne (New York: Routledge, 2012), 39-54.

³¹ Peter Ward argues that economic concerns were subordinate to psychological tensions. He explains that white British Columbians psychologically yearned for a racially homogenous society and that the 'Oriental immigrant' was believed to be endangering the fulfillment of this aspiration. Peter Ward, *White Canada Forever: Popular Attitudes and Public Policy Toward Orientals in British Columbia*, 3rd Edition (Montreal: McGill-Queen's University Press, 2002), xxiii, 115-119, 123-127, 169. Patricia Roy, taking a more nuanced approach, maintains that prejudice against Asian immigrants was rooted in a combination of economic and racial concerns. Roy explains that economic motives usually inspired anti-Asian outbursts and the reasons for demanding restrictions on Asian immigrants was often couched in racial terms. Patricia Roy, *A White Man's Province: British Columbia Politicians and Chinese and Japanese Immigrants, 1858-1914* (Vancouver: UBC Press, 1989), vii, x, xiii, 13-14, 91 and *The Oriental Question: Consolidating a White Man's Province, 1914-41* (Vancouver: UBC Press, 2003), 7, 11, 231.

and were subject to a wide variety of controls and regulations that governed most aspects of their lives.³² As Renisa Miwani explains, these racialized groups were thought to be endangering the white population in B.C., albeit in different ways, and thus needed to be “expunged and eliminated.” Asian immigrants (and Asian-Canadians) were subjected to immigration restrictions, deportation, and political exclusion while Indigenous people were the targets of a ‘civilizing mission’ that had the goal of total assimilation.³³

A few historical works examine race in B.C.’s asylums during the mid-nineteenth to mid-twentieth centuries. These studies have tended to focus on male patients and they take a similar approach to the topic by examining the ways in which broader social patterns of racialization and racial attitudes were reflected in the asylums and in the care and treatment of visible minorities. In “Society, Place, Work: The B.C. Public Hospital for the Insane, 1872-1902,” Scott examines the male Chinese population in B.C.’s asylums in the late nineteenth century and explores segregation in living and working spaces.³⁴ As he notes, male and female patients’ living and working spaces were segregated within the institutions, but male Chinese patients were also segregated from the wider male population. Scott argues that broader social patterns of race were reflected and reinforced in the asylum’s architecture, living arrangements, work places, and work assignments of the patients.³⁵ He maintains that Chinese patients were given female jobs

³² See Sarah Carter, “Categories and Terrains of Exclusion: Constructing the ‘Indian Woman’ in the Early Settlement Era in Western Canada,” in *Gender and History in Canada*, edited by Joy Parr and Mark Rosenfeld (Toronto: Copp Clark Ltd., 1996), 30-49 for a discussion of the many negative stereotypes associated with Indigenous peoples, primarily women, which existed during this period.

³³ Renisa Mawani, *Colonial Proximities: Crossracial Encounters and Juridical Truths in British Columbia, 1871-1921* (Vancouver: UBC Press, 2009), 8, 29.

³⁴ Between 1872 and 1897, male Chinese patients made up between 9 percent and 20 percent of the total asylum population. Scott, “Society, Place, Work,” 96.

³⁵ Scott, “Society, Place, Work,” 93.

like laundry work, and they were required to undertake the dirtier and more labour intensive tasks within the laundry. White female patients were segregated from Chinese men in the laundry as a means of safeguarding their respectability, an issue that was also of concern in the wider society.³⁶ Scott argues that, in the highly controlled environment of the asylum, the white middle-class ideal of racial segregation of the workplace could be fully attained. He concludes that the segregation and racialization of Chinese patients was a more negative and exaggerated reflection of social attitudes and relations of power found in the wider B.C. society.³⁷

Robert Menzies, in “Race, Reason, and Regulation: British Columbia’s Mass Exile of Chinese ‘Lunatics’ aboard the Empress of Russia,” examines the experiences of male Chinese psychiatric patients in a B.C. asylum and their mass deportation in 1935. In offering a profile of these patients, he identifies their ages, civil status, admission patterns, and treatment. He found that most of the men came from similar backgrounds and faced similar experiences within the asylum.³⁸ Menzies paints a dismal picture of their incarceration; the asylum was largely bereft of energy, pleasure, or hope. The Chinese inmates were cut off by language, culture, and the intolerance they encountered from hospital staff and other patients. He emphasizes that, to the staff of the asylum, “the Chinese were an amorphous crowd of alien faces, bizarre in their habits, and potentially dangerous. Their value was measured mainly by their level of docility and willingness to

³⁶ Scott, “Society, Place, Work,” 109-110.

³⁷ Scott, “Society, Place, Work,” 110.

³⁸ Robert Menzies, “Race, Reason, and Regulation: British Columbia’s Mass Exile of Chinese ‘Lunatics’ aboard the Empress of Russia, 9 February 1935,” in *Regulating Lives: Historical Essays on the State, Society, Individual, and the Law* edited by John McLaren, Robert Menzies, and Dorothy E. Chunn (Vancouver: UBC Press, 2002), 208-121.

work.” Furthermore, they were never the subjects of rehabilitative measures.³⁹ While in the asylum, Chinese inmates were mostly just ignored, and their ‘foreign’ appearance and lack of English skills made communication with hospital staff difficult. Menzies importantly points out that the Chinese inmates should not simply be seen as powerless victims. Many Chinese patients protested their incarceration through verbal resistance, complaints, and escape.⁴⁰ He concludes that, above all else, the power of medical professionals over the Chinese inmates was marked by the fact that they had to ability to remove these patients through deportation.⁴¹ Similar to Scott, Menzies maintains that the “mass banishment” of these patients signifies the dominant ideologies of race and reason that were hegemonic throughout Canada and B.C. during this period. These ideologies excluded those who deviated from the requisite standards of sanity, docility, and racial purity.⁴²

The final significant study of race in B.C.’s asylums is “Turbulent Spirits: Aboriginal Patients in the British Columbia Psychiatric System, 1879-1950” by Robert Menzies and Ted Palys. In this work, they take a patient-centered approach to investigating the Indigenous patient population in the province’s asylums. Using quantitative methods, Menzies and Palys provide statistics on Indigenous patients, both male and female, and compare them with the wider, largely white, asylum population. Menzies and Palys use patient case files to examine the experience of these patients while incarcerated. Their analysis considers how ideas about Aboriginality and disease figured into the medico-legal management of Indigenous people deemed insane and it also

³⁹ Menzies, “Race, Reason, and Regulation,” 212.

⁴⁰ Menzies, “Race, Reason, and Regulation,” 213-214.

⁴¹ Menzies, “Race, Reason, and Regulation,” 215.

⁴² Menzies, “Race, Reason, and Regulation,” 197.

importantly documents how patients and their advocates resisted their incarceration.⁴³ Menzies and Palys also examine the social forces that brought these individuals into the institution and argue that the incarceration of Indigenous peoples was a form of “social regulation”; these patients were viewed as troublesome, wild, abusive, and indecipherable. One common thread Menzies and Palys found that linked all the diverse Indigenous inmates was their perceived unruliness and unmanageability and the fact that they were often believed to have been in breach of social and racial conventions.⁴⁴ Their investigation of Indigenous case files also sheds light on how isolation and the racist attitudes, words, and actions of the asylum staff profoundly shaped the experiences of Indigenous patients during their incarceration.⁴⁵

While gender and race have been examined in histories of asylums in Canada and B.C., they are also of interest to historians of eugenics in Canada. The eugenics movement gained momentum in the late nineteenth century following Francis Galton’s coining of the term “eugenics,” from the Greek root meaning “good in birth,” to describe the science of improving the racial qualities of future generations, both physically and mentally, by encouraging selective breeding.⁴⁶ By the 1900s and especially after the First World War, middle- and upper class reformers across North America became increasingly worried about the “quality” of the population. Individuals and families

⁴³ Robert Menzies and Ted Palys, “Turbulent Spirits: Aboriginal Patients in the British Columbia Psychiatric System, 1879-1950,” in *Mental Health and Canadian Society: Historical Perspectives*, edited by James E. Moran and David Wright (Montreal: McGill-Queen’s University Press, 2006), 153-154.

⁴⁴ Menzies and Palys, “Turbulent Spirits,” 161.

⁴⁵ Menzies and Palys, “Turbulent Spirits,” 159-166.

⁴⁶ Wendy Kline, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley and Los Angeles: University of California Press, 2001), 13; Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland & Stewart, 1990), 15.

exhibiting mental illness, disability, or ‘unfit’ behaviour became a source of alarm in a society concerned with designing healthy, working, and prosperous communities.⁴⁷ According to Erika Dyck, the possibility of eugenics captivated reform-minded individuals who sought scientific solutions to a range of problems associated with urbanization, disease, poverty, moral degeneration, immigration, and ‘race suicide.’ Eugenic societies provided intellectual credibility to these ideas and popularized eugenics as a progressive response.⁴⁸ During the early twentieth century, the eugenics movement in Canada focused on individuals and populations deemed “mentally unfit” or “defective” and was primarily concerned about the inheritability of a wide range of “defective” qualities or behaviors.⁴⁹ The eugenics programs developed in Canada took a variety of forms, but at their heart lay a desire to exert power and control over individuals who did not suit the national plan.⁵⁰ Alberta and British Columbia enacted sexual sterilization acts and implemented public health reforms and initiatives that involved the surveillance of individuals, families, and children. After the Second World War, as people became aware of the Holocaust, eugenic practices became linked to genocide.⁵¹

Historians agree that the Canadian eugenics movement had two main concerns. The first focused on “unfit” immigrants coming into the country and taking advantage of the Canadian welfare system. The second concentrated on the “unfit” in the Canadian population, as it was believed that they would cause the “degeneration” of the Anglo-Saxon race and the human race more broadly. The national movement, however, was

⁴⁷ Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), 9-10.

⁴⁸ Dyck, *Facing Eugenics*, 5.

⁴⁹ Dyck, *Facing Eugenics*, 6-8.

⁵⁰ Dyck, *Facing Eugenics*, 7.

⁵¹ Dyck, *Facing Eugenics*, 8.

never unified in deciding whether it should focus on “unfit” immigrants or Canadian-born individuals.⁵² Historians categorize the movement as one of both moral and social reform that included programs of social and population control such as surveillance, segregation, marriage restriction, immigration reform, deportation, and sexual sterilization of those considered “feeble-minded,” “unfit,” or “undesirable.” They agree that eugenics offered an appealing solution to the perceived problems of social and moral decay by promising to support stricter immigration policies and promoting measures to ensure that the ‘unfit’ population was unable to reproduce.⁵³ Eugenics offered a powerful discourse through which authorities could attribute the problem of flawed citizens to the intrinsic genetic, biological, and cognitive inferiority of both “aliens” and citizens who had no place in modern Canada.⁵⁴

Historians have focused attention on understanding why so many “respectable” and indeed progressive Canadians subscribed to the notion that the Anglo-Saxon race was in danger and why eugenic ideology became a guide for defensive action.⁵⁵ In answering this question, Angus McLaren, Ian Dowbiggin, Robert Menzies, and Amy Samson have examined a number of prominent individuals, including social reformers, psychiatrists, medical professionals, teachers, and social workers. In particular, McLaren, Dowbiggin, and Menzies have explored the ‘professionals’ in the eugenics movement such as

⁵² McLaren, *Our Own Master Race*, 11.

⁵³ Dyck, *Facing Eugenics*, 9.

⁵⁴ Robert Menzies, “‘Unfit’ Citizens and the B.C. Royal Commission on Mental Hygiene, 1925-1928,” in *Contesting Canadian Citizenship: Historical Readings*, edited by Robert Adamoski, Dorothy Chunn, and Robert Menzies (Peterborough, Ontario: Broadview Press, 2002), 389.

⁵⁵ McLaren, *Our Own Master Race*, 9,11; Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 2003), vii, xi; Robert Menzies, “Governing Mentalities: The Deportation of ‘Insane’ and ‘Feeble-minded’ Immigrants out of British Columbia from Confederation to World War II,” in *Crime and Deviance in Canada: Historical Perspectives* edited by Chris McCormick and Len Green (Toronto: Canadian Scholars’ Press Inc., 2005), 161-162.

physicians, psychiatrists, mental hygienists, and geneticists. By taking a biographical approach, these historians have analyzed how individual professional careers represented a wider professional group and how the Canadian eugenics movement was about the social control of those considered “unfit” by an elite population. These studies are “top down” in their perspective as they are more concerned with the role that the individuals played in creating and influencing policies and practices on a national (or sometimes provincial) scale and less concerned with how those policies directly affected those they were meant to control.

To date, the most comprehensive study of the Canadian eugenics movement is McLaren’s *Our Own Master Race: Eugenics in Canada, 1885-1945*. McLaren uses a biographical approach to illuminate the various ways in which assumptions about defective heredity manifested in the late nineteenth to mid-twentieth century. The main purpose of the book is to document the broad appeal of eugenic ideology and to understand the circumstances that led so many Canadians to embrace eugenic discourse that focused on the dangers of racial inefficiency, social inadequacy, and ill health.⁵⁶ The individuals examined in McLaren’s study are “hereditarians,” those who believed in the primacy of heredity and most of whom described themselves as eugenicists. McLaren concludes that the prominent eugenicists of the twentieth century were attracted to eugenics because of their desire to bring a new world order into existence.⁵⁷ These eugenicists, which included prominent individuals such as Helen MacMurchy, C.K. Clarke, and Clarence Hincks, envisioned a future where there was no disease or “degeneration” and they viewed themselves as the only ones able to intervene in the lives

⁵⁶ McLaren, *Our Own Master Race*, 9-11.

⁵⁷ McLaren, *Our Own Master Race*, 165.

of the poor and “unfit” to prevent the emergence and spread of social problems.⁵⁸ Along with seeing themselves as the protectors of this newly envisioned social order, McLaren points out that the medical doctors among the eugenicists were concerned with the quality of immigrants and apprehended that their profession had much to gain from supporting the movement to restrict immigration to only the “desirable.” He maintains that doctors realized they would play a key role in the screening of new immigrants, due to their training in detecting hereditary traits. In general, they believed that their profession would become the authorities on this issue in the eyes of the government.⁵⁹ As such, McLaren points to both an ideological attraction and perceived professional gain to explain why prominent Canadians became involved in the eugenics movement in the twentieth century.

In *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* and “Keeping this Young Country Sane: C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925,” Ian Dowbiggin argues that all psychiatrists, at one time or another in this period, expressed opinions that were favorable to eugenics.⁶⁰ His answer to the question as to why psychiatrists became involved in the movement focuses on the professional opportunities it offered to them.⁶¹ Dowbiggin explains that psychiatrists in this period were under great pressure from the government to be more cost effective, utilitarian, and accountable so they leaned towards eugenic initiatives to demonstrate their willingness to change, modernize, and streamline services. At the same time, they were concerned with keeping up with scientific “progress” and

⁵⁸ McLaren, *Our Own Master Race*, 165-166.

⁵⁹ McLaren, *Our Own Master Race*, 47, 49-50.

⁶⁰ Dowbiggin, *Keeping America Sane*, vii, xi.

⁶¹ Dowbiggin, *Keeping America Sane*, ix-x, 233-234.

staying relevant in both the government's and the public's eyes.⁶² Using C.K. Clarke as a case study of Canadian psychiatrists, Dowbiggin traces Clarke's career as an asylum psychiatrist and later as a mental hygienist as a way to explore the intersection between psychiatry and eugenics, specifically the program of immigration restriction. He concludes that Clarke's interest in the program was due to a complex combination of personal, professional, and cultural factors.⁶³ Dowbiggin maintains that Clarke's career acts as a reminder to historians that eugenics in its own right was highly attractive. Public asylum psychiatrists found the theory of eugenics convincing because, when faced with the problem of trying to manage and cure patients in overcrowded, underfunded, and deteriorating facilities, eugenics provided a convincing scientific explanation for psychiatry's low cure rates. Eugenic measures, such as immigration restriction, implied that state hospital psychiatrists were not accountable for their therapeutic failures.⁶⁴

Looking specifically at B.C., Menzies comes to a similar conclusion as McLaren and Dowbiggin. In "Governing Mentalities: The Deportation of 'Insane' and 'Feeble-minded' Immigrants out of British Columbia From Confederation to World War II," he chronicles the role of B.C.'s medical practitioners and provincial authorities in securing the removal of immigrants that were deemed "unworthy of citizenship by virtue of their disordered and deficient mentalities."⁶⁵ Menzies notes that, although B.C.'s psychiatrists were fairly far removed from the federal corridors of influence over immigration policy, they became crusaders who allied themselves with provincial

⁶² Dowbiggin, *Keeping America Sane*, x, 234, 236.

⁶³ Ian Dowbiggin, "'Keeping this Young Country Sane': C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925," *The Canadian Historical Review* 76, 4 (1995): 600.

⁶⁴ Dowbiggin, "'Keeping this Young Country Sane," 626.

⁶⁵ Menzies, "Governing Mentalities," 161.

politicians and anti-immigration organizations in a campaign aimed at reforming the medical assessment of immigrants and denying entry to those who did not pass the test.⁶⁶ While they were bolstered by theories of eugenics and race betterment and drew on public fears about unregulated immigration, B.C.'s psychiatric professionals turned to the deportation of foreign asylum inmates primarily for professional purposes. Like Dowbiggin, Menzies argues that these psychiatrists, by demonstrating their concern with larger social issues, sought to raise the prestige of their profession and demonstrate their relevance in the fast-changing medical world of the early twentieth-century. Deporting the foreign insane also helped the physicians conserve resources and open up asylum beds in their institutions for the Canadian-born insane.

McLaren's, Dowbiggin's, and Menzies' studies focus on well-known "elite" individuals, but Samson's study examines the involvement of particular professions that implemented the eugenic programs on the ground in Alberta. In "Eugenics in the Community: Gendered Professions and Eugenic Sterilization in Alberta, 1928-1972," Samson takes a gendered approach and explores the largely female-dominated professions (teaching, public health nursing, and social work) that were responsible for the daily operation of Alberta's eugenics program at the community level rather than in provincial mental health institutions. As Samson points out, when women are discussed in histories of eugenics, they tend to focus on the same individuals, like Helen MacMurchy, or those in positions of influence in political parties.⁶⁷ Samson asserts that the eugenics movement developed within the context of maternalism, which praised the capability of women to mother beyond the family. This ideology granted white, middle-

⁶⁶ Menzies, "Governing Mentalities," 179.

⁶⁷ Amy Samson, "Eugenics in the Community: Gendered Professions and Eugenic Sterilization in Alberta, 1928-1972," *Canadian Bulletin of Medical History* 31, 1 (2014): 144.

class women the authority to apply their allegedly innate nurturing skills to broader social problems, such as “mental deficiency,” and it is within this context that many women turned to “helping professions.”⁶⁸ These professions had access to individuals, families, homes, and schools, which allowed them to establish themselves as critical players within the eugenics and mental hygiene movements. Samson’s overall conclusion is that these female-dominated professions recognized their importance to the movement and this served their professional interests. Her conclusion is similar to Dowbiggin’s, McLaren’s, and Menzies’ in that the women in these professions used the movement to maintain and extend their professional authority.⁶⁹ Samson’s study alters the image of a primarily male elite dominated eugenics movement that historians, such as Dowbiggin, McLaren, and Menzies, have created by identifying influential women’s professional groups that were also involved in the dissemination of eugenics programs.

The examination of the eugenics movement on a national scale is important because it illuminates the involvement of policy makers and demonstrates that there really was not a united transnational or national agenda. However, historians like Erika Dyck argue that the movement was more complex and must be studied on a smaller, more regional level in order to understand how policy and discourse shaped what was happening on the ground. Dyck maintains that eugenics advocates in different regions in Canada adopted aspects of eugenic rhetoric they believed was most relevant to their context and manipulated the program to suit their perceived needs.⁷⁰ This approach can help us to explain why Alberta and British Columbia were the only two Canadian

⁶⁸ Samson, “Eugenics in the Community,” 145.

⁶⁹ Samson, “Eugenics in the Community,” 144.

⁷⁰ Dyck, *Facing Eugenics*, 7.

provinces that implemented sexual sterilization acts and encourages us to reconsider what programs can actually be considered eugenic in nature. For example, a range of public health initiatives, baby beauty contests, and elective sexual sterilization as a means of birth control have more recently been considered by historians to be part of the eugenics movement.⁷¹

Historians of eugenics have recently begun to focus on the relationship between eugenics and racialized populations, specifically Indigenous peoples. They have examined the relationship between the eugenic program of sexual sterilization and Indigenous populations. In “Sterilizing the ‘Feeble-minded’: Eugenics in Alberta, Canada, 1929-1972,” Jana Grekul, Harvey Krahn, and David Odynak investigate racial/ethnic groups that were targeted by the Alberta Eugenics Board. In this quantitative study, they show that Indigenous peoples were the most prominent victims of Alberta’s Eugenic Board and were over-represented among Alberta cases. Importantly, they found that most Indigenous patients presented before the Eugenics Board were eventually sterilized; 74 percent of Indigenous patients presented to the board were eventually

⁷¹ Leslie Baker’s study of Halifax following the 1917 explosion invites us to expand our interpretation of eugenics programs beyond coercive sterilization to recognize the ways in which bodies and families were surveyed and controlled under the guise of progressive health reforms. Leslie Baker, “‘A Visitation of Providence’: Public Health and Eugenic Reform in the Wake of the Halifax Disaster,” *Canadian Bulletin of Medical History* 31, 1 (2014): 99-122. In Gerald Thomson’s study of the better baby contests in Vancouver and New Westminster from 1913 to 1929, he argues that the contests cannot simply be understood as beauty pageants; instead, they must be understood as part of the province’s eugenic project, “a highly coercive form of social engineering that perverted evolutionary theory.” Gerald E. Thomson, “‘A baby show means work in the hardest sense’: The Better Baby Contests of the Vancouver and New Westminster Local Councils of Women, 1913-1929,” *BC Studies* 128 (2000/2001): 5-36. Finally, Erica Dyck’s study of middle-class women’s use of sterilization as a form of birth control in Alberta during the eugenics movement invites us to reconsider our understanding of the connections between eugenics and contraception. Erika Dyck, “Sterilization and Birth Control in the Shadow of Eugenics: Married, Middle-Class Women in Alberta, 1930-1960s,” *Canadian Bulletin of Medical History*, 31, 1 (2014): 168-187.

sterilized compared to 60 percent of all patients presented.⁷² Finally, Indigenous patients were the most likely to be classified as ‘mentally defective,’ which meant that they seldom had a chance to say ‘no’ to being sterilized as consent was not needed in cases diagnosed as such.⁷³

Karen Stote’s analysis in “The Coercive Sterilization of Aboriginal Women,” also largely quantitative in nature, comes to a similar conclusion. Her study focuses on Indigenous women throughout Canada over the course of the twentieth century with specific attention paid to the post-1950 period. She argues that Indigenous women were subject to sterilization both under enacted legislation and in provinces where no formal legislation existed.⁷⁴ In considering Indigenous women’s reproduction, Stote also links sterilization to colonialism, the goals of Canada’s Indian Act, and the oppression of women more generally. She maintains that sexual sterilization cannot be seen as an isolated instance of abuse, but instead as just one of many colonial policies that were used to disempower Indigenous peoples.⁷⁵

In *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*, Dyck’s examination of Indigenous peoples in relation to eugenics is more qualitative than Grekul et al.’s and Stote’s. She presents a case study involving an Indigenous man who faced the Alberta eugenics board as a way to illuminate the effects of eugenic policies on real, lived experience.⁷⁶ According to Dyck, it is extremely difficult to examine the relationship between eugenics policies and Indigenous peoples beyond citing the numbers

⁷² Jana Grekul, Harvey Krahn, and Dave Odynak, “Sterilizing the ‘Feeble-minded’: Eugenics in Alberta, Canada, 1929-1972,” *Journal of Historical Sociology* 17, 4 (2004): 375.

⁷³ Grekul, Krahn, and Odynak, “Sterilizing the ‘Feeble-minded,” 375.

⁷⁴ Karen Stote, “The Coercive Sterilization of Aboriginal Women.” *American Indian Culture and Research Journal* 36, 3 (2012): 141.

⁷⁵ Stote, “The Coercive Sterilization of Aboriginal Women,” 117-119, 139-141.

⁷⁶ Dyck, *Facing Eugenics*, 20, 56-57.

that were sterilized. Dyck indicates that in documented political and medical discussions, there is little to no evidence to suggest that Indigenous communities were specifically targeted.⁷⁷ She admits that no voices from Indigenous communities were included in her study; instead, she relied on textual evidence, primarily how public officials and medical authorities viewed Indigenous reproduction within the context of eugenics, as a way to avoid conspiratorial allegations that government officials simply approved sterilization in an effort to curtail reproductive capabilities within these communities.⁷⁸ Dyck's assessment of the relationship between the eugenics sterilization program and Indigenous people differs from Grekul et al.'s and Stote's conclusions as she paints a more complicated picture. She suggests that Indigenous peoples largely escaped Alberta's formal eugenic policy, but elements of eugenics were woven into assimilation strategies. The belief that the Indigenous population was already in a state of natural decline meant that eugenicists felt they did not need to expend energy or resources on speeding up the process. However, once it became evident in the second half of the twentieth century that this was not the case, the focus shifted to these communities.⁷⁹ Dyck's main point is that Alberta's official eugenics program did not explicitly identify Indigenous peoples as candidates for sexual sterilization, but the eugenic language of ideal citizenship relied on racial hierarchies that were conceptualized within a broader colonial framework. Intelligence was seen as a measure of human worth and white, middle-class reformers associated it with 'whiteness,' English language ability, and Western customs.⁸⁰ Dyck does acknowledge the statistics provided by Grekul et al. that indicate that Indigenous

⁷⁷ Dyck, *Facing Eugenics*, 56-57.

⁷⁸ Dyck, *Facing Eugenics*, 62.

⁷⁹ Dyck, *Facing Eugenics*, 56-57.

⁸⁰ Dyck, *Facing Eugenics*, 59, 83.

patients were over-represented among those sterilized in Alberta; however, she suggests her that the statistics were not presented properly. They do not show the numbers broken down by years or that the majority of the sterilizations of Indigenous patients actually took place during the second half of the twentieth century and not throughout the entire program.⁸¹ Taken together, these three studies present a good, but preliminary, understanding of how Indigenous peoples were affected by the eugenics policies and offer a basis for further research on the relationship between Indigenous people, and racialized populations more generally, and the eugenics movement.

Although not focused on race, Monica Wosilius' MA thesis, "Eugenics, Insanity and Feeble-mindedness: British Columbia's Sterilization Policy from 1933-1943," investigates the selection of patients for sexual sterilization in the first decade following the enactment of the Sexual Sterilization Act in 1933. Drawing on patient case files, she takes a nuanced approach to the study of sterilization. Moving away from a strictly social control perspective, Wosilius argues that sterilization must be viewed as a negotiated experience between various social groups. Patients, their families, mental health professionals, and social service workers negotiated, rejected, and redefined sterilization policy based on a multitude of factors, including class, race, gender, sexuality, and morality. These factors influenced the selection of sterilization candidates based on definitions of insanity, feeble-mindedness, and proper motherhood.⁸² Wosilius importantly suggests that, while sterilization legislation was inherently eugenical in nature, in the first decade following its enactment, sterilization never became a policy imposed on all asylum patients. Instead, each year only a few individuals, primarily young Canadian

⁸¹ Dyck, *Facing Eugenics*, 60-61.

⁸² Monica Wosilius, "Eugenics, Insanity and Feeble-mindedness: British Columbia's Sterilization Policy from 1933-1943" (MA Thesis, University of Victoria, 1995), 24-28, 33, 53-56.

women diagnosed with mental deficiency, were selected.⁸³

Finally, historians of psychiatric history and eugenics have been interested in understanding the relationship between gender and mental health. Most studies have examined the relationship physicians perceived between a patient's mental health and their body, specifically their reproductive system. In *The Female Malady: Women, Madness, and English Culture, 1830-1980*, Elaine Showalter argues that the theories of sexual difference were incorporated into a highly prescriptive psychology of women. Physicians agreed that women's brains were connected to the operation of their reproductive organs and therefore their mentalities were different from men's. These physical and mental differences were central components of 'woman's nature' and when women defied their 'nature,' for example by competing with men or denying their maternal functions, they would mentally break down. Showalter concludes that women were believed to be more vulnerable to insanity than men, to experience it in specifically feminine ways, and to be differently affected by it in their everyday lives.⁸⁴

Wendy Mitchinson's *Body Failure: Medical Views of Women, 1900-1950* investigates the centrality of the female reproductive system in medical practice. Similar to Showalter, Mitchinson argues that the medicalization of women's bodies in this period was a reflection of the value system of the time and the reality of woman's place in that system. The popular ideology of separate spheres bolstered differences between the sexes, with men being perceived as the superior sex and physicians seeing their bodies as the 'norm.' Deviations from that body, such as menstruation, childbirth, and menopause, appeared suspect and left women prone to weakness. As Mitchinson asserts, physicians'

⁸³ Wosilius, "Eugenics, Insanity and Feeble-mindedness," 32, 36, 45, 50.

⁸⁴ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York: Pantheon Books, 1985), 7.

views on the causation of mental illness reflected their own gendered perception. Underlying much of their understanding of women and mental illness was the image of what a healthy woman was and how she should act. Many physicians believed that deviation from that ideal could result in mental problems.⁸⁵ Reproduction itself was perceived to be one of the life-cycle transitions that placed more stress on women's bodies than men's, which could lead to mental disturbance. It was believed that all women in some way became 'upset' during pregnancy, but some crossed the line that separated the psychologically normal from the pathological.⁸⁶ Like Showalter, Mitchinson argues that, in this period, the threat of mental breakdown followed women throughout their lives. It did so for men as well, but the difference was that many causes of mental illness were linked to women's bodies, particularly to those elements that separated them from men. While theories linking insanity to menstruation, pregnancy, and childbirth were strong and widespread from the nineteenth century to the First World War, they began to be challenged by many physicians during the interwar years as understandings of the causation of mental illness began to shift to heredity, although female specific causation did not completely disappear.⁸⁷

Historians concur that there was a gendered aspect to the eugenic understanding of inheritance, which was believed to be the cause of most mental disorders in this period. In Lykke de la Cour's PhD thesis "From 'Moron' to 'Maladjusted': Eugenics, Psychiatry, and the Regulation of Women, Ontario, 1930s-1960s," she suggests that eugenics in the early twentieth century placed a heightened emphasis on biology,

⁸⁵ Wendy Mitchinson, *Body Failure, Medical Views of Women, 1900-1950* (Toronto: University of Toronto Press, 2013), 249.

⁸⁶ Mitchinson, *Body Failure*, 246.

⁸⁷ Mitchinson *Body Failure*, 244-246.

reproduction, and motherhood as the primary means through which mental defect was produced. De la Cour argues that women considered ‘feeble-minded’ were cast as the “harbingers of mental defect” through their propensity to pass on mental defects to offspring.⁸⁸ Similarly, Showalter and Mitchinson explain that understandings of heredity were gendered in nature during this period. Physicians believed that there was a relationship between the health of the mother and the health of the fetus; women were most likely to pass on their “tainted heredity” to the next generation. They also maintain that physicians thought that mothers had a greater tendency to transmit insanity to their female children than did fathers.⁸⁹

This thesis builds on the histories of psychiatric institutionalization and eugenics in Canada. As Dyck asserts, the Canadian eugenics movement must be studied on a local scale in order to understand how discourse shaped what was happening “on the ground.” Wosilius’ thesis considers eugenics in the context of the Sexual Sterilization Act; however, eugenic discourse in the period prior to the passing of the Act has yet to be investigated. This thesis also adds to the work of historians, such as McLaren, Dowbiggin, and Menzies, who are interested in understanding why prominent individuals became strong supporters of the eugenics movement by examining the ways in which asylum physicians used the eugenic discourse of “defective heredity” in institutional practice. Additionally, this thesis is concerned with the relationship between eugenic discourse, gender, and race in psychiatric practice. This thesis falls in line with the insights of Showalter and Mitchinson who suggest that, in regards to women’s mental

⁸⁸ Lykke de la Cour, “From ‘Moron’ to ‘Maladjusted’: Eugenics, Psychiatry, and the Regulation of Women, Ontario, 1930s-1960s,” (PhD thesis, University of Toronto, 2013), 156-157.

⁸⁹ Showalter, *The Female Malady*, 122-123; Mitchinson, *Body Failure*, 244-245.

health, the eugenic understanding of inheritance was gendered and women were seen as the primary transmitters of ‘tainted’ heredity. While these historians focused on medical discourse broadly and the eugenic reproductive control of women (both encouraging reproduction of the ‘fit’ and limiting reproduction of the ‘unfit’), I am interested in how this gendered discourse of inheritance played out on the institutional level in the classification and diagnoses of patients.

Sources

This thesis uses patient case files from the Public Hospital for the Insane and Essondale as primary sources. These case files are housed at the British Columbia Provincial Archives. Permission to access the case files was obtained under the Freedom of Information and Protection of Privacy Act. Following the guidelines of the Act, all patient names, individual identifiers, and case file numbers referred to in this thesis have been changed to protect anonymity. Patient case files are rich sources of information. Included in most case files are a photograph of the individual, applications for admission, physical examination, laboratory reports, clinical charts, personal and family history, ward notes, correspondence, visitor’s log, discharge notes, and death certificates. In some cases, there are also transcripts from the patient’s interview. Patient case files are a key source for this study as they allow for the investigation of how eugenic discourse was used in psychiatric practice in this period and offer insight into the asylum physicians’ understandings of the ‘causes’ of mental illness among female patients.

Admission books were also used extensively as a source for this thesis. While much of the information in the admission books can also be found in the patient case files, they were a useful resource for selecting case files and for compiling quantitative

data. The admission books chronologically list patient admissions and include information on nationality, education, occupation, civil status, diagnosis, and length of mental illness. Most importantly, the books list the supposed ‘cause’ of mental illness of new patients admitted.

Published annual reports on B.C.’s mental hospitals from 1918 to 1930 were also useful sources primarily for compiling quantitative data. The annual reports were divided into three sections. The first section was of most relevance because it provided statistics on the patient population. It offered data on admissions, discharges, deportations, deaths, nationality, occupation, age, statistics on heredity, alleged causes of insanity, and form of mental disorder. The second section in the annual reports provided information on the financial aspects of the institution and patient labour. The third section focused on profits, losses, livestock, and food cultivation. In addition, numerous contemporary medical handbooks and published journal articles were also valuable sources. The medical journals used were the *Canadian Medical Association Journal*, the *Vancouver Medical Association Journal*, and the *Canadian Journal of Mental Hygiene*.

Chapter Overviews

Drawing on medical journals, as well as books, interviews conducted by the B.C. Royal Commission on Mental Hygiene, and newspaper articles from major B.C. newspapers, Chapter One examines the popular and medical discourses on mental health and eugenics in B.C. during the 1920s. This chapter adds to the broader Canadian historiography on eugenics as it documents the medical and lay communities’ understandings of and theories on the nature of insanity and mental deficiency. It also analyzes the important role that the eugenic discourse of “defective heredity” played in

heightening public concern over the apparent unprecedented increase in such individuals in the population. B.C.'s eugenicists, who included asylum physicians, agreed that something needed to be done to stop individuals with poor heredity from reproducing and passing on a predisposition to mental disorders to their offspring. Both lay and medical eugenicists in the province, like those in the rest of Canada, promoted programs that identified and segregated these individuals, controlled their reproduction, and restricted their immigration as the only way to protect the health and safety of the province and the country.

Chapter Two examines how the eugenic discourse of “defective heredity” was used in psychiatric practice. During the 1920s, a high percentage of asylum patients’ mental conditions were directly connected to their heredity. In its analysis of patients in the Public Hospital for the Insane and Essondale, this thesis considers both gender and race. Chapter Two focuses on gender. Asylum physicians frequently used heredity as an explanation for mental illness, especially among female patients. Female patients were more likely than their male counterparts to be labeled as mentally ill due to heredity, often despite evidence available to asylum physicians. This chapter relies on patient case files, admission books, and annual reports to investigate the role of heredity in diagnoses. It considers two diagnostic categories specifically: “heredity inferred” and “constitutional.” All female admissions classified as “heredity inferred” from the years 1920, 1923, 1927, and 1930 were selected and all female admissions classified as “constitutional” from the years 1927 and 1930 were selected.⁹⁰ The two categories had loose definitions, making them flexible, while maintaining the perception that the

⁹⁰ ‘Constitutional’ only became a major diagnostic category in the late 1920s.

physicians were able to determine a scientific reason for mental illness. They were also useful to eugenically minded asylum physicians as the latter were absolved from having to provide a 'cure' and the blame for the perceived increase in mental illness could be placed on the individuals and their families.

Like Chapter Two, Chapter Three also explores the relationship between eugenic discourse and psychiatric practice. In examining female asylum patients, it focuses on race. While this chapter is not concerned with the relationship between race and sexual sterilization as discussed by Stote, Grekul et al., and Dyck, it does contribute to the historiography of eugenics and race by examining the ways in which the eugenic discourse of defective heredity, along with the ideology that promoted a model of Anglo-Saxon biological racial superiority, influenced the classification and diagnoses of racialized female patients. Using the case files of racialized women admitted to the asylum from 1918 to 1930, I argue that heredity was used as an explanation for mental illness among racialized women at an even higher rate than among the overall female population. Furthermore, this thesis adds to the work of Scott, Menzies and Palys by examining the asylum experience of racialized female patients. Like these historians, I suggest that the racist attitudes of asylum staff reflected the broader discriminatory ideologies that existed in B.C. and shaped the institutional experience of racialized patient populations.

Overall, this thesis contributes to the historiography of psychiatric institutions, mental health, gender, race, and eugenics in Canada by examining the relationship between psychiatric practice and the eugenic discourse of inheritance that was dominant in B.C. throughout the 1920s. Historians have studied the relationship between eugenics

and psychiatric practice, but they have primarily focused on the sexual sterilization of asylum patients and the period prior to the passing of the Sexual Sterilization Act has largely been overlooked. The 1920s was a period when the eugenic discourse of defective heredity was strong and widespread in B.C. Public asylum physicians reported that a high percentage of their patients were mentally ill due to heredity and promoted eugenic programs of segregation, marriage restriction, sexual sterilization, and immigration constraints as solutions to this perceived problem. Female patients were targeted by this discourse as they were considered the primary transmitters of hereditary 'defects.' This discourse eventually led to the passing of the Sexual Sterilization Act in 1933 and until it was repealed almost 40 years later, approximately 350 individuals, the majority of whom were women, underwent sexual sterilization.

Chapter One: Medical and popular understandings of mental health and eugenics in British Columbia, 1918-1933

After the First World War in British Columbia, the eugenics and mental hygiene movements' concerns about individuals and families believed to be insane and mentally defective increased dramatically. The inter-connected eugenics and mental hygiene theories found many supporters among the medical and lay communities. Due to the belief that mental disorders were increasing in unprecedented numbers, it was argued that the insane and 'feeble-minded' posed a threat to the health and prosperity of society.¹ Many believed that, if the number of those defined as insane and mentally defective were not controlled, then those with the lowest intelligence would overwhelm the intelligent and become great social and financial burdens.² Both medical and public discourses reproduced the idea that the primary cause of all mental disorders was "defective heredity." Mental hygiene reformers, concerned with the social and political consequences of unchecked mental diseases, formed the Canadian National Committee on Mental Hygiene (CNCMH) to investigate psychiatric facilities, immigration policies, public education, and prison populations. In the interwar years, the mental hygiene movement and eugenics, with its program of population control measures, were interlinked as they found common ground in the notions that the insane and 'feeble-minded' posed a genetic threat to a healthy society and that the state and science together

¹ In the 1930 Annual Report for Mental Hospitals, Dr. Crease stated that in B.C. 1 in every 300 people was insane and that there were 400 'feeble-minded' individuals in the mental institutions. British Columbia Sessional Papers. Annual Report of the Mental Hospitals of the Province of British Columbia 1930 (Victoria, B.C.: Government Printer), 10. (Hereafter Annual Report, Year).

² Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), 10, 39-40.

were the instruments of social reform.³ This chapter first discusses the contemporary medical understanding of insanity and mental deficiency. It then examines the eugenic discourse produced by British Columbia's medical and lay communities, specifically their ideas about the inheritance of defective heredity and the need to control it through programs of segregation, marriage restriction, sexual sterilization, and stricter immigration policies.

By the beginning of the nineteenth century, insanity had become a clearly designated mental disorder as it was understood that the mind was a function of the brain and that the deviant behaviour of those deemed insane was due to a diseased brain. Early in the century, it was believed that diseased brains were the result of "psychological events" such as grief, disappointment in love or business, religious or political excitement, or inadequate home life. Physical causes like injury, intoxication, or hereditary influence were thought to be of less importance. A few decades later, the emphasis on the causes of mental diseases shifted with more importance being placed on physical causes, especially heredity.⁴ Into the twentieth century, medical practitioners increasingly argued that the primary cause of all mental disorders was "defective heredity" that created a predisposition to mental disease. Defining "defective heredity" in the *Canadian Medical Association Journal*, Dr. G.H. Stevenson of Ontario explained that insanity itself (e.g., manic depression or dementia praecox) was not inherited; instead, it was a predisposition to insanity that was passed down. "Defective heredity" referred to

³ Dyck, *Facing Eugenics*, 39-40; Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland & Stewart, 1990), 111; Robert Menzies, "'Unfit' Citizens and the B.C. Royal Commission on Mental Hygiene, 1925-1928," in *Contesting Canadian Citizenship: Historical Readings*, edited by Robert Adamoski, Dorothy Chunn, and Robert Menzies (Peterborough, Ontario: Broadview Press, 2002), 391.

⁴ S.E.D. Shortt, *Victorian Lunacy, Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry* (Cambridge: Cambridge University Press, 1986), 95-96.

the defects in near relatives that might indicate that an individual had not been “fully endowed qualitatively at birth.” Actual psychosis, marked eccentricity, alcoholic excesses, and suicides were all viewed as defective traits. If passed on to the next generation, they would appear in the character of the individual and the ways in which they reacted to circumstances. It was understood that individuals with these “defective traits” were unable to achieve a well-rounded and adaptable life.⁵

At the turn of the twentieth century, another category of mental disease that had its roots in hereditary emerged. “Feeble-mindedness,” according to Angus McLaren, was “created” at this time when education was made both free and compulsory. Massive numbers of children were subjected to intelligence tests and medical inspections and those who did not meet the new norms were labeled as “inadequate” or “deficient.”⁶ In 1925, Provincial Secretary William Sloan urged the B.C. Legislature to establish a provincial Royal Commission on Mental Hygiene (RCMH). The order was passed at the end of that year and Dr. Edwin Rothwell was elected chairman of the Commission. The Commission was mandated to investigate the reason for the increase in mental hospital patients, the causes and prevention of insanity, the entry of insane and mentally deficient immigrants into the province, the care and treatment of subnormal children, and “any other matters and things that related to the subject of insanity.” During its work in the province from 1925 to 1928, the RCMH used the terms mental deficiency, mental defect, and feeble-mindedness synonymously to define a condition of apparent arrested development of the mind due to some physical defect in the brain that was present from birth or early age. The commissioners explained that there was no cure for people in this

⁵ G.H Stevenson, “The Psychogenic Psychoses: Their Causes and Symptoms,” *Canadian Medical Association Journal* 16, 12 (1926): 1432.

⁶ McLaren, *Our Own Master Race*, 91.

category but training could greatly help them. Within this group, they identified three different “grades” based on a sliding scale of intelligence. First, there were the “idiots” who had “no mind at all” and a mental age of three years or less. Next were the “imbeciles” who had a mental age of three to seven years. Finally, there were the “morons” or “feeble-minded.” Their mental age was between seven and eleven years and it was believed they were the ones who could “get by” in the community unnoticed until they were faced by the problems of life that their “stunted mentality” could not deal with. The authors of the RCMH’s report explained that it was easy to spot the idiots and imbeciles, but the morons were less easy to recognize and therefore posed the greatest threat to society.⁷

Dr. H.C. Steeves, the superintendent of the Public Hospital for the Insane and Essondale from 1920 until 1926, followed a similar categorization of mental disorders in asylum practice, but his definitions differed slightly from the RCMH’s. Dr. Steeves included epileptics in the feeble-minded category and he defined the feeble-minded as individuals who “had never had a mind and would never have a mind.” According to him, these people were automatons with a mental age of two to eight years.⁸ Dr. Steeves believed that this group would never be able to care for themselves and did not think they would ever be useful in any way. He did explain that they could benefit from training, but it had to be “mechanical training” like the training of a horse or a dog. Treatment for

⁷ Royal Commission on Mental Hygiene, *Final Report of the Royal Commission on Mental Hygiene* (Victoria, B.C., Government Printer, 1928), 4-5. (Hereafter RCMH, *Final Report of the RCMH*); Royal Commission on Mental Hygiene, *Report of the Royal Commission on Mental Hygiene* (Victoria, B.C., Government Printer, 1927), 21 (Hereafter RCMH, *Report of the RCMH 1927*.)

⁸ British Columbia Archives, Royal Commission on Mental Hygiene, GR 0865, Box 1 File 7, Report of the Mental Hygiene Commission held in Vancouver 13-14 April 1926, and in Victoria 16 April 1926, 4-5 (Hereafter BCA, RMHC April 1926).

feeble-mindedness was limited and the condition was incurable.⁹ Hereditary nature also accounted for another group, the “subnormal.” Dr. Steeves maintained that individuals in this group had some degree of intelligence and mental age of approximately nine years. He believed that with training they could possibly fill useful positions in society. With assistance from Social Services, Dr. Steeves thought that these individuals would likely be able to care for themselves. While the subnormal could not be cured, much could be accomplished by providing them with intelligent care.¹⁰ In general, medical discourse constructed the notion that both insanity and feeble-mindedness were caused by “defective heredity,” but the primary difference between the two conditions was that insanity constituted a breakdown of a developed brain and needed to be treated as a disease while mental deficiency was the result of a physical defect in the brain and could not be cured.¹¹

Physicians also agreed that individuals with “defective heredity” were more likely to become insane when faced with the stresses of life. Dr. Steeves found that the majority of patients who were entering the asylum were doing so between the ages of thirty-five and forty and he believed that this was because this was the time of life when stress was the greatest. According to him, “those who enter the game of life handicapped by poor heredity break under the responsibilities incident to progress.” He suggested that those who were predisposed to mental illness should therefore avoid taking on more responsibility than necessary in their desire to accumulate wealth.¹² Throughout Canada,

⁹ BCA, RMHC April 1926, 4.

¹⁰ BCA, RMHC April 1926, 4-5.

¹¹ RCMH, *Report of the RCMH* 1927, 21.

¹² Annual Report 1922, 9-10; Annual Report 1924, 10; H.C. Steeves, “Community Mental Health Problems,” *The Vancouver Medical Association Journal* (March 1926), 13.

physicians linked mental breakdowns to the physiological “epochs” of life. For both men and women, according to Dr. Stevenson of Ontario, this included puberty and, for women, these epochs also included pregnancy, childbirth, and menopause. When those with inherited defects faced these stages in life, they were often unable to bear “the tremendous extra load put on him or her” at these periods and would break down.¹³ The notion of a breakdown at the “epochs” of life was an idea that had its roots in the nineteenth century when it was usually linked to women, as it was believed that they were prone to breakdown when their reproductive systems were put under stress during menstruation and childbirth.¹⁴

Following the wider North American medical discourse that positioned heredity at the top of the causes of mental illness, B.C. asylums identified heredity as a cause of mental disorders as early as 1886¹⁵ and, over the years, the number of cases of insanity attributed to heredity steadily increased, reaching its peak in the mid-1920s. Throughout his career as superintendent, Dr. Steeves expressed concerns about the hereditary nature of manic-depression and dementia praecox, the two disorders that were believed to be “essentially hereditary” in nature.¹⁶ In 1921, Dr. Steeves was alarmed by the fact that 50 percent of the asylum’s population was made up of patients suffering from these types of mental illness. He suggested that a public education campaign be instituted, which would educate citizens on the hereditary nature of these mental illnesses and on the effect that transmission of such diseases would have on the future “quality” of the Anglo-Saxon

¹³ Stevenson, “The Psychogenic Psychoses,” 1434.

¹⁴ Wendy Mitchinson, *The Nature of their Bodies: Women and their Doctors in Victorian Canada* (Toronto, University of Toronto Press, 1991), 296-297.

¹⁵ Annual Report 1886.

¹⁶ Annual Report 1921. 9.

race.¹⁷ When heredity was not reported or ascertained by staff, it was “inferred from investigation which could not be pursued to a positive conclusion.” For example, in 1924, heredity was reported as being a cause in 200 admissions, of which 104 were “inferred.”¹⁸ Cases of paranoia were added to the calculations of hereditary cases in 1925, as paranoia was considered another form of mental disease in which heredity was an “outstanding factor.”¹⁹ Private asylum practitioners reported heredity along the same lines. Dr. McKay, former public asylum physician and founder of the private Hollywood Sanitarium in New Westminster, indicated that he believed heredity was paramount in the causation of insanity and that, according to his estimation, 60 to 70 percent of all asylum cases were caused by defective heredity. Dr. McKay explained that if you included the feeble-minded, then the percentage of patients seen in practice with defective heredity was as high as 90 percent.²⁰

Those defined as feeble-minded, subnormal, idiots, imbeciles, and morons were also admitted to the asylums in B.C. during this period. The RCMH asserted that feeble-mindedness was not due to poverty or lack of education. In a few cases, it was attributed to injuries or diseases at birth, but in two-thirds of all cases the cause was heredity.²¹ Medical practitioners agreed that, in cases where both parents were or even just one parent was feeble-minded, the offspring would most certainly be mentally defective.²² Dr. Farrer, director of the Toronto Psychopathic Hospital, explained that “the tendency is like

¹⁷ Annual Report 1921, 9.

¹⁸ Annual Report 1924, 9.

¹⁹ Annual Report 1925, 10.

²⁰ BCA, RMHC April 1926, 19.

²¹ RCMH, *Final Report of the RCMH*, G9.

²² D.S. Davies, “Inheritance of Mental Defect,” *Canadian Medical Association Journal* 19, 2 (1928): 251.

to like; the feeble-minded people keep together ... if there are two defective strains, then the child is a hopeless imbecile.”²³ Mental deficiency was seen to be the root of a number of serious social problems as well, including crime, juvenile delinquency, prostitution, and pauperism.²⁴ Medical practitioners agreed that there was an intimate relationship between mental deficiency and crime, estimating that 30 to 50 percent of the chronic delinquent class was mentally deficient. The Canadian National Committee for Mental Hygiene (CNCMH) considered the feeble-minded to pose a more serious problem to public safety than the insane because they were more liable to fall into “evil ways” (criminality and vice).²⁵

B.C. medical practitioners agreed that heredity played the primary role as the cause of various forms of mental disorders, some thought that environmental factors also played an important role. However, heredity and environmental causes were not viewed as being separate; it was argued that they were intimately interconnected, but heredity was ultimately the most important factor.²⁶ As Mary-Ellen Kelm explains, by the beginning of the twentieth century, environmental causes were seen as “exciting” factors that would affect an individual already predisposed to insanity through poor heredity (similar to the idea of breakdown during “epochs” of life mentioned above).²⁷ Physicians argued that individuals who developed psychoses frequently had “unfortunate” home lives during their developmental years. Often they had to associate with peculiar

²³ BCA, RMHC April 1926, 26.

²⁴ Canadian National Committee for Mental Hygiene, Mental Hygiene Survey of the Province of British Columbia,” *Canadian Journal of Mental Hygiene* 2,1 (April 1920): 55.

²⁵ C.M. Hincks, “Recent Progress in the Mental Hygiene Movement in Canada,” *Canadian Medical Association Journal* 11,11 (1921): 824.

²⁶ BCA, RMHC April 1926, 26; Lewellys F. Barker, “Address by Dr. Barker on ‘Nervous Breakdown,’” *The Vancouver Medical Association Bulletin* (September 1925): 9.

²⁷ Mary-Ellen Kelm, “Women, Families, and the Provincial Hospital for the Insane, British Columbia, 1905-1915.” *Journal of Family History* 19, 2 (1994): 180.

individuals, received too much or too little attention, lacked training, and lived in homes that lacked control. Basically, they argued that everything that came to bear on individuals in their early life, like the training and influence of others, could make certain abnormal tendencies more like second nature, leading them to grow up in a “semi-warped fashion.”²⁸ In order to avoid a mental breakdown, then, individuals who were predisposed to mental disorders needed to “be guided along those channels in life which will present the least mental strain or fatigue.”²⁹ Some physicians actually placed more importance on environment than heredity. For example, Dr. Dobson, a neuro-psychiatrist in Vancouver, argued that it was the environment that exerted control over the individual and that, when an environment was unfavorable, the person became “vicious” or broke the law.³⁰

While most members of the B.C. medical community agreed on the important role of heredity and the influence environment may have in causing mental disorders, some had different theories. One physician believed that religion, its numerous cults, spiritualism, and “religious fears” sometimes caused insanity.³¹ Another placed more importance on septic teeth. Victoria’s *Daily Colonist* reported that, according to a physician in London, infected teeth spread toxins to the brain.³² This theory was actually dismissed by most professional psychiatrists of the time.³³ Dr. Steeves commented that he did not believe that removing healthy teeth would cure mental disease.³⁴ However, in general, the medical community in B.C., and Canada more broadly, emphasized the

²⁸ Stevenson, “The Psychogenic Psychoses,” 1433; BCA, RMHC April 1926, 26, 46.

²⁹ Steeves, “Community Mental Health Problems,” 14.

³⁰ “Expert Explains Object of Mental Hygiene Work,” *Daily Colonist*, 23 April 1926, 11.

³¹ BCA, RMHC April 1926, 46.

³² “Mental Hygiene,” *Daily Colonist*, 16 August 1927, 4.

³³ Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton, N.J.: Princeton University Press, 1983), 124.

³⁴ Annual Report 1921, 10.

importance of heredity as the cause of mental disorders.

Influenced by the rise and popularity of the eugenics and mental hygiene movements, theories of hereditary degeneration were sources of public concern in B.C. as well. Those who were involved in policing and social service roles shared the medical community's perspectives on mental disorders. However, physicians generally made more of an effort to differentiate between insanity and feeble-mindedness than the lay-community did. During its work in the province, the RCMH interviewed a number of individuals involved in community roles about what they thought to be the cause of mental disorders and the majority focused on the issue of defective heredity. Police magistrate and juvenile court judge Henry Shaw shared that his experience had led him to believe that mental deficiency was the result of heredity, as "mental deficient parents will produce mentally deficient offspring" and suggested that environment and habits played an important role as well.³⁵ Another police magistrate spoke about his experience with children of low mentality coming from families where the parents exhibit the same tendencies,³⁶ and the superintendent of a local detention home concurred, wondering "does the child not act the way he does because he is the child of those parents?"³⁷ Reginald Hayward, a businessman and MLA who was appointed to the RCMH to investigate the role of heredity, agreed that it played the most important role in causing mental disorders and noted that the numbers of mentally deficient individuals were actually higher than believed. According to him, if physicians could get full and accurate family histories from their patients (which Hayward thought were being kept hidden to

³⁵ BCA, RMHC April 1926, 36.

³⁶ BCA, RMHC April 1926, 21.

³⁷ BCA, RMHC April 1926, 31-32.

avoid stigma), then “many medical charts would appear far worse than they now do ... they would show black marks when at the present time they appeared free of taint.”³⁸

In order to safeguard the community and the Anglo-Saxon race and to protect mentally deficient people from themselves, there was general agreement that some type of “prophylaxis” was needed to tackle the hereditary cause of mental disorders.³⁹

Physicians, those in social service roles, and the general public promoted a number of different types of prevention programs. For example, eugenic marriages, or restriction on who was permitted to wed, was proposed by a number of individuals. While speaking before the B.C. Legislature in 1924, W.A. MacKenzie and Dr. Rothwell both promoted the benefits of eugenic marriages. They urged that some corrective measures needed to be taken and incorporated into the laws of the province to stop the intermarriage of the “mentally affected.” Citing a law in Ontario that compelled both men and women to produce a medical certificate on application for marriage and prohibited the union of two mentally deficient people, McKenzie proposed the enactment of similar legislation in B.C.⁴⁰ Dr. Irene Bastow Hudson was another strong supporter of marriage regulations. She believed that many unsuitable marriages would be prevented and the transmission of syphilis, mental diseases, and predisposing conditions would be lessened with a requirement of a clean bill of health before union.⁴¹ The B.C. Medical Association published their stance on this question in the *Victoria Times* in 1926, wondering “why should we allow more feeble-minded children to be born? If you have poor stock born

³⁸ BCA, Royal Commission on Mental Hygiene, GR 0865, Box 1 File 8, Report on the ‘Hereditary’ Phase of the Cause of Insanity, by R. Hayward, 1.

³⁹ McLaren, *Our Own Master Race*, 98.

⁴⁰ “Suggests Wedding Fees for Doctors,” *Daily Colonist*, 6 December 1924, 1.

⁴¹ BCA, RMHC April 1926, 41.

among cattle or pigs ... you kill them off. But we cannot do this with children- the only thing we can do is prevent the marriages of feeble-minded people who are sure to have such children.”⁴² The Vancouver Child Welfare Association was a strong supporter of eugenic marriages as well. They urged that legislation be passed to prohibit marriage between mentally defective persons, even when just one partner was mentally deficient. They also advocated that no marriage licenses should be issued without first securing medical certificates .⁴³

On the other side of the debate, some physicians maintained that they saw no benefits to restricting marriages. Dr. H.E. Young, calling the practice a “dead letter,” argued that there would be no point in imposing restriction as nothing was stopping people from traveling to another province or to the United States to get married.⁴⁴ Dr. McKay, when asked by the RCMH if he would restrict the issuing of marriage licenses, replied that he actually saw it as a “negative action.” Agreeing with Dr. Young, he explained that, if people could not get married in B.C., they could simply go to Alberta. Furthermore, even if they could not get a license anywhere, this would not stop them from engaging in a sexual relationship. Dr. McKay believed it was best to just let people have access to legal marriages.⁴⁵

Although there was considerable support for eugenic marriages, sexual sterilization was touted as being the most effective method for combating the problem of increasing mental deficiency in the province. Some physicians, such as Dr. Farrer, saw it

⁴² “Our Hereditary Feeble-Minded,” *Victoria Times*, 1 March 1926.

⁴³ BCA, Royal Commission on Mental Hygiene, GR 0865, Box 1 File 4, Resolution submitted by the Vancouver Child Welfare Association, December 1925.

⁴⁴ BCA, RMHC April 1926, 51.

⁴⁵ BCA, RMHC April 1926, 19-20.

as the best way to “strike the thing right at the roots.”⁴⁶ Sexual sterilization was not a new practice by any means. Wendy Mitchinson indicates that, in the nineteenth century, reproductive surgery was used by some physicians in Canada, both inside and outside asylums, as a way to treat both physical and mental disorders as some believed it would bring about mental improvement in their patients, usually women. Theories at the time connected women’s mental health to their reproductive systems and it was argued that irritation in the pelvis was transmitted to the brain. Women were believed to be dominated by their sexual organs and the uterus was considered unstable. Menstruation, childbearing, and lactation were assumed to predispose women to some mental illnesses, usually hysteria, simply because they were female.⁴⁷ In men, reproductive surgery was sometimes used to bring about a cure in cases of “masturbatory insanity.”⁴⁸ These ideas, linking reproductive organs to mental health, became much less common by the 1920s.⁴⁹ While reproductive surgery in the nineteenth century was generally advocated for therapeutic reasons (i.e. to cure insanity), as the eugenics movement became stronger in the 1920s, sterilization began to be promoted as a birth control method to stop the reproduction of the mentally unfit.⁵⁰ Eugenics discourse was increasingly accepted in B.C. among both the medical and lay communities, which included physicians, police officers, and social workers and, within this discourse, sexual sterilization was seen as the

⁴⁶ BCA, RMHC April 1926, 26.

⁴⁷ Mitchinson, *The Nature of their Bodies*, 255; Shortt, *Victorian Lunacy*, 143; Wendy Mitchinson, “Gynecological Operations on Insane Women, London, Ontario 1895-1901,” *Journal of Social History* 15, 3 (1982): 468; Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen’s University Press, 1989), 53.

⁴⁸ Shortt, *Victorian Lunacy*, 125-127.

⁴⁹ Wendy Mitchinson, *Body Failure, Medical Views of Women, 1900-1950* (Toronto: University of Toronto Press, 2013), 246.

⁵⁰ Mitchinson, *Body Failure*, 244-245.

best way of protecting the citizens of the province from hereditary degeneration.

Ian Dowbiggin argues that, in early twentieth-century Canada, asylum psychiatrists were in favour of sterilization as they saw it as essential to improving public health.⁵¹ In B.C.'s asylum practice, reproductive control was first mentioned in asylum superintendent Dr. Steeves' 1923 annual report. He stated that he was in support of "better control ... in mating and reproducing the race."⁵² In 1925, he made a similar suggestion. After indicating that 71 percent of all asylum admissions that year were hereditary in nature, he emphasized that "some action [must be taken] to prevent the reproduction of the species by persons handicapped in this way." He went on to state that, along with strict supervision of who was allowed to marry, this matter could be effectively controlled through the sterilization of select individuals clearly affected by the hereditary factor.⁵³ The following year, Dr. Steeves made a distinction between groups of mental disorders and clarified his stance on sterilization. He stated that individuals who were "highly neurotic" and likely had actual psychoses (the insane) who wanted to marry should first be advised on their responsibility to future generations and should seriously consider sterilization. He also believed that the feeble-minded and epileptics should have no choice in the matter and should have their marriages prohibited until they underwent a

⁵¹ Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada 1880-1940* (Ithaca, New York: Cornell University Press, 2003), 134. Many other physicians in the province held the same opinions as Dr. Steeves. For the views of doctors McKay, Rothwell, and Hall, see Mitchinson, *The Nature of their Bodies*, 341; "B.C. Expected to Pass Law this Year," *Vancouver Sun*, 12 September 1927; BCA, RMHC April 1926, 19, 45; "Suggests Wedding Fees for Doctors," *Daily Colonist*, 6 December 1924, 1; and "Psychopathic Wards in Hospitals of B.C. Urged," *Daily Colonist*, 17 April 1926, 1-2. The B.C. Veterinary Association also added their voice to the sterilization discussion. See "Poor Types Getting Supremacy in State," *Daily Colonist*, 15 September 1925, 2.

⁵² Annual Report 1923.

⁵³ Annual Report 1925. 9-10.

sterilization procedure.⁵⁴ Dr. Steeves' distinction between the insane and the feeble-minded was in line with the eugenics movement's perspectives. The movement primarily targeted the feeble-minded for sterilization as they were believed to be more of a threat to the community.⁵⁵

The wider public discourse on sexual sterilization was similar to the one espoused by the medical community because medical professionals played a role in disseminating information on the subject. The opinions of Doctors Steeves and Rothwell, along with other B.C. physicians and lay-members of the RCMH, were often published in public newspapers. They also frequently visited local community groups to give lectures on the escalating problem of mental deficiency and on what actions needed to be taken. At the beginning of the RCMH's work in 1926, Reginald Hayward gave a lecture to the Local Council of Women in Victoria that presented his stance on sterilization. While explaining to the Council that "weak minded" men and women could still make good wives and husbands, he argued that they should not be permitted to reproduce and advocated for government-controlled sterilization.⁵⁶ These lectures were persuasive. For example, following a presentation by Doctors Steeves and Rothwell, the Child Welfare Association announced that they were in support of eugenic sterilization.⁵⁷

The RCMH, with its goal of trying to gauge the public's opinion on the subject of sterilization, interviewed a number of non-medical professionals and all were in support of sterilization. Superintendent of the Vancouver Detention Home and Chief Probation

⁵⁴ Steeves, "Community Mental Health Problems," 14-15.

⁵⁵ Dyck, *Facing Eugenics*, 3.

⁵⁶ BCA, Royal Commission on Mental Hygiene, GR 0865, Box 2 File 1, "Mental Hygiene" R. Hayward to Local Council of Women 10 February 1926, 3-5.

⁵⁷ BCA, RMHC April 1926, 23.

Officer Herbert Collier had “no hesitation in recommending sterilization for the delinquent [child] defective [because] the sex problem (i.e. uncontrolled sexual behaviour that resulted in reproduction) is a tremendous one.”⁵⁸ Provincial Secretary William Sloan used a farming metaphor that compared humans to seeds, explaining that, “in the field of humanity ... [we] take no care whatsoever to see that the stock is good. As a result, we are reaping a harvest of human wreckage and misery.” Taking a religious themed tone, he called the public’s lack of care “unchristian” and argued “that the people of Canada are guilty of the sin of omission when they allow and encourage the mating of mental defectives, and produce a result of “human derelicts.” He went on to state that it was unpatriotic to not care because “we are building, in peace, a liability that will be a menace in war.” He suggested that measures must be taken to build up a strong, virile race in B.C.⁵⁹

B.C. newspapers even took a position on the subject of reproductive control of the insane and feeble-minded, often using the terms interchangeably. In 1927, the *Vancouver Western Tribune* published an article indicating their long-time support for the sterilization of the feeble-minded prior to discharge from the asylums. The *Tribune*, using a garden metaphor to describe their “breeding habits,” considered the feeble-minded to be “the true weeds of society.” The newspaper saw sterilization as an “act of humanity [for] the unfortunate victims of insanity” and argued that steps had to be taken “to protect them from themselves, from the torture of the sex urge to an enfeebled mind and undisciplined character.” Citing economic arguments against the reproduction of the “unfit,” the *Tribune* hoped sterilization would save the taxpayer from the burden of having to provide

⁵⁸ BCA, RMHC April 1926, 31.

⁵⁹ “Mental Patients for Increasing Menace in B.C.,” *Daily Colonist*, 19 November 1925, 5.

for the support and comfort “of this most hopeless section of the community.”⁶⁰

While there was a seemingly large, vocal group of medical and lay people in B.C. promoting sterilization, some medical practitioners opposed it for a variety of reasons.⁶¹ Dr. H.E. Young of the Provincial Health Office did not believe in sterilization except in “obvious cases.” He was against it for practical reasons; he did not believe sterilization could be properly controlled. He argued that there were many “borderline” cases where there was no obvious manifestation of defect, but that it was possible that a “recessive dormant seed” may be present which could manifest itself in any future generation. He argued that, in these cases and many others, it was not clear enough where the line could be drawn.⁶² Others were against sterilization on moral and religious grounds. In B.C., Dr. Irene Bastow Hudson was the most vocal medical opponent of sterilization. She advocated adolescent education, stringent marriage laws, and segregation. According to her, sterilization was a crime and it could not be justified morally until all other measures had been tried. According to Dr. Hudson, enforced sterilization would be “one of the greatest sins against humanity and would ensure the downfall of the Empire and the decay of the race.” She saw sterilization as a “man-made law that would break the fundamental laws of Nature and God.” She further argued that this method would lead to the creation of “monsters of sex perversions” and it would glorify self-gratification. If

⁶⁰ Untitled, *Vancouver Western Tribune*, 19 March 1927. Individuals also wrote to the newspapers and shared their opinions on this subject. For example, a self-proclaimed “humanitarian” wrote to the *Morning Star* that they believed the families of criminals and mental deficient were becoming an increasing menace to civilization and that the primary objective should be to “remove the cause of the production of imbecile and deficient children.” Furthermore, “humanitarian” believed that “the idea that every child born into the world is a soul is ridiculous.” According to him, “such a conception ... is making a monster of the Creator.” “Sterilization and Prevention find Defender,” *Morning Star*, 22 December 1927.

⁶¹ For a discussion of opposition in the lay community, specifically Ada and Alan Muir, see McLaren, *Our Own Master Race*, 101-103.

⁶² BCA, RMHC April 1926, 51.

those considered insane and mentally deficient were such a danger to society, liable to reproduce without marriage, and if they could not be trained, then she saw segregation as the answer. However, like many who argued in support of sterilization, Dr. Hudson realized that segregation would probably be an economic impossibility. She stated that, temporarily, it might be necessary to “descend to the measure of castration.” This suggestion was based on her argument that castration was a less dangerous procedure and that it would remove sexual gratification as well.⁶³

While sexual sterilization was promoted as the best way to prevent the reproduction of the province’s ‘unfit,’ mentally deficient outsiders, or foreign-born people, were also considered to be a major threat to the economic and social well-being of the community. As historians have documented, by the turn of the twentieth century, increasing numbers of Canadians were calling for the Federal Immigration branch to prevent undesirable immigrants from landing. From 1896 to 1914, Canada had admitted three million immigrants and reformers were concerned that many of these newcomers were of “poor quality.”⁶⁴ The 1910 Immigration Act prohibited the entry of individuals believed to be idiots, imbeciles, feeble-minded, epileptic, insane, and those who had been deemed insane within five years previous. A 1927 amendment added people with anti-social personality traits to the list of prohibited classes.⁶⁵ However, concerned citizens felt that not enough was being done to prevent B.C., and Canada more generally, from becoming a “dumping ground” for other countries’ mentally deficient and insane

⁶³ BCA, RMHC April 1926, 41-43.

⁶⁴ Ian Dowbiggin, “‘Keeping this Young Country Sane’: C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925,” *The Canadian Historical Review* 76, 4 (1995): 606-607.

⁶⁵ Canada, *Immigration Act* 1910, section three; see also Ena Chadha, “‘Mentally Defectives’ not Welcome: Mental Disability in Canadian Immigration Law, 1859-1927,” *Disability Studies Quarterly* 28, 1 (2008): 1-30.

people.⁶⁶ Many Canadian-born citizens believed that these “unfit” immigrants were swamping the Anglo-Saxon race and some argued that this would lead to “race suicide.”⁶⁷ Throughout the 1920s, the medical and public discourse on immigration regulation was xenophobic and racist in tone and there was much concern expressed about the economic cost of caring for the undesirable foreign-born.

Each year, B.C.’s asylum superintendent reported on the high numbers of admissions coming from outside the province and the country and the burden this was putting on taxpayers. Robert Menzies argues that Dr. Steeves’ views were representative of medical professionals’ perspectives on immigration during this period as he stressed economic concerns and invoked eugenics ideology and a xenophobia theme.⁶⁸ In the early 1920s, Dr. Steeves reported that only 35.9 percent of admissions that year were Canadian-born. To him, this figure proved that there needed to be more careful supervision of people entering the country.⁶⁹ In 1923, trying to garner support from businessmen for immigration restrictions, Dr. Steeves commented on the work being done in partnership with the Immigration Department in deporting non-Canadian citizens from the institutions. He explained that, on average, it took three months to investigate and deport a patient and, during that period, \$100 was spent on care of each of these individuals—a considerable expense to the taxpayer.⁷⁰ Two years later, he again strongly urged the thorough examination of immigrants, “otherwise it would seem that, rather than

⁶⁶ Dyck, *Facing Eugenics*, 41.

⁶⁷ Dowbiggin, “Keeping this Young Country Sane,” 607; McLaren, *Our Own Master Race*, 93.

⁶⁸ Robert Menzies, “Governing Mentalities: The Deportation of ‘Insane’ and ‘Feebleminded’ Immigrants out of British Columbia from Confederation to World War II,” in *Crime and Deviance in Canada: Historical Perspectives* edited by Chris McCormick and Len Green (Toronto: Canadian Scholars’ Press Inc., 2005), 171.

⁶⁹ Annual Report 1922, 9.

⁷⁰ Annual Report 1926, 9.

being valuable assets as citizens, they are to become liabilities as residents of public institutions to be maintained at the expense of the province.”⁷¹ Dr. Price, Victoria’s medical officer, believed that too many “asiatics of low mentality are allowed to come into the province and many come from Europe [as well] who are undesirable from a medical standpoint.”⁷² In general, most physicians in B.C. supported immigration as a way to build up and maintain Canada as a “great country,” but argued for a more selective immigration policy with a eugenic lens.⁷³ Dr. C.K. Clarke, the most vigorous campaigner in Canada for immigration reform,⁷⁴ stressed quality over quantity, asserting that “we need to get the right kind of children ... we need ones that will grow up in touch with our ways, not the wrong kind that will add to our burdens and troubles.”⁷⁵ Dr. Steeves agreed; he emphasized that the people emigrating to the country must be strong in body and mind “in order that a virile, intelligent race of Canadians may result.”⁷⁶

Public anxiety about the high number of foreign-born with mental disorders echoed the concerns of the medical community. B.C. newspaper articles discussed the notion that the majority of criminals and insane people in the province were actually foreign-born. Specifically identifying the threat of Chinese and Hindu “aliens” as they appeared to be “the worst citizens from a law-abiding point of view,” one article published in the *Daily Colonist* in 1921 claimed that caring for foreign inmates in public institutions was costing the province one million dollars a year. It was argued that, until immigration standards were designed to only allow in those of high mental standards, the

⁷¹ Annual Report 1925, 9.

⁷² BCA, RMHC April 1926, 47.

⁷³ “Our Hereditary Feeble-Minded,” *Victoria Times*, 1 March 1926.

⁷⁴ Dowbiggin, “Keeping this Young Country Sane,” 599.

⁷⁵ C.K. Clarke, “Mental Hygiene in Canada,” *The Lancet* (June 2, 1923): 1139.

⁷⁶ Steeves, “Community Mental Health Problems,” 13.

burden would be great and the province would be poorer mentally, morally, and physically.⁷⁷ Some supporters of immigration restriction even stressed that the physicians who examined immigrants at the ports of embarkation should be educated on the types of physical and mental strain newcomers to the country underwent in order to determine who would be fit enough to face the challenges.⁷⁸

The RCMH, during its investigation in B.C., concluded that 66 percent of asylum inmates were not Canadian born and 90 percent were from outside the province.⁷⁹ They found that individuals born in the British Isles made up the highest percentage of insane patients at 39.5 percent. Those born in Canada made up 27.8 percent, in Europe 17.2 percent, in the United States 8.2 percent, in Asia 4.5 percent, and in British possessions 2.5 percent.⁸⁰ The Committee's final recommendations on the subject of immigration used the same discourse as did the medical and lay communities. They suggested that entry examinations needed to be improved to ensure the total exclusion of the mentally unfit and those liable to insanity.⁸¹ The Committee also concurred that, in general terms, immigration was a good idea in order to build up the Canadian population, but worried that quantity would be given priority over quality and allow for the admission of a considerable number of individuals with mental abnormalities who would add to the

⁷⁷ "Immigration Law Must be Tighter," *Daily Colonist*, 29 June 1920, 5; "Immigration Casts Burden Upon B.C.," *Daily Colonist*, 15 December 1921, 5.

⁷⁸ BCA, RMHC April 1926, 40.

⁷⁹ RCMH, *Report of the RCMH 1927*, 5. Based on the 1921 census, the RCMH found that, in the population of B.C., 50.34 percent were Canadian born (29.94 percent were B.C. born), 29.31 percent were born in the British Isles, and the remaining 20.35 percent were born in Europe, Asia, South America, or the USA. RCMH, *Report of the RCMH 1927*, 43.

⁸⁰ These are the percentages calculated for those considered 'insane.' 'Feeble-minded' percentages were different. For a list of the countries included in each category, see RCMH, *Report of the RCMH 1927*, 43-46.

⁸¹ RCMH, *Report of the RCMH 1927*, 17.

burdens of the nation.⁸² Finally, the Committee was unsure about why B.C. seemed to have such a high number of foreign-born with mental abnormalities and concluded that it must either be because these types of people were naturally restless, unsuccessful at home because of their disability, or they were being shipped away by relatives. The Committee determined that no individuals with mental abnormalities should be allowed to stay owing to the fact that their heredity was defective and they would pass on their condition to their offspring.⁸³

As this chapter has demonstrated, there was great concern among eugenicists, which included B.C.'s asylum superintendents, that individuals with mental conditions were reproducing in unprecedented numbers and passing on their "defective heredity" to offspring. Both lay and medical professionals that supported eugenics promoted programs that identified and segregated these individuals, controlled their reproduction, and restricted their immigration as the only way to protect the health and safety of the province, and more broadly, the country. The following chapter will focus more closely on the discourse of "defective heredity" and how it was used to diagnose and classify individuals who were incarcerated within the Public Hospital for the Insane and Essondale during the 1920s.

⁸² RCMH, *Report of the RCMH 1927*, 30.

⁸³ RCMH, *Report of the RCMH 1927*, 30-31.

Chapter Two: Heredity as the cause of mental illness among female patients in British Columbia's psychiatric institutions, 1920-1930

In British Columbia's two psychiatric hospitals, the Public Hospital for the Insane (PHI) and Essondale, during the 1920s, a large number of patients had their mental troubles directly linked to their heredity. Using admission registers, annual reports, and a sample of patient case files classified as "heredity inferred" and "constitutional," this chapter will examine the ways in which ideas about the relationship between "defective heredity" and mental health, strengthened by the influence of the eugenics and mental hygiene movements, played out in practice and influenced the classification and diagnoses of asylum patients by physicians.

As argued in the previous chapter, public asylum physicians believed that the majority of cases they saw were caused by an inherited predisposition to mental disease. In practice, there were two ways for physicians to determine if a patient's mental illness was indeed due to heredity. The most common method was through Form C. This form had to be filled out by the admitting agent, most commonly a family member, friend, or the police, and they were to disclose if any relatives were similarly affected or if there were any instances of institutionalization in the family. The difficulty asylum physicians faced in relying on this question was that it depended on who was admitting the patient. Some believed that, when a family member was the admitting agent, there was a possibility that a history of mental disease in the family tree might deliberately be hidden. In other cases, the person admitting the patient simply did not know the family history. As both Megan Davies and Wendy Mitchinson suggest in their studies of asylum populations in B.C. and Ontario, the majority of men admitted to these institutions were

admitted through the jails.¹ As a result, the police officers admitting inmates were unlikely to know the family history and therefore it would be recorded as unknown.

The second way that a family history of mental disorders could be uncovered was through an interview with the patient. In most cases, patient interviews took place a few weeks to a few months after admission and, during these interviews, asylum physicians pressed patients to disclose their complete family history. The interviewer asked the patient questions about their parents' and siblings' mental health and used questions, such as "does your mother worry over things more than necessary?," as a way to uncover "neurotic conditions" and "eccentricities," which most physicians, including the asylums' superintendents during the 1920s, believed to be the forerunners of insanity.² However, answers obtained during these interviews were not always considered reliable. Many of the family histories indicated that the patient denied any history of mental or nervous disease in the family. According to Dr. Doherty, superintendent of PHI and Essondale from 1905 until 1920, the patient could not always be relied on for obtaining accurate information as he believed that "their word that there was no history of mental disease in the family was not acceptable." He argued that, when a history of insanity was absolutely denied, it was still possible, and important, to obtain that history.³ However, when the patient did disclose a history of mental disorder in the family, their word was accepted. In the patient case files, instances in the family tree of mental disorders or 'eccentric'

¹ Wendy Mitchinson, *Body Failure, Medical Views of Women, 1900-1950* (Toronto: University of Toronto Press, 2013), 104; Megan Jean Davies, "The Patients' World: British Columbia's Mental Health Facilities, 1910-1935" (MA Thesis, University of Waterloo, 1989), 102.

² British Columbia Sessional Papers. Annual Report of the Mental Hospitals of the Province of British Columbia 1914 (Victoria, B.C.: Government Printer), 8. (Hereafter Annual Report, Year.) For a full list of what information asylum physicians were looking to obtain from an interview, see Annual Report 1911, 42.

³ Annual Report 1914, 8.

behaviour was recorded in red ink to highlight their importance.

As a result of the asylum physicians' focus on obtaining family histories of mental disorders and the strong belief that most mental disease was due to a hereditary predisposition, a large percentage of both male and female patients were categorized under different 'types' of hereditary causes of insanity during the 1920s. As will be explored below, this often happened regardless of whether or not there was a disclosure of heredity in their case file. In the annual asylum reports for PHI and Essondale, we find that heredity was included among the list of the "alleged causes" of the attack of insanity that led to institutionalization. Here, among a variety of causes, such as drugs and alcohol, physical illnesses, old age, childbirth, worry, and shock, heredity was included. Heredity was organized by "type." "Heredity" was to be used in cases where a predisposition was declared and "heredity inferred" for when it appeared to have been uncovered by physicians through investigation. "Heredity ascertained" was used for cases where the mental condition was ascertained by asylum physicians to have been inherited from either the maternal or paternal side of the patient's family. As it will be explored in this chapter as well as Chapter Three, the definitions for these categories acted as guidelines and were often not strictly adhered to. When the heredity of a patient was determined to be unknown, the cause of their mental attack was attributed to one of the other causes.⁴

The concept of heredity itself was not necessarily gendered, but the inheritability of mental illness was definitely gendered. As Wendy Mitchinson argues, in the early years of the twentieth century, a gendered concept of heredity emerged in the relationship

⁴ Annual Reports 1920-1930.

that was believed to exist between the health of the mother and the health of the fetus. Any physical or mental weakness in the mother, such as insanity or feeble-mindedness, could lead to the same in the child. It was thought that, if the child was female, then the chance of acquiring the same traits was even higher.⁵ While heredity was generally considered to be a major cause of mental weakness, or strength, the heredity that was passed down through the maternal side was considered especially influential due to the close relationship between mother and fetus in utero and later through breast-feeding.⁶ One contemporary manual on insanity for practitioners indicated that it was possible for a healthy maternal influence to neutralize the influence of “aberrant” male ancestry, but that a healthy male influence would be unable to “neutralize the evil influence of a [defective] female parentage.”⁷

In B.C.’s psychiatric hospitals, a higher percentage of female patients in comparison to male patients had their cause of mental illness linked to an inherited predisposition. In the 1920s, a total of 6,008 patients, 3,979 men and 2,029 women were admitted to PHI and Essondale. Of these 6,008 admissions, a total of 2,107, 35.6 percent of all admissions, had their cause of mental attack linked to their heredity. As Table A illustrates, 38.3 percent of all female admissions were linked to heredity, while 33.5 percent of all male admissions were.⁸ Table A also shows the different ‘types’ of heredity asylum physicians used to categorize patients whose mental illnesses were assumed to be directly caused by their heredity.

⁵ Edward Charles Spitzka, *Insanity: its classification, diagnosis, and treatment: a manual for students and practitioners of medicine* (New York: E.B. Treat, 1887), 82-83; William A. White, *Outlines of Psychiatry* (Washington: Nervous and Mental Disease Pub. Co., 1921), 20.

⁶ Mitchinson, *Body Failure*, 121, 244-245.

⁷ Spitzka, *Insanity*, 82-83.

⁸ Annual Reports 1920-1930.

Table A: Percent of admissions with mental illness 'caused' by heredity

	% of male admissions	% of female admissions
'Heredity'	15.7	17.7
'Heredity maternal'	1.3	3.5
'Heredity paternal'	1.3	2.2
'Heredity maternal & paternal'	0	0.3
'Heredity inferred'	15.2	14.6
Total	33.5	38.3

Source: Annual Reports 1920-1930

From 1920 to 1930, there was a total of 901 cases, 15 percent of all admissions that were categorized as “heredity inferred.” As Table A above shows, 15.2 percent of male admissions and 14.6 percent of female admissions were placed in this category.⁹ Inferring heredity in asylum cases actually began almost a decade earlier, in 1911, when the term was first linked to individuals whose heredity was described as “unknown but presumed.”¹⁰ As illustrated in Figure A, from 1911 until 1930, the number of admissions that had their heredity inferred fluctuated from as high as 22 percent of all admissions to as low as 3 percent.¹¹ By the 1920s, primarily under superintendent Dr. Steeves’ tenure (1920 to 1926), inferring heredity as a cause of insanity reached its peak, with a range of 23 percent to 38 percent of all admissions being placed in this category between 1923 and 1925.¹² Dr. Steeves explained that, when it was not possible to positively conclude that a patient’s mental disorder was due to heredity, he believed it could be inferred through investigation.¹³ As it will be explored below, this investigation included using Form C, patient interviews, observation, and inference.

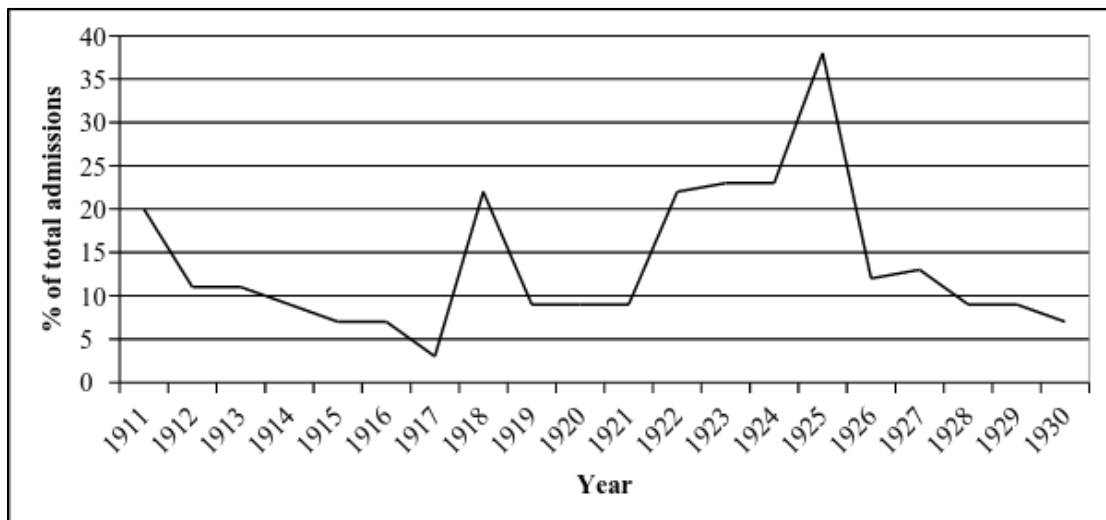
⁹ Annual Reports 1920-1930.

¹⁰ Annual Report 1911.

¹¹ Annual Reports 1911-1920.

¹² Annual Reports 1923-1925.

¹³ Annual Report 1924. 9.

Figure A: Admissions classified as 'heredity inferred'

Source: Annual Reports 1911-1930

As a number of historians have argued, many physicians in Canada's asylums embraced the eugenic discourse that stressed the hereditary roots of mental deviance for professional purposes. Those with mental disorders presented a challenge to physicians' power as curative experts in an era when physicians had limited therapeutic abilities. By agreeing that "tainted" or "defective" heredity was responsible for the majority of asylum patients' mental troubles, it "exempted" them from any responsibility for the decline in cure rates occurring in this period and was a way for them to demonstrate their relevance and legitimacy in a fast changing medical world.¹⁴ As Ian Dowbiggin maintains, even when many asylum physicians were unable to determine the exact mental problem patients faced, they were often nonetheless convinced that the problem existed due to a morbid hereditary predisposition.¹⁵ In British Columbia's asylums, the category of

¹⁴ S.E.D. Shortt, *Victorian Lunacy, Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry* (Cambridge: Cambridge University Press, 1986), 104; Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 2003), x.

¹⁵ Ian Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France* (Berkeley: University of California Press, 1991), 122.

“heredity inferred” and later the related category of “constitutional,” which came to dominate in the second half of the decade, were the two most ‘useful’ categories for asylum physicians to classify the assumed ‘cause’ of mental attack. They both had broad and somewhat vague definitions, which allowed the categories to be flexible in nature, while retaining the perception that the physician was able to determine a scientific cause for mental illness.

In order to closely examine the cases that were classified as ‘heredity inferred’ and ‘constitutional’ from 1918 to 1930, I collected a sample of patient case files. All female admissions to the PHI and Essondale from the years 1920, 1923, 1927, and 1930 that had the ‘cause’ of their mental condition listed in the asylums’ admission book as “heredity inferred” were selected. This resulted in 67 female case files. While my focus in this study is primarily on women, I wanted a comparative sample of men because the percentages of men and women classified as “heredity inferred” were very similar. Therefore, male admissions from 1927 and 1930 that had the ‘cause’ of their mental condition listed as “heredity inferred” in the asylums’ admission book were examined. This resulted in 59 male cases. In total, I collected 126 case files classified as “heredity inferred.” The same method was used for an examination of case files that were classified as “constitutional.” All female admissions to PHI and Essondale from the years 1927 and 1930 that had the ‘cause’ of their mental condition listed in the asylums’ admission book as “constitutional” were selected. This resulted in 110 female case files. Following the guidelines of the Freedom of Information and Protection of Privacy Act, all names and file numbers have been anonymized.

In the majority of the sample cases in the category of “heredity inferred,” 71.6

percent of the female cases and 86.4 percent of the male cases, there was no disclosure of a history of mental disorders, institutionalization, or behavioural “eccentricities” in the family. This high percentage of cases with no statement of mental disorder in the family tree demonstrates that the asylum physicians took advantage of the ‘inferred’ aspect of the category in order to classify cases where they strongly suspected that hereditary taint was the cause of the mental attack, regardless of whether evidence actually existed.

Of the 126 “heredity inferred” sample case files examined, 28.4 percent (19 cases) of the female cases and 13.6 percent (8 cases) of the male cases contained a disclosure of a family history of mental disorder, institutionalization, or “eccentric” behaviour. Among these 27 cases, 4 of them (1 male and 3 female) included a statement on Form C by the admitting agent that indicated that they believed the cause of the patient’s mental attack was due to their heredity. Three of the case files indicated that a family member was similarly affected: a sister and grandmother, an uncle, and, in one case, “several” family members had similar conditions. In the fourth case, the admitting agent did not disclose whether any family members suffered from a similar affliction.¹⁶ In cases where the admitting agent linked the patient’s mental health to their heredity, the asylum physicians agreed with the diagnosis.

In the remaining 23 “heredity inferred” case files in this sample that had a disclosure of a hereditary predisposition but the admitting agent linked the patient’s mental health to another cause such as worry, over-work or over-study, childbirth, grief, injury, or illness, the statements of heredity found in the files varied. Some were explicit statements of similar afflictions, instances of institutionalization, or suicides. For

¹⁶ British Columbia Archives, Mental Health Services Patient Case Files, GR2880, Files 291, 285, 114, 137. (Hereafter BCA, Patient Case Files, #.)

example, Jane S. stated in her interview that her mother was put into an asylum shortly after Jane's birth.¹⁷ In the case of Hazel F., a twenty-seven year old journalist, her mother disclosed that Hazel's aunt had committed suicide and her sister had attempted the same.¹⁸ Charles P.'s mother died of toxic insanity in the asylum and his uncle experienced a similar affliction.¹⁹ In these 3 cases, the asylum psychiatrists linked these histories to the cause of the patient's mental attack. In another instance, a mother and daughter were admitted together and both were diagnosed with manic depression. The cause of the daughter's mental attack was listed as "heredity maternal"; an obvious link was made to her mother's admission and condition. The mother was put into the "heredity inferred" category and, in the minds of the physicians, the fact that her daughter was suffering from the same ailment clearly pointed to hereditary taint in the family tree.²⁰

Other statements of heredity in the case files are less explicit than the ones described above, instead describing "eccentric" behaviours or personalities, which eugenicists and asylum physicians believed were important signs of a predisposition to mental disorders. According to Dr. Doherty, any abnormal behaviour was considered a predisposition and he believed that the majority of cases seen in practice had a predisposition.²¹ Eleanor L., Helen R., and George F. all denied a history of epilepsy, insanity, or nervous disorders in their families, but described various family members as being "queer just before death," "always peculiar ... [with] strange notions," and "a

¹⁷ BCA, Patient Case Files, 127.

¹⁸ BCA, Patient Case Files, 125

¹⁹ BCA, Patient Case Files, 169.

²⁰ BCA, Patient Case Files, 6330; British Columbia Archives, Provincial Mental Hospital, Essondale, GR1754, Volumes 2-4, Admissions Book, January 1913-April 1930. (Hereafter BCA, Admissions Book Volumes 2-4.)

²¹ Annual Report 1912.

sufferer of nervous headaches.”²² Angela W. divulged that she had once heard her mother describe her uncle as “very very sensitive.”²³ In another case, Maggie K. explained that all the relatives on her mother’s side were “very bad tempered.”²⁴

In one of the cases examined, the patient themselves made a link between their mental attack and their heredity. Maria D. was admitted in 1923 at the age of thirty-one and diagnosed with manic depression. Maria’s husband believed that her mental affliction was the result of her worrying over him being away for work and later he suggested that a lump on her head was a contributing factor as well. However, the asylum physicians did not agree and classified Maria’s case as “heredity inferred” as Maria disclosed that she thought that her parentage was the true cause of her mental trouble. While Maria did not state that a mental disorder was directly passed down to her, she indicated that she was an illegitimate child, the daughter of a fortuneteller and a drunkard. This parentage, she suggested, was the root of all her mental troubles.²⁵ The asylum physicians agreed.

In a few of the cases under study where there was no disclosure of heredity in the admittance papers or in the patient interview, asylum physicians ‘uncovered’ hereditary taint through observation of the patient or by observing the patient’s relatives when they came to visit. The cases of Frederick L., Samuel M., and Ann K. offer some examples. Frederick, a returned soldier, linked his mental trouble to shellshock. Instead of concluding that his war service was the problem, the asylum physicians diagnosed Frederick with dementia praecox. In an update on Frederick’s work ethic in his file, one physician determined that “hereditary taint was certainly present to a marked degree” as

²² BCA, Patient Case Files, 108, 156, 161.

²³ BCA, Patient Case Files, 116.

²⁴ BCA, Patient Case Files, 121.

²⁵ BCA, Patient Case Files, 176.

he observed that Frederick was unable to concentrate in his work, wandered from one thing to another, and would never be able to earn a steady living,²⁶ obviously pointing to an unstable mental state. In the case of Samuel, his hereditary taint was observed in the behaviour of his sister who visited him on a regular basis. After one visit, an asylum physician remarked that “this patient’s sister . . . is very similar to her brother, and it is most fortunate that she is not bearing any children,” implying that if she had she would most definitely pass on the apparent hereditary taint in the family.²⁷ Finally, in Ann’s case, her hereditary predisposition was made certain after her entire family came under investigation. In trying to determine whether it would be safe to discharge Ann into the care of her husband, Dr. Crease, superintendent from 1926 until 1950, requested that the local police investigate the family home. Upon investigation, the entire family was determined to be “not normal in any respect” and “of low type.” Along with Ann who was “mentally deranged,” her husband was “given to drink” and unable to work and one son was recently in the Boy’s Industrial School. The condition of the family home, animals being kept inside and allowed on the beds and tables, was also a point against the “fitness” of the family and clearly pointed to the fact that there was defective heredity being passed down.²⁸ As these three cases suggest, there was a wide range of what could be considered a hereditary predisposition and evidence could come from a variety of sources. All of the cases described above, those with explicit statements, those with more vague ones, and those where hereditary taint was uncovered through investigation, indicate that asylum physicians adopted a flexible definition of what was evidence of

²⁶ BCA, Patient Case Files, 182.

²⁷ BCA, Patient Case Files, 163.

²⁸ BCA, Patient Case Files, 9269.

defective heredity. These physicians used these disclosures, whether explicit or vague, to connect patients' mental health to their family background. However, in the majority of "heredity inferred" cases investigated, 71.6 percent of the female cases and 85.7 percent of the male cases, there is no evidence of any disclosure of heredity (or inferences made on the basis of even flimsy evidence of heredity) but they were still placed in the category of "heredity inferred." This further points to the fluidity of this category. It was often used to include cases where the physicians simply suspected, either through their own speculation or contemporary medical understandings of mental disorders, that heredity was the primary cause.

In both male and female cases that had their heredity inferred, the diagnosis given most frequently was dementia praecox. Manic depression was a close second. For male patients, this is not unusual. In the overall asylum population, men were most commonly diagnosed with dementia praecox.²⁹ However, the high number of "heredity inferred" female patients diagnosed with dementia praecox was unusual. In the overall asylum population, women were most commonly diagnosed with manic depression.³⁰ The contemporary understanding of dementia praecox may shed some light on why it was diagnosed in many of these "heredity inferred" cases; it was a diagnosis that encompassed a wide range of symptoms, was believed to be hereditary in nature, and was deemed to be incurable. Dementia praecox was understood as a disorder, with an onset after puberty, that was characterized by peculiar trends of thought with odd, impulsive, or negativistic behaviour. Reclusive personalities, abnormalities in the development of instincts and feelings, discrepancies between thought and behaviour, and delusions of any

²⁹ Annual Reports 1920-1930.

³⁰ Annual Reports 1920-1930.

kind were some of the symptoms.³¹ In general, dementia praecox was believed to be a process of progressive deterioration that would result in an irreversible “mental weakness.” There was no real therapeutic hope for individuals afflicted with the condition. As a result, as Richard Noll argues, the contemporary understanding of dementia praecox offered an excuse, or a justification, for therapeutic pessimism³² and some physicians viewed dementia praecox as a “comfortable dumping ground” in terms of diagnosis.³³ The root of the condition was believed to be defective heredity and different disorders found in family members, such as epilepsy or manic depression, would lead to dementia praecox in the offspring. Eccentric personalities were also believed to be latent forms of dementia praecox and alcoholism, in either of the parents, influenced the development of dementia praecox in offspring.³⁴

In the four sample years of 1920, 1923, 1927, and 1930, a total of 464 asylum cases were diagnosed with dementia praecox, 340 male and 124 female. Heredity was believed to be the cause in a total of 226 cases, 162 male and 64 female. Among these 226 cases, heredity was inferred in 64 of the male cases and 30 of the female cases.³⁵

Clearly, dementia praecox was a useful diagnosis for asylum physicians as it

³¹ Other behaviours associated with dementia praecox included indifference, silliness, defects in judgment, hypochondriacal complaints, suspicion, fantastic ideas, dream like ideas, feelings of being forced or of mental interference, physical and mystical influences with retention of clearness in orientation or memory. There were also four subtypes of dementia praecox and transitions between the types were believed to be common. American Medico-Psychiatric Association, *Statistical Manual for the use of Institutions for the Insane* (New York: National Committee for Mental Hygiene, 1918), 24-25.

³² Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Cambridge, Mass.: Harvard University Press, 2011), 95.

³³ Noll, *American Madness*, 103.

³⁴ Lewellys F. Barker, “Address by Dr. Barker on ‘Nervous Breakdown,’” *The Vancouver Medical Association Bulletin* (September 1925): 11; W.S. Jagoe Shaw, “The Heredity of Dementia Praecox,” *The British Medical Journal* (September 1928): 566; Emil Kraepelin, *Dementia Praecox and Paraphrenia* (Chicago: Chicago Medical Book Co., 1919), 233-235.

³⁵ Among all admissions from the years 1920, 1923, 1927, and 1930. Admission Books, vol. 2-4.

encompassed a wide range of symptoms. The fact that it was believed to be rooted in defective heredity absolved them of the duty, and ability, to provide a cure. Other diagnoses that appeared in the “heredity inferred” category include melancholia, various forms of epilepsy, senile dementia, psychopathic inferiority, paranoia, and mental deficiencies, all of which were believed to be hereditary in nature, but not all of which were deemed incurable.³⁶

Along with dementia praecox, mental deficiency was also believed to be incurable and rooted in defective heredity.³⁷ As mentioned in the previous chapter, individuals with mental deficiency became the primary targets of the eugenics and mental hygiene movements due to the belief that deficiency was easily inherited, affected individuals had high rates of reproduction, and they were able to sometimes hide among the ‘normal’ population.³⁸ While cases diagnosed with mental deficiency did not make up a large percentage of admissions, in the majority of these cases, the ‘cause’ was linked to heredity. Among all new admissions in the years 1920, 1923, 1926, and 1930, there were a total of 159 cases that had a diagnosis of mental deficiency. In 139 (87.4 percent) of these cases, heredity was listed as the cause of the condition. Among these 139 cases where heredity was believed to be the cause, 39 cases were classified as “heredity inferred.”³⁹ These cases of mental deficiency are significant because they clearly show the strong link that asylum physicians made between mental deficiency and heredity.

³⁶ See Daniel Brower and Henry Bannister, *A Practical Manual of Insanity for the Medical Student and General Practitioner* (Philadelphia: Saunders, 1902); White, *Outlines of Psychiatry*, 140-170; and Thomas Orbison, “Constitutional Psychopathic Inferior Personality with or without Psychosis,” *California and Western Medicine* 30, 2 (1928): 78.

³⁷ When referring to mental deficiency as a category, I included the diagnoses of idiot, imbecile, moron, and mentally deficient.

³⁸ RMCH, *Final Report of the RCMH*, 4-5; RCMH, *Report of the RCMH 1927*, 21.

³⁹ The other ‘causes’ of mental deficiency in this sample include congenital, constitutional, syphilis, and brain injury. BCA, Admissions Book Volumes 2-4.

Looking more specifically at my sample of 126 “heredity inferred” cases,⁴⁰ there were 13 cases that were diagnosed with a form of mental deficiency. In 3 of these cases, there was evidence of a family member with a similar affliction or who had been institutionalized.⁴¹ Therefore, in the remaining 10 cases, a hereditary predisposition was inferred simply based on the assumption that mental deficiency was an inherited condition. In all of these cases, descriptions of the patients by the admitting agents and physicians, both inside and outside the asylums, echoed the discourse of the eugenics movement. Patients diagnosed as “mentally defective” were described by their family members as being “born defective” and “mentally weak.”⁴² Physicians described the patients as “a little below par mentally,” “not up to normal,” and “childish and simple.”⁴³ One patient stated that he had done well in school and completed high school, but an asylum physician concluded that he was “much below normal mentally” because he answered questions poorly.⁴⁴ As mentioned in the previous chapter, eugenicists, and more specifically B.C.’s Royal Commission on Mental Hygiene, contended that, in many cases, the mentally deficient could be easily spotted.⁴⁵ This was evident in the case files in instances where physicians indicated that they were able to determine the intelligence of their patient simply by looking at them. Some were “immediately recognizable at a glance” as “low-grade imbeciles” while others had “the typical appearance of an idiot.” Other patients were described as having the appearance of “a person of inferior

⁴⁰ From the years 1920, 1923, 1927, and 1930.

⁴¹ BCA, Patient Case Files, 185, 186, 360.

⁴² BCA, Patient Case Files, 360, 130.

⁴³ BCA, Patient Case Files, 183 130.

⁴⁴ BCA, Patient Case Files, 313.

⁴⁵ Royal Commission on Mental Hygiene, *Final Report of the Royal Commission on Mental Hygiene* (Victoria, B.C., Government Printer, 1928), 5. (Hereafter RCMH, *Final Report of the RCMH*.)

intelligence” and “miserable looking, obviously defective.”⁴⁶ One patient was examined by a physician who concluded that “the shape and size of his head would suggest a sub-normal mentality.”⁴⁷ As evident in all of the above cases, the lay community, along with asylum physicians, drew on the discourse made popular by the eugenics and mental hygiene movements to describe individuals they believed to be mentally deficient.

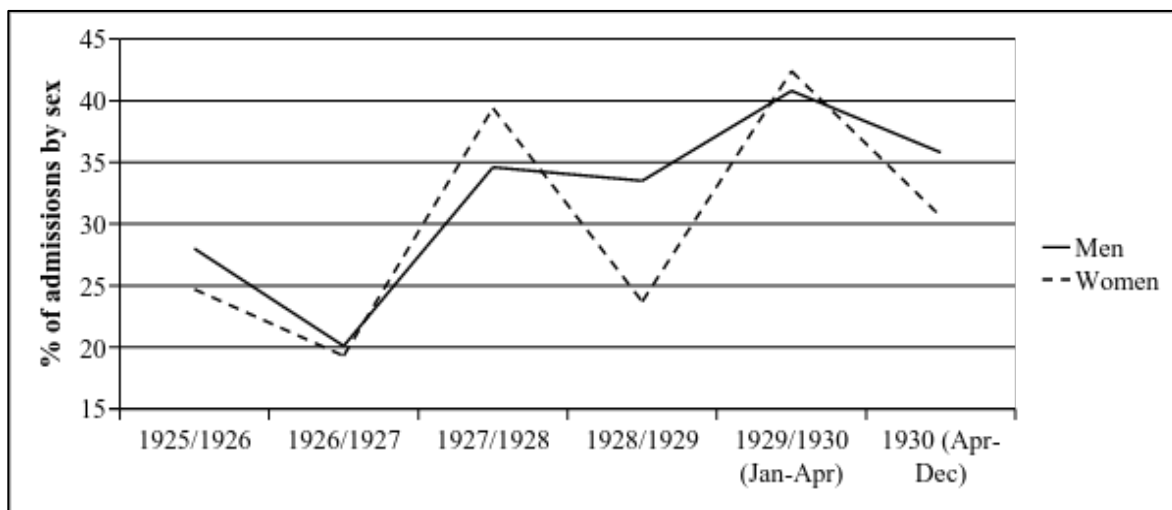
The category of “heredity inferred” was flexible enough to allow asylum physicians to use it to classify any case as being caused by defective heredity regardless of evidence. However, there was another category that appeared in the 1925/1926 annual report that became the most common ‘assumed cause’ of mental trouble during the second half of the decade. As a category, it had even more fluid boundaries.

“Constitutional” was listed as the cause of mental attack in 992 cases between 1925 and 1930, 31.8 percent of all admissions. Figure B offers a comparison of the numbers of male and female admissions and shows that men and women had almost the same chances of having their mental attack linked to their “constitution,” 32.3 percent of all male admissions and 30.8 percent of all female admissions.⁴⁸

⁴⁶ BCA, Patient Case Files, 156, 158, 174, 360, 334.

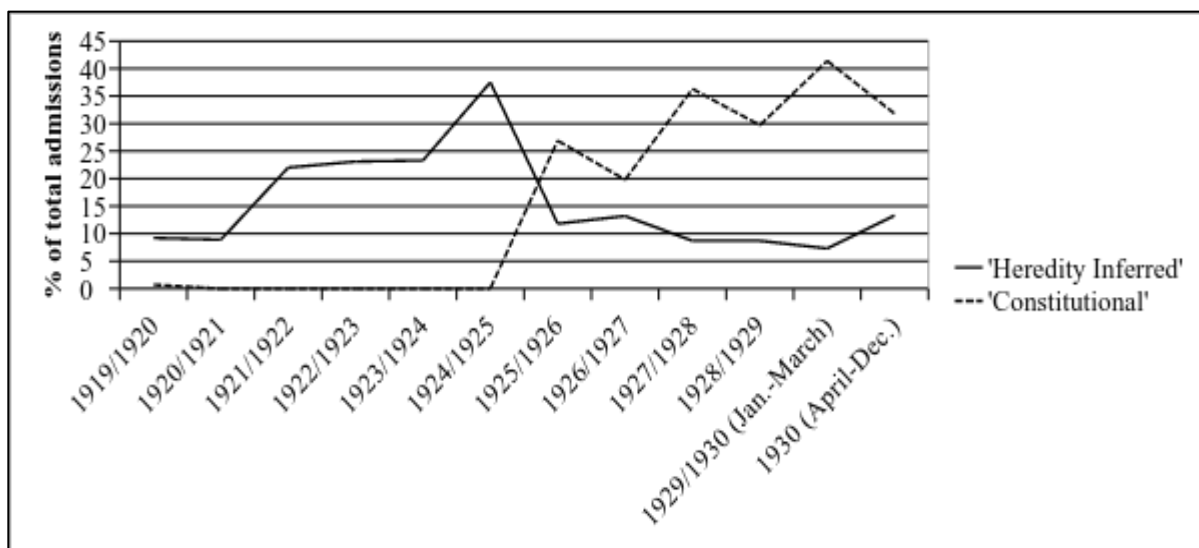
⁴⁷ BCA, Patient Case Files, 145.

⁴⁸ Annual Reports 1925-1930.

Figure B: Total admissions classified as 'constitutional'

Source: Annual Reports 1925-1930

Interestingly, as Figure C demonstrates, when “constitutional” began appearing as a cause in the records, the number of patients classified in the “heredity inferred” category dramatically decreased and remained low (under 10 percent of all admissions) through to the close of the decade. “Constitutional” became a much more useful ‘cause’ of mental attack for asylum physicians as its definition included more than just heredity.

Figure C: Total admissions classified as 'heredity inferred' & 'constitutional'

Source: Annual Reports 1919-1930

The contemporary theory of “constitution” had a broad definition that made it a category that was flexible enough to include a wide variety of cases. An individual’s “constitution” was believed to be made up of two parts that worked together, the inherited (heredity) and the “acquired.” The “acquired” part of an individual’s constitution included “influences and adaptations,” sometimes called “environmental factors.” This meant that a variety of things, such as all influences on a person in their early life, such as unhealthy living conditions, poor nutrition, disease, neglect, and improper training, would create and allow “abnormal tendencies” to become like second nature and lead to mental disorder among those who were already burdened with poor heredity.⁴⁹ One physician explained that individuals with a weak constitution had a “special sensitiveness” towards influences that would produce psychotic manifestations.⁵⁰ Unlike an individual’s heredity, which was static and unchangeable, the “acquired” traits were not. It was believed that this part of a constitution could be altered at any time in a person’s life, in utero, during childhood, and even in adulthood by infection, trauma, and just through the general “wear and tear of existence.”⁵¹ Another contemporary physician indicated that an individual’s constitution included general mental reactions, the capacity for work, and resistance towards stress. If these qualities were abnormal in any way, then the individual had an abnormal mental constitution.⁵² For example, it was believed that

⁴⁹ BCA, RMHC April 1926, 26; G.H Stevenson, “The Psychogenic Psychoses: Their Causes and Symptoms,” *Canadian Medical Association Journal* 16, 12 (1926): 1432-1433; Lewellys F. Barker, “On the Relations of Heredity and Environment, of ‘Constitution’ and ‘Condition,’ to Predisposition to Disease,” *The Canadian Medical Association Journal* 12, 9 (September 1922): 602-604; Albert M. Barrett, “Constitution and Disposition in Psychiatric Relations,” *American Journal of Psychiatry* 81, 2 (October 1924): 248.

⁵⁰ Barrett, “Constitution and Disposition,” 249-250.

⁵¹ Abraham Myerson, *The Inheritance of Mental Disease* (Baltimore: Williams & Wilkins Co., 1925), 55.

⁵² Barrett, “Constitution and Disposition,” 248.

those with defective mental constitutions often had unusual or peculiar emotional reactions to situations; they reacted in ways that were unexpected.⁵³ B.C.'s asylum superintendents maintained that some people were constitutionally susceptible to abnormal, psychopathic, and psychotic mental conditions and that most of the cases they saw in practice were due to these "unstable and nervous" mental constitutions.⁵⁴

Physicians also admitted that it was very difficult to practically determine what was inherited and what was "acquired,"⁵⁵ which meant that almost any abnormal behaviour could be linked to a defective constitution. Physicians also did not always agree on which influenced an individual more: their heredity or their "acquired," or environmental, traits. Some physicians stressed the equal influence of both, while others, including superintendent Crease, believed that inheritance was of primary importance.⁵⁶ Overall, a mental disorder that was to be "constitutional" in nature was one that was rooted in biology and could be influenced by environmental factors.

Similar to the cases categorized as "heredity inferred" examined above, "constitutional" cases did not necessarily require that the patient case file include evidence of defective heredity (or poor environment) to be placed in this category. To further examine the cases classified in the "constitutional" category, I collected all female cases admitted to PHI and Essondale from 1927 and 1930 that had the "cause" of their mental condition listed as "constitutional" in the asylums' admission books. This resulted

⁵³ Louis Bisch, *Clinical Psychology* (Baltimore: Williams and Wilkins Co., 1925), 102.

⁵⁴ Annual Reports 1913 and 1926; British Columbia Archives. Mental Health Services director's records. GR 0542. Box 22 File 2. Correspondence between Dr. A.L. Crease and Dr. C.M. Hincks, 10 April 1930.

⁵⁵ Barrett, "Constitution and Disposition," 257; Barker, "On the Relations of Heredity and Environment," 603.

⁵⁶ BCA, RMHC April 1926, 26; BCA, Correspondence between Dr. A.L. Crease and Dr. C.M. Hincks, 10 April 1930; Barker; "Address by Dr. Barker," 11.

in a sample of 110 cases. In these 110 cases files, only 26 (23.6 percent) contained a statement that disclosed a similarly affected family member, instances of institutionalization, suicide, or “eccentric” behaviour. As with the “heredity inferred” cases, the statements found in the files vary from explicit to vague descriptions of abnormal behaviour among relatives. Six of the patients disclosed that their father, mother, brother, sister, grandparent, or uncle had been admitted to an asylum.⁵⁷ Others had suicides in their family. For example, Sylvia P.’s brother was “driven out of his mind” by financial worries, murdered his wife, and then committed suicide,⁵⁸ and Celia F.’s father committed suicide after a long battle with tuberculosis.⁵⁹ Numerous patients disclosed that their mothers were “troubled at change of life” (menopause) and others explained that they had relatives suffering from “nervous breakdowns,” were “highly neurotic,” or “acted strangely.”⁶⁰ In these cases, asylum physicians automatically assumed that a predisposition to mental disorder was passed down to these patients. In the 84 cases that contained no declaration of heredity but the mental disorder was determined to be “constitutional,” the asylum physicians tended to place more emphasis on the “acquired,” or environmental, influences.

In order to uncover the “acquired” aspect of an individual’s constitution, asylum physicians relied on the patient’s personal history that was disclosed during an interview or by the admitting agent on Form C. Margaret M.’s case is a good example of how the physicians connected a patient’s life history to their mental disorder. Margaret was admitted in 1927 at the age of thirty-one and ultimately diagnosed with dementia

⁵⁷ BCA, Patient Case Files, 231, 270, 224, 218, 249, 240.

⁵⁸ BCA, Patient Case Files, 227.

⁵⁹ BCA, Patient Case Files, 238.

⁶⁰ BCA, Patient Case Files, 224, 371, 231, 333, 11210, 295, 246.

praecox. Her childhood was unremarkable, but when she was seventeen, she became pregnant with an illegitimate child, was sent away to give birth, and the child was adopted out. Heartbroken over the loss of her child, Margaret secluded herself from the outside world for almost four years. Following this, she travelled through Canada and the United States, became involved with various men, and, at one point, became infected with gonorrhoea. She received treatment in a hospital for two months and following that was sent to a Catholic convent. Still ill, she was moved to another hospital and then back to the convent. Margaret applied for further treatment, was denied, and she was sent to jail. Still ill, Margaret was sent home to B.C. where she underwent surgery to have her fallopian tubes and one ovary removed. After recovering, she found a job, got married, and had an affair with another man. During this time, her husband was admitted to the New Westminster asylum where he soon died of general paresis (syphilis). Margaret married the other man who quickly abandoned her. Based on this history, Dr. Crease concluded that it was obvious that Margaret's mental disease began early in her life and had been gradually worsening as her behaviour was "shocking ... and not normal." Margaret also disclosed that her parents were first cousins. Many physicians believed that in cases of consanguinity, transmission of mental disease was almost a certainty and that those with "neurotic tendencies" were actually more likely to intermarry.⁶¹ Therefore, Margaret's life history (environmental) and her parents' relationship (heredity) determined that her mental attack was "constitutional" in nature.

The case of Irene V. provides another example of the connection between an individual's heredity and environment to their "constitution." At the age of twenty-one,

⁶¹ BCA, Patient Case Files, 234; "Consanguinity and Mental Unsoundness," *Science* 9, 209 (February 1887): 118; White, *Outlines of Psychiatry*, 35.

Irene was admitted by her husband to Essondale. Her husband explained that she was seeing things in the dark, had developed a stammer, and was becoming violent and suicidal. On Form C, he indicated that the cause of Irene's mental trouble was poor heredity (her father was a chronic alcoholic), a "lack of home training and bad environment" when she was young, and failure as a student. He believed Irene's inability to "match the increasing complexity of her [current] environment" was the root of her mental trouble. He also accused her of committing adultery with a Chinese man and using drugs. Irene herself made a connection between her environment and her mental health and disclosed that her husband had been "beating her up" and had thrown her out of the house on several occasions. The asylum physicians diagnosed Irene with manic depression. In evaluating all the information supplied to them, her husband's statement of her poor childhood environment, failure as a young student, adultery, and possible drug use, the physicians categorized the cause of her mental attack as "constitutional." Asylum physicians seemed to ignore the issue of domestic abuse as a factor contributing to Irene's mental condition and instead preferred to focus on early environmental and hereditary factors.⁶²

While Margaret's and Irene's case files contain much richer background histories and details than the majority of the case files, the two cases demonstrate the connections that asylum psychiatrists made between a patient's heredity and the "acquired" traits of their constitution. In the case of Margaret, it was her actions in her early life that played a role and, in Irene's case, it was a combination of her early years and her husband's assessment of her current situation (i.e. that she was unable to adapt) that was evidence of

⁶² BCA, Patient Case Files, 305.

an unstable constitution.

The majority of the cases files providing information about patients who were categorized as “constitutional” are less detailed and, in most instances, they contain no statement of a hereditary predisposition at all. In some cases, the patient themselves explained that they had always been “nervous” and this provided asylum physicians with evidence to conclude that they had weakened, unstable constitutions extending years back. In other cases, Form C was a useful tool for the physicians as it allowed the admitting agent to state what they believed the cause of the patient’s mental trouble to be. As mentioned above, when an individual was perceived to have a weak constitution, any precipitating emotional or physical cause could lead to a mental attack. Some physicians also argued that women were more likely to be influenced by emotional factors and men by environmental factors such as social and occupational circumstances.⁶³ Therefore, using evidence given on Form C, asylum physicians could conclude that these individuals had abnormal reactions to challenges they faced because they were predisposed to having weakened constitutions. For example, Ada L. had a “nervous breakdown” after she saw her husband in the bedroom with their housekeeper. Her husband explained that, since then, she had been excessively worrying about infidelity even though he had denied it.⁶⁴ In another case, Agnes H. had become apathetic and violent after her home had been destroyed in a fire.⁶⁵

In 16 of the cases, excessive worry was believed to be the immediate cause of the patient’s mental attack and, in 5 cases, the patient’s mental trouble was due to a death in

⁶³ Barrett, “Constitution and Disposition,” 249.

⁶⁴ BCA, Patient Case Files, 325.

⁶⁵ BCA, Patient Case Files, 268.

the family (child, parent, or sibling). In other cases, the precipitating cause of the mental disorder was believed to be physical in nature. In 27 cases, admitting agents believed that an illness the patient experienced or an operation they have undergone in the recent past was the cause and, in 14 cases, the mental attack was linked to the patient's reproductive organs. While asylum physicians generally did not believe that mental disorders were directly caused by the reproductive organs as they had in the nineteenth century, it was thought that if an individual was predisposed to a mental condition due to heredity, then the stress of menstruation, the puerperal state (childbirth period), and menopause could lead to mental trouble.⁶⁶ Six women were described as having abnormal mental reactions following childbirth; in the majority of cases, they experienced depression. For example, following a difficult pregnancy and delivery of twins, Elizabeth M. developed feelings of guilt, had "queer" thoughts, and attempted suicide. Upon examination, the asylum physician found her to be "mentally unstable" and depressed.⁶⁷ In the case of Doris S., her mental trouble appeared when she began menstruation at the age of fifteen and experienced dizzy spells. The physicians made the connection between Doris' menstrual cycle and her mental condition, noting that each month she became "restless, excited, and agitated," clearly pointing to an abnormal mental reaction to her cycle.⁶⁸

Asylum physicians relied on the information relayed to them by the admitting agent in order to determine the assumed cause of the patient's mental attack. If a patient had an 'abnormal' reaction to either an emotional or physical cause, it was thought to be due to a poor mental constitution. In the above cases, it was assumed that there was both

⁶⁶ Barrett, "Constitution and Disposition," 249; BCA, Correspondence between Dr. A.L. Crease and Dr. C.M. Hincks, 10 April 1930.

⁶⁷ BCA, Patient Case Files, 300.

⁶⁸ BCA, Patient Case Files, 293.

an immediate cause (e.g. menstruation, childbirth, worry, etc.) and the overarching cause (a constitutional predisposition). In general, the category ‘constitutional’ as a cause of mental illness appeared to be very broad and many factors could be considered a ‘cause.’ However, there were cases during the 1920s where insanity was not linked to an individual's constitution or to their heredity and were believed to be directly caused by another factor. For example, there were cases where a patient’s mental condition was thought to be the direct result of their old age/senility. There were also cases where syphilis, arteriosclerosis, or alcohol and drugs were considered the cause. Unlike the category of “heredity inferred,” the diagnoses among “constitutional” cases matched the wider asylum population. Men were more likely to be diagnosed with dementia praecox and women with manic depression. In a sample of all “constitutional” cases in the years between 1927 and 1930, 50.2 percent of men and 29.4 percent of women were diagnosed with dementia praecox and 37.2 percent of men and 55.6 percent of women with manic depression.⁶⁹ Other diagnoses included in the “constitutional” category were acute and chronic mania, senile dementia, melancholia, paranoia, toxic psychosis, psychoneurosis, and psychopathic inferiority.⁷⁰ In the two years sampled, there was only one case (male) of mental deficiency classified under “constitutional.” Since the eugenics and mental hygiene movements assumed a strong connection between mental deficiency and defective heredity, mental deficiency was almost never categorized as “constitutional,” which included both environment and heredity as inter-linked causes. The “constitutional” category seemed to signal a move away from the focus on mental conditions being caused strictly by heredity to a category that was broader. By

⁶⁹ For the years 1927 and 1930. BCA, Admissions Book Volumes 2-4.

⁷⁰ For the years 1927 and 1930. BCA, Admissions Book Volumes 2-4.

concluding that a patient's mental disorder was a result of a poor constitution, physicians pathologized the environment and the heredity of individuals whose behaviour and responses to physical or emotional causes was considered 'abnormal.'

Due to the dominance of a discourse of inheritability of mental disease among both lay and medical professionals and the fact that it was believed that the inheritance of mental disorders was stronger if the mother was affected, there was obvious concern about the children of female asylum patients. At a meeting of the Vancouver Medical Association in 1925, American physician Lewellys Barker spoke to local physicians on the adoptability of such children. He explained that it was their duty to carefully consider all hereditary possibilities and investigate the history of the ancestors as thoroughly as possible when determining a child's adoptability.⁷¹ In the sample of both "heredity inferred" and "constitutional" female case files, there were a few cases where the patient gave birth either shortly before admission or during her incarceration and the child was put into adoption services and the inheritability of the mother's mental disorder was scrutinized.

Maria D. gave birth three months after her admission to the asylum. Shortly after, Dr. Steeves was contacted by the Children's Aid Society on behalf of a family that was interested in adoption. The Society wanted to know if the mother's mental trouble was likely to reappear in the child or make the child otherwise undesirable for adoption. Dr. Steeves replied, explaining that, while "the question of hereditary influence upon the child is a wide one ... and opens up a very large technical field," if the father was normal then there was only a small percentage chance that the child would be mentally affected.

⁷¹ Barker, "Address by Dr. Barker," 12.

He did, however, warn that the child would undoubtedly be “high strung with a nervous temperament.”⁷² Dr. Steeves clearly followed the theory that, while inheritance of an actual mental disorder was rare, children were likely to inherit a predisposition to mental disorder, especially from their mother. In the case of Florence. B., she gave birth six months prior to her admission to the asylum. While in the asylum, Florence was diagnosed with epilepsy with dementia praecox and her husband left the child with a local couple and then deserted. When the child was five years of age, the family expressed interest in legal adoption. Dr. Ryan, assistant medical superintendent for PHI, replied to the family stating that, due to the inheritability of both epilepsy and dementia praecox, “adoption could not be recommended in this case.”⁷³ As these two examples suggest, the belief in the inheritability of a predisposition to a mental disorder from the mother was evident among asylum physicians. By warning against the danger of adopting a child with known hereditary taint, or simply not recommending adoption, the asylum physicians perhaps wanted to save ‘normal’ families from having to care for ‘mentally abnormal’ children.

The eugenic discourse of “defective heredity” was an important, and frequently used, diagnostic tool in B.C.’s psychiatric institutions. As this chapter demonstrated, female patients were more likely to be victims of this discourse than male patients. Overall, women admitted to the asylums were more likely than their male counterparts to be defined as mentally ill as a result of their heredity, whether or not this diagnosis could be directly linked to evidence available to the asylum physicians. Chapter Three will focus more closely on a specific population of female patients, racialized women, who

⁷² BCA, Patient Case Files, 172.

⁷³ BCA, Patient Case Files, 318.

were targeted more frequently as being mentally ill due to defective heredity and also faced other forms of discrimination based on contemporary ideas of race.

Chapter Three: The classification and diagnosis of racialized female patients in British Columbia's psychiatric institutions, 1918-1933

While Chapter Two examined the ways in which the eugenic ideology of “defective heredity” operated in the classification of female asylum population in British Columbia, this chapter continues this examination with a focus on racialized female patients. It explores the ways in which the eugenic discourse of defective heredity, along with the ideology that promoted a model of Anglo-Saxon biological racial superiority, influenced the classification and diagnoses of racialized female patients. Using the case files of racialized women within B.C.'s asylums, the Public Hospital for the Insane (PHI) and Essondale, I argue that defective heredity was used even more as an explanation for mental illness among racialized women than among women as a whole.

Racialized women have yet to be examined as a population within B.C.'s asylums. Therefore, in addition to the focus on eugenics practices, this chapter will also explore the specific challenges and isolation the women experienced as inmates in these institutions due to distance from family and friends, language barriers, and the racist attitudes of asylum staff.

It is important to note that Indigenous peoples were especially marginalized in B.C. Not only did they face widespread discrimination but colonial assimilation projects, including residential schools, were well underway by this period. Indigenous peoples were segregated on reserves where they did not have access to the full privileges of citizenship. They were subject to a ‘civilizing mission’ overseen by colonial administrators, Indian Agents, missionaries, and legal and medical authorities that controlled and

governed most aspects of their lives.¹ As it will be seen below, the majority of female Indigenous asylum admissions during the 1920s were under the authority of an Indian agent or medical or legal authority. Furthermore, Sarah Carter and Mary-Ellen Kelm explain that Indigenous women were considered inherently immoral and classified as prostitutes and ‘sexual deviants;’ they were often viewed as threats to the health and morality of society.²

Racialized women were a minority among the patient population of B.C.’s asylums. 2,173 women were admitted to PHI and Essondale between 1918 and 1930 and racialized women only made up 2.1 percent of these admissions. For this study, I collected a total of 42 case files of women who were recorded in PHI’s and Essondale’s admission books in the years between 1918 and 1933 as “Indian,” “Japanese,” “Chinese,” or “coloured.” In this sample, there are 15 Japanese women (all born in Japan), twelve Indigenous women (10 born in B.C., 1 born in the Yukon, and 1 born in Manitoba), 9 Chinese women (6 born in B.C. and 3 born in China), 4 African-American women (all born in the United States), 1 Mexican woman (born in Mexico or New Mexico), and 1 Spanish/English woman (born in England and recorded as “coloured”).³

When comparing the age, civil status, level of education, and admission patterns of these racialized women with the wider female asylum population, it is evident that there were many similarities and some differences. As Megan Davies pointed out, women

¹ Sarah Carter, “Categories and Terrains of Exclusion: Constructing the ‘Indian Woman’ in the Early Settlement Era in Western Canada,” in *Gender and History in Canada*, edited by Joy Parr and Mark Rosenfeld (Toronto: Copp Clark Ltd., 1996), 30-49.

² Carter, “Categories and Terrains of Exclusion,” 39-40; Mary-Ellen Kelm, “Diagnosing the Discursive Indian: Medicine, Gender, and the Dying Race,” *Ethnohistory* 52, 2 (2005), 389.

³ British Columbia Archives, Provincial Mental Hospital, Essondale, GR1754, Volumes 2-4, Admissions Book, January 1913-April 1930. (Hereafter BCA, Admissions Book Volumes 2-4.)

admitted to B.C.'s asylums were generally middle-aged or approaching middle age. In her study, she found that 55.1 percent were married and that single women, including widows, were a minority in the asylums.⁴ The racialized women had a similar demographic profile: 57.1 percent entered the asylum between the age of twenty and forty and 59.5 percent were married.⁵ As historians have suggested, many married women in the early to mid-twentieth century faced extreme physical and emotional demands within the home. Fatiguing housework, childcare, isolation, and, in many cases, immigration to a new land and the pressures of finding work caused many to break down under the stress.⁶ In some cases, unhappy marriages and domestic abuse were also a reality and, as Veronica Strong-Boag maintains, women in these situations were often under considerable pressure from the wider society to stay in their marriages.⁷ Take, for example, the case of Mei M. She immigrated with her parents from China when she was eleven years old and, when she was twenty-nine, she was admitted to Essondale by a friend who believed that Mei's mental condition was brought on by domestic trouble and childbirth. During her incarceration, any time Mei's husband was brought up in conversation, she became "morose, seclusive, and fearful." Mei's friends, who visited her

⁴ Megan Jean Davies, "The Patients' World: British Columbia's Mental Health Facilities, 1910-1935" (MA Thesis, University of Waterloo, 1989), 89. For an earlier period, see Mary-Ellen Kelm, "The only place likely to do her any good: The Admission of Women to BC's Provincial Hospital for the Insane, 1905-1915," *BC Studies* 96 (1992/1993): 69.

⁵ 19 percent of the patients admitted were under twenty years of age, 11.9 percent were between forty and sixty, and 11.9 percent were older than sixty. The youngest patient in this sample was six years old and the oldest was seventy-eight years old. 31 percent were single and 9.5 percent were widowed. BCA, Admissions Book Volumes 2-4.

⁶ Davies, "The Patients' World," 89, 92; Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1911-1939* (Toronto: Copp Clark Pitman, 1988), 92-95. It is possible that many of the Japanese women in this sample came to Canada as picture brides. For a study that examines the picture bride system in early twentieth-century B.C. and the challenges these women faced, see Midge Ayukawa, "Good Wives and Wise Mothers: Japanese Picture Brides in Early Twentieth-Century British Columbia," *BC Studies* 105/106 (1995): 103-118.

⁷ Strong-Boag, *The New Day Recalled*, 97-99.

often, informed asylum physicians that she had been married against her will when she was seventeen and that her husband was mean to her. In an interview, Mei told a physician that her husband had once given her a severe beating and had been “unusually cruel and that [he was] trying to get her to run away and leave her family.” One of the physicians responsible for her committal agreed with Mei’s analysis and indicated that he believed this “poor unfortunate woman is suffering as the result of abuse and hard work.” Mei had six children and helped her husband with his store, laundry, and rooming house. However, asylum physicians did not concur. Despite no evidence, Mei’s cause of mental trouble was determined to be due to poor heredity and superintendent Crease asserted that her descriptions of her life of hard work and mistreatment might very well be “delusional.” After four months in the asylum, Mei was discharged into the care of her husband.⁸

When compared to the wider female asylum population, racialized women tended to have less education. In the sample of racialized women, 50 percent had “common” education while 65.2 percent of the total female population did.⁹ The other 50 percent of the racialized female sample had “poor” or no education. Among the total female population, the percentage with this level of education was much lower; only 16.5 percent had a poor education.¹⁰ Japanese women in the sample were the most likely to have some education, while Indigenous women were the least likely.¹¹

As both Mary-Ellen Kelm and Megan Davies point out, a patient’s family was the

⁸ British Columbia Archives, Mental Health Services Patient Case Files, GR2880, File 10164. (Hereafter BCA, Patient Case Files, #.)

⁹ BCA, Admissions Book Volumes 2-4. ‘Common’ education included public school education or ‘a short time at school.’

¹⁰ BCA, Admissions Book Volumes 2-4.

¹¹ 86.7 percent of the Japanese women had “common” education, while only 8.3 percent of the Indigenous women did. BCA, Admissions Book Volumes 2-4.

source of the majority of female committals and, in most cases, it was a male relative who was responsible for the admission.¹² In her study, Davies found that 85.1 percent of women had been admitted by a family member.¹³ I found that racialized women were less likely to be admitted by a family member. As Table A illustrates, only 50 percent were signed in by a relative and, in all of these cases except one, the admitting agent was either the patient's husband, brother, son, or uncle.¹⁴ As Davies explains, accessibility to the asylum played a role in determining whether families saw the asylum as an option. Families that were located on the Lower Mainland and Vancouver Island were the most likely to use the asylums as they were easier to access.¹⁵ This pattern is evident in the case files of the racialized women as well. Of the women who were admitted by a relative, most came from Vancouver or Victoria. Japanese and Chinese women were the most likely to be admitted by a relative as they tended to live in communities that were geographically close to PHI in New Westminster and Essondale in Coquitlam.¹⁶

Kelm argues that women in conflict with the law were especially vulnerable to psychiatric confinement,¹⁷ and this was especially true in the case of racialized women in B.C. Police initiated admission when a woman came into conflict with the law or had no family in the province.¹⁸ Davies found that the police carried out 9.4 percent of female

¹² Kelm, "The only place," 89; Davies, "The Patients' World," 102-103.

¹³ Davies, "The Patients' World," 103.

¹⁴ BCA, Patient Case Files.

¹⁵ Davies, "The Patients' World," 104-105.

¹⁶ 80 percent of the Japanese female patients came from Vancouver or the surrounding area and 88.9 percent of the Chinese female patients came from either Vancouver or Victoria. BCA, Patient Case Files.

¹⁷ Kelm, "The only place," 80.

¹⁸ Kelm, "The only place," 80. In Dorothy Chunn's and Robert Menzies' study of women who were admitted to the province's asylums through Order-in-Councils, they found that a disproportionate percentage were racial and ethnic minorities. Dorothy Chunn and Robert Menzies, "Out of Mind, Out of Law: The Regulation of Criminally Insane Women Inside BC's

asylum admissions. However, as Table A illustrates, 21.4 percent of racialized women were admitted to the asylums after an encounter with the police. According to Davies, the state used the asylum to contain the “disorderly...male poor” who were seen as posing a threat to “property, decorum, and the social order.”¹⁹ This trend can be extended to include racialized women as well. Racialized women who were admitted by police were seen to be displaying unacceptable and disruptive behaviour prior to incarceration. For example, Pauline H. was brought in by the police after she was found “acting so queer on the street ... singing, preaching, and jumping up and down clapping her hands.” Rose L. was admitted after it was reported to the police that she had been “annoying her neighbours and using foul language.” Ruth R., well known to the police after having been convicted six times as a keeper of a disreputable house, was again arrested after she threw a cup at a man in a restaurant who she believed had poisoned her coffee.²⁰ Only 2 of the patients in the sample were admitted to the asylum after committing a major violent crime. Katherine J. had committed murder in the Yukon and was found insane and Yuka K. murdered her 2 children and then attempted suicide.²¹ Along with the police, Indigenous patients were also often admitted by another state authority, the Indian agent in 41.7 percent of cases.

Public Mental Hospitals, 1888-1973,” *Canadian Journal of Women and Law* 10, 2 (1998): 314.

¹⁹ Davies, “The Patients’ World,” 110.

²⁰ BCA, Patient Case Files, 102, 204, 158.

²¹ BCA, Patient Case Files, 162, 349.

Table B: Admitting agent of racialized female patients

Admitting Agent	Percent
Family member	50%
Friend	2.4%
Employer/Supervisor	4.8%
Physician	4.8%
Police	21.4%
Indian Agent	11.9%
Unclear	4.8%

Source: BCA, Patient Case Files, 1918-1933

The diagnoses of racialized women were similar to those of the wider female asylum population. Manic depression and dementia praecox were the two most common diagnoses among all female patients during the 1920s. Among racialized women, manic depression was diagnosed in 31% percent of cases and dementia praecox in 26.2 percent. Other diagnoses in this sample included senile dementia, various forms of epilepsy, mental deficiency, toxic psychosis, acute mania, general paresis, psychopathic inferiority with psychoneurosis, and puerperal insanity. One patient was ultimately deemed “not insane.”²²

As I discussed in Chapter Two, the idea of “defective heredity” was overplayed as the cause of mental illness among both male and female patients. Female patients were slightly more likely than male patients to have their mental illness linked to a hereditary predisposition. However, in the cases of racialized women, the connection between heredity and mental illness was particularly strong. Between 1918 and 1933, 38.6 percent of all female admissions had their mental trouble linked to their heredity, but 47.6 percent

²² BCA, Patient Case Files.

of racialized women had their mental trouble attributed to their heredity by asylum physicians.²³ These statistics indicate that the eugenic idea of defective heredity played a central role in the asylum physicians' diagnoses of mental illness among racialized women. The fact that a high number of racialized women were likely to be defined as mentally ill by reason of heredity is not entirely surprising. As indicated in the first chapter, eugenic supporters in this period, which included asylum physicians, had already targeted non-white citizens as being biologically inferior to the superior white, Anglo-Saxon race.

Among racialized women defined as insane on the basis of heredity, less than one third (30%) of the case files included a declaration of heredity. The declarations of heredity were similar to those discussed in Chapter Two. Some were explicit statements referring to the institutionalization of family members or descriptions of relatives with similar afflictions. For example, Ruth R. admitted that her sister also suffered from a drug addiction and had died in an asylum from general paresis (syphilis). Others contained notes explaining that their father, sister, or mother had a similar affliction.²⁴ Some of the statements were vaguer and described "eccentric" behaviour observed in family members. Asylum physicians noted that, in the case of Tsuyako Y., the cause of her mental trouble "appears to be hereditary, as her father died of some brain disease."²⁵ Pauline H.'s file included a statement that her sister had "always been nervous" and recently had suffered a short "nervous breakdown." Pauline's parents were also first

²³ 65 percent were classified as "heredity," 25 percent as "heredity inferred," and 5 percent of each were "heredity maternal" and "heredity and drugs." BCA, Admissions Book Volumes 2-4.

²⁴ BCA, Patient Case Files, 102, 104, 103, 179, 281.

²⁵ BCA, Patient Case Files, 128.

cousins.²⁶ In the case of Katherine J., a hereditary predisposition to mental illness was inferred from the fact that her brother, who had died shortly before she was admitted, had been born an “imbecile.”²⁷

In the majority of cases where heredity was determined to be the cause of mental illness among these racialized women, there was no evidence in the file to support the claims that heredity was indeed the cause. For example, in the case of Mei M. discussed above, the asylum physicians disregarded the abuse and other challenges she faced at home and concluded that her mental illness stemmed from poor heredity.²⁸ Kun N. was admitted by her brother who indicated that, before she had contracted meningitis as a young child, she had been healthy and intelligent, but following the illness, she became “deaf, dumb, and blind.” Asylum physicians nonetheless listed the cause of her mental trouble as “heredity.”²⁹ In the case of Fang M., a sixteen year-old who was ultimately diagnosed as an “imbecile,” the cause of her mental trouble was categorized as “heredity maternal.” Her file, however, contains no evidence of her mother having a mental disorder. Fang was admitted by the police after she was found wandering on the grounds of the B.C. Legislature, laughing and talking to herself. The police matron stated that Fang’s home environment was the cause of her mental trouble, explaining that her mother was a known prostitute.³⁰ Asylum physicians concluded that Fang’s mental deficiency stemmed from her mother’s behaviour, as eugenic experts, such as C.M. Hincks,

²⁶ BCA, Patient Case Files, 204.

²⁷ BCA, Patient Case Files, 162.

²⁸ BCA, Patient Case Files, 276.

²⁹ BCA, Patient Case Files, 278.

³⁰ BCA, Patient Case Files, 191.

considered prostitutes to be, in most cases, feebleminded.³¹ In all of the above cases, it is clear that heredity was often used as an explanation for the cause of mental illness among racialized women, despite a lack of evidence in many cases.

Table C: Cause of mental illness among racialized female patients

Cause of mental illness	Percent
Alcohol & drugs	2.4
Epilepsy	2.4
Constitutional	11.9
Heredity	47.6
Illness	2.4
Not Insane	2.4
Old Age	9.5
Puerperal	7.1
Syphilis	2.4
Unknown	2.4
Worry	9.5

Source: BCA, Admissions Book Volumes 2-4, 1918-1933

Unlike some of the cases classified as “constitutional” discussed in Chapter Two, the cases files of racialized women classified as such contained no declaration of heredity. 11.9 percent of the cases in my sample had their mental condition linked to their “constitution.”³² In one of the cases, the Indian Agent who was responsible for the committal described the patient’s father as an alcoholic and he noted that trait had been passed onto the daughter.³³ As mentioned in the previous chapter, alcoholism in a parent

³¹ In CM Hincks’ investigation of the links between criminality, immorality, and mental deficiency, he concluded that 60 percent of all prostitutes were mentally deficient. CM Hincks, ‘The Scope and Aims of the Mental Hygiene Movement in Canada,’ *Canadian Journal of Mental Hygiene* 1, 1 (April 1919): 25. The 1920 Mental Hygiene Survey of the Province of British Columbia, undertaken by the CNCMH, also concluded that there was a link between mental abnormality and immorality (i.e. prostitution or illegitimate children). Canadian National Committee for Mental Hygiene, *Mental Hygiene Survey of the Province of British Columbia*, *Canadian Journal of Mental Hygiene* 2, 1 (April 1920): 44.

³² BCA, Admissions Book Volumes 2-4; BCA, Patient Case Files.

³³ BCA, Patient Case Files, 259.

was believed to be potentially damaging to the “constitution” of the offspring. Ida H.’s personal history provides a good example of how asylum physicians came to determine that a poor “constitution” was the cause of mental trouble. Diagnosed with psychopathic inferiority with psychoneurosis of a hysterical type,³⁴ Ida was admitted after she became depressed and suicidal when she was told by her nursing instructor that she would not be able to continue her training. When asked by the asylum physicians to describe Ida’s behaviour, the nursing supervisor explained that Ida had an “unaccountable morbidity and moroseness,” she was “too abrupt in her manner,” and she often made “threats of self-destruction.” Ida explained that this rejection had been a “death blow to all her ambitions” and, as a result, she fell into a depression. According to asylum physicians, this negative reaction to finding out she was not a suitable nursing candidate proved that Ida had an unstable mental “constitution.”³⁵

Although heredity and “constitution” were believed to be the cause of mental trouble in more than half of the cases of racialized women, other causes of mental illness among the women in this sample were physical in nature and included old age, childbirth, alcohol and morphine, epilepsy, syphilis, and tuberculosis. The only “emotional” cause was worry.³⁶

As Robert Menzies and Ted Palys discovered in their study of Indigenous asylum patients in B.C., the inability to understand or communicate in English could be a

³⁴ Psychopathic inferiority with psychoneurosis was a condition where an abnormality of mental make-up was expressed in the character and intensity of an individual’s emotions and decision making reactions. Individuals with this diagnosis were also often considered to have criminal traits, moral deficiency, sexual perversions, inadequate personalities, and be pathological liars. American Medico-Psychiatric Association, *Statistical Manual for the use of Institutions for the Insane* (New York: National Committee for Mental Hygiene, 1918), 26-28; Louis Bisch, *Clinical Psychology* (Baltimore: Williams and Wilkins Co., 1925), 100-109.

³⁵ BCA, Patient Case Files, 205

³⁶ BCA, Admissions Book Volumes 2-4

profoundly alienating cultural experience for these patients who generally had few or no others on the ward with whom they could communicate.³⁷ My examination of the racialized female case files indicates that this was not just the case for Indigenous patients, but for many Japanese and Chinese women as well. The case files reveal the challenges these women faced in communicating with their physicians at PHI and Essondale. Non-English speech was incomprehensible to physicians both inside and outside the asylums. For example, physicians noted that one patient was “impossible to understand [as she] talked at random in Japanese,” while another “sang hymns in some unintelligible language.”³⁸ Keiko M.’s speech was described as “jabbering” and “gurgling” and it was noted that “she talks and gestures in her own language regardless of those in the room.”³⁹ In some cases, patients who could not understand English were seen as having low intelligence; they were described as “dull and stupid” or “childish” when spoken to.⁴⁰

The stress and subsequent isolation caused by the inability to communicate with staff and other patients was evident in the case of Shu N. Born in China, Shu was admitted at the age of thirty-two by her husband who described her as being “afraid of everything.” The asylum physicians noted that she did not speak English and, as a result, they never took a personal history of her case. One week into her incarceration, an

³⁷ Robert Menzies and Ted Palys, “Turbulent Spirits: Aboriginal Patients in the British Columbia Psychiatric System, 1879-1950,” in *Mental Health and Canadian Society: Historical Perspectives*, edited by James E. Moran and David E. Wright (Montreal: McGill-Queen’s University Press, 2006), 162; In their study of the Indigenous Maori in New Zealand, Lorelle Barry and Catharine Coleman found the same. Lorelle Barry and Catharine Coleman, “Insanity and Ethnicity in New Zealand: Maori Encounters with the Auckland Mental Hospital, 1860-1900,” *History of Psychiatry* 22, 3 (2011): 291.

³⁸ BCA, Patient Case Files, 7543, 204.

³⁹ BCA, Patient Case Files, 275.

⁴⁰ BCA, Patient Case Files, 104, 247.

asylum physician indicated that Shu “seems very lonesome,” but since she “does not speak English ... we cannot talk to her.” Shu was often observed to be sitting quietly by herself on the ward and not speaking to any of the other patients. In one instance, another patient “jokingly tried to talk Chinese to her [and] she just smiled in an apathetic way.” Shu was not completely isolated. Friends visited and these visits temporarily lifted her spirits. On one occasion, Shu told her friends that she “cries because the nurses cannot understand her.” The asylum did not acquire the services of a translator to help with a mental examination of Shu; instead, they questioned her husband and her friends following visits in order to determine the nature of her mental status and condition.⁴¹

The case of Shu was not the only example of isolation caused by an inability to communicate in English. It was observed in the case of Kigo M. that she did not speak English well and was “very seclusive” and “stay[ed] very much by herself, saying nothing to the other patients.”⁴² In the case of Katherine J., the asylum physicians were aware that her inability to speak and understand English was affecting her mental health. They noted that she spent most of her time alone and “takes very little interest in what is going on about her and is quite quiet and more or less depressed. This ... may be largely due to the fact that she is out of her own sphere and amongst strangers who speak a different language.”⁴³ Finally, Ming G., a twenty-seven year-old Chinese woman born in B.C., was described as understanding practically no English and that “it [was] impossible to gain her in conversation, when spoken to she looks at one in a very dull and stupid way.” Lack of English skills, in combination with a growth on her face that was

⁴¹ BCA, Patient Case Files, 277.

⁴² BCA, Patient Case Files, 279.

⁴³ BCA, Patient Case Files, 162.

described by a physician as “a grewsome [sic] deformity,” drove Ming into seclusion. Her monthly reports stated that she spent her days silently sitting alone with her hand over her mouth. She spent eighteen years in this way until her death in 1937.⁴⁴

The case files of the racialized women also reveal the various negative ways in which the asylum staff treated them.⁴⁵ Physically, the racial features of the patients were commented on during their examination. For example, one patient’s physical description read: “her features are those of an Indian ... she is quite dark complexioned and looks as though she has a little Indian blood in her.”⁴⁶ One patient was described as a “Mexican greaser”⁴⁷ and another was a “wild and unkempt Chinese girl.”⁴⁸

Descriptions of these patients’ behaviour also often took a racialized tone with Indigenous women being the primary victims of this discourse. As Sarah Carter has pointed out, Indigenous women in the West during this period were often negatively stereotyped as being dirty, lazy, immoral, and sullen.⁴⁹ In a later period, Lykke de la Cour found that, in the Cobourg Ontario asylum, racialized stereotypes infused psychiatric assessments of Indigenous women. For example, Indigenous women were often described in their admission papers as “lazy.”⁵⁰ These stereotypes, along with the eugenic idea that non-white people were intellectually and culturally inferior, were clearly evident in the case files of racialized women in B.C.’s psychiatric asylums throughout the 1920s.

⁴⁴ BCA, Patient Case Files, 104.

⁴⁵ Menzies and Palys, “Turbulent Spirits,” 163.

⁴⁶ BCA, Patient Case Files, 205.

⁴⁷ BCA, Patient Case Files, 150.

⁴⁸ BCA, Patient Case Files, 201.

⁴⁹ Sarah Carter, “Categories and Terrains of Exclusion: Constructing the ‘Indian Woman’ in the Early Settlement Era in Western Canada,” in *Gender and History in Canada*, edited by Joy Parr and Mark Rosenfeld (Toronto: Copp Clark Ltd., 1996), 33, 39-40.

⁵⁰ Lykke de la Cour, “From ‘Moron’ to ‘Maladjusted’: Eugenics, Psychiatry, and the Regulation of Women, Ontario, 1930s-1960s” (PhD thesis, University of Toronto, 2013), 210-212.

For example, Ann M., admitted from a reserve in central B.C., was said to live the “Indian mode of life” and was described as being inclined towards stealing, smoking, and being restless.⁵¹ Katherine J. was portrayed as having “the usual habits of an Indian” in regards to her health. Although she was depicted as being well behaved, she was “inclined to be somewhat untidy as is customary with her race.”⁵² Sara J. was also described as well behaved and “for an Indian keeps herself fairly tidy.” She did not speak English well and the physician noted that “as far as can be judged by talking to her in English, with her poor understanding and appreciation of such, she shows nothing other than that she is an Indian with an Indian’s habits and customs.”⁵³ Finally, Margaret D. was portrayed as having a naturally surly disposition and, while in the asylum, she “behaved as an Indian would in a new environment.”⁵⁴

In the case of Ida H., asylum staff made a direct connection between her race and her mental disorder. Ida was described by one asylum physician as having a “peculiar disposition”; she was “of a rather complaining nature, and takes a sort of paranoidal attitude towards things in general. She shows a simplicity of mind and few neurotic behavioristic features.” He believed that her peculiar behaviour “may be accounted for in that she seems to have considerable Indian blood in her.”⁵⁵

In the nineteenth century, B.C.’s asylums segregated male patients by race.⁵⁶

⁵¹ BCA, Patient Case Files, 103.

⁵² BCA, Patient Case Files, 162.

⁵³ BCA, Patient Case Files, 274.

⁵⁴ BCA, Patient Case Files, 203.

⁵⁵ BCA, Patient Case Files, 205.

⁵⁶ In the nineteenth century, there was a separate ward for male Chinese patients. In the 1890s, most of these men were deported back to China and the Chinese ward was eliminated. Mary-Ellen Kelm, “Women, Families, and the Provincial Hospital for the Insane, British Columbia, 1905-1915,” *Journal of Family History* 19, 2 (1994): 184; Ken Scott. “Society, Place, Work: the BC Public Hospital for the Insane, 1872-1902,” *BC Studies* 171 (2011): 100.

However, in the 1920s patients were only segregated by sex. There is little evidence available to determine what the wider, primarily Anglo-Saxon female population thought about living on the same wards as racialized women. However, one example is telling. In the case of Kigo M., a Japanese woman, it was noted that she was getting along “fairly well, except that some of the other patients pass remarks about being in with a person of her colour.”⁵⁷ This case suggests that the discrimination against Asian immigrants in the province was present on the wards of the asylum.⁵⁸

Robert Menzies and Ted Palys point out that life in the asylum for many Indigenous patients ultimately became a “slow decline towards death.”⁵⁹ This is true for all racialized women in PHI and Essondale. Overall, 25 percent of all female patients died while incarcerated, but racialized women died at the much higher rate of 48.6 percent. The majority (40%) of racialized women who died were Indigenous, but many Japanese, Chinese, and African-American women shared the same fate.⁶⁰ Most of these women succumbed to respiratory diseases, such as tuberculosis and pneumonia, exacerbated by the over-crowded conditions of the asylum.⁶¹ Other causes of death included heart failure, cerebral hemorrhage following a fall, and exhaustion of their

⁵⁷ BCA, Patient Case Files, 279.

⁵⁸ In “Society, Place, Work,” Ken Scott argues that in the late nineteenth century asylum, male Chinese patients were segregated and racialized in ways that were more negative and exaggerated than they were in the wider society.

⁵⁹ Menzies and Palys found that 62 percent of the Indigenous patients in their sample died while institutionalized. Menzies and Palys, “Turbulent Spirits,” 167; Barry and Coleborne had similar findings in their study of Maori incarcerated in New Zealand’s asylums; 55.6 percent of Maori admitted died in the asylum, the majority from respiratory disease. Barry and Coleman, “Insanity and Ethnicity,” 297.

⁶⁰ 66.7 percent of all the Indigenous women in the sample died, 55.6 percent of all the Chinese women died, 50 percent of the African-American women died, and 33.3 percent of the Japanese women died. BCA, Patient Case Files.

⁶¹ Menzies and Palys, “Turbulent Spirits,” 166; Barry and Coleman, “Insanity and Ethnicity,” 291.

mental condition.⁶² In some of these cases, the family made funeral arrangements and the body was taken for private internment. When the family was too far away, too poor, or non-existent, the patient was given an institutional burial. In the case of Ann M., her husband received word of her death one month later and requested that her body be sent to him. However, it was too late as she had already received an institutional burial.⁶³ Figure D shows the length of time racialized women spent in the asylum prior to death and illustrates that the majority of racialized patients who died in the asylum did so within the first year.⁶⁴ The shortest stay in the institution before death was only one week and the longest stay was eighteen years.⁶⁵ While racialized women were most likely to die within the first year of incarceration, non-racialized women were not. Although for a slightly earlier period, Kelm found that the majority of female patients who died in the asylums did so after longer stays of ten years or more.⁶⁶

Patients who did not die in the asylum were discharged. A total of 51.4 percent of racialized women in my sample were discharged. As Figure D indicates, racialized women who were institutionalized for less than one year were more likely to be discharged than those who stayed longer.⁶⁷ The shortest stay in this sample before discharge was one month and the longest was one year four months.⁶⁸ This trend matches

⁶² BCA, Patient Case Files.

⁶³ BCA, Patient Case Files, 103.

⁶⁴ Among the sample that died, 45 percent died in less than a year, 25 percent between one to five years, 12 percent between five and ten years, and 15 percent died after long stays of more than ten years.

⁶⁵ BCA, Patient Case Files.

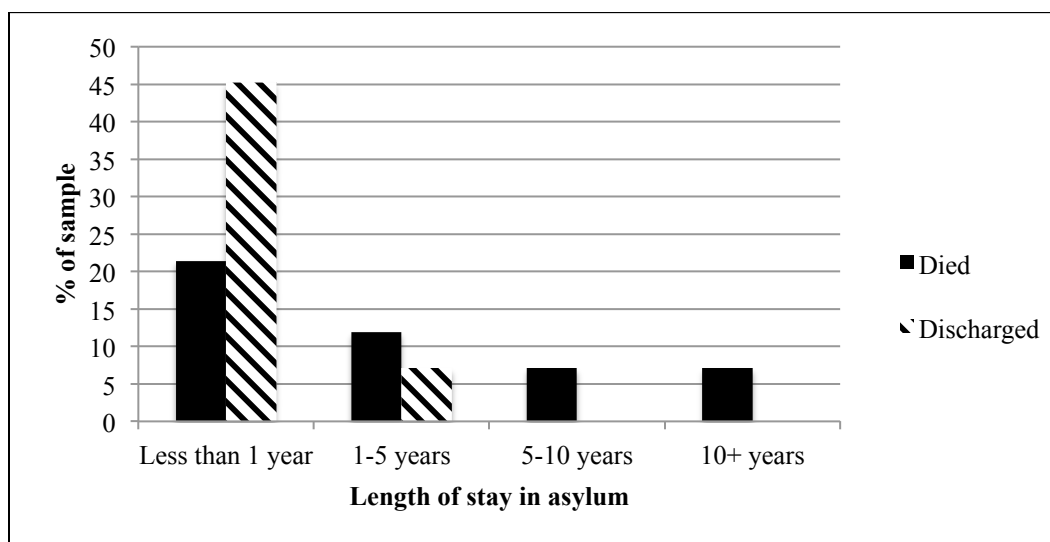
⁶⁶ Mary-Ellen Kelm, "A Life Apart: The Experience of Women and the Asylum Practice of Charles Doherty at British Columbia's Provincial Hospital for the Insane, 1905-1915," *Canadian Bulletin of Medical History* 11 (1994): 344.

⁶⁷ Among all the cases of racialized women that were discharged, 86.4 percent were released within one year while the remaining 13.6% stayed for longer than a year.

⁶⁸ BCA, Patient Case Files.

that of the wider asylum female population. Overall, female patients were most likely to be discharged within their first year of incarceration.⁶⁹ In the majority of these cases, the patient was discharged into the care of a relative or friend who took on the responsibility for keeping continuous watch over the patient for six months and was required to periodically send updates to the asylum on the patient's mental condition.

Figure D: Length of stay of all racialized female patients



Source: BCA, Patient Case Files, 1918-1933

While some patients were discharged back to their homes, others faced deportation back to their country of birth. As mentioned in Chapter One, each year the asylum superintendents raised concern about the high numbers of foreign-born patients admitted to the province's asylums. Their concerns were economic and xenophobic in tone. During the period under study, the number of Canadian-born patients admitted to the province's asylums ranged between 29 percent and 39 percent.⁷⁰ The asylum superintendents were concerned about the quality of immigrants being allowed to enter

⁶⁹ Kelm, "A Life Apart," 344.

⁷⁰ British Columbia Sessional Papers. Annual Reports of the Mental Hospitals of the Province of British Columbia 1918-1930 (Victoria, B.C., Government Printer).

Canada. As Robert Menzies argues, it appeared to many that untold numbers of physically and mentally defective immigrants were entering Canada and that the result would be deterioration of the nation's health, welfare, and security.⁷¹ In this period, superintendents Doherty, Steeves, and Crease were all strong supporters of stricter immigration policies and deportation of "unfit" immigrants.

Although eugenic theories of race betterment and economic concerns about the cost of caring for ill foreign-born patients played an important role in the superintendents' support for better immigration control, Menzies points out that this discourse also appealed to superintendents for professional reasons.⁷² Deportation and immigration restrictions would lower the institutions' rate of incurable patients while the physician's involvement in deportation would enhance the prestige of their profession. By drawing on public fears about unregulated immigration and the apparently high prevalence of insanity among the foreign born, psychiatric officials embraced deportation as an opportune and permanent device for ridding their hospitals of their most unwanted inmates.⁷³ Menzies calls the 1920s and 1930s the 'Golden Age' of deportation as 750 B.C. mental hospital patients were officially removed or informally repatriated to their countries of origin during these two decades.⁷⁴

⁷¹ Robert Menzies, "'Unfit' Citizens and the B.C. Royal Commission on Mental Hygiene, 1925-1928," in *Contesting Canadian Citizenship: Historical Readings*, edited by Robert Adamoski, Dorothy Chunn, and Robert Menzies (Peterborough, Ontario: Broadview Press, 2002), 389.

⁷² Robert Menzies, "Governing Mentalities: The Deportation of 'Insane' and 'Feebleminded' Immigrants out of British Columbia from Confederation to World War II," in *Crime and Deviance in Canada: Historical Perspectives*, edited by Chris McCormick and Len Green (Toronto: Canadian Scholars' Press Inc., 2005), 161. For an examination of the involvement and support of immigration restriction by Canadian psychiatrists, specifically C.K. Clarke, see Ian Dowbiggin, "'Keeping this Young Country Sane': C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925." *The Canadian Historical Review* 76, 4 (1995): 598-627.

⁷³ Menzies, "Governing Mentalities," 161.

⁷⁴ Menzies, "Governing Mentalities," 161. In 1935, sixty-five male Chinese patients were mass

Among racialized women who were discharged, 36.4 percent were deported, some officially and some unofficially. In 25 percent of the deportation cases, the patient was returned to their home country by their family. In these cases, the family took on the responsibility for the arrangements and cost. The remaining 75 percent of deportation cases involved the Department of Immigration and the patient's removal to their country of birth, which included Japan, China, and the United States.⁷⁵

Among all of the women who were deported, it was determined that their mental condition would be long-term or recurring and therefore care for a long period would be needed. Many of these patients were also considered undesirable citizens for other reasons. Some had committed murder; others were considered to be 'drug fiends,' prostitutes, or habitual criminals. In some cases, measures were taken to ensure that these patients did not return. For example, in Betty M.'s case, assistant medical superintendent Dr. Ryan wrote to the commissioner of the Vancouver Immigration Department and enclosed a detailed description of Betty, informing them which border crossing she would be likely to use if she attempted to return and urged the commissioner to advise his officers to prevent that from happening.⁷⁶

The eugenic discourse of 'defective heredity' played a central role in the asylum physicians' diagnoses of mental illness among racialized female patients at PHI and Essondale during the 1920s. As this chapter demonstrates, hereditary predisposition was frequently used as an explanation for the cause of mental illness among racialized women

deported back to China. Robert Menzies, "Race, Reason, and Regulation: British Columbia's Mass Exile of Chinese 'Lunatics' aboard the Empress of Russia, 9 February 1935," in *Regulating Lives: Historical Essays on the State, Society, Individual, and the Law* edited by John McLaren, Robert Menzies, and Dorothy E. Chunn (Vancouver: UBC Press, 2002), 196.

⁷⁵ BCA, Patient Case Files.

⁷⁶ BCA, Patient Case Files, 199.

at a higher rate than among the wider female asylum population. During their incarceration, these minority women faced extreme isolation, which was compounded by the racist attitudes and treatment by asylum staff. Non-English speech was deemed incomprehensible and communication between physician and patient was limited, often resulting in patient stress and isolation. Asylum staff made direct connections between race and 'abnormal' behaviour. These links were influenced by the contemporary discourse of white, Anglo-Saxon biological and cultural superiority. Finally, a large percentage of racialized women never left the asylum as they succumbed to infectious respiratory diseases. Indigenous women had particularly high death rates. As a result of wider economic, xenophobic, and professional concerns, many racialized women who did leave the asylum faced deportation back to their country of birth. For racialized female patients in B.C.'s psychiatric institutions, both the eugenic discourse of heredity and contemporary ideas about race played an important role in the asylum physicians' classification and diagnoses of their mental illnesses.

Conclusion

In 1926, Dr. McKay, a former public asylum physician, declared that heredity was paramount in the causation of mental disorders. Indeed, as argued in this thesis, heredity was considered responsible for a large percentage of asylum cases in British Columbia in the 1920s, as in other parts of the US and Canada. B.C.'s asylum physicians reported that the majority of cases they saw in the asylums ended up there as the result of an inherited predisposition to mental disease. Across North America during this period, it was argued that insanity and feeble-mindedness were rooted in "defective heredity"; individuals inherited a predisposition to mental disease and were prone to passing it on to future generations. Eugenicists in the medical and lay communities of the province were concerned that these individuals were reproducing at an unprecedented rate and that many 'unfit' were being allowed into the country through lax immigration laws. Asylum physicians also repeatedly raised the alarm over the high numbers of foreign born being admitted to their asylums. Concerned with the health and safety of the white settler community and, more generally, the white, Anglo-Saxon race, eugenicists proposed a number of programs aimed at limiting the reproduction and immigration of the 'unfit.' Marriage restriction, sexual sterilization, restrictive immigration laws, and deportation of the mentally and physically 'unfit' foreign born were seen as reasonable solutions. The discourse surrounding the usefulness of these programs varied. Economic concerns were paramount; it was emphasized that having to care for these individuals and their families was expensive and that the foreign-born were taking advantage of the generous state. The discourse was also nationalist and racist in nature as it argued that Canada needed to be built up by the best quality of immigrants and the Anglo-Saxon citizens has to be

protected from ‘race suicide.’ Many also believed that eugenic programs were an “act of humanity”; they would help protect these individuals from themselves and those who might take advantage of them. Objections to eugenic programs were limited during the 1920s.

Eugenic discourse was central to the practice of B.C.’s asylum physicians during the 1920s. Using admissions forms, patient interviews, observation, and inference, and oftentimes despite a lack of any evidence, asylum physicians concluded that many of their patients had inherited a predisposition to mental disease. The categories “heredity inferred” and “constitutional” that were used in the classification of the ‘cause’ of mental illness among patients were vague, which allowed for flexibility while still maintaining the perception that physicians were able to determine a scientific cause of mental illness. Some cases classified in these categories had explicit statements of instances of mental illness or institutionalization in the family attached to them, but, in many of the cases, the statements provided vague descriptions of “eccentric” behaviour or personalities. In the majority of case files researched, there was no evidence of any predisposition to mental illness among family members. Classifying patients as mentally ill due to heredity was not only ideologically appealing to the eugenically minded asylum physicians, it had professional benefits as well. In this period, mental disorders posed a challenge to physicians as they had limited therapeutic means to treat them. Focusing on heredity as a central cause of mental illness exempted physicians from any responsibility for low cure rates and demonstrated their relevance and legitimacy in a fast changing medical world. It placed the blame for mental illness on the patients and their families.

As this thesis demonstrates, women admitted to B.C.’s Public Hospital for the

Insane and Essondale were more likely than their male counterparts to have their mental condition linked to heredity. When considered in the wider context of the eugenics movement in the 1920s, this is not entirely surprising. Women tended to be the primary targets of eugenic discourse and programs and female heredity was considered especially influential due to the close relationship between mother and fetus. Any “eccentric” or “abnormal” behaviour or personality in the patient or their family, was considered by eugenicists and asylum physicians to be evidence of a predisposition to mental disorder. Within the population of female asylum patients, racialized women were the most likely to be labeled as having “defective heredity.” Widespread racial discrimination in the province, combined with the fact that eugenic discourse targeted non-white citizens as being biologically and culturally inferior, shaped and influenced the asylum physicians’ classification and diagnoses of mental illness among racialized women. The experiences of these women during their incarceration were also shaped by this racialized discourse and their behaviour was negatively stereotyped by asylum staff. The women were often unable to communicate in English and, as a result, many faced isolation in B.C.’s psychiatric asylums. In many cases, these patients were also considered undesirable citizens. Deportation of these racialized women was seen as the most appealing solution, both economically and professionally, to rid the asylums, and the province, of these “undesirable” mentally ill women.

The 1920s in British Columbia was an important decade in the history of eugenics. As this thesis suggests, the province’s public asylum physicians were greatly influenced by eugenic ideas. Eugenic ideas focused on concerns about the reproduction of the mentally ‘unfit’ and targeted ‘insane’ and ‘mentally deficient’ female patients,

especially racialized women, and on the transmission of ‘defective’ heredity. Throughout this period, eugenicists argued that sexual sterilization of such individuals was the best method for controlling the reproduction of the ‘unfit.’ This type of eugenic thought led the province to pass the Sexual Sterilization Act in 1933. Under this Act, patients in provincial psychiatric institutions who were considered “likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or deficiency” could be sterilized with consent from the individual or their family. During the first decade after the enactment of the Act, 64 individuals were sterilized and the majority were women. Until the Act was repealed in 1972, it is estimated that approximately 350 individuals were sterilized.¹ As Monica Wosilius points out in her thesis on sexual sterilization in the province’s psychiatric institutions, the actual selection of patients for sterilization was more complex than simply preventing the reproduction of those considered genetically unfit. A variety of concerns and factors were taken into consideration.² However, this is perhaps not surprising since, as my thesis demonstrates, there was a shift from strictly hereditarian concerns in the mid-1920s with the introduction of the diagnostic category “constitutional” that tended to pathologize environmental factors along with heredity. By the time the Act was passed in 1933, asylum physicians had already begun to broaden their focus from seeing mentally ill individuals as only being hereditary threats to the gene pool.

This thesis contributes new and important information about the history of gender, race, eugenics, and psychiatric diagnoses in the 1920s but there is still much more

¹ Monica Wosilius, “Eugenics, Insanity and Feeble-mindedness: British Columbia’s Sterilization Policy from 1933-1943” (MA Thesis, University of Victoria, 1995), 109.

² Wosilius, “Eugenics, Insanity and Feeble-mindedness,” 53, 65.

research to be done on this topic. This study examines the eugenic discourse of heredity and how it affected the ways in which female patients were classified by asylum physicians in the 1920s. How eugenic discourse operated in practice has also been examined in the context of 1930s and 1940s. Monica Wosilius has investigated the selection of asylum patients for sexual sterilization in the 1930s and early 1940s. However, the eugenic discourse and programs of the post-World War II period in B.C. have yet to be investigated in the same way as they have been in Alberta. Historians studying Alberta have found that, in the second half of the twentieth century, eugenicists and their programs specifically targeted Indigenous women. Further research would broaden our understanding as to whether or not this was also the case in B.C., and if race, or at least a focus on one particular racial group, became an even greater focus of eugenic discourse and practice in the postwar period than it had been in the 1920s. Angus McLaren has indicated that the records of B.C.'s Board of Eugenics have been either lost or destroyed.³ However, it is possible that, by taking a similar approach to the one taken in this thesis, sampling and investigating the actual patient case files, that information may be revealed about the selection of patients for sexual sterilization in the post-World War II years. This would enhance our understanding of eugenic discourse and the implementation of eugenic programs by medical professions in B.C.'s psychiatric institutions throughout the twentieth century.

³ Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland & Stewart, 1990), 159.

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