EUGENICS, INSANITY AND FEEBLEMINDEDNESS: British Columbia's Sterilization Policy from 1933-1943

by

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Abstract

This thesis looks at the people who were sterilized from British Columbia's Provincial Mental Hospital, Essondale, pursuant to British Columbia's 1933 sterilization act. This study examines the early period of sterilization policy from 1933-1943. In particular, this thesis looks at how patients, their families, physicians, and social welfare workers all were involved in the implementation of social policy. Sterilization resulted from the culmination of numerous inter-related issues such as eugenics, morality, medical practices and perceptions of proper motherhood. Issues of race, class, gender and sexuality contributed to the discourses of insanity and feeblemindedness and led to the selection of sterilization candidates.

Proponents of the social control model have argued that physicians and middle-class reformers attempted to control the reproduction of those deemed "unfit". These scholars generally have looked at a singular issue such as race or class in the social control of the lower and working-classes. Patients and their families are often portrayed as autonomous units and are pitted against the policies of middle-class reformers. Even though sterilization was a social control policy, implemented in order to preserve racial hygiene through selective breeding, patients and

their families, at times, were able to negotiate, redefine and/or reject sterilization policy. Thus a more nuanced approach is taken in the analysis of patient case files that includes issues of race, class, gender and sexuality. Furthermore, generational and gender conflict within and between various social groups is examined in order to show that families did not always share similar interests. Implementation of sterilization policy required compromise and a flexible notion of existing social welfare policies on the part of mental health professionals, patients, and their families.

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Chapter One

Introduction

In 1933, British Columbia followed Alberta in passing Canada's second eugenical sterilization bill. British Columbia's law differed from Alberta's mainly in that sterilization of the feebleminded in B.C. required consent from the patient; in Alberta, consent was not required.[1] According to B.C.'s sterilization act, each patient had to consent in writing to the operation. In practice, at least one other family member also signed consent forms. This consent thereby necessitated approval and understanding by the patient and by families of the patient. To date, no one has questioned what that approval and understanding meant and whether or not patients and families were coerced into consent. Instead, sterilization has almost always been discussed in association with the broader eugenic movement and the medicalization of insanity - the control and segregation of the deviant and feebleminded by the dominant middle-classes.

This study of the early period of sterilization in British Columbia from 1933-1943 shows how patients, families, mental health professionals and social service

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[1] Alberta's 1928 Sexual Sterilization Act was amended in 1937 to remove the consent clause. See Tim Christian, "The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act," unpublished manuscript, The University of Alberta, The Alberta Law Foundation and the Department of Justice, n.d., p. 26.

workers negotiated, rejected, or redefined sterilization policy. Selection of sterilization candidates was based on a number of inter-related factors such as eugenics, morality, medical practices, and perceptions of proper motherhood. These issues were defined within social, medical and professional perceptions of race, class, gender and sexuality. Most studies of eugenics describe the movement and tend to focus on a singular issue such as class or race. Consequently, these studies tend to ignore the complex issues that led to the selection of sterilization candidates. In a more nuanced approach, this study attempts to show how conflict and negotiation within and between various social groups led to the selection of sterilization candidates and how perceptions of race, class, gender, and sexuality contributed to definitions of insanity and feeblemindedness.

Generally, most secondary literature on asylum and psychiatric history in the Western World has been concerned with the rise of the asylum, the purpose and nature of treatment, and recently, the relationship of patients and their families to the mental hospital and to psychiatric professionals. Recently, some historians have searched for a more nuanced approach to medical history and have turned away from traditional progressive and revisionist history, and turned to patient case files to discover that patients and their families were not always victims of policies, but

that the asylum functioned as a "negotiated social space."[2]

Traditional medical historiography in British Columbia is limited to local hospital histories or biographical sketches of important medical practitioners. These progressive histories emphasized the growth of care facilities and the increasingly humanitarian care of the sick and insane.[3] The strong notion of progress and enlightenment in the treatment of the insane was linked to scientific advancements in medicine. Patients and issues such as race, class and gender were completely ignored. In response, some historians questioned this simplistic equation of asylum history as simply medicine and science equalling progress.[4] These "revisionist" historians of psychiatric and asylum history instead argued that institutions and medical practices and social policy cannot be viewed outside of a social, political and cultural context.

In Madness and Civilization, Michel Foucault was the

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[2] Thomas E. Brown, "Foucault Plus Twenty: On Writing the History of the 1980's." Canadian Bulletin of Medical History, vol. 2 (Summer 1985), p. 37.

[3] For example see, Richard A Foulkes, "British Columbia Mental Health Services: Historical Perspectives to 1961." Canadian Medical Association Journal vol. 85 (Sept. 1961), pp. 649-655; Val Adolph, History of Woodlands (Victoria: Mental Health Branch, 1978).

[4] Andrew T. Scull, "Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry." Rice University Studies, vol. 67, no. 1 (Winter 1981), p. 23.

first revisionist historian to argue that the asylum functioned primarily as a mechanism of social control and that the incarceration and treatment of the insane was less humanitarian and more political. Foucault demonstrates how the discourse of insanity defined the insane as the socially idle. He links the rise of the asylum to the market economy, increased social dislocation, and bourgeois cultural norms and values. "The new meanings assigned to poverty, the importance given to the obligation to work, and all the ethical values linked to labor, ultimately determined the existence of madness and inflected its course."[5]

More importantly, Foucault argues that insanity and sanity are culturally constructed - one can not study unreason without knowing what constitutes reason, therefore, the middle-class bourgeoisie were not only defining what and who were deviant and insane, they were also defining themselves and their actions as rational and normal, thereby constructing a culture of rationality and reason / insanity and unreason. This discourse of insanity defined a relationship of power between the middle-class and the poor, dependent and deviant.

In his later work Discipline and Punish, Foucault defines this relationship of power as a conflict or struggle

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[5] Michel Foucault, Madness and Civilization: A History of Insanity in the Age of Reason, trans. Richard Howard (New York: Vintage Books, 1988), p. 63.

(not simply of the dominant over the weak), but as a constantly changing relationship between the two. Therefore power is an affirmation of possibilities and is manifested throughout society as a whole:

> ...this power is not exercised simply as an obligation or a prohibition on those who 'do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them. This means that these relations go right down into the depths of society....[6]

Important in Foucault's definition of power is the fact that resistance and acceptance is not simply between the weak and the powerful, but is constantly redefined and negotiated between all social groups.

Foucault's social history of madness, medicine and institutions, and his concepts of power relations have generated enormous interest and response. Recently, three models have emerged in response. The first model emphasizes economic and political structures of social control. The second focuses on professionalization and medicalization of insanity. The most recent feminist model attempts to include gender as well as class analysis in the history of asylums and social control policies.

The most prominent use of economic and political structures of social control is seen in Andrew T. Scull's

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[6] Michel Foucault, Discipline and Punish: The Birth of the Prison, trans. Alan Sheridan (New York: Vintage, 1979), p. 27.

Museums of Madness and The Most Solitary of Afflictions. In both works, Scull argues that in pre-urban and especially pre-capitalist society, exclusion was the method of dealing with deviants. In a capitalist society, one national market and one central political authority necessitated a universal "state-sponsored system of segregative control."[7] Scull maintains that capitalist structures precipitated the rise of segregative asylums for the deviant and that the drive to institutionalize the deviant and dependent was based on the ruling class's social control over the poor and undesirable. He is correct in arguing that the rise of commercialization, urbanization, and industrialization eroded traditional responsibility for the poor and dependent: instead of being cared for by family members or the local community, the poor, sick, and dependent were turned over to the state. Scull fails to question why families would turn to public institutions for the care of sick family members. Instead, Scull simply portrays patients and their families as helpless victims of social control policies, and he never explores how the so-called victims may have used the asylum system to their own advantage. Furthermore, they are presented as a homogenous group and Scull makes no allowances for gender, or racial differences in the

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[7] Andrew T. Scull, Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England (Harmondsworth: Penguin, 1979), p. 48.

treatment of the poor, dependent and insane.[8]

Even though the social control model was a good method of placing the rise of the asylum and psychiatric care in a social, political, and cultural context,[9] critics of the social control model argue that gender and class conflict are neglected. As Thomas E. Brown has argued, power is viewed not as a relationship, but rather as unilateral domination of "an all powerful ruling class [over] an inert and passive working class."[10] Brown further states that

> Missing, then, in the social control account is the centrality of conflict and struggle, whether of a class nature or otherwise. In its place is posited what amounts to little more than a conspiracy theory of historical explanation.[11]

Brown, and other critics of the social control model, have suggested that an emphasis on the family experience of institutionalization would include conflict between social groups and alleviate many of the problems of the

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[8] Scull, Museums of Madness; see also Andrew T. Scull, The Most Solitary of Afflictions: Madness and Society in Britain (Yale University Press, 1993).

[9] For other examples of the use of the social control model see also, Klaus Doerner, Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry (Toronto: Oxford University Press, 1986); Erving Goffman Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (New York, 1961); Patricia T. Rooke and R.L. Schnell, Discarding the Asylum: From Child Rescue to the Welfare State in English-Canada, 1800-1950 (Lanham: University Press of America, 1983); Harvey G. Simmons, From Asylum to Welfare (Downsview: National Institute on Mental Retardation, 1982).

[10] Brown, "Foucault Plus Twenty," p. 33.

[11] Ibid., p. 33.

villain/victim dichotomy.[12]

In So Far Disordered in Mind, Richard Fox has attempted to solve the problem by looking at patient case files. He is mostly interested in how the family played a role in the committal process and concludes that gender and class differences were significant in asylum committals.[13] Fox suggests that most social control historians fail to understand that "families in the nineteenth century were themselves instrumental in bringing about the confinement of their own disturbed or disturbing relatives and neighbours."[14] While this is a particularly important point, Fox rarely questions the relationship between patients, their families, and medical professionals.

In other responses to the social control model, some historians have argued that the social control theory, such as Scull's model, is too conspiratorial and that the rise of asylums and treatment of the insane was more often benevolent and/or ad hoc. Roy Porter and Gerald Grob are

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[12] Brown, "Foucault Plus Twenty," p. 36; Richard Fox, "'Beyond Social Control': Institutions and Disorder in Bourgeois Society," History of Education Quarterly, vol. 16 (Summer, 1976), pp. 203-7; Michael Ignatieff, "State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Punishment," Crime and Justice, An Annual Review of Research, vol. III (1981), p. 183.

[13] Richard Fox, So Far Disordered in Mind: Insanity in California, 1870-1930 (Berkeley: University of California Press, 1978).

[14] Ibid., p. 10.

more interested in the rise of a professional body of mental health practitioners.[15] Porter is less interested in political and economic structures and more interested in placing insanity in its social context. Grob, in his study of American asylums from 1875 to 1940, likewise argues that in a constant attempt to professionalize psychiatry as a "scientific" medicine, "the new psychiatry...had to reach beyond institutional walls and play a crucial part in the great movement for social betterment."[16] Grob and Porter's works are important in placing mental health professionals in the social realm and not just confined to medical care. Nevertheless, Grob, Porter, Scull and Fox all view patients as victims, but as Scull saw them as the object of middle-class dominance, Grob, Porter and Fox portray them as victims of unfortunate circumstances thrown into a custodial mental health care system. All four historians completely ignore conflict between patients, families, and medical professionals.

All previously mentioned histories of insanity have emphasized class over gender analysis. Recently, feminist historians have attempted to discover how the female experience of insanity was different than the male

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[15] Roy Porter, Mind-Forg'd Manacles: A History of Madness in England from the Restoration to Regency (London: Athlone, 1987); and Gerald Grob, Mental Illness and American Society, 1875-1940 (Princeton: Princeton University Press, 1983).

[16] Grob, p. 145.

experience. Nancy Tomes's excellent account of Thomas Story Kirkbride and the Pennsylvania Hospital for the Insane is particularly important for this study because she attempts to view the asylum from within. Tomes links the asylum to the lay community - the families of the insane - and shows how the patients and their families were not simply rendered passive, but were active in the committal process, type of treatment and the discharge process. She also compares female and male experiences of insanity and concludes that women did indeed receive different treatment. Tomes' study is a move away from the social control model because Tomes shows how the asylum served numerous interests: patients, their families, and psychiatric professionals.[17]

Nevertheless, A Generous Confidence is essentially a biography of Kirkbride and Tomes' most in depth discussion of female insanity is of one patient who later became Kirkbride's wife. Furthermore, the whole discussion of the institution can not be viewed as typical particularly since the Pennsylvania hospital catered to a middle-class clientele.[18]

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[17] Nancy Tomes, A generous confidence: Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883 (Cambridge: Cambridge University Press, 1984).

[18] See also, Ann Digby, Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914 (London: Cambridge University Press, 1985), Digby's study is also not typical because the York Retreat catered mostly to a Quaker population and therefore care of the insane was based mostly on religious ideology.

Other feminist historians, such as Wendy Mitchinson have looked more closely at the relationship between gender and medicine. Although not directly focused on insanity, Mitchinson argues that medical treatment of women in 19th Century Canada was linked to social and cultural perceptions of gender. The fact that women's (as opposed to men's) sexuality and reproductive organs were more closely associated with illness, meant that women were viewed as less healthy and in need of more treatment. Mitchinson's work is particularly important in defining certain female-specific illnesses. In the perceived causes of insanity, there existed "the tendency to apply sex-specific causes of insanity to women and thus emphasize the close relationship that was thought to exist between a woman's reproductive system and her mind."[19] Therefore, while insanity was experienced by both men and women, women were recipients of specific gynaecological operations heralded as a cure.

The link between reproductive organs and insanity is particularly important when discussing eugenics and sterilization. Unfortunately, most historians of eugenics ignore gender and ignore this important link between women and insanity. Instead, historians of eugenics have followed a social control model and have argued that the eugenics movement was essentially a moral reform movement, led by

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[19] Wendy Mitchinson, The Nature of Their Bodies: Women and Their Doctors in Victorian Canada (Toronto: University of Toronto Press, 1991), p. 310.

middle-class reformers and medical professionals who attempted to define and control deviant behaviour according to middle-class social norms. While it is particularly important to note that the eugenics movement was essentially a moral reform movement based on social control, most eugenic scholars ignore contemporary views of insanity and how such views were linked to social and cultural perceptions of insanity. These scholars also ignore the experiences of patients and their families.

Perhaps the most comprehensive study of eugenics is Daniel J. Kevles' study of the American and British eugenic movement from its inception to the present day. In In the Name of Eugenics, Kevles focuses on the literature - lectures, personal correspondence, and publications - of scientists and eugenicists. Kevles makes a significant point regarding how science and ideology became linked to stratified views of race, class, gender and ethnicity, but he tends to emphasize the eugenicists' drive for scientific legitimacy and to ignore cultural and social definitions of race, class, and gender. Like historians who advocate a model of social control, Kevles presents scientists, doctors, and moral reformers as imposing their view of social order on lower-income groups.[20] The poor, dependent and insane, although primarily absent from Kevles work, are

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[20] Daniel J. Kevles, In the Name of Eugenics, Genetics and the uses of Human Heredity (Berkeley: University of California Press, 1985), p. 76.

viewed as victims of coercive eugenic policies.

Other eugenic scholars, such as Troy Duster, Philip Reilly and Angus McLaren have attempted to place eugenics within a social, cultural and political context. These historians, more so than psychiatric or asylum historians, look at how social perceptions of race, class and gender have influenced eugenic policies. The weakness in most of these studies is that usually the above mentioned perceptions are based on middle-class standards so conflict between and within social groups is absent.

Troy Duster, in Backdoor to Eugenics, looks at how IQ testing and genetic screening campaigns of various racial and ethnic target populations were essentially eugenic and strongly built on views of race, ethnicity and class. Duster looks at how screening programs for sickle-cell anaemia carriers (primarily Afro-Americans) were typically under-funded and lacked qualified staffing. Furthermore, testing was mandatory in many states and often resulted in punitive consequences for the carriers. In sharp contrast to sickle-cell anaemia screening, the Tay-Sachs screening campaign was supported by the Jewish community, was well-funded, well received and staffed by qualified medical professional.[21] Such examples clearly demonstrate how social perceptions of race and ethnicity led to racist

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[21] Troy Duster, Backdoor to Eugenics (New York: Routledge, 1990), p. 45, and particularly chapter 3.

eugenic and genetic programs. Although Duster successfully looks at how social and cultural responses figured prominently in modern eugenic programs that emphasized race, class, and ethnic differences, he fails to include gender differences or even to examine how individuals (or victims as Duster portrays them) may have responded to these various campaigns.

Philip R. Reilly's study of involuntary sterilization in the United States is primarily a legal survey of eugenic legislation. Although he attempts to look at the social and cultural context of sterilization by surveying patient case files, he adds little to the general patient experience or to familial responses to sterilization. Reilly does look at gender and how throughout different stages of the eugenic movement, males, and then later, females were favoured for sterilization campaigns.[22] Nevertheless, his emphasis on legal processes and institutional records fails to examine the social context of such changes; he discusses what happened but not why.

The most comprehensive study of the Canadian eugenics movement is Angus McLaren's Our Own Master Race. McLaren's excellent study of the eugenic movement is very important for this study because eugenics has mostly been viewed from within a European or American (particularly Nazi or

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[22] Philip R. Reilly, The Surgical Solution: A History of Involuntary Sterilization in the United States (Baltimore: John Hopkins, 1991), p. 98.

Californian) context. As McLaren has shown, Canada had a very strong eugenic movement even though legislation was enacted in only two provinces. McLaren is less interested than Reilly in actual sterilization legislation, and more interested in how eugenic ideology shaped the policy of various issues such as education, public health, immigration and welfare. Eugenicists advocated a biological solution for many late nineteenth and early twentieth century social problems. Thus, eugenics was essentially a moral reform movement led by the dominant Anglo-Saxon middle-class and directed at defining the lower-classes as unfit, deviant or "undesirable".[23] McLaren's discussion of how eugenics was linked to issues of morality is particularly important because he clearly shows how the discourse of sterilization was less hereditarian and biological, and more environmental and cultural. Thus, sterilization was advocated essentially for moral, as well as economic purposes, and to discipline what was perceived to be amoral behaviour.[24]

McLaren's study strongly follows a model of social control. He reminds us that eugenicists and moral reformers imposed harsh policies on the unsuspecting poor, and that

> ...it must not be forgotten that in campaigning for the sterilization of the feeble-minded, eugenicists were responsible for serious crimes

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[23] Angus McLaren, Our Own Master Race: Eugenics in Canada, 1885-1945 (Toronto: McClelland and Stewart, 1990), p. 166.

[24] Ibid., p. 97-8.

being committed against the weakest members of the community.[25]

McLaren further laments the fact that we know so little about the policies' victims. Even though McLaren uses a wide variety of popular and official sources, he uses no case studies and no personal accounts which gives the reader no idea of how the so-called victims responded to eugenical claims. This study attempts to build on McLaren's work by examining case histories of sterilization patients and analysing how various social groups were involved in the selection of sterilization candidates.

Numerous other scholars have written articles that have contributed to the history of eugenics.[26] The two most important works for the purpose of this study are John Radford's and Peter Tyor's articles on custodial institutions for the feebleminded.

Radford explores the debate of segregation versus sterilization of the feebleminded and examines two early twentieth century institutions. He briefly outlines the historical context of the eugenics movement and describes a

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[25] Ibid., p. 169.

[26] For example see, Nicole Rafter, "Claims-Making and Socio-Cultural Context in the First U.S. Eugenics Campaign," Social Problems, vol. 39:1 (February, 1992), pp. 17-34; David Gibson, "Involuntary Sterilization of the Mentally Retarded: A Western Canadian Phenomenon," Canadian Psychiatric Association Journal, vol. 19 (1974), pp. 59-63; Ann Oakley, "Eugenics, social medicine and the career of Richard Titmuss in Britain, 1935-50," British Journal of Sociology, vol. 12 (1991), pp. 165-194.

model of "the dominant manifestation of the eugenic argument."[27] He concludes that negative eugenic arguments espoused either the segregation or sterilization of the feebleminded. Radford's work is important in noting that "mental handicap is both a set of medical diagnoses and a collection of social constructs."[28] Nevertheless, he fails to uncover how "social constructs" defined an individual as feebleminded and how these constructs led to sterilization or segregation.

Peter Tyor's examination of custodial institutions for the feebleminded carries Radford's argument one step further by actually looking at the social construction of feeblemindedness. His emphasis is on how perceptions of sexuality relate to the definition of mental defectiveness. He states that:

> ...19th century sexual norms and gender roles encouraged physicians to treat deviant female sexual behavior as evidence of mental retardation which warranted strident [sic] measures of social control.[29]

While both authors point to one important aspect of eugenics and sterilization, each work is incomplete in that one issue

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[27] John P. Radford, "Sterilization versus Segregation: Control of the 'Feebleminded', 1900-1938," Social Science and Medicine, vol. 33:4 (1991), p. 452-454.

[28] Ibid., p. 449.

[29] Peter L. Tyor, "Denied the power to choose the good: Sexuality and Mental Defect in American Medical Practice, 1850-1920," Journal of Social History, vol. 10 (1977), p. 473.

is emphasized over all others.

Other scholars have looked at the link between female sexuality and deviance.[30] Most argue, as Radford does, that eugenicists often used deviant female sexual behaviour as evidence of mental deficiency and thereby defined amoral women as feebleminded and "unfit." Eugenic programs, such as sterilization, attempted to prevent the reproduction of those deemed as "unfit." Thus, those defined as feebleminded were considered unfit to perpetuate the race.

Women's reproductive role in this context has been examined by numerous scholars. But, even though female sexual behaviour has been linked to reproduction, few historians have discussed how the reproduction of those deemed as "unfit" was connected to social and cultural perceptions of ideal motherhood.

Some historians, such as Katherine Arnup, have looked at how the concept of ideal motherhood was defined and reinforced in society. In Education for Motherhood, Arnup examines how reformers and physicians attempted to educate mothers through various educational campaigns. She discusses how over the course of the twentieth century,

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[30] See for example, Carolyn Strange, "From Modern Babylon to a City Upon a Hill: The Toronto Social Survey Commission of 1915 and the Search for Sexual Order in the City," in Patterns of the Past: Interpreting Ontario's History, eds. Roger Hall, et.al. (Toronto: Dundurn, 1988); and Tamara Vrooman, "The Wayward and the Feeble-minded: Euthenics, Eugenics, and the Provincial Industrial Home for Girls," Master's Thesis, University of Victoria, 1994.

"control over the process of birth shifted increasingly into the hands of the medical profession."[31] This control also extended to the care and rearing of children. Arnup argues that so-called experts actively defined and reinforced methods of proper childcare. In this way, those unable to provide the type of care and attention advocated by physicians and reformers, were defined as unfit mothers. Although Arnup does not clearly link perceptions of ideal motherhood to eugenics, she does show how eugenicists were involved in the education of mothers and in the process of defining the ideal mother.

As Mariana Valverde has argued, some women were defined as potentially better "mothers of the race" based on race, class, gender, and sexuality. She states that,

> Women did not merely have babies: they reproduced 'the race.' Women did not merely have just enough babies or too much sex: through their childbearing they either helped or hindered the forward march of (Anglo-Saxon) civilization.[32]

The process of defining proper and improper sexual behaviour thereby linked issues of race, class, gender and sexuality to the social and moral reform movement. Therefore, all

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[31] Katherine Arnup, Education for Motherhood Advice for Mothers in Twentieth-Century Canada (Toronto: University of Toronto Press, 1994), p. 75.

[32] Mariana Valverde, "When the Mother of the Race is Free: Race, Reproduction, and Sexuality in First-Wave Feminism," in Gender Conflicts: New Essays in Women's History, eds. Franca Iacovetta and Mariana Valverde (Toronto: University of Toronto Press, 1992), p. 4.

women's sexual behaviour became the focus of reformers.

Valverde's The Age of Light, Soap, and Water is particularly important when discussing eugenics and sterilization because she examines how the social purity movement was primarily concerned with the regulation of sexual and moral behaviour. The fear of national and racial degeneration linked race and deviant female sexual behaviour to the "vague category of feeble-mindedness." Reformers argued that immigrants, prostitutes and unwed mothers were all over-represented among the feebleminded. "The connections linking deviant sexuality, immigrants, and national degeneration were thus firmly established."[33] Valverde examines how moral reform discourses were a process of defining individual and nation character through moral regulation. This was a "process through which race, class and gender tied to nation-building."[34]

More importantly, Valverde makes the point, similar to Foucault's point, that while moral regulation imposed values on another class, it was also "simultaneously a process of creating and reaffirming one's own class."[35] Therefore, power is not only administered by the state, but regulation

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[33] Mariana Valverde, The Age of Light, Soap and Water: Moral Reform on English Canada, 1885-1925 (Toronto: McClelland and Stewart, 1991), p. 108.

[34] Ibid., p. 16.

[35] Ibid., p. 29.

of behaviour must be affirmed and "internalized" by individuals and must have "the full and active co-operation of the family and of voluntary organizations."[36] This is a move away from the social control perspective and the villain/victim dichotomy because Valverde explores how and why moral regulation was accepted, defined and negotiated by those it attempted to regulate.

In opposition to what most historians have written on health care and eugenics, Valverde argues that such regulation was not merely a "campaign to punish and repress," but was instead an attempt to "preserve and enhance a certain type of human life."[37] The ideal human life to be preserved was based on Anglo-Saxon middle-class standards. Therefore, even though Valverde discusses class formation as a dialectical process, moral regulation of the poor, the deviant and the dependent is essentially an issue of control from the top down. Furthermore, because Valverde focuses on the actions and literature of moral reformers, the victims remain silent.

Linda Gordon, as a strong opponent to the social control and top down approach, argues that moral reform and moral regulation cannot be viewed simply "from top to bottom, from professionals to clients, from elite to

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[36] Ibid., p. 25.

[37] Ibid., p. 29.

subordinate,"[38] but instead as an active relationship between social groups. In a much more nuanced approach than the social control "top down" perspective, her study on family violence in Boston between 1880-1960, draws heavily on social work case files. She emphasizes first and foremost the gender and generational relationships of power within the family. In this sense, families simply can not be viewed as autonomous units because gender and generational differences within the family often resulted in varied interests and perspectives. Secondly, Gordon emphasizes the gender and class relationships of power between families and social welfare agencies. At times, families often were victimized by social-control policies. But, not only did they actively seek help from social welfare agencies, they also "attempted aggressively to influence agency policy and the definition of the problems themselves."[39] Even though many of the families Gordon studies are immigrant families, she is less inclined to look at how race and ethnicity influenced relations between various social groups.

Gordon's study is particularly important in defining family violence as politically and historically constructed because definitions of what constituted unacceptable

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[38] Linda Gordon, Heros of Their Own Lives: The Politics and History of Family Violence, Boston 1880-1960 (New York: Penguin, 1988), p. 295.

[39] Ibid., p. 6.

behaviour changed over time. Therefore, even though family life was traditionally considered private, it became public and social. Even issues such as poverty take on a public and class dimension when poverty was defined by reformers as child neglect. Furthermore, Gordon argues that within the family

> ... violence usually arises out of power struggles in which individuals are contesting real resources and benefits. These contests arise not only from personal aspirations but also from changing social norms and conditions.[40]

Gordon, unlike other historians of mental health, eugenics or moral reform, manages to avoid the victim/villain dichotomy by exploring how social-control policies were used and adapted by the so-called victims. Gordon succeeds in this endeavour by looking at struggle and conflict within family groups and family responses to social welfare policies. This is particularly important when attempting to understand why patients and their families would have consented to social control policies such as sterilization. Because the sterilization campaign in British Columbia required individual and family consent, Gordon's model is particularly useful in examining how an essentially coercive, social-control policy was adapted or negotiated for individual or familial needs. Gordon's model of gender and generational conflict also shows how families were not always in agreement as to what was best suited for

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[40] Ibid., p. 3.

the family as a whole.

This thesis attempts to add to the secondary literature on mental health, eugenics, and social reform by looking at how patients, families, physicians, and social welfare workers all were involved in the implementation of social policy. Specifically, by examining sterilization case files, I attempt to show how gender and generational, as well as class, relations of power were negotiated and adapted in the asylum experience. Sterilization resulted from the culmination of numerous inter-related issues such as eugenics, morality, medical practices and perceptions of proper motherhood. These issues led to the incarceration and sterilization of those defined as deviant or "unfit". Medical professionals, social welfare workers, and patients' family members all co-contributed to the selection of sterilization candidates. Eugenical sterilization was undoubtedly a social control policy, defined and legislated by middle-class reformers and medical professionals, but families were often more involved in the initial diagnosis and committal of an insane person than were medical practitioners. Once in the hospital environment, patients and their families further attempted to use for their own benefit, (and in some cases, reject) social control policies. Thus, although the social control perspective is not completely abandoned in this study, a more nuanced approach is taken in the analysis of sterilization case

files. Instead of just looking at a singular issue such as class or race, this approach examines how race, class, gender and sexuality influenced definitions of insanity, feeblemindedness and proper motherhood.

A 1945 report, written for the Provincial Secretary, on the success of sterilization in British Columbia identified 64 patients who had been sterilized under the 1933 Sexual Sterilization Act. These 64 patients were tracked through the Essondale admission records, and 34 of the 64 sterilization cases subsequently were found in the boxes of patient case files.[41] Additional information on the 30 missing sterilization case histories was acquired from Essondale's admission records and from the Stewart Report. This additional information shows that the missing sterilization case histories differed little from the sample in this study. Thus, there is no reason to believe that the 34 sterilization case histories used in this study are unrepresentative of the 64 case histories mentioned in the Stewart Report.

For detailed information regarding the general asylum population, a systematic sample was undertaken of patients

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[41] The other 30 sterilization case files are missing from the material housed at the British Columbia Provincial Archives. These missing case histories may have been considered active when the Riverview and Essondale case files were moved to the Provincial Archives in 1987. They subsequently have been purged to bare medical information, which means that all of the patient and family correspondence would have been destroyed.

between the ages 14-39 in every tenth box of Essondale patient case files. This group of 95 patients hereafter will be referred to as the sample population of Essondale case files. All other information on the asylum population was derived from the Annual Reports of the Medical Superintendent at Essondale which were published yearly in the British Columbia Sessional Papers. This study relies almost solely on case files and hospital records in order to emphasize the patient experience, and to examine how and why certain individuals were selected for sterilization.

Chapter two discusses who was sterilized and how race, class, gender and sexuality contributed to the selection of sterilization candidates. A comparison of the differences and similarities between the general asylum population and sterilization patients shows that there was little difference between the two groups on the basis of race, and some difference in socio-economic status. The sterilization patients instead differed markedly from the general asylum population on the basis of gender and perceptions of sexual behaviour. Thus, people with specific medical and social characteristics of insanity were more likely to be selected as candidates for sterilization.

Chapter three makes two points on how gender ideologies influenced professional diagnoses of insanity and feeblemindedness. First of all, the nineteenth century legacy of female insanity linked to reproductive organs

survived well into the twentieth century. Many married women had the cause of their insanity linked to childbirth. For these women, sterilization often was used as a "cure" for insanity in cases of postpartum breakdowns. Secondly, physicians and numerous social welfare agencies cooperated in selecting candidates for sterilization. Many of the young women sterilization candidates were defined as feebleminded according to social standards of proper and improper sexual behaviour. Furthermore, these young single women were labelled as "unfit" mothers.

Finally, chapter four examines how patients and their families cannot simply be viewed as victims of social control policies because in many cases family members also actively contributed to the selection of sterilization candidates. An analysis of case files indicates that families were not always in agreement on decisions to sterilize and that male family members' opinions generally received more authority with hospital officials in the commitment and sterilization of female family members. Furthermore, patients' responses to sterilization indicate that in some cases patients were able to refuse sterilization or to redefine policy.

Even though sterilization policy was undoubtedly a social control policy, sterilization patients were not simply victims of a middle-class conspiracy to regulate and control the behaviour of the poor, deviant and insane.

While the social control perspective will not be completely abandoned in this study, a simplistic view of the villain/victim social control model fails to view relationships of power within and between various social groups. An examination of institutional case files gives the historian a glimpse into the lives of patients and their families. Admittedly, such an approach is a reconstruction, pieced together from the fragmented social, medical and institutional information that was deemed important by hospital officials. Nevertheless, responses and actions of the patients and families to treatment and policies, as well as negotiations of conflict and struggle between patients, their families and mental health professionals are recorded in these valuable sources of historical explanation. In this way, the asylum experience is viewed as a negotiated experience between various social groups in which inter-related issues such as eugenics, morality, medical practices and perceptions of proper motherhood led to the selection of sterilization candidates.

Chapter 2

The Characteristics of Asylum and Sterilization Patients.

This chapter looks at who was defined as a prime candidate for sterilization and how race, class, gender and sexuality contributed to the selection process. According to the British Columbia Sterilization Act, the Superintendent of the mental hospital was required to recommend patients for sterilization and have them appear before an established Board of Eugenics. Because the sterilization act was extremely vague in defining who should be sterilized, patients were selected individually from the general asylum population as candidates for sterilization. Nevertheless, sterilization patients were a relatively homogenous group exhibiting many similar characteristics. A comparison of the differences and similarities of the sterilization patients to the general asylum population shows that the two groups were similar in socio-economic status and racial composition, but that they differed markedly in characteristics of gender and issues of sexual behaviour.

On April 7, 1933 the Legislative Assembly of British Columbia passed a Sexual Sterilization Act that defined the establishment of a three person Board of Eugenics.[42] Appointed by the Lieutenant-Governor, this Board consisted

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[42] Revised Statutes of British Columbia, "An Act respecting Sexual Sterilization," Chap. 59, Victoria: King's Printer, 1936, p. 199.

of a judge, a psychiatrist, and a person "experienced in social-welfare work."[43] The Board of Eugenics was ordered to meet occasionally and approve recommendations for sterilization by the Superintendents of public hospitals for the insane and industrial schools. The Act stated that:

> Where it appears to the Superintendent of any institution...that any inmate of that institution, if discharged therefrom without being subjected to an operation for sexual sterilization, would be likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or deficiency, the Superintendent may submit to the Board of Eugenics a recommendation that a surgical operation be performed upon that inmate for sexual sterilization.[44]

Patient consent was important in B.C.'s Sterilization Act. The sterilization operation would not take place unless the so-called inmate consented in writing to the Board of Eugenics. If that inmate were incapable of consent then a family member was directed to sign for the inmate.[45] The Act required only one person's consent, but in practice, the hospital always acquired consent from the patient and at least one other family member.

Physicians and psychiatrists generally agreed that mental disease and mental deficiency was mostly hereditary

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[43] Ibid., p. 199.

[44] Ibid., p. 199-200.

[45] Ibid., p. 200.

but also partially environmental.[46] In either case, offspring of mentally deficient or diseased people would be either genetically or environmentally predisposed to mental illness. As Dr. Adami stated during his 1912 lecture on the causes of insanity:

> ...clean living makes the great nation; that if the parents eat sour grapes the children's teeth, ay, and much more than their teeth, are liable to be set on edge, that evil living must tell upon the race even unto the third and fourth generation.[47]

Therefore, inheritance of mental disease and deficiency, in the broadest sense, meant that potentially all persons in the above mentioned institutions were likely to predispose their offspring to mental illness. The vagueness of the Sterilization Act, thus meant that recommendations for sterilization were based on individual selection and were left solely to the Superintendent's discretion.

For the purpose of analysis this chapter only discusses who was sterilized and how race, class, gender and sexuality distinguished prime candidates for sterilization. How people were selected, and who was involved in the selection process will not be discussed until the following chapters.

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[46] J.G. Adami, "'Unto the third and fourth generation': A Study in Eugenics," The Canadian Medical Association Journal (vol. 2, 1912), p. 963-980; C.B. Farrar, "Sterilization and Mental Hygiene," Canadian Public Health Journal (vol. 22, Jan. 1931), p. 92-94; W.L. Hutton, "Problems of Sterilization," The Canadian Medical Association Journal (vol 33, 1935), p. 192-193.

[47] Adami, "'Unto the third and fourth generation'," p. 980.

Sterilization legislation was inherently eugenical in that it attempted to improve the quality of the human race through selective breeding.[48] Nevertheless, sterilization in B.C. never became a policy for all patients. Instead, only a few individuals a year were selected for sterilization.

In 1945, M. Stewart produced a report for the Provincial Secretary which discussed the success of sterilization to date in British Columbia. He isolated 64 cases of people who had been sterilized from Essondale up to 1943.[49] Stewart noted that there was no way to know how much of mental deficiency was inherited, and concluded that it would be impossible to sterilize all mental defectives and all carriers of the defect. Instead, he cautioned that:

> Each case of this type needs to be considered on its own merits, with consideration being given to the probability of recurrence, the probable extent of transmissibility, the extent to which the psychosis is due to environmental factors, whether or not it would produce effects leading to ineffective care of children, and whether

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[48] For example, see Ellsworth Huntington, Tomorrow's Children: The Goal of Eugenics (New York: John Wile & Sons, 1935); and E.S. Gosney, ed. Collected Papers on Eugenical Sterilization in California: A Critical Study of Results in 6000 Cases (Pasadena: The Human Betterment Foundation of Pasadena, 1930).

[49] M.Stewart, "Some Aspects of Eugenical Sterilization in British Columbia with Special Reference to Patients Sterilized From Essondale Provincial Mental Hospital Since 1935," August 17, 1945, Provincial Secretary Correspondence, GR 496, Box 38, file 3, British Columbia Archives and Record Services. [Hereafter referred to as the Stewart Report].

> childbearing would be likely to cause recurrence.[50]

Stewart emphasized individual selection of sterilization candidates, but outlined numerous environmental and heredity factors that could contribute to selection decisions. By comparing the sterilization patients to the general population of Essondale, one can see that the people who underwent sterilization were, as Stewart suggested, individually selected and were not representative of the whole population of Essondale. Even though contemporary eugenic discourse heralded sterilization as a policy of negative eugenics - meant to inhibit the reproduction of persons likely to reproduce "subnormal" offspring - sterilization was not simply a policy for all mentally ill or feebleminded persons. Selection of sterilization candidates was based on definitions of insanity and feeblemindedness which were informed by race, class, gender and sexuality.

Sterilization legislation was implemented primarily as a measure of racial hygiene. According to eugenicists, this meant that racial integrity needed to be preserved and protected. Eugenicists assumed that the inferior classes were reproducing more than the superior classes which would eventually result in "racial degeneration".[51] Early

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[50] Ibid., p. 9.

[51] McLaren, Our Own Master Race, p. 46.

twentieth century eugenicists based their definition of the superior and inferior on a racial hierarchy. White Anglo-Saxon cultural norms and values represented a model of racial superiority. Eugenicists saw white cultural values as superior, but the "scientific" appeal of biological determinism often strengthened their arguments.

The inherent racism in eugenic discourse is particularly apparent in eugenicists' rhetoric on immigration. As McLaren has shown, eugenicists' fears of racial degeneration resulted in a demand for restrictive immigration:

> English Canadians assumed that white Anglo-Saxons were racially superior and immigrants were welcomed according to the degree to which they approached this ideal. British and Americans were viewed as the most desirable, next northern and western Europeans, after them the central and eastern Europeans (including the Jews), and last of all the Asians and blacks.[52]

This hierarchy of desirable immigrants parallels a social Darwinist hierarchy of racial intelligence. Missing from the immigrant hierarchy are First Nations peoples - they would have been grouped last along with Asians and blacks.[53] Even though Asians consistently scored in the upper percentile on intelligence exams, they were viewed morally and culturally as an inferior class. Not only were non-whites and non-Anglo-Saxon immigrants defined as

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[52] Ibid., p. 47.

[53] On biological determinism see Stephen Jay Gould, The Mismeasure of Man (London: W.W. Norton and Co., 1981).

intellectually and culturally inferior, the eugenicists argued that Canada was becoming the dumping ground of the mentally deficient.[54] As an ardent eugenicist, Judge Emily Murphy wrote a series of editorials in 1932 in favour of sterilization. She cautioned Vancouver Sun readers to take note of the Alberta situation:

> To forestall any would-be wits, permit me to say that 70% of Alberta's insane are not natives of this, the newest province in Confederation, but come from countries outside of Canada.[55]

With such arguments, eugenicists were thus able to establish a hierarchy of intelligence based on race and a justification for the sterilization of those deemed inferior.

If, as eugenicists claimed, the racially inferior classes were filling asylums, one would expect to find a high percentage of immigrants in Essondale. However, most patients were Canadian citizens. A ten percent sample of the Essondale patient population indicates that 68% of the 95 patients were born in Canada, or had spent most of their lives in Canada. Three men were of Asian descent, but only one was a recent immigrant. Even though hospital officials were careful to indicate Asian and Native racial categories, no Natives show up at all in the sample population, and no

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[54] McLaren, Our Own Master Race, chapter 3.

[55] Emily Murphy, "Sterilize the Insane," Vancouver Sun, Sun. Sept. 3, 1932, p. 3.

female Asians. Most people were listed as Canadian.[56]

Like the general asylum population, race did not figure prominently in the sterilization patients. One woman was of Japanese descent but born in Canada, and another woman was Native. Only one woman could have been considered a recent immigrant: she was born in Russia, but had landed immigrant status.[57] An overwhelming 51 of the 64 sterilization patients were born in Canada, and 24 of those patients were born locally in British Columbia. The other 12 sterilization patients were born in the British Isles or the United States.[58] Even though eugenic discourse directed sterilization toward specific racial and ethnic groups, the actual policy was implemented predominantly on Canadians.

Considering that during the 1930s British Columbia's population was extremely mobile, strong extended familial ties would have been non-existent. These people, without

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[56] British Columbia Mental Hospital, Essondale, Patient Case Histories, G-87-024, BCARS; A sampling of every patient between the ages of 14 and 49 was taken from every tenth box between the years 1933-1943 [Hereafter referred to as Sample Population of Essondale patients].

[57] British Columbia Mental Hospital, Essondale, Sterilization Patient Case Histories, G-87-024, BCARS; Every sterilization case that could be found was used in the sampling of sterilization patients. This search resulted in 34 of the 64 patients who were identified by A. Stewart in the "Stewart Report." [Hereafter referred to as Sterilization Case Histories].

[58] Information on location of birth taken from Essondale Provincial Hospital Admissions Books, box 2, vol. 3-5, GR 1754, BCARS.

family support would have been most likely to turn to the asylum for care of their sick relatives. The fact that so few First Nations people were represented in the asylum and as candidates for sterilization can probably be explained by the fact that they had stronger ties to their community and would have been able to rely on more support during a familial crisis.

In his study on the Alberta sterilization policy, Tim Christian also found that race did not figure prominently in sterilization candidates in the inter-war period. He notes that race was less important in the earlier periods of study from 1929-43, but race and ethnicity became increasingly more important in cases that appeared before the Board of Eugenics between 1949-72.[59]

Philip Reilly, in his study on the history of sterilization in the United States, also notes that race was not particularly significant in the inter-war period. He adds that during the depression eugenicists shifted their focus from men to women:

> They [eugenicists] became less concerned with preventing the birth of children with genetic defects and more concerned with preventing parenthood in those individuals who were thought to be unable to care for children. The goal was

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[59] Tim Christian does note that Native people were slightly over-represented in the earlier periods of sterilization policy, but in the 1969-72 period, Indian or Metis peoples represented 3.4% of Alberta's population and 25% of those sterilized; Christian, "The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act," p. 84-90.

> to reduce new burdens on the public purse. This generated a dramatic change in who was sterilized.[60]

Even though in eugenic discourse race was important in defining the inferior classes, Christian and Reilly both show that race was not significant in the inter-war period, but became increasingly more important in post-war sterilization policies. British Columbia's policy probably followed a similar pattern. For the period examined in this study, race was important factor in eugenic discourse but not in the implementation of sterilization policy. Reilly points to the fact that proper care of children translated into economic means. This shift in emphasis refocused the definition of the inferior from race to class.

The existence of private institutions for the insane indicates that insanity itself was not confined to a particular class of people. Because the policy of eugenical sterilization was only available through state or provincial institutions, it is important to note that sterilization was directed toward persons committed to public, as opposed to private, institutions. Since private care was expensive, most people admitted to a provincial mental hospital were from poor or moderate socio-economic backgrounds.

Although hospital records do not explicitly indicate the class of patients, socio-economic background can be

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[60] Reilly, The Surgical Solution, p. 94-95.

partially inferred through Essondale's Annual Reports of patient occupations. The new admittances in 1933 were mostly from the working classes. The largest occupational group for a total of 402 males was labourer (124), followed by farmer (45), and no occupation (44). For a total of 233 females, 139 were listed as housewives and 44 women were recorded as having no occupation.[61] While the Annual Report's occupational list is somewhat revealing as to the class of male patients, it does not indicate whether a woman was a housewife in a middle or working-class family. Ellen Dwyer also cautions historians in using occupational categories because, "those struggling with insanity frequently slide down the occupational ladder before ending up in an institution."[62] In this sense, case file analysis becomes extremely important. A close look at the sample population of Essondale case histories is more revealing for socio-economic backgrounds (see table 1). In some instances, even though a person's occupation may have been listed as a labourer, that person and their family may have been unemployed and collecting relief. Hospital officials were extremely careful in noting any financial dependence,

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[61] Department of Provincial Secretary, "Annual Report of the Mental Hospitals of the Province of British Columbia, 1933," British Columbia Sessional Papers (Victoria: Queen's Printer, 1933), p. L24. [hereafter referred to as the Annual Report].

[62] Ellen Dwyer, Homes for the Mad: Life Inside Two Nineteenth-Century Asylums (London: Rutger's University Press, 1987), p. 105.

particularly since dependence denoted social redundancy. As table 1 indicates, 40% of the patients had no source of income and were dependant upon relief. Only 11% of the patients seemed to have any assets or were, as the hospital records indicate, "successful" in their businesses or "comfortable" in their financial situation. Twenty-three percent of the patients were working in low income jobs prior to admission. Only 34% of the patients were self-sufficient.[63] This sample indicates that most patients were from poor or moderate socio-economic backgrounds.

Table 1:

Financial Situation of Sample Population of Essondale Case Histories from 1930-1943.

Information	Males		Females		Total	
indication of poverty*	21	40%	17	40%	38	40%
working-class occupation**	15	29%	7	17%	22	23%
some indication of assets or success in business***	5	10%	5	12%	10	11%
over 18 and supported by family member other than husband or wife	6	12%	5	12%	11	12%
unknown financial status	3	6%	9	21%	12	13%

[63] British Columbia Mental Hospital, Essondale, Sample patient population case histories.

no education / no occupation	1	2%	1	2%	2	2%
Totals	51	%	44	%	95	%

* - Patient or patient's husband or family is unemployed and/or receiving social assistance, city relief, mothers' pension, or charity.
** - Patient or patient's husband or family is a domestic, labourer, farm labourer, miner or mill-worker.
*** - Assets include: house, property, insurance, or savings account. Success in business includes: successful business or average to good income employment.
Source: Patient case files, Essondale Provincial Mental Hospital.

An analysis of sterilization case files indicates that these patients' socio-economic backgrounds were considerably lower than the general asylum population. Twenty-four (73%) of the 34 sterilization patients or patients' families were receiving social assistance and five patients were adults supported by parents or in-laws. Only 4 of the 34 had good finances or were successful in business. Of these 4, three were married women who had just had a child and were obviously suffering a postpartum breakdown. The fourth woman's committal papers stated that her finances were good, but the case file indicated that her husband did not want her returned home and was not willing to support her (SCH # 33). Essentially, only three of the 34 sterilization patients were self-sufficient or came from self-sufficient families. At the time of committal, these three patients were not dependent on financial assistance from outside sources; the rest all exhibited a dependence on social services or family members.

Considering that the period under study is during the depression, many so-called normal persons also would have relied on social assistance. Furthermore, most persons in the general asylum population were from low socio-economic backgrounds. Therefore, class is not a major distinguishing feature between sterilization patients and the general asylum population. Nevertheless, even though selection for sterilization was not based solely on economic status, most of the sterilization patients exhibited economic dependence.

Economic dependence does not fully explain why, as Reilly argues, sterilization policy shifted from men to women during the depression - particularly since historically men have always been regarded as the "breadwinners." Furthermore, even though sterilization patients were much more dependent on social assistance than the general asylum population, not all patients who were on relief were sterilized. An analysis of how gender influenced the likelihood of committal, age at time of committal, marital status, and diagnoses shows that sterilization patients were not representative of the general asylum population.

Most historians of mental health have argued that asylums generally housed more females than males.[64] But

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[64] For example see, Mary Ellen Kelm, "'The only place to do her any good': The Admission of Women to British Columbia's Provincial Hospital for the Insane," BC Studies, No. 96 (Winter 1992-93), pp 66-89; Cheryl Krasnick Warsh, Moments of Unreason: The Practice of Canadian Psychiatry

during the 1930s, Essondale's male population exceeded the female population by approximately 30 percent. For example, in 1933, British Columbia's three provincial mental hospitals, Essondale, New Westminster, and Saanich (asylum for criminally insane males) housed 1,861 males and 963 females. Essondale itself housed 1,375 males and 776 females.[65] The British Columbia situation can in part be explained by the general population of British Columbia. The 1931 Canadian Census shows that B.C. had the highest provincial ratio of male to females (there were approximately 125 males for every 100 females).[66]

Gender is particularly important when discussing sterilization in British Columbia because most of the people sterilized were female.[67] Of the 64 people sterilized from

and the Homewood Retreat, 1883-1923 (Montreal: McGill-Queen's University Press, 1989), p. 78.

[65] Ibid., p. L9.

[66] Dominion Bureau of Statistics, Canada, Seventh Census of Canada, 1931, vol. II, Population by Areas (Ottawa, 1933), p. 156. British Columbia's population was listed as: male - 385,219 and female - 309,044.

[67] Even though studies on the Alberta sterilization policy show that relatively equal numbers of males and females were sterilized, Christian has found that this was not the case in the earlier periods of sterilization policy. Of the people sterilized between 1929-33: 22.2% were males and 77.8% were females; between 1939-43: 40% were males and 60% were females. Christian, "The Mentally Ill and Human Rights in Alberta," p. 41.

May 31, 1935 to May 27, 1943, 57 were women and 7 were men.[68] Even though the vasectomy operation for men was relatively simple and the salpingectomy for women was a much more complex operation,[69] it is not surprising that sterilization was directed toward women because reproduction, although biologically not confined to women, was socially perceived to be solely a female concern.

Even though by the 1930s homes for the aged, and schools for feebleminded children had opened in British Columbia, people of a wide range of ages were admitted to Essondale. The admittances between April 1933 and March 1934 indicate that the largest group of females (102) were admitted between the ages of 15-40, whereas, most males (168) were admitted between the ages of 40-65.[70] These numbers clearly show that a woman was more likely to be hospitalized during child-bearing years and a man was more likely to be hospitalized over the age of 40, when presumably, most men have had their children. These figures

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[68] Unless otherwise indicated, the information on the sterilization cases is derived from the "Stewart Report."

[69] For a detailed description of the two operations see the "Stewart Report," and also, Collected Papers on Eugenic Sterilization, Robert L. Dickinson, M.D., "Sterilization Without Unsexing."

[70] "Annual Report, 1933," p. L25; The rest of the admittances are as follows: 28 males and 16 females were under the age of 15, 140 males and 102 females were between 15-40, 168 males and 87 females were between 40-65, 38 males and 31 females were over 65.

change marginally from year to year, but the average figure of the highest age group in the mental hospital over a ten year period hovers around the 30s and 40s for women and the 40s and 50s for men.

In comparison to the general asylum population, the average age of sterilization patients was much younger than the typical asylum patient. The youngest female sterilized was 12 years old. When the director of the Social Service Department at Essondale wrote to the Secretary of the Board of Eugenics to ask if she were too young to be sterilized, the secretary responded that anyone past puberty would be given consideration (SCH # 2). Eleven young women sterilized were under the age of 18. The average age for a single woman was 21.8, and for a married woman 28.6. The extremely young ages of the female sterilization patients reflects the fact that sterilization was implemented before a young woman could potentially become a mother. In contrast, the youngest (and only unmarried) male sterilized was 22. The average age for the rest of the married men was 32.5. Clearly, sterilization policy was directed primarily toward young women.

The differences in marital status between men and women in the general asylum population were also informed by gender and perceptions of male and female roles. In 1934, of the new admissions, 53% of women were married and 36% were single, whereas, 30% of men were married and 62% were

single (other variables include divorced, widowed, deserted or separated). The marital status figures for the ten year period between 1933 and 1943 remain relatively the same as the above percentages.[71] This means that married women and single men were more likely to be hospitalized. Wendy Mitchinson found a similar pattern in her study of 19th century mental institutions in Ontario. She states that "from the beginning of the asylum's history more married women than single entered the asylum, and more single than married men entered."[72] The marital status of mental patients in Canada obviously remained the same well into the twentieth century. Mitchinson concludes that a sick or mentally ill married woman was more disruptive to the family home than a sick married man because a married man with a sick wife would have had to go to work and leave the wife at home alone to care for the children. Instead, a married woman with a sick husband could look after him at home and the loss of his income could be supplemented with charity.[73] The care of his illness would have been considered another household chore. Mitchinson also mentions that families were less likely to institutionalize married men because the stigma of having a mental illness

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[71] "Annual Reports," 1933-1943.

[72] Mitchinson, The Nature of Their Bodies, p. 305; see also Nancy Tomes, A generous confidence, p. 28.

[73] Mitchinson, p. 310.

may have affected future employment. This also explains why more single and elderly men are represented in the mental hospital: because presumably, they did not have a family to look after them during bouts of mental illness. A comparison of the asylum marital status figures to the 1931 Census of Canada shows that single males were slightly over-represented in the asylum. Between the ages of 20-60, 55.3% men were single and 41.7% were married.[74] Ultimately, single men were more vulnerable to institutionalization and families could not be burdened with a female who was disruptive to the family household. Social construction of gendered male and female roles strongly influenced the likelihood of committal, and whether or not a person received institutional or home care.

The sterilization patients, in comparison, do not reflect the marital status of the general asylum population. Of the sterilization patients: 47 of the females were single, 5 were married, 4 were separated, and 1 was widowed, whereas, 6 of the males were married and 1 was single. This distribution is completely opposite to the marital status of the general asylum population - where single males and married females were most likely to be hospitalized.

Gender also influenced and informed the diagnoses of patients. During the 1930s, mental hospitals operated as

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[74] Dominion Bureau of Statistics, Canada, Seventh Census of Canada, 1931, vol. I, Summary, p. 431.

old age homes, detoxification centres and homes for incurables; mental hospitals also housed patients who suffered from a wide variety of environmental and congenital mental disorders and also dementia caused by advanced syphilis. Even though the disorders were extremely varied, men were more likely to suffer from mental diseases such as dementia praecox (schizophrenia), and women from manic depression.[75] This can once again be explained by social perceptions of male and female roles. Schizophrenia was often associated with violent tendencies and depression with listlessness and apathy. A man suffering from schizophrenia was considered a greater social threat than a man suffering from depression disorders. For example, of the 26 males diagnosed with schizophrenia or dementia praecox, 6 of them exhibited violent or threatening behaviour toward family members and 7 were jailed prior to committal for theft, vagrancy, or public nuisance charges.[76] In comparison, only two female schizophrenics were charged with minor offences, and none was described as violent.[77] A women suffering from depression would have been completely disruptive to the family environment if that disorder

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[75] "Annual Report, 1933," p. L27.

[76] Essondale sample population case files: male schizophrenics jailed - # 2, 27, 52, 66, 72, 77, 94; attacked or threatened family members - # 33, 36, 45; violent behaviour toward family - # 4, 38.

[77] Essondale sample population case files: female schizophrenics jailed - # 23, 68.

interfered with household chores and the care of children. The women admitted with depressive disorders were described as confused, quiet or dull - four of them attempted suicide and one woman was not properly looking after her child.[78] These case histories show that women instead internalized violence and were more likely to be violent toward themselves as opposed to family members.

What is particularly important to note about the sterilization cases is that their diagnoses reflect marital status. Of the five married women, three were diagnosed with manic depression, one had dementia praecox, and one was diagnosed as having puerperal psychosis which was a psychosis associated with childbirth. These illnesses were all recognized as mental diseases and were considered curable. All five of the separated or widowed women were diagnosed as feebleminded or suffered from epilepsy. While epilepsy was considered a mental disease, it was also incurable. More importantly, both epilepsy and feeblemindedness defined these women as unsuitable mothers because their mental conditions interfered with proper child-care, and not surprisingly, their children were either in the care of the children's biological fathers or wards of the Children's Aid Society.

Of the 47 single women sterilized, 37 of them were

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[78] Essondale sample population case files: depressed females who were suicidal - # 24, 59, 74, 84; improper care of children - # 64.

characterized and diagnosed as morons or imbeciles and therefore were considered "feebleminded." Five single women had dementia praecox, four had epilepsy and only one was diagnosed with manic depression. In all, only four of the total married and single women who were sterilized had depressive disorders, which contradicts the general population's characteristic of a typical female mental patient who would have been married and diagnosed with a depressive disorder. Of the men sterilized, the one and only single male sterilized was diagnosed as feebleminded. Of the six married men, one was diagnosed with manic depression and the other five had either dementia praecox or were classified as psychopathic. This is in character with common diagnoses of men; a man suffering from a mental, as opposed to a depressive disorder, was more likely to be considered dangerous and therefore, was also more likely to be sterilized.

Most of the general asylum population had a mental disease that was believed to be curable; most of the sterilization patients had a mental deficiency which was considered incurable. A 1927 Royal Commission on Mental Hygiene emphasized the importance of distinguishing mental disease from mental deficiency:

> ...mental deficiency, commonly known on this continent under the general term of feeble-mindedness, must be regarded as being entirely separate from mental disease (insanity).
> ...insanity is a disorder or breakdown of a normal and developed faculty, whereas mental deficiency

> is a condition of arrested development of the mind usually due to some physical defect of the brain.[79]

The Commission argued that the feebleminded and the insane posed separate problems and therefore recommended that separate institutions be established for each. The insane were generally regarded as a medical problem, while the mentally deficient were defined as a social problem. The Commission suggested that most persons dependent on relief and social assistance were below par mentality. A greater problem, according to the Commission's findings, was the threat the feebleminded posed to social order:

> There is also abundant proof that mental deficiency is the major factor in producing the habitual criminal, particularly of the petty class....mental deficiency creates a great burden on the community, and that it contributes largely to dependency, delinquency, crime, prostitution, illegitimacy, vagrancy, and destitution.[80]

Thus, the feebleminded were defined as deviant and were to be segregated in institutions for life. The Commission's final recommendation approved of and suggested sterilization as an alternative to segregation.

For many feebleminded young women, the predominant factor in the characterization of deficiency and the selection for sterilization was related to social

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[79] British Columbia Sessional Papers, Report on the Royal Commission on Mental Hygiene, 1927, "Mental Deficiency: Care and Treatment of Subnormal Children," Appendix D, p. CC21.

[80] Ibid., p. CC22.

perceptions of improper sexual conduct. Many historians have argued that physicians and reformers viewed immorality as evidence of mental deficiency in young women. Paul Tyor states that:

> ...19th century sexual norms and gender roles encouraged physicians to treat deviant female behavior as evidence of mental retardation which warranted strigent [sic] measures of social control.[81]

Others have looked at how the feebleminded were linked to prostitution, crime, vice, and immorality through the multiple discourses of deviance and morality.[82] The feebleminded were blamed for many of the social problems affecting society, but emphasis on female sexuality led to the linkage of feeblemindedness and moral delinquency.

Of the 47 single women sterilized, 17 of them had had illegitimate children and six had been pregnant when they were admitted to Essondale. For most of these pregnant women, a therapeutical abortion was performed almost as soon as they were admitted.[83] Ten single childless women between the ages 14-24 had "marked sexual tendencies" or

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[81] Tyor, "Denied the Power to Choose the Good," p. 473.

[82] Valverde, The Age of Light, Soap and Water, p. 94.

[83] SCH # 31, 32, 43 and 44 (the first three of which) had a therapeutical abortion a month after they were admitted. SCH # 34 and 54 where admitted pregnant, but the record does not indicate if they carried their pregnancies to term. Even though the case files do not record an operation, it is very likely they too had abortions because the Stewart Report lists them as having "no children."

showed "sexual propensities." And two single women were said to be "too friendly." In all, 35 of the 47 single women in one way or another exhibited what was perceived to be improper sexual behaviour. In one case, a 14 year old young woman was said to be "too friendly." The Stewart Report stated that "according to social service recommendation, this patient has not the appearance of being low mentally, and is too friendly towards strangers" (SCH # 64). The assumption, of course, is that men would not be alerted to her "feebleminded" state and because of her "too friendly" nature, this young woman would have been a prime target for seduction. For another young woman, age 12, Superintendent Ryan stated in his recommendation for sterilization that "her general reactions and emotional behaviour are such that she would easily get into trouble" (SCH # 2). Both of the above mentioned young women were selected for sterilization according to social perceptions of improper female behaviour. Social perceptions of sexuality dictated that young women must exhibit self-control.[84] If they had children out of wedlock, or approached men in a "too friendly" manner, they were likely to be characterized as feebleminded, institutionalized and selected for sterilization.

Deviant male sexuality also contributed to diagnoses of insanity and feeblemindedness. Only one male was diagnosed

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[84] Valverde, p. 29.

as feebleminded. He also had crossed the limits of proper sexual behaviour: the fact that he was arrested for dressing in women's clothing helped produce his diagnosis and the reason for his sterilization operation (SCH # 5). Another male sterilization patient, who was not diagnosed as feebleminded, but had had intercourse with his nine year old daughter, undoubtedly was sterilized also because of deviant sexual behaviour (SCH # 8). Even so, five males from the sample population of Essondale case files were diagnosed as feebleminded, and sterilization was not mentioned in their case histories. Of the seven feebleminded women in the sample population, sterilization was performed on one woman and was mentioned in two other case histories.[85] Even though deviant male sexuality at times led to diagnoses of insanity and feeblemindedness, improper sexual behaviour linked to feeblemindedness was found more often in women's case histories, and thus many more young women than men were sterilized.

Even though the Stewart Report emphasized individual selection of sterilization patients according to characteristics of insanity, insanity and mental deficiency were strongly based on race, class, gender and sexuality. Patients were selected for sterilization from the general asylum population, and a comparison of the differences and

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[85] Essondale sample population case files: # 14, 26, and 42.

similarities between the two groups shows that sterilization patients were not representative of the general asylum population. Class and race figure prominently in eugenic discourse, but sterilization patients differed little in socio-economic status and race from the general asylum population. Gender informed issues such as the likelihood of committal, the age at time of committal, marital status, and diagnoses of patients. Sexuality and social perceptions of proper sexual behaviour led to the diagnosis and definition of mental deficiency. These issues all differentiated sterilization patients from the general asylum population and contributed to the selection process.

Race, class, gender and sexuality all contributed to the multiple discourses of eugenics, insanity and feeblemindedness - each of these discourses influenced the others and can not be viewed separately. These multiple discourses also aided in the selection of sterilization candidates. Chapter three builds on the issues of gender and sexuality and looks at how physicians and social welfare workers were instrumental in selecting candidates for sterilization.

Chapter 3

Sterilization as Medical, Social and Moral Control.

Early twentieth century gender ideologies on insanity, sexuality and motherhood assisted doctors and social welfare workers in the selection of sterilization candidates. Married women's insanity was linked to childbirth, and sterilization was thereby viewed as treatment or a cure. Single women, who violated social and moral standards, were labelled as feebleminded, and therefore considered unfit mothers. Both doctors and social welfare workers, in accordance with eugenic discourse, believed feebleminded young women posed a threat to themselves and society and needed to be either segregated or sterilized. Sterilization was thus a measure of social and moral regulation. Doctors and social welfare agents often wielded extreme pressure on families to commit candidates and approve of sterilization recommendations. This chapter looks at how various inter-connected gender ideologies led to the selection of sterilization candidates. The active role of families and patients in this process will not be discussed until the following chapter.

Even though sterilization legislation was not passed in British Columbia until 1933, doctors previously had been performing gynaecological operations on women for mental disorders. As Wendy Mitchinson has discovered, in her study of nineteenth century mental health in Ontario, doctors

performed surgical operations as treatments for insane women. Although these operations were primarily for physical diseases, doctors made a distinct connection between a woman's mental health and her reproductive organs. Mitchinson states that:

> Their predisposition to credit the surgery for the mental recovery of their patients stemmed from their belief that organic disease in the reproductive system of women was a major cause of female insanity.[86]

Mitchinson argues that some superintendents of insane asylums may have been too quick to see mental recovery in the insane from surgical treatments. And some doctors completely disagreed with gynaecological surgery as a cure for insanity. Nevertheless, popular attitudes toward women and insanity in part supported such practices. Therefore, diagnoses and characterizations of insanity were socially and historically constructed.

Western doctors and superintendents likewise were influenced by traditional cultural perceptions of female insanity. As Mitchinson states, perhaps the most enthusiastic supporter of gynaecological surgery as treatment for insanity was Dr. Ernest Hall from Victoria, British Columbia. He convinced the superintendent of the provincial asylum to allow him to examine insane female

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[86] Wendy Mitchinson, "Gynaecological Operations on Insane Women: London, Ontario, 1895-1901," Journal of Social History, vol. 15, no. 4 (1982), p. 478.

patients for evidence of gynaecological disorders.[87] In a published paper reporting his findings, Hall stated:

> My first attempt in Gynecological [sic] treatment of the insane was made on January 5, 1896, with such remarkable results that I have lost no opportunity of investigation in this direction.[88]

Hall continued to explain that further results were not as successful as his first attempts, but that results were "sufficiently encouraging to justify a more systematic and thorough investigation into the relations between pathological conditions of the pelvic organs and abnormal psychic phenomena."[89] He examined 42 patients and treated 23 women with various surgical procedures, such as removal of one or both ovaries and/or tubes, amputation of the cervix, a hysterectomy, or removal of cysts. Hall stated that 8 women recovered from their mental condition, 3 improved, 2 slightly improved, 9 remained unimproved, and 1 woman died from surgery. Even though the results really were less than satisfactory, and Hall admitted that further research needed to be done, Hall concluded that "gynaecological treatment should be recognized as a most important part of asylum therapeutics."[90]

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[87] Mitchinson, p. 341.

[88] Ernest Hall, "The Unofficial Gynaecological Treatment of the Insane in British Columbia," Medical Sentinel (n.d.).

[89] Ibid.

[90] Ibid.

The legacy of female gynaecological surgery for treatment of insanity survived well past the turn of the century.[91] In 1932, a year before sterilization legislation was passed in British Columbia, a female Essondale patient was recommended for gynaecological surgery. She was admitted by her husband six weeks after the birth of their first child. She had no previous committals and her husband stated on the committal forms that the supposed cause of her breakdown was from childbirth. A letter written by Doctor Crease on March 14, 1932, to the patient's husband indicates that nineteenth century perceptions of female insanity linked to reproductive organs still existed in the early twentieth century. Crease stated:

> Examination of her physical condition, especially of the pelvic condition, shows that this no doubt has something to do with her mental upsets at her period times....She is receiving treatment for this and the suggestion we would make is, should we be able to get her by one of her periods without any excitement, that she have an operation for removal of her uterus.[92]

The fact that this operation would have effectively sterilized the patient was not mentioned by Crease, but he nevertheless equated her mental upsets with her monthly reproductive functions and concluded that essentially a

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[91] Angus McLaren also has discovered that gynaecological operations were done on insane women without the consent and support of sterilization legislation, Our Own Master Race, p. 163.

[92] Sample patient population case file # 20.

gynaecological operation would cure her insanity.

All of the married women sterilized between 1935-43 had the cause of their insanity linked to childbirth. Doctors, patients, and their families concluded mental breakdowns were caused by pregnancy. Therefore, removing the threat of pregnancy would remove the possibility of another breakdown. This use of the sterilization operation was not officially sanctioned by the sterilization act. Even so, these women appeared before the Board of Eugenics and were passed for surgery.

Not surprisingly, the first woman sterilized under the Sterilization Act, on May 31, 1935 was diagnosed with Puerperal Psychosis - a psychosis associated with childbirth. Elizabeth J. was a 26 year old married woman who had had mental breakdowns after her first, fourth and fifth pregnancies. Her husband cared for her after the fourth pregnancy, but on the other two occasions, she was hospitalized. The committal papers said she was "sullen and sulky," and that "she would not sleep nor eat the last 24 hours"(SCH # 3). The Social Service Department stated that her "Husband reported patient to be most sexual and would not take any precautions against further pregnancies." Even if she would have wanted to use birth control, in 1935, her access to safe and effective birth control methods would

have been limited.[93] Instead, Elizabeth was sterilized, and released as recovered. But contrary to the fact that the cause of her breakdowns supposedly was removed, she was recommitted three years later and died during her stay in Essondale (SCH # 3).

Of the 34 sterilization cases, all four of the married women were admitted one month postpartum.[94] Karen N. had a three week old child when she was admitted to Essondale by her husband. She was described as being dishevelled, troubled, irrational, and showed "no emotion when questioned about her family or little baby." She also refused nourishment and needed to be tube-fed. Two of the Essondale doctors discussed sterilization with her husband. She recovered from her depression very quickly, and two months later, while she was out on leave, Karen and her husband discussed sterilization with their family physician. He

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[93] Jane Lewis, "'Motherhood Issues' in the Late Nineteenth and Twentieth Centuries," in Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries (London: Routledge, 1990), eds. Katherine Arnup, Andree Levesque and Ruth Roach Pierson, p. 11.

[94] The fifth married woman sterilized (whose case file I do not have) also had 5 children. The Stewart Report recorded Dr. Ryan's recommendation for sterilization as follows: "Taking into consideration the history in this case of definite mental breakdown following the last three pregnancies, I feel further pregnancy would probably result in a complete breakdown, and the effect be transmitted to the child." Considering that her case file was "active" when all inactive files were brought to the Provincial Archives, this patient must have had further breakdowns after sterilization.

concurred with the Essondale doctors. In a letter to one of the hospital doctors, Karen wrote:

> Mr. N. tells me you advised that I be sterilized and that we could have it done at the General. It does seem at times a family of two would be very nice but no doubt that would be showing poor judgment on my part after all the worry I have caused others with one.[95]

Even though Karen essentially disapproved of being rendered sterile, she accepted a passive role and conceded to the recommendations of three doctors. Furthermore, because Karen and her husband were Christian Scientists, they also went against their religious beliefs when they agreed to surgery. Karen's case history shows the immense influence doctors had in convincing patients to have the sterilization operation.[96]

Jane J. also was admitted by her husband three weeks after the birth of their first child. The Social Service Record indicated that a doctor relative of Jane's mother initially recommended sterilization. Jane was excited, restless, and suicidal throughout her stay in the asylum. She was diagnosed with dementia praecox and was treated with metrazol convulsion therapy, but once the therapy was discontinued, she was released on probation. Jane appeared before the Board of Eugenics while out on leave, was

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[95] SCH # 14, letter to Essondale from patient dated May 28, 1936.

[96] See also Harvey Simmons' discussion on the influence and respect doctors commanded in all social matters, From Asylum To Welfare, p. 177.

sterilized seven months later and immediately discharged on probation (SCH # 23). Again, a doctor outside of the mental hospital was consulted, and the family had no objections to the medical recommendations.

Fanny C. was another sterilization patient admitted by her husband a month after the birth of her first child. Her mother had had a history of mental breakdowns with each of her pregnancies. In his recommendation to the Board of Eugenics, Dr. Ryan stated that "There is a definite history of heredity in this case, the mother having had three or four breakdowns, each with pregnancy..." (SCH # 11). It is interesting to note that even though Fanny clearly was being sterilized to "cure" her of further breakdowns, Dr. Ryan emphasized the heredity factor in his recommendation to the Board. Essentially, he made a link to the eugenic cause, even though the operation was being used for other purposes.

Karen, Jane and Fanny's case histories share numerous commonalities. All three women were in stable marriages and had just had their first child. None had a history of mental illness and none was recommitted. In each case, the women and their husbands abided by the doctors' recommendation for sterilization - even when those recommendations went against personal or religious beliefs. The doctors were attempting to alleviate and cure mental breakdowns that occurred with pregnancies. Essentially, the doctors were more interested in the patient's mental state

as opposed to the eugenic purpose of preventing the mentally deficient from producing deficient offspring. The Essondale doctors also were not concerned about releasing the patients prior to the sterilization operation. These married women in a stable family environment did not pose a threat to the social order. Instead, as all their case files indicate, the family life was disrupted by having a young mother institutionalized. These women were therefore released prior to surgery to resume female responsibility in the home. Sterilization was seen as being for the good of the women, and not as eugenic discourse dictated, for the good of society. This use of sterilization as a cure for female insanity has been completely overlooked by historians and scholars of the twentieth century.

While doctors recognized a link between pregnancy and mental breakdowns, postpartum depression was not really recognized as a mental disorder.[97] Other than the woman who was diagnosed with puerperal psychosis, and one woman with dementia praecox, all above mentioned women were diagnosed with manic depression. It is impossible to know how many other women were sterilized for postpartum depressive disorders. Three married women from the sample

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[97] A search through three major psychiatric journals published between 1930-1940 revealed that no mention was made of postpartum depression, depression related to childbirth, or puerperal psychosis; American Journal of Psychology, vols. 31-53; Journal of Applied Psychology, vols. 14-24; and The psychological Review, vols. 37-47.

of the general asylum population likewise were sterilized because of breakdowns after pregnancies. Although these women never appeared before the Board of Eugenics, two of them were recommended for sterilization while in Essondale Hospital. Four months after the birth of her second child, and after a failed suicide attempt, the third woman had a sterilization operation. The case file is unclear as to who recommended sterilization, but the woman probably arranged the procedure through her family physician.[98] Considering she was suicidal after the birth of her second child, the physician would have agreed that surgery to prevent recurring pregnancies was needed.

Clearly, the nineteenth century perception that linked female insanity to reproductive organs was prevalent in the early twentieth century. Although the purpose of sterilization surgery was to prevent the reproduction of mentally deficient offspring, doctors used sterilization as treatment for female insanity in the cases of married women with postpartum breakdowns. Patients and their families deferred to medical opinion, and doctors were able to recommend sterilization with little resistance. Nevertheless, doctors' power over sterilization decisions was not absolute - patients and their families simply followed "expert" medical advice.

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[98] Sample of Essondale hospital population, cases # 22, 24, and 31.

This study looks at the early period of sterilization policy in British Columbia from 1935-45. Who was selected for sterilization during this period changed over time. All five of the 64 sterilized married women, who had suffered a postpartum breakdown, were sterilized within the first five years of the sterilization policy. Also, in the first five years, greater diversity existed in the diagnoses of all patients. In the latter period, the policy focused on sterilizing single feebleminded young women.

A number of inter-related issues led to the definition of the feebleminded as "unfit". As numerous historians such as McLaren, Radford and Simmons[99] have noted, the myth of the menace of the feebleminded preoccupied physicians and reformers in the inter-war period. As discussed in the previous chapter, the discourse of eugenics labelled the mentally deficient as feebleminded and defined them as potential criminals, drunks, prostitutes and paupers.[100] The importance of testing and labelling young individuals, before they resorted to delinquency and criminality, was evident in the increased use of I.Q. testing by schools and

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[99] McLaren, Our Own Master Race, p. 29; Simmons, From Asylum to Welfare, chapters 3-4; Radford, "Sterilization versus Segregation."

[100] On feeblemindedness and prostitution see McLaren, Our Own Master Race, p. 73 and Valverde, The Age of Light, Soap, and Water, p. 94; on criminality and the feebleminded see Simmons, From Asylum to Welfare, ch. 3-4 and Radford, "Sterilization versus Segregation," p. 451.

social service agencies.[101] Even though these tests are now viewed as culturally, racially and class biased, the Binet-Simon test was widely used in British Columbia to officially certify individuals as feebleminded. There is a general sense that doctors simply used promiscuous behaviour to define young single women as feebleminded, but intelligence testing "scientifically" supported such definitions. Therefore, although the category of feeblemindedness was socially and historically constructed, testing led doctors and social workers to see feeblemindedness as a "real" category of mental deficiency.

The early twentieth century emphasis on female sexual behaviour stems from the perception that all women, as mothers or potential mothers, were responsible for perpetuating the race.[102] Improper female sexual behaviour defined certain women as "unfit". The linkages between immorality, vice and mental deficiency were reinforced by contemporary perceptions of female sexual behaviour and supported by eugenic ideology. As Carolyn Strange has shown:

> 'Feeble mindedness' was not confined to women but its long-term impact on 'the race' manifested itself most alarmingly in 'sub-normal' women's breeding propensities....'Sub-normal' women presented a grave and growing danger: they were

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[101] McLaren, p. 92.

[102] Vrooman, "The Wayward and the Feeble-minded," p. 20.

> not only incapable of restraining their sexual urges but were also more than normally fertile.[103]

The sexual behaviour of so-called amoral women thus was defined as a social problem. These women, who were "incapable of restraining their sexual urges" were deemed unfit to perpetuate the race.

In her study on the social purity movement in Canada, Mariana Valverde has shown how doctors were intricately involved in the moral regulation of sexuality. She argues that:

> Doctors, while primarily in the secular realm, had by the early twentieth century managed to claim jurisdiction over many ethical issues, particularly those relating to sexuality, and thus they were in a perfect position to speak the mixed religious-scientific language of social purity.[104]

Sterilization of young so-called morally deviant women was simply one manifestation of the social purity movement. Physicians and reformers attempted to define and reinforce proper female sexual behaviour and thereby defined who was considered fit or unfit to reproduce the race.

Not only were many of these young women labelled as morally deviant, they were also considered unfit mothers. Moral and social regulation was as much concerned with

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[103] Carolyn Strange, "The Perils and Pleasures of the City: Single, Wage-earning Women in Toronto, 1880-1930," PhD Dissertation, Rutgers University, 1991, p. 170.

[104] Valverde, The Age of Light, Soap, and Water, p. 47.

sexuality as it was with the regulation of family life. The abundance of advice literature in the early twentieth century on motherhood and family life contributed to the definition of the ideal mother and family.[105] As Katherine Arnup has shown, "to stem the tide of 'race suicide,' eugenicists also sought to elevate the role of motherhood, and so make it once again an attractive option for women."[106] They directed their attention toward the wealthier classes, and thereby defined the lower classes as inadequate and incapable of providing a proper family environment.

The ideal family was based on middle-class ideology, with a working father, and children reared mostly by the mother according to the new "scientific" methods. In her study on the shaping of the ideal family, Franca Iacovetta states that the ideology underlining the construction of the family,

> ...assumed a gendered arrangement in which husbands supported a wage-dependent wife and children, and women took on the task of running an efficient household and cultivating a moral

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[105] See for example, Katherine Arnup, Education for Motherhood; and also, Arnup, "Educating Mothers: Government Advice for Women in the Inter-War Years," in Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries, eds. Katherine Arnup, Andree Levesque, and Ruth Roach Pierson (London: Routledge, 1990), pp. 190-210.

[106] Arnup, Education for Motherhood, p. 38.

environment for their children.[107]

Feebleminded young single women could not provide the proper environment to raise children: first of all, they were unmarried; secondly, they were considered immoral themselves so they could not possibly provide a moral environment for their children. Hence, they were defined as "unfit mothers." The fact that so many of the sterilized feebleminded mothers had their children taken away from them supports the assumption of unfit motherhood. Not only should they be prevented from becoming mothers, they were viewed as being incapable of providing a proper family environment for the children they already had.

As Radford has argued, only two measures remained economically feasible and socially acceptable to curb the reproduction of the "unfit":

> Both targeted the "problem population", and if adopted seemed likely to arrest the supposed decline in the quality of the racial stock. Individuals certified as feebleminded would either be *sterilized*, or *segregated by gender* for life, or at least during their reproductive years [emphasis his].[108]

Although eugenicists were divided on the issue, Radford argues that most opted for a combination of the two

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[107] Franca Iacovetta, "Making 'New Canadians': Social Workers, Women, and the Reshaping of Immigrant Families," in Gender Conflicts: New Essays in Women's History, eds. Franca Iacovetta and Mariana Valverde (Toronto: University of Toronto Press, 1992), p. 263.

[108] Radford, "Sterilization versus Segregation," p. 452.

measures.[109] Therefore, the feebleminded would be institutionalized for a period of "training" and sterilized before release. But, for many of the young female patients at Essondale, this period of training translated to a period of punishment.

In a revealing letter to the Provincial Secretary, that shows how various gender ideologies worked together to select candidates for sterilization, Superintendent Ryan explained that two sisters, known to all social service agencies, were institutionalized at Essondale. Ryan stated that both Rita and Ruth were promiscuous, and that:

> From the history of the family, it is quite possible we will receive other members as they become older and more difficult to handle....The mother shows no insight or judgement into her daughters' condition, is quite untidy in her appearance and looks upon the children to look after the home....It is unfortunate that sterilization did not take place in this family years ago and, before any move could be considered, we would strongly recommend sterilization for these girls.[110]

Not only were Rita and Ruth defined as unfit, their mother was blamed for not providing a proper environment for her children - therefore she was also an unfit mother and should have been prevented from raising a family.

The above letter was written in response to the family's attempt to have Ruth released from Essondale. Ruth

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[109] Ibid., p. 453.

[110] SCH # 29, Medical Superintendent to Honourable Dr. G.M. Weir, Provincial Secretary, November, 30, 1936.

had just had an illegitimate child with a married man. Her older sister wrote, on behalf of Ruth's mother, to a local politician because she heard he was "higher than the Doctors." She argued that Essondale had her sister because she had had a baby, and that the police had coaxed her father to sign the committal forms. She stated: "I can send you one hundred or more names showing you that this girl is not insane," and added that she would care for her sister and the child.[111] In this case, the family did not follow the eugenic discourse that defined Ruth as feebleminded, deviant and unfit. Instead, Ruth's sister viewed her sister's mental state as quite normal.

Obviously, her sister, if not only Ruth herself, felt that Ruth was serving a period of punishment for having had a child. In her study of juvenile delinquent court cases, Mary Odem has shown that the difference between punishment and medical measures was often indistinguishable. Only females were detained and quarantined when they tested positive for venereal diseases; young men were tested and treated, but did not face long periods of detention. Odem concludes that:

> The policy of detaining only young women and girls reflected deep cultural beliefs that held females responsible for the consequences of illicit relations. More than a medical measure, quarantine was a form of punishment for girls who

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[111] SCH # 16, letter from Mrs. F.G. to Honourable Pierson, November 12, 1936.

had violated prevailing moral codes.[112]

Ruth was held responsible for her pregnancy and the alleged father of her child was not even held responsible for conception. Also, despite the fact that both males and females conceived offspring, the sterilization policy in British Columbia was primarily directed toward women. As Odem has found in her study, young single females at Essondale also were punished for violating moral standards of proper female behaviour.

In spite of her family's opposition, Ruth was not released on probation until a few weeks after the sterilization operation. Her sister, Rita, also was not released until she was sterilized.[113] Both young women were considered borderline feebleminded, and both exhibited "marked sexual tendencies" which, according to contemporary gender ideologies and eugenic discourse, labelled them as feebleminded and as sexual delinquents and potential prostitutes.

In another example of how medicine and moral regulation were linked to the eugenic cause, doctors were called to examine a young delinquent woman. Amanda T. was 19 when she was taken to the police station for running away from home. She was examined there for committal to the asylum. One

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[112] Mary Odem, "Single Mothers, Delinquent Daughters, and the Juvenile Court in Early 20th Century Los Angeles," Journal of Social History, vol. 25 (Fall 1991), p. 37.

[113] SCH # 16 and 29.

doctor stated that she "talked in a silly way using a good deal of slang," and that the "police matron stated that she used very bad language in front of several officers and suggested intercourse with them." The family, on the other hand, stated that Amanda, "had given no evidence of such interests or behaviour at home." They were simply worried about her because she would leave home for days at a time. In spite of the fact that she never had any actual sexual experience, Amanda's behaviour prior to commitment led authorities to believe that she exhibited "marked sexual propensities and has to be closely watched at all times." Ryan indicted in Amanda's ward notes that "The question of giving her a trial on probation has been raised, but it was deemed advisable that she be sterilized before any move be made." In this case, the hospital officials were less adamant about releasing a "sexually promiscuous" feebleminded young woman prior to sterilization -- possibly because of a more supportive family environment than that of Ruth and Rita's. She was released, but returned six months later because "her mother's ill-health necessitated her return." The doctors made no further mentions of her sexual propensities, and two years later, she was sterilized and released on probation the following month (SCH # 22). Obviously, doctors did not force the issue of sterilization before release, as they seemingly had done with Ruth and Rita. But, when her family was unable to care for her, she

was returned to the hospital and not released until sterilized.

Another young woman, Gillian C., was admitted to Essondale pregnant with her second illegitimate child at the age of 23. She delivered her second child while in the hospital and the baby was taken into the care of the Catholic Children's Aid Society. The social service report stated that Dr. Manchester [previous superintendent of Essondale] had suggested sterilization, but "the family were not willing to have it done." Numerous letters were written to the hospital asking for her release, which prompted Ryan to state in her ward notes:

> Upon the constant demand of the relatives of this patient she was discharged on Special Probation into the care of her sister. She was fully warned as to what might occur, and we are still endeavouring to have her sterilized. Unfortunately, there has been no meeting of the Board of Eugenics during the summer months.[114]

Her sister obviously was warned that Gillian may again become pregnant. The doctors were hesitant to release her before the operation, and had Gillian and her parents sign consent forms for sterilization before her release. Despite the fact that Gillian and her family were Roman Catholics, they agreed to the operation, and she was sterilized while out on probation.

All of the above mentioned single and married women essentially were selected for sterilization by the doctors

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[114] SCH # 55.

at Essondale while the patients were institutionalized. Husbands supported medical decisions of seemingly necessary operations for treatment of postpartum breakdowns, and parents agreed to have promiscuous feebleminded young women sterilized with little objection. Because doctors had control of when patients were released, the choice for the parents and the patients was often between prolonged segregation or sterilization.

While some patients were recommended for sterilization when they were in the hospital, other patients were selected for sterilization prior to committal by various social welfare agencies. Most of these welfare agencies were primarily concerned with economic factors. Because single women with illegitimate children had no financial support, they often were dependent on social assistance. Nevertheless, these agents were equally influenced, as doctors were, by gender ideologies that defined the so-called sexually deviant young women as feebleminded and as unfit mothers. These social control agencies worked in conjunction with hospital officials to have these young women sterilized. At least seven of the sterilization patients were committed to Essondale by non-family members. Three patients were committed by the manager or relief investigator of the Children's Aid Society. One woman, age 20, only spent one night at Essondale before she was transferred to the Vancouver General Hospital for

sterilization. Ryan signed the recommendation for sterilization, but stated that the Children's Aid Society was responsible for the operation (SCH # 1). Other sterilization patients were admitted by: a nurse at the Royal Columbia Hospital, a police matron, the Girls' Industrial School, and one sterilization patient was committed through an Order in Council and was transferred from Oakalla Prison Farm.[115]

An interesting example of sterilization as a mechanism of social control is the case history of a young Japanese woman, age 18, committed by the Girls' Industrial School. Dr. Ryan stated that Eiko L. ran away from the school several times. Her uncontrollable behaviour defined her as feebleminded and deviant. Two months after her committal, her ward notes stated that on October 6, 1940, the question of sterilization was discussed and her relatives gave their permission. But on January 4, 1941, before Eiko appeared before the Board of Eugenics, a male family friend, on the family's behalf, wrote to the hospital wanting to know why Eiko was being kept at Essondale. Although the letter was written in broken English,[116] it clearly stated the parents' objection to the operation:

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[115] SCH # 2, 7, 24, 42.

[116] Letters from Eiko's mother show that her english was far superior to the male friend who wrote to the hospital. Mrs. L. probably felt that for such an important request, the male friend garnered more authority than she did. See also, Fox, <u>So Far Disordered in Mind</u>, p. 98.

> There is noding Wronge with the girls mind acording to the Dr at Assondale. They say she may have a babe some day. The parents are redy to take that responsibilety. The Dr. at Assondale recomandet an operation and told them the girl could not be relesed untill efter an operation. So they agreed But did not like to How Ever they will look efter the girl. So it will not be nessesery. How Ever let me know what this parens have to do to take there Dotter home.[117]

It is interesting to note that the parents were told that it was not Eiko's mind but her behaviour that was considered a problem. Ryan responded that the parents in the past were not able to supervise her and that she would not be discharged. He did not mention sterilization. Clearly, Eiko was committed for sterilization and would not be released until she had the operation. Once again, the parents were left with the choice of sterilization or segregation, and ultimately agreed to have their daughter sterilized. The fact that the decision was made under such circumstances really negates the voluntary condition of sterilization, and further supports the fact that doctors did exercise extreme measures of control.

Numerous other sterilization patients were selected for sterilization prior to committal by various social welfare agents. In the Social Service Report of Rachel H.'s case file, the agent indicated that "The patient's father stated that the city relief have been at him for a long time to

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[117] SCH # 42, Letter written on January 4, 1941 from a friend of the parents to the Superintendent of the Mental Hospital.

send her to Essondale for an operation so that is why she is here." Rachel had one illegitimate child and was admitted on September 12, 1941 to have a "therapeutic" abortion as well as the sterilization operation. The family had a long history with social service agencies, and the father, being dependent on city relief himself, would not have been in a position to object. Even though the family wanted her released prior to the operation, Essondale doctors refused until she was sterilized in April, 1942 (SCH # 59).

In another case history, the Superintendent of Neglected Children wrote to the head of the Social Service department at Essondale about a young 16 year old woman, who was three weeks postpartum of an illegitimate child, and stated:

> We are anxious to have her child committed and it had been suggested that it would be in order to have [Lisa Q.] sterilized.[118]

The letter concluded with a request to have the proper forms sent to the agency. Also included with Lisa's committal forms were the sterilization consent forms signed by her mother. In both Lisa and Rachel's cases, social service agents pressured family members to commit the young women for sterilization. Both Lisa and Rachel were defined as "unfit" because they had had illegitimate children. Furthermore, Lisa's child was removed from her care.

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[118] SCH # 40, letter from Superintendent of Neglected Children to Miss Kilburn, July 18, 1941.

These women were all defined as feebleminded, and were considered unfit mothers. Many of them would not have been institutionalized without the explicit purpose of sterilization. Social service agencies often were able to pressure families into committing female members for the sole purpose of sterilization to prevent them from being a further liability on the welfare system. Because many of the family members were also dependent on social services, they were not in a position to argue.

The following case is an interesting example of how a woman was more likely to be selected for sterilization by social service agents. The social service department at Essondale maintained contact with family members while a patient was committed, and during a patient's probationary period. Often when a husband was committed, a wife was visited and social services arranged temporary support. These social service workers were also in the position to select and recommend patients for sterilization. In the case of Charles J., admitted by his wife for paranoidal dementia praecox, the social service agencies first targeted his wife for sterilization.

Mr. and Mrs. J. had received support from the Family Welfare Bureau and from City Relief prior to his committal. Mrs. J. received Mothers' Pension while her husband was committed to help support their two children, and the Essondale Social Service department recommended "active

psychiatric case work with the family."[119] On December 22, 1937, three months after Charles' committal, the social service visitor reported: "Discussed case with Miss Kilburn [Essondale Social Service Department] and Miss King [Mothers' Pension]. It was decided that sterilization should be considered for patient's wife" (SCH # 21). Mrs. J. had been given a psychiatric examination and was diagnosed as "dull normal," which meant that she was considered borderline feebleminded -- she also had epilepsy.[120] Eventually, her husband was sterilized, but not until she pointed out that he was the one who was institutionalized. It is interesting to note that the social service agents would recommend the female family member for sterilization even though it was her husband who was committed. This supports the gender ideology that feebleminded mothers - and not fathers - were incapable of providing a moral environment for their children.

All of the above mentioned case histories indicate that even though sterilization in British Columbia was considered voluntary, in many of the cases, patients and families were

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[119] SCH # 21, Social Service Report.

[120] Wendy Mitchinson has found that medical views of epilepsy were influenced by perceptions of gender roles: "...doctors perceived that epilepsy was more frequent among women when indeed this was not the case either in asylums or in the wider society. The lack of control exhibited by epileptics may be the answer. Victorians would be less willing to tolerate this in women than in men and would have been more sensitive to it when it occurred in women." The Nature of Their Bodies, p. 293.

left little choice when faced with expert medical opinion, or committing a family member for prolonged segregation. Nevertheless, families were not completely victimized by social control policies. In some cases, families negotiated the release of patients, and succeeded in having patients released prior to the superintendent's decision. Families also put off recommendations of sterilizations until later dates.

Sterilization was essentially a social control policy supported by the social and moral reform movement. Medical professionals and social welfare agents were influenced by discourses of female insanity and proper motherhood. These discourses linked female reproductive organs with diagnoses of insanity in the cases of married women, and defined single women as feebleminded and as unfit mothers. Doctors and social welfare agencies used their power to enforce recommendations for sterilization, but patients and families, at times, played an important role in the negotiation of sterilization practices. The following chapter explores patients' objections to sterilization and how families were involved in the selection of sterilization candidates.

Chapter 4

Negotiation of Sterilization Policy

Historians and scholars generally have approached eugenics and mental health from a social control perspective. Physicians, social workers and middle-class reformers were viewed as dominant players in a movement to protect society from deviants and undesirables. Although a policy such as sterilization was undoubtedly initiated in order to control reproduction of so-called unfit persons, a social control approach emphasizes monolithic power structures and fails to account for the involvement of families in the selection of sterilization candidates. Physicians and social workers were instrumental in committing patients for sterilization, but patients' families also played a role in the selection of sterilization candidates. While families were actively involved in the committal and selection of sterilization patients, not all patients and their families agreed to the conditions of sterilization.

Few scholars have yet examined how families and patients interacted and used social control policies for their own purposes.[121] Some historians of mental health

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[121] A few notable exceptions are Gordon, Heroes of Their Own Lives and Tomes, A Generous Confidence; some historians have looked at how families used public and private institutions, such as orphanages, in times of family crisis, Bettina Bradbury, "The Fragmented Family: Family Strategies in the Face of Death, Illness, and Poverty, Montreal, 1860-1885" in Joy Parr, ed. Childhood and Family

have noted that families, more so than public authorities, were instrumental in committing family members to institutions.[122] In response to Andrew Scull's social control model of asylums, Mark Finnane argues that asylums

> ...had become indeed a new regime for the management of social crisis. And in this role they were moulded by the perceptions and actions of the population they served. The state defined the contours of the institutions. Yet in important ways we can see that its wishes and intentions were defied, contradicted or simply ignored.[123]

Finnane also points to the fact that families were more likely to give specific social and familial conflicts as reasons for committing a family member. Instead of simply dealing with medical conditions, the asylum officials often had to deal with family wishes and resolve crisis situations. The asylum thus was forced to function also as an "arbitrator of social and familial conflict."[124]

Historians such as Finnane, Fox, and Patricia Prestwich[125] have contested the social control model of

in Canadian History (Toronto: McClelland and Stewart, 1982); and Diane Purvey, "Alexandra Orphanage and Families in Crisis in Vancouver, 1892 to 1938," unpublished thesis, University of Victoria, Department of History, 1990.

[122] For example, see Richard Fox, So Far Disordered in Mind, p. 98.

[123] Mark Finnane, "Asylums, Families and the State," History Workshop Journal, vol. 20 (Autumn, 1985), p. 141.

[124] Ibid., p. 135.

[125] Finnane, "Asylums, Families and the State"; Richard Fox, So Far Disordered in Mind; Patricia E. Prestwich, "Family Strategies and Medical Power:

insane asylums and have argued that it fails to account for the fact that most patients were committed by family members. The function of mental institutions was primarily to house and cure the mentally insane; in the case of feebleminded young women, institutions were to provide needed training and discipline to those who needed to be segregated from society.[126] Families also turned to the asylum to cure sick relatives or to control wayward daughters, but usually only in response to a family crisis. And as the previous chapter has shown, families often objected to prolonged segregation. Families instead attempted to redefine the parameters of the asylum and, if possible, use it to meet their own needs. As many of the sterilization case files indicate, families most often turned to institutions as a last resort and for assistance during an family crisis.

At Essondale, committal of a patient resulted in only three ways. The most common method of committal was the regular committal process that required the examination of the prospective patient by two physicians, their statements of insanity, an order by a Justice of the Peace, and the committal form signed by a family member, a friend,

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'Voluntary' Committal in a Parisian Asylum, 1876-1914," Journal of Social History, vol 22, no. 4 (Summer, 1994), pp. 799-818.

[126] McLaren, Our Own Master Race, p. 39-40; Simmons, From Asylum to Welfare, p. 69, 74-75; Reilly, The Surgical Solution, p. 14; Stewart, "The Stewart Report," p. 16.

neighbour, employer, a social service worker, or any person initiating the committal of the prospective patient.[127] Those who signed the committal forms were the ones who made the initial decisions to commit a person. Most Essondale patients were committed this way. The only other two ways to enter the mental hospital were through voluntary committal or through an Order in Council, which often resulted from a criminal court hearing. Voluntary committals were extremely rare, and often when a person admitted themselves, the hospital officials would discharge that person and re-commit the patient under regular committal. This gave the hospital officials the power of discharge and release, because as a voluntary patient, the person could discharge him or herself.[128]

Of the sample population of Essondale case files, sixty-seven percent of the total 95 patients were committed by family members. Even more revealing though, is the

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[127] The committal papers comprised: two Medical certificates (Form B), one committal order (Form A), and an Application for Reception of Patient (Form C). This final form is the form that contains social, economic, and mental status of the patient and is signed by the person admitting the patient. Patient case files, Essondale Provincial Hospital.

[128] Most of the voluntary committal cases I have come across were drug and alcohol addicts. If the doctors could diagnose toxic psychosis, then the patient was in almost every case re-committed under regular committal. The others usually left the hospital within a few days. Nevertheless, these cases were extremely rare, and only one voluntary committal case occurred in the sample population of Essondale Patient Case Histories, Case # 79.

difference between male and female committals. Fifty-two percent of the males were committed by a family member, while a staggering eighty-six percent of the females were committed by family members (see Table 2). Males were almost equally likely to be committed by a male family member or by a police officer, a medical professional or a social welfare worker. Women, on the other hand, were overwhelmingly committed by male family members.

Table 2: Committals of sample population of Essondale Patients from 1930-1943.

Committed by:	Males		Females		Totals	
	N	%	N	%	N	%
Male family member	18	35	28	65	46	48
Female family member	9	17	9	21	18	19
Doctor, police, or social welfare worker*	17	33	3	7	20	21
Male friend	4	8	1	2	5	5
Female friend	1	2	1	2	2	2
Unknown**	2	4	1	2	3	3
Voluntary	1	2	0	0	1	1
Total Number	52	%	43	%	95	%

* - One female was committed by her minister
** - In some cases the committal forms were unsigned
Source: BCARS, Patient case files, Essondale Provincial Mental Hospital.

Most sterilization patients also were committed by male

family members. Of the twenty-nine female sterilization patients, fifty-five percent (n=16) were committed by male family members and twenty-four percent (n=7) were committed by female family members. The remaining twenty-four percent (n=7) were committed by social service or medical professionals.[129] This percentage is much higher than the seven percent of the general female asylum population. This greater percentage is undoubtedly a reflection of the lower socio-economic background of the sterilization patients and their more extended contact with social service agencies.

Family involvement in the committal process is particularly important when considering certain conditions that may have motivated family members to turn to the asylum for assistance. A primary condition of committal was an illness that family members could not treat. Committal to an asylum inevitably resulted in a social stigma. Therefore, families must have viewed the asylum as a last resort. Even though mental health professionals repeatedly stressed the medical nature of treatment and the importance

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[129] The breakdown for the committals of female sterilization patients is as follows: Father-8, Mother-4, Sister-2, Brother-1, Husband-6, Social Service Agent-1, Grandmother-1, Order-in-Council-1, Nurse-1, Police-1, Children's Aid Society-2, Welfare Relief Investigator-1. For the males, 1 single male was committed by his mother, and 3 married males were committed by their wives. Sterilization Case Histories, Essondale Provincial Mental Hospital.

of early committal,[130] in many cases, patients were committed to an asylum only as a final desperate solution to a familial crisis.

Family members of sterilization patients often turned to the institution for a specific purpose other than treatment of illness. Particularly in the cases of young women, a family crisis - such as the pregnancy of a young single female - may have motivated families to institutionalize a family member. In the sterilization cases, two dominant conditions seemed to have led families to commit and sterilize family members. These conditions were poverty, and inappropriate and uncontrollable female behaviour. It is difficult to know whether or not families supported dominant notions of sexual immorality linked to feeblemindedness. But, families certainly viewed promiscuity and uncontrollable female behaviour as a crisis - particularly when such behaviour led to illegitimate pregnancies. Considering that many sterilization patients and their families were dependent on social assistance, poverty (and the inability to feed another mouth) also may have been a condition that motivated families to commit and sterilize young single women. Nevertheless, the role families played in the commitment and approval of sterilization can not be ignored.

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[130] See for example, Scull, Museums of Madness, p. 111-112; and Tomes, A Generous Confidence, p. 187.

In a revealing example of a patient being committed solely for sterilization by a family member, a young woman was admitted by her mother on November 17, 1941. The doctor stated in Janet Y.'s ward notes that she was "quiet and cooperative" and that she usually just answered yes or no to questions (SCH # 47). No behavioural problems were indicated as Janet was described as obedient and cheerful. She was not the typical deviant feebleminded young woman. She was not promiscuous or incorrigible, instead social services noted that she was closely supervised by her mother. Such a comment indicated that Janet could potentially be a problem, even though no evidence of prior deviant behaviour existed. Janet was twenty years old, but an I.Q. test placed her as having a mental age of approximately five years of age. A social history report, dated a week prior to Janet's committal, stated that both Janet and her widowed mother were on relief, and that her mother wanted her sterilized "owing to [Janet's] low mentality, and the close supervision this entails."[131] Because Janet and her widowed mother were both on social assistance, it is likely that her mother feared the responsibility of the financial burden of another child to support.

Ten days after Janet was committed her mother and

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[131] SCH # 47, Social History Outline, November, 10, 1941.

uncle, a constable of the Provincial Police Department in Chilliwack, visited the hospital and were upset with "the method in which the patient was committed to the institution." The ward doctor noted that Janet's mother and uncle believed that the committal process was only for sterilization:

> They stated they did not want patient institutionalized, but merely wished to have her sterilized; Also that they had been misinformed by the Vancouver City Social Service department, as they were under the impression that as soon as patient was brought here she would be immediately sterilized and discharged as soon as she recovered from the operation.[132]

The notation concluded with Janet's mother's demand for her release. Janet was released on probation the following week and finally appeared before the Board of Eugenics on July 11, 1942 - nearly eight months after her committal. Had her mother not demanded her release, Janet would have remained segregated in the institution until her operation, as was standard policy for the sterilization of young feebleminded women.

This case is particularly important in showing the complex power relationship between families and institutions. Janet's mother obviously turned to Social Services for assistance in having her daughter sterilized. She must have been told that the operation had to be performed through the mental hospital and proceeded to have

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[132] SCH # 47, Ward Notes, November 28, 1941.

Janet committed. Clearly, Janet's behaviour was not a problem and she would not have been committed other than for sterilization. Janet's mother was able to have her daughter released and to use the process of institutionalization to have her daughter sterilized.[133]

In another case history, a provincial welfare worker wrote to a physician at Essondale and stated that Donna J., a twenty-three year old woman, who was deaf and had a mental age of eight, was seduced by a boarder at her sister's house and that the sister now wanted her sterilized (SCH # 31). The worker stated that the local physician might consider the operation for Donna but that the local hospital had "raised such a fuss" about another case that the worker did not want to send the patient there. All of the consent forms were signed for the abortion and sterilization operations and the patient was admitted to Essondale. The social history summary for the Board of Eugenics stated that the patient's reason for committal to the hospital was that she was feebleminded and that:

> hospital care had been advocated for some years, but patient's sister refused to have her committed. However, she recently became pregnant and was committed for termination of pregnancy and sterilization.[134]

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[133] For other studies on how working-class families used institutions for their own purposes, see Bradbury, "The Fragmented Family," and Purvey, "Alexandra Orphanage."

[134] SCH # 31, Social History Summary for Board of Eugenics, December, 7, 1939.

Clearly, the patient's sister only resorted to committal and sterilization when faced with a crisis situation - the seduction and pregnancy of her dependent sister. Even though, as the social service report indicated, pressure had been placed on her to have her sister committed, presumably for segregation and a period of training, the sister refused until, in her mind, her sister's condition warranted institutionalization for an abortion and sterilization operation. Both Donna and Janet were committed by family members solely for a sterilization operation.

Even though some historians have speculated that doctors performed eugenical sterilizations outside of mental hospitals, in British Columbia at least some doctors clearly were uncomfortable performing the surgery without the consent of the Board of Eugenics. As mentioned in Donna's case history, a doctor was willing to perform the surgery, but the local hospital opposed the operation. In another sterilization case, the social service worker reported that "the local doctors are not anxious to do a sterilization without the consent of the Board, although the father is willing to have the operation done" (SCH # 28). Thus, families who wanted sterilization operations for family members, had to go through the proper legal channels of committing a family member to the asylum in order that that person could appear before the Board.

As the previous mentioned case histories indicate,

families contributed in the social control of feebleminded young women. But, as Linda Gordon has argued, "Neither positive nor negative appraisals of social control had gender or generational analyses."[135] Gordon states that critics of social control policies made the mistake of discussing the family unit as an independent household. Gordon's point is important because most historians of eugenics and mental health tend to posit patients and their families as an autonomous unit on one end and medical professionals and social workers on the other end of a struggle, with both groups competing for their own interests. Such an approach neglects gender and generational conflict within and between various family groups. The sterilization cases instead indicate, as Gordon has argued, that the relationship between physicians, social workers, patients and their families was complex and conditions of committal, release, and sterilization were negotiated within and between the various groups.

Many sterilization case histories show that the male family member's opinion held more authority with hospital officials. In some cases, females would enlist the aid of another male family member to strengthen their demands. In Janet's case, her mother brought her police officer brother-in-law with her to demand the release of Janet (SCH # 47). In Donna's case, even though her sister was her legal

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[135] Gordon, Heroes of Their Own Lives, p. 292.

guardian, and Donna lived with her sister, the welfare worker obtained the consent for sterilization from Donna's sister and both of her brothers - "just in case" (SCH # 31). This was the only time Donna's brothers were mentioned in her case history.

Most of the case histories present clear generational power inequities, particularly when parents were attempting to control the behaviour of delinquent young female members. One mother stated that she wanted her eighteen year old daughter sterilized and that the daughter's consent was not needed (SCH # 50). Realizing that patient consent was needed, the hospital officials did acquire consent from the daughter. Even though the Board of Eugenics required consent of the patient, in practice, this often translated to consent of the person in charge of the patient. Because of generational power inequities within the family, families of sterilization patients cannot be viewed as autonomous units of familial harmony.

In some sterilization case histories, families did not work together in harmonious decision-making relationships. A compelling example of clear gender conflict within the family is the case of seventeen year old Nora H., who was committed to Essondale by her father. Her family history summary indicated that Nora's parents were divorced and her father had remarried. She occasionally worked and lived with her grandmother, but she was "close to her mother."

Nora's mother had a history of manic depression, and was committed for a short time while Nora was in the asylum (SCH # 15). Nora's case history is an example of how conflict existed within the family on the decision to sterilize a family member, and how the hospital followed the male family member's decision.

Nora was diagnosed with dementia praecox, and a psychometric exam indicated that her mental age was fourteen, which placed her in the "dull normal" category. Her case history indicated that she was admitted to Essondale because Insulin/Metrazol treatment was cheaper there than at Vancouver General Hospital. Treatment was started immediately and within a few months she was allowed out on probation. A week later, she was returned to Essondale because she was going out too much and was "very forward with boys." The Social History Summary for the Board of Eugenics stated that: "It was at this time the family [father and step-mother] asked for sterilization." Her behaviour during her probation period led her father to believe that sterilization was necessary. She appeared before the Board of Eugenics on May 19, 1939, but before she had the operation, her maternal aunt wrote to the hospital protesting the decision. She stated:

> Neither her mother or myself are in favor [sic] of an operation at this time, and I write you in behalf of [Nora's] mother and on my own to protest

against same.[136]

In an alternative to sterilization, her aunt suggested that Nora should be moved to live with another aunt in Alberta. She also asked the hospital to speak to Nora's father because he was not helping to support her and her sisters. The hospital did not respond to the letter and less than a week later Nora was taken to Vancouver General Hospital for the sterilization operation. A month later she was discharged on probation to her father.

It is interesting to note that even though Nora seemed closer to her mother's side of the family, the social service workers focused on interviewing her father, and obtained consent for sterilization from him, (even though she did not live with him) and not from her mother. In the case of Donna's sterilization decision, consent was received from her brothers, even though her sister was clearly her guardian and sole supporter. In Nora's case, her mother's and aunt's objection was not even considered. Admittedly, the fact that Nora's mother had had a history of mental illness herself, probably lessened her authority with mental health professionals for making decisions regarding Nora. Nevertheless, as Gordon has argued, "Usually 'the family' becomes a representation of the interests of the family head, if it is a man, carrying an assumption that all family

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[136] SCH # 15, Letter to Dr. Ryan, August 21, 1939.

members share his interests."[137] In Nora's case, hospital and social work professionals placed more authority on her father's consent for sterilization. But, as the sterilization cases indicate, not all family members shared the male head's interests and perspectives. Not all family members were able to obtain what they wanted from the asylum.

Even though families and mental health professionals exerted extreme pressure and control on sterilization patients, the British Columbia Sterilization Act required consent of the patient. Most patients probably were told that sterilization was the best thing for them and that they would not be released until they consented to sterilization. Some patients undoubtedly were coerced into consent, but some sterilization candidates simply refused to have the operation. Rejection of sterilization policy often indicated generational conflict of interests within the family unit. Parents often decided to have young women sterilized, and the young women did not always share their parents' decisions to have them sterilized.

The case history of twenty-four year old Gertrude T. is an example of generational conflict within the family on the decision to sterilize. Gertrude was admitted by her mother following her first mental attack. Asylum officials diagnoses her as "borderline" feebleminded and the committal

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[137] Gordon, Heroes of Their Own Lives, p. 296.

papers stated that the supposed cause of her attack was due "to worry over finances" regarding her illegitimate child. The putative father was a married man who denied the paternity of the child. Gertrude worked as a housekeeper and was assisted in the support of her child by social services. During her stay in the hospital, like so many other sterilization patients, her child was taken into the care of the Children's Aid Society.[138] Her mother was unable to financially care for the child. A month after Gertrude's committal, the ward notes stated that she:

> ...has become rather irritable at the prolonged stay in the Hospital and feels that she is quite well enough to be home. She was rather upset following a visit from her mother, when the mother explained to her that sterilization is being considered before patient should be allowed to go home.[139]

One month later, Gertrude agreed to sterilization in order to be released, but when she later appeared before the Board of Eugenics, she caused such a disturbance[140] that the Board did not pass her for sterilization. The social service worker noted that Gertrude's mother "was sorry that she had not been down there at the time and she might have tried to get patient to give her consent. She cannot

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[138] BCARS, Patient Case Histories, Essondale Provincial Hospital, Additional Sterilization Case History # 65.

[139] Ibid.

[140] As noted in SCH # 33.

understand this as patient had signed the forms."[141] It is difficult to know what motivated Gertrude's mother to agree to sterilization - perhaps she was simply following medical opinions. Even though hospital officials and Gertrude's mother both wanted her sterilized, and Gertrude signed the consent forms, the Board of Eugenics was not willing to pass a candidate for sterilization if that patient verbally disagreed.

In most of the case files, social workers and/or physicians first approached the family with the suggestion of sterilization. Clearly, mental health professionals placed authority over such decisions with the family and not the patient. The Essondale social workers always stated that the operation had been fully explained to the patient. But, as noted in Gertrude's case history, the suggestion for sterilization was left to the mother to explain to the patient.

In another case history, an eighteen year old woman was admitted by her parents because of her troublesome and uncontrollable behaviour. Nancy F. was diagnosed with "low average or dull normal" mentality which placed her in the "borderline feebleminded" category. She was also pregnant when she was admitted to the hospital and her parents wanted a therapeutical abortion performed on her. They signed the

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[141] BCARS, Patient Case Histories, Essondale Provincial Hospital, Add.SCH # 65.

papers, but Nancy refused to have the abortion. Josephine Kilburn, supervisor of the Social Service Department at Essondale, prepared a lengthy Social History Summary for the Board of Eugenics, but Nancy never appeared before the Board.[142] Considering that she refused the abortion operation, she probably also refused the sterilization operation, although the case history is unclear on why she never appeared before the Board.

What is interesting to note in Nancy's case is that in all ways her behaviour indicated that she was a typical promiscuous and "deviant" feebleminded young woman, but Nancy's parents were considerably wealthy and her case history even stated that she was "unable to adjust to the level of society to which her adopted parents [were] accustomed to [sic]."[143] This case history clearly shows that her family linked her immoral behaviour to her mental status. Nancy's mother stated that Nancy was "behaving like a prostitute and was quite lavish with her powder rouge and lipstick." She also made numerous references to Nancy's "disgusting" behaviour. Her family essentially committed Nancy for her immoral behaviour. This is further supported by the fact that physicians seemed to have a difficult time diagnosing mental illness, and the ward doctor, in a surprising statement regarding a patient, stated that Nancy

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142 Add.SCH # 66.

143 Ibid.

> appears to have fairly good insight into her condition, judgement is fairly good and she is correctly oriented in all spheres and there is no evidence of psychosis present.[144]

This is a clear example of parents responding to a family crisis such as the pregnancy and uncontrollable behaviour of a young single daughter; institutionalization may have been the family's best solution to a perceived problem. Nancy's rejection of the abortion and sterilization shows that her interests and motivations were in conflict with her parents.

It is impossible to know exactly how many other patients rejected or refused the idea of sterilization. Sterilization was mentioned - and rejected - in at least four case histories of the ten percent sample population of patients at Essondale. In the case history of a nineteen year old diagnosed as a moral delinquent, the ward doctor noted that her father:

> would be willing to have the patient sterilized but on this occasion he refused to sign the permission, apparently because the patient does not wish to have the operation done.[145]

In another case history, a social welfare worker visited the wife of a patient and suggested sterilization for the wife. The patient's wife was noted as being opposed to sterilization and was urged to seek "reliable advice from a

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[144] Ibid.

[145] BCARS, Patient Case Histories, Essondale Provincial Hospital, Case # 26.

doctor" for alternate birth control methods.[146] A third patient signed the consent forms for sterilization but he escaped while out on leave and he was not heard from again.[147] In this instance, escape must be viewed as both a rejection of institutional constraints and a rejection of sterilization. In a fourth case file, a twenty-one year old "morally delinquent," feebleminded female was suggested for sterilization by the city social service department, but the idea was rejected immediately by the social service worker because of the young woman's Roman Catholic religion.[148] Angus McLaren has argued that sterilization legislation was not implemented in Manitoba and Ontario because the Catholic minority was strong enough to raise opposition to sterilization.[149] Certainly, case # 42 supports the assumption that religion may have been a deterrent in selecting candidates for sterilization. Nevertheless, at least five of the sixty-four sterilization patients were Roman Catholic.[150]

While sterilization policy was a social control policy, some patients were able to simply refuse the procedure. Therefore, sterilization candidates cannot simply be viewed

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146 Ibid., # 65.

147 Ibid., # 45.

148 Ibid., # 42.

149 McLaren, Our Own Master Race, p. 104.

150 SCH # 7, 12, 25, 49, 55.

as victims of social control policies because the conditions of sterilization were negotiated and successful implementation of sterilization policy necessitated the combined efforts of physicians, social welfare workers, patients, and their families.

The question of whether or not patients who agreed to the operation actually understood the implications is important for this study. Historians and scholars of eugenics generally have ignored the issue of consent. Even though there is no evidence to show that those who refused consent were sterilized anyway, those who did consent may have done so under extreme pressure from doctors, social workers, and family members. Consent for sterilization implies agreement and understanding of the conditions and procedure of the policy. Obviously those who refused to be sterilized rejected the idea of being rendered infertile. They seemed to understand that the operation was irreversible. But this is not true of some who were sterilized. One patient, who was sterilized at the age of thirteen, wrote to the secretary of the Board of Eugenics ten years after her operation wanting to know if she could have the operation reversed - she stated she was getting married and wanted to have children (SCH # 2). It seems that even though she had agreed to the operation, she really did not understand the premise of eugenical sterilization. Included in the condition of sterilization was the idea of

restricted parenthood; eugenic discourse deemed female sterilization candidates as unfit mothers.

At least four of the sterilization patients tried to adopt children after they were released.[151] This is particularly important to note in relation to eugenic ideology. If patients agreed to the conditions of sterilization why did they attempt to adopt children? In all except one case, the hospital officials informed adoption agencies that these women should not adopt children; officials firmly stuck with their opinion that these women were not only sterilized to prevent reproduction of mentally deficient offspring, but also because they were not considered fit mothers. A few women succeeded in adopting children even against the hospital's recommendations. In the only case where the hospital approved the adoption application, a patient attempted to adopt her brother's children five years after her sterilization operation. The brother had been committed to Essondale and the social service worker lamented that the sister's home would be "normally not an adequate adoption home," but since the children would not be placed easily elsewhere, they should remain with their aunt (SCH # 16). Three sterilization patients also had a difficult time adopting back their own biological children from the

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[151] SCH # 16, 23, 24, 30.

Children's Aid Society once the children became wards.[152] It took two of the women at least four years, and one woman six years before the children were finally returned to their mothers. Obviously, the above mentioned women for various reasons had consented to a physical procedure, (possibly only to be released from the hospital) but they did not consent to a possibility of restricted parenthood. Sterilization was not simply a biological method of preventing the births of mentally deficient offspring, it was also used as an environmental solution to prevent parenthood of those deemed as unfit mothers. However, many sterilization patients became parents in spite of the discourse on unfit motherhood.

Clearly sterilization candidates were selected not only by doctors and numerous social welfare agencies, but also by various family members. Often, committal and selection of sterilization candidates was determined by a familial crisis, and was not in every case agreed upon by all family members. Gender and generational conflicts existed within families in decisions to sterilize. Male family members' opinions almost always received more authority over decisions to commit and sterilize female patients. Nevertheless, some patients were able to refuse the operation and those who refused were not sterilized. Inevitably, sterilization was not initiated simply to

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[152] SCH # 7, 40, and 59.

prevent the reproduction of potentially deficient offspring. As shown in many of the case files, sterilization was often requested by family members in the event of a familial crisis, particularly the pregnancy of a young single female member. Sterilization, as a mechanism of social control, also served to prevent parenthood of those who were deemed unfit mothers by medical and social welfare professionals. Even though many patients had consented to sterilization, they did not agree with the idea of restricted parenthood.

Sterilization cannot be viewed simply as a social control policy that pitted middle-class reformers and mental health professionals against poor working-class families. In some cases patients and their families were victimized by social control policies, but the role families played in the committal and selection of sterilization candidates can not be ignored. Committal and selection of sterilization patients necessitated the combined efforts of various groups of doctors, social welfare agents, and family members. A gender and generational analysis of mental health case files indicates that families often resorted to existing social control policies in times of a familial crisis. Nevertheless, families can not be viewed as autonomous household units because family members did not always have similar interests and perspectives. Standard institutional and sterilization policy was often negotiated or redefined by its users. Successful implementation of sterilization

required compromise and a flexible notion of existing social welfare policies on the part of mental health professionals, patients, and their families.

Conclusions

This study has looked at the case histories of sterilization patients in the first decade of sterilization policy in British Columbia from 1933-1943. Previous historians of eugenics and sterilization have ignored case histories and therefore were unable to adequately answer questions on who was selected for sterilization and how patients and their families responded to sterilization policy.

It is impossible to know exactly how many people were sterilized in British Columbia under the Sexual Sterilization Act. Tim Christian estimates that seven times as many people were sterilized in Alberta (2,500) compared to the number of people sterilized pursuant to B.C.'s sterilization legislation.[153] According to Christian, in B.C. approximately 350 people may have been sterilized up to 1972, when both Alberta and B.C. finally removed the legislation from their books. But as Angus McLaren has shown, hundreds of eugenical sterilization operations were still being performed in Ontario up to 1978 - even in absence of legislation.[154]

Eugenical sterilization policy was undoubtedly a social

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[153] Tim Christian, "The Mentally Ill and Human Rights in Alberta," p. 30.

[154] McLaren, Our Own Master Race, p. 169.

control policy - implemented in order to improve the race and control the reproduction of mentally deficient and insane persons. Most scholars of eugenics and mental health have adopted a social control theory of institutions and social policy that focused on a singular issue such as class or race and have ignored issues such as gender and sexuality. The social control perspective emphasized monolithic power relations and ignored the role of patients and their families. This study has attempted to overcome these weaknesses by adopting a more nuanced approach that includes analysis of race, class, gender and sexuality in the historical and social construction of mental deficiency and insanity. Selection of sterilization candidates was based on a number of inter-related factors such as eugenic ideology, morality and sexuality, the intersection of medical practices and gender ideologies, and perceptions of proper motherhood.

According to the Sterilization Act, persons likely to reproduce mentally deficient offspring were to be recommended for sterilization by the superintendent of the mental hospital and to appear before a Board of Eugenics. But, the Sterilization Act does not explain how people were selected as candidates for sterilization and why the policy was directed toward women. A comparison of sterilization patients to the general asylum population indicates that persons with specific medical and social characteristics

were selected for sterilization. Issues of race and class were significant in eugenic discourse. But, even though sterilization patients were generally from lower socio-economic backgrounds, they differed little from the general asylum population on the basis of race and class. The two groups differed markedly on issues of gender and sexuality. Contemporary gender ideologies led to the selection of sterilization patients and informed issues such as the likelihood of committal, age at time of committal, marital status and diagnoses of patients. Perceptions of proper female sexual behaviour contributed to definitions of mental deficiency and feeblemindedness, and labelled certain so-called promiscuous young women as morally deviant. Race, class, gender and sexuality contributed to the multiple discourses of eugenics, insanity, and feeblemindedness - each of these discourses influences the others and can not be viewed separately.

Also, various social groups were involved in the selection of sterilization candidates and in the complicated process of defining individuals as deviant and "unfit." Selection of sterilization patients resulted from the combined efforts of medical professionals, social welfare agents, patients and their families.

Nineteenth century gender ideologies that linked female insanity to reproductive organs led some doctors even in the twentieth century to treat a specific type of female

insanity (postpartum depression) with a gynaecological operation. The married women who suffered from postpartum breakdowns had the cause of their insanity linked to childbirth. These women and their families followed the "expert" advice of their doctors and agreed to sterilization. Little objection to the procedure was noted in these case histories. Furthermore, these married women were not viewed as a threat to society and often were released prior to surgery. Sterilization was used essentially as treatment or a "cure" for insanity, and was seen to be for the good of the women and not necessarily for the good of society. Twentieth century historians of eugenics have completely overlooked this link between insanity and female reproductive organs.

Gender ideologies on morality contributed to definitions of feeblemindedness in the cases of "morally delinquent" young single females. According to eugenic discourse, these young women needed to be segregated in asylums for uncontrollable sexuality because they were considered a menace to society. Sterilization was heralded as an alternative to segregation, and as the case histories show, these women were not released until they were sterilized. For the patients and their families, the choice was between sterilization or prolonged segregation. Thus, consent for sterilization must be viewed with caution.

The discourses of eugenics and feeblemindedness also

defined "morally delinquent" young women as "unfit" mothers. Sterilization was implemented for eugenic purposes, but also to prevent these women from becoming or being mothers. Many of the single women had their children taken from them while they were institutionalized. Other women attempted to adopt children, but the hospital officials generally persisted with their view that these feebleminded and "morally delinquent" women would not make good mothers.

Nevertheless, patients and their families can not be viewed simply as victims of social control policies. An analysis of mental health case files shows that some patients were able to refuse sterilization, and those who refused generally were not sterilized. Not all patients agreed with the conditions of sterilization - particularly with restricted parenthood. Families also can not be viewed as victims because they often were instrumental in the committal and selection of sterilization candidates for their own purposes. In some cases, families were able to demand the release of a patient, even in opposition to hospital policy. In other cases, families were not always successful in receiving what they wanted. But as Linda Gordon has pointed out, families can not always be viewed as autonomous units. Some of the sterilization cases show that gender and generational conflicts existed within families on decisions to sterilize young female family members.

Thus, sterilization can not be viewed simply as a

social control policy that pitted poor working-class families against middle-class professionals and reformers. Successful implementation of sterilization policy required the combined efforts of medical professionals, social welfare workers, patients and their families. Therefore, sterilization must be viewed as a negotiated policy that was redefined within and/or between the various social groups.

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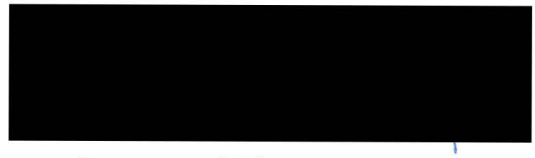
Author 

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May 23 1995.