

**Women and Families in the Asylum Practice  
of Charles Edward Doherty  
at the  
Provincial Hospital for the Insane  
1905-1915**

by

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B.A.(History) University of Windsor, 1987**

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## Abstract

This thesis examines the mental hospital's role in the lives of women and their families. The Provincial Hospital for the Insane, located at New Westminster, British Columbia is the focus of this study. The period chosen, 1905-1915, corresponds to the tenure of medical superintendent Dr. Charles Edward Doherty. Doherty was known for his success at modernizing the provincial institution. Using patient records, this thesis shows, however, that this 'improvement' of asylum care of the insane did not result in the advancement of women's treatment. The therapies used on women remained virtually unchanged and focussed on the ability of institutional staff to control inmates.

But this control was incomplete. Asylum authorities had virtually no influence over families' decisions to admit women to the institution nor were Doherty's notions about the origins of insanity widely shared by the non-psychiatric community. Once women were incarcerated, their autonomy was diminished, but even within the institution, they and their families could exert some influence. Patient behaviour and family pressure could affect treatment and the timing of discharge. For these reasons, this thesis argues that asylum practice was a negotiated phenomenon; one in which the superintendent's therapeutic goals interacted with the needs and demands of women and families who used the institution.

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## **Chapter 1: Introduction and Historiography.**

The writing of psychiatric history has matured in the last twenty years. Taking over from the psychiatrists and doctors who previously dominated the field, social historians have increasingly come to examine, discuss and debate the importance of psychiatry as a form of social and gender control. They have looked at the rise of the asylum in various contexts and have examined the role that the institution played in the emergence of mental therapeutics as a legitimate and distinct field of medicine. Further, psychiatric historians have begun to examine the uses of the asylum in the resolution of community and family crises.

Soc  
gender  
control

Most of this recent work has focussed on psychiatry and its institutions in Western European society since the Enlightenment and in North American society in the nineteenth and early twentieth centuries. Comparatively few historians have studied mental therapeutics in non-Western or pre-Enlightenment societies. In North America, mental illness and healing in non-European communities has been neglected, as have comprehensive studies of western American or Canadian institutions.<sup>1</sup> This thesis, which examines the role of the Provincial Hospital for the Insane of British Columbia in the lives of Western Canadian women, will prepare for a more broadly based history of psychiatry in Canada. Yet it must start by discussing the context of psychiatric historiography.

A comprehensive history of mental health care facilities in British Columbia remains to be written. Neglected by Canadian historians with strong regional biases towards the east, the studies that do focus on British Columbia are primarily tales of 'progress' and 'humanity' written by and for mental health care workers.<sup>2</sup> Accounts by contemporary alienists Henry M.

Hurd and his Canadian counterpart T. J. W. Burgess addressed the west and informed subsequent work on British Columbia.<sup>3</sup> Like the amateur historians that followed, they took personal and professional pride in the progress they saw around them. As Bill Van der Zalm, then British Columbian Minister for Human Resources, wrote of one such study "On occasion when one reads history...[one may feel] satisfaction with the knowledge that we have moved toward more humane and informed programmes ...[for] the handicapped and retarded."<sup>4</sup> In these studies, the mad appear as an undifferentiated mass of hapless victims of mental disease, intolerant families and parsimonious politicians. The story of psychiatry in Canada emerges, in these accounts, as a tale of the triumph of medicine and the humanitarian state over the irrational individual.<sup>5</sup>

More recently, European and American psychiatric historians have taken different approaches. Three perspectives have dominated the writing of psychiatric history in the last twenty years: social control, feminist, and multi-causal/organicist. The first, stimulated by Michel Foucault's Madness and Civilization, focussed primarily on the asylum as a mechanism of social control.<sup>6</sup> Social control historians linked the rise of the asylum and other institutions with the expansion of capitalism, the market economy, and the spread of social dislocation. For historians and sociologists such as Andrew Scull, D. J. Mellett and Klaus Doerner, economic transformations in the late eighteenth and nineteenth century led to a bourgeois hegemony over cultural values that resulted in the segregation of the insane in asylums. David Rothman argued that fears of social disorder in the Jacksonian period led to a similar result in America.<sup>7</sup> As George Rosen wrote: "Folly and madness were no longer to roam aimlessly. Order was necessary, and the

mentally and emotionally deranged were to be subjected to discipline in institutions created for this purpose."<sup>8</sup>

Much of the work written from a social control perspective emphasized the ideology of psychiatry and the rhetoric of lunacy reformers. They noted that an element of class control existed behind the 'humanitarianism' of psychiatry and medical science. Scull, Rothman and Christopher Lasch argued that the 'moral treatment' philosophy which was behind much lunacy reform in this period was primarily concerned with retraining the insane to become reliable, productive workers. Asylums emerged as the 'fit receptacle' for the mad because Victorian alienists believed that the insane needed to be removed from their environment to expedite moral treatment but also, social control historians argued, because economic and social conditions destroyed traditional mechanisms of care, and bourgeois Victorians on both sides of the Atlantic saw segregative institutions as the most efficient way to handle the various classes of capitalism's casualties.<sup>9</sup> Despite the attempts of some lay people to control psychiatry in this period, physicians maintained their monopoly on the treatment of the mad by defining mental disease as somatically based.<sup>10</sup> In this way, psychiatrists portioned off a population of deviants, established the necessity, form and nature of their care and, at the behest of the Victorian bourgeoisie, began the long struggle to eradicate behavioural non-conformity. According to this view then, the asylum did not, as contemporaries argued, 'decline' into custodialism with the failure of 'moral treatment' but rather was always repressive.<sup>11</sup>

The emphasis on the words and motives of reformers, doctors and politicians arose, in part, out of the social control school's adherence to the principles of the anti-psychiatry movement of the 1960's and 1970's.<sup>12</sup>

Drawing on the view that the diagnosis of mental illness has always been essentially a 'labelling process', social control historians demonstrated the extent to which contemporary understandings of mental illness were culturally-bound and therefore incomprehensible apart from their socio-economic, political, and ideological contexts. Despite this insight, however, these historians were unable to penetrate the world of madness. Like the lunatics of Whiggish accounts, the stigmatized victims of 'the great confinement' remained obscure behind anonymous statistics and sweeping generalizations. The insane appeared only as a homogeneous mass, incarcerated, disempowered and silent.

Feminist scholars noted that the mad were not homogeneous and that psychiatry differentiated between male and female insanity. They contended that the structuralists, who saw class as the primary social dichotomy failed to recognize the ways in which psychiatry was particularly repressive for women. In attempting to impose bourgeois 'normalcy' on all Victorians, alienists sought to perpetuate gender role stereotypes essential to patriarchal society. Elaine Showalter examined British cultural mores and discovered that throughout the nineteenth and twentieth centuries, the perceived face of madness was female.<sup>13</sup> The work of Deirdre English, Barbara Ehrenreich, Carroll Smith-Rosenberg and Lorna Duffin, among others pointed out that the Victorian medical and psychiatric profession viewed women as either 'sick' or 'sickening.'<sup>14</sup> Using the work of anthropologist Mary Douglas, these historians discovered how the patriarchal bourgeoisie of the Victorian and Edwardian eras used medical ideology to transfer their fears of a disordered society onto the female body. Like the body politic, women were described as superficially disciplined, even morally superior,

but that beneath the surface of decorum lay potentially unruly, and uncontrollably powerful reproductive organs. Thus male fears of women's bodies and social disorder merged in an era of overwhelming socio-cultural and economic change to produce psychiatric ideology that was designed not only to enforce bourgeois notions of social order, but also to uphold the gender *status quo*. The result was the emergence of a host of medical and psychiatric theories which sought to explain how women's reproductive organs made them particularly susceptible to insanity.

Feminists also went beyond either their liberal or social control counterparts by attempting to see what role insanity may have played in the Victorian bourgeois family. Some feminist historians of psychiatry argued that middle-class women used insanity as a form of rebellion, subverting the sick role into which society had cast them. Women were denied the ability to express anger, Carrol Smith-Rosenberg asserted, and therefore turned their frustration into manipulative hysterical fits. In so doing, they gained power within their families, using doctors as sometimes resentful and hostile accomplices. Smith-Rosenberg's study revealed how medical ideology could be appropriated by women in ways that were at odds with its intent.<sup>15</sup> Smith-Rosenberg's work, however, like most other feminist psychiatric historians focussed on the view of women produced by physicians and other elite commentators. Even her assertion that hysteria may have been disguised rebellion came largely from the observations of doctors rather than the mouths of women. Therefore, although feminists expanded and differentiated the field of inquiry within psychiatric history, their approach remained closely allied with that of the social control historians. For this reason, when criticism of the social control perspective emerged in the early

1980's, although it did not explicitly address itself to the feminist version of 'gender control', it may also be applied to feminist scholarship in the field of psychiatric history.<sup>16</sup>

In the early 1980's, social control historians came into conflict with those who viewed their work as reductionist, biased and polemical. To its credit, critics remarked, the social control perspective (and by inference the feminist) released the study of the institutional state from the "semantic straitjacket" of progressive reform.<sup>17</sup> By questioning the link between institutional development and humanitarianism, or intellectual advance, social control and feminist historians re-immersed the heroes of hagiographic accounts into their social and intellectual contexts. Critics of these approaches, however, pointed out that the continued emphasis on reformers' rhetoric and intentions had produced a version of history that was primarily "a tale of monumental class domination," or, it followed, male domination.<sup>18</sup> Calling for a more dialectical approach, new Marxist writers asserted that the agency of those who used various capitalist institutions must not be denied.<sup>19</sup>

This last point was particularly relevant to the study of the asylum. Mental institutions were built, at least in part, to attract clients. This element alone differentiated their emergence from that of penitentiaries and workhouses.<sup>20</sup> Thus an understanding of popular perceptions of madness and its treatment cannot be ignored when examining the establishment and evolution of mental institutions.<sup>21</sup> This point has relevance as well for feminist historians who must also examine the ways in which the asylum as well as other state institutions were used by women to meet their own needs within particular contexts. Without wholly invalidating the work presented

by either social control or first generation feminist scholars, the new psychiatric history that has emerged in the 1980's has attempted to broaden that base and therefore produce histories that go beyond discussions of the 'controlling' impulses of patriarchal and bourgeois psychiatrists and their institutions.

In the 1980s, historians of psychiatry increasingly began to look at madness and mad-doctors with a wider field of vision. Despite Marxists' demands for models describing organic totalities and dialectical development, it was historians who were alleged to be without "a set political agenda" who first applied these to the mental institution.<sup>22</sup> Such historians emphasize the multiplicity of causes that has shaped psychiatry and asylum practice and see the mental institution as a organic entity, shaped by ideology, but also by the exigencies in the lives of those who ran, used and funded it. One result of this new perspective is the increasing use of psychiatric case files as a methodological window through which to view the asylum's internal functioning. The gradual acceptance of quantitative method and the growing accessibility of computer technology have facilitated more detailed scrutiny of voluminous institutional records.<sup>23</sup> Such study has allowed scholars to examine how psychiatric theory was put into practice in an institutional setting and how other factors such as family input mediated the psychiatrist's role in treatment.

One element of institutionalization that has been further illuminated through the use of patient files is the committal process. Mark Finnaine, Michael MacDonald, Nancy Tomes, and Constance McGovern all have pointed to the centrality of the family in the process of defining 'abnormal' behaviour and choosing the appropriate method of care.<sup>24</sup> Since decidedly few asylum committals originated with authority figures of the state, it

appears that the asylum was not being used primarily to contain perceived threats to public order.<sup>25</sup> Instead these historians argue that, for instance, women predominated in asylum populations either because there were more of them in the general population from which the institution drew its patients or because working-class men were compelled to commit women because they could not care for them and maintain their jobs.<sup>26</sup> Further, while Ann Digby concedes that the constraints of gender role expectations created stress for women, she does not see patriarchal authority acting within the committal process to wrongfully confine women merely for rebellious behaviour.<sup>27</sup> Finally Nancy Tomes discovered among her middle-class patient population that most families attempted to delay asylum committal until care for the insane became too burdensome at home.<sup>28</sup>

These historians do not dispute that gender and class played significant roles in the ways in which the insane were seen and treated by asylum officials. But they have discovered that institutional oppression was not complete. For instance, Nancy Tomes found that middle-class families were quite willing to advise asylum doctors at the Pennsylvania Hospital for the Insane on the appropriate care of their inmate kin.<sup>29</sup> Even psychiatry's own notions of reproductively-induced female mental frailty may have advantageously affected women, Constance McGovern asserts. Because women were seen to have definite physical bases for their mental illnesses, McGovern argues that asylum officials were more hopeful about their recoveries and therefore paid more attention to them.<sup>30</sup> This conclusion compliments Lawrence Ray's work which argues that different models of madness resulted in differentiated treatment patterns within individual institutions. In this way, custodial or curative treatment could be meted out to patients according to the degree of 'recoverability' psychiatrists

believed was possible in their individual cases.<sup>31</sup> Similarly, Nancy Tomes and John Walton examined case notes to determine how 'cure' and criteria for release were affected by gender and class. Tomes describes 'moral treatment' as being similar to religious conversion and notes the differences between male and female responses both to the treatment and to the moral therapist himself. In this way, Tomes provides a nineteenth-century background to Phyllis Chesler's study of the complexities of the male therapist-female patient relationship.<sup>32</sup> Walton discovered that working-class women experienced shorter stays at a Lancaster asylum as a result of lobbying efforts by labouring families who had difficulty coping without adult women.<sup>33</sup> Thus the use of case files has added to the complexity of our views of asylum life in ways that integrate questions of gender and class while modifying our assumptions about the level of control that existed over women and the poor.

Yet despite the flurry of research and debate that has emerged on the subject of madness in the last twenty years, the voice of the mad themselves remains muffled. The only historical literature that has been published that purports to give the insane a voice is Roy Porter's A Social History of Madness and Mind Forg'd Manacles.<sup>34</sup> Significantly, the sources Porter uses in these volumes are predominantly autobiographies of former patients not psychiatric case files. The history of the anonymous mad is still constrained by most historical documents. Scholars who use institutional records are reminded by Michael MacDonald that they are not studying the insane but rather the observations of the insane.<sup>35</sup> Since the majority of asylum patients did not leave any autobiographical record of their institutional lives, the statements made about them in medical notes cannot be corroborated, nor can motives or rationales be safely inferred. Still, the committal forms,

letters from families, seized patient correspondence, and ward notes that appear in institutional files can be used to reconstruct the lives of patients and their families before, during and after their confinement. These records can also reveal how insanity was experienced by those who came into contact with it and sometimes how 'recovered' patients viewed it retrospectively. The experience of actually being mad, however, is something about which only those who have experienced it first hand can comment.

In some ways, discussing the work of Canadian psychiatric historians separately from that of their European and American peers presents a false distinction within the literature. Canadian psychiatry in the past endeavoured to see itself not as a parochial discipline but rather as a part of the broader, international field. Similarly, Canadian historians of the discipline often cite American or British predecessors as the source of their intellectual inspiration.<sup>36</sup> And although the conceptual framework of this thesis was largely shaped by non-Canadian literature, since Canadian psychiatric historiography forms the immediate backdrop of this thesis, it deserves special attention.

Generally speaking Canadian psychiatric historians have steered clear of the ideological battles waged by their American and European counterparts. Only one article produced by a Canadian historian can rightly be seen as a social control argument and that is Thomas Brown's study of the rise of the Upper Canadian asylum.<sup>37</sup> In this article, Brown argues that its emergence followed the development of capitalism in Upper Canada and that as a result, the colonial bourgeoisie sought to confine unproductive paupers in a variety of new institutions one of which was the Asylum for the Insane at Toronto.<sup>38</sup> Brown has also tried to integrate Canadian historiography into

the larger debate around the social control argument in a subsequent review article. Here, he generally praises the work of social control historians elsewhere, but concedes that they have largely denied the agency of the working classes, and have failed to account for the role of the family in asylum committal.<sup>39</sup> However, in this article, he ignores the ways in which a generalized social control perspective obscures the gender-specificity of psychiatric ideology and practice. In a further Canadian contribution to the social control debate, Harvey Simmons refutes many of Brown's assertions on the origins of the Upper Canadian asylum. Moreover, he argues that Brown and others failed to recognize the real physical and mental ills of those confined to asylums, and reminds social control historians that families willingly used public institutions often in ways that dismayed contemporary alienists.<sup>40</sup> These articles, however, mark the only evidence of a Canadian debate on the social control concept in psychiatric literature.

Wendy Mitchinson has contributed most to our knowledge of the Canadian psychiatric and medical profession's views of female health and illness. Using nineteenth-century medical journals, she has shown that Canadian physicians and alienists agreed that women were naturally sicker and more prone to mental illness than men.<sup>41</sup> Mitchinson has also gone beyond this work, to show how these views were reified by the practices of Richard Maurice Bucke at the London Ontario Asylum. During the last decades of Bucke's tenure at that institution he performed hundreds of ovariectomies in an attempt to alleviate patients' mental suffering. Mitchinson shows how Bucke's choice of this surgical strategy logically emerged from contemporary views on the impact of damaged reproductive organs on the brain.<sup>42</sup>

Angus McLaren's article on eugenics in British Columbia also shows how psychiatric theory has been put into practice. Focussing on the move by the provincial government to sterilize primarily the female mentally ill, McLaren describes the variety of social causes that supporters of that plan encompassed in the early twentieth century. By showing how maternal feminists came to be involved in the eugenics movement, McLaren combines a gender analysis with one involving class.<sup>43</sup>

The 'new' psychiatric history is best exemplified in Canada by S.E.D. Shortt in his work on Richard Bucke. Shortt argues that though Bucke was trained in a medical environment that was therapeutically conservative by comparison to its 'heroic' antecedents, he eventually sought to both control male masturbators and 'fix' women's reproductive problems out of frustration with his inability to effect cures through 'moral' means such as amusement and work therapy.<sup>44</sup> Shortt also goes beyond Bucke to discuss the role of attendants as well as the impact of governmental supervision on the evolving nature of the London asylum and on inmate experience. He describes the working conditions of attendants and their wages and class backgrounds in an effort to understand those most intimately involved with patients.<sup>45</sup> He also discusses the importance of governmental supervision and restraint and convincingly argues that asylum superintendents had much less control over their institutions than was previously thought.<sup>46</sup>

The more recent work of Wendy Mitchinson also draws on the new scholarly approaches that emphasize the areas of psychiatric jurisdiction which evaded institutional alienists. Specifically, Mitchinson examined the timing and reasons for committal of the insane to the asylum at Toronto and argues that it was used by families to provide care for individuals whom they could not handle themselves. Most admitted relatives who had become

violent or disruptive. By focussing on the asylum's "multiplicity of purposes", Mitchinson argues, 'we are freed somewhat from the debate over whether its primary function was to control or cure the insane.'<sup>47</sup>

Other studies consider Canadian psychiatry more generally.

Rainier Baehre's doctoral dissertation places Ontario psychiatrists within the context of their international fields. His chapter on Charles K. Clarke, for instance, argues that Clarke, like his American counterparts, was drawn both to the founding of the psychiatric clinic at Toronto General Hospital and to the mental hygiene movement in an attempt to distance himself from more traditional aspects of psychiatry. Thomas Brown's articles on the impact of psychoanalysis and 'shell shock' on the Ontario psychiatric profession assert that men such as Clarke steered clear of psychoanalytic interpretations and focussed more on war neuroses as part of an evolution which led to a "new found sense of professional identity and self-worth."<sup>48</sup> Theresa Richardson similarly discusses the rise of the mental hygiene movement and the reformulation of child-rearing philosophy in the early twentieth century as part of psychiatry's attempt to achieve a higher degree of professionalization and greater social relevance.

All of these studies, have two major flaws. First, Richardson, Baehre and Brown, all fail to see the far-reaching implications which the mental hygiene movement had, or had the potential to have, on women. Second, with the exception of McLaren's article, none of these scholars examine any area of Canada outside Ontario.

While historians of Canadian psychiatry have contributed relatively little to the larger debates within the field, they have not been unaware of their existence or importance. What they do lack, however, is an awareness of asylums in provinces other than Ontario. This problem has been

recognized by some Canadian psychiatric historians. Thomas Brown has written:

In substantive terms we need studies of the origins of 'lunacy reform' in every province; of the bureaucratization and rationalization of each province's asylum system and of the State servants who carried through these programs... and finally case studies of daily life in as many Canadian asylums as proves practicable.<sup>49</sup>

This thesis attempts, in part, to answer this call, by examining the role of the Provincial Hospital for the Insane [PHI] at New Westminster, British Columbia through the lives of the women it treated from 1905 to 1915.

Three questions guided the research and writing of this study. First, it became abundantly clear from the Whiggish accounts of the Provincial Hospital's history that the tenure of Charles Edward Doherty was a watershed in the 'progress' of asylum treatment of the insane in British Columbia. As a result, Doherty, who acted as medical superintendent from 1905 until he joined the Canadian Army Medical Corps in 1915, was seen as the institution's most 'successful' administrator. The first question, then, was: why was Doherty seen to be so 'successful'? In answering this question, it appeared that Doherty's tenure was indeed important. Doherty was the only long-standing medical superintendent not to be investigated by a governmentally-appointed commission, and he was the first administrative head to leave asylum service with his reputation not only unscathed but measurably advanced.<sup>50</sup> Doherty's success, it appeared, was due primarily to his ability to maintain utmost control over the institution, a feat which eluded his predecessors. All of Doherty's forerunners had been roundly criticized for their inability to control asylum affairs.<sup>51</sup> Doherty, by contrast, was able to exert a considerable influence over the government's psychiatric

services, in part, because of his popularity with the provincial government and the medical profession. As well, Doherty shrewdly chose a program of 'modernization' for the Provincial Hospital which would further enhance both his reputation and his dominance over public services for the insane in the province.

This observation led to the final two questions. Did the 'modernization' of the Provincial Hospital improve the treatment of women there? And finally, if Doherty's success was partly attributable to his increased control over the governmental psychiatric services, did this influence extend to women inmates? The answers to these questions form the central arguments of this study.

First, this thesis argues that female patients did not benefit either from Doherty's prestige or from his efforts to bring the Provincial Hospital up to international standards. Their treatment remained, in Doherty's words, one of 'moral control' which emphasized dietary regulation, ward work, a 'persuasive' system of rewards and punishments involving mechanical and chemical restraint and ward transfers. The continued use of mechanical restraint is particularly important since early in his tenure, Doherty boasted that all such practices had been abolished.<sup>52</sup> Further, the improvements to asylum life which Doherty 'pioneered' in British Columbia did not involve women. The Colony Farm, an adjunct to the PHI which used outdoor occupational therapy, was widely praised, but only men were sent there.

\* Hydrotherapy was also introduced to the PHI in this period. It was also seen as an 'advanced' form of treatment, but this too was not applied to women until associated apparatus was installed in one female ward in 1911. Finally, the planning of a new asylum facility at Essondale was hailed as the epitome of 'modern' psychiatric treatment but women were not sent there until 1930.

Clearly, Doherty's attempts to modernize psychiatric services in British Columbia had relatively little impact on the women who entered the PHI in this period.

Second, I argue that Doherty's control over female inmates was incomplete despite his attempts to consolidate his dominance over the institution generally. He had literally no influence over the types of patients he received. The decision to commit women to the PHI usually rested entirely with the family and only occasionally with doctors and police. Also, while Doherty certainly had more power over inmates' lives, the experience of women within the institution was often mediated by the influence of her family as well as her own ability or willingness to conform to asylum standards of behaviour. Doherty and his staff could attempt to 'morally control' women, but ultimately the PHI was a negotiated space formed by the coalescence and conflict of the often competing interests of asylum officials, families and patients.

This thesis begins with a broad examination of Doherty's tenure at the Provincial Hospital for the Insane. Chapter 2 focuses on the nature of Doherty's success as an asylum administrator, his 'modernization' program and the treatment of women at the PHI. This chapter argues that Doherty's 'modernization' program did not 'advance' the treatment of women at the Provincial Hospital. The next chapters focus on the issue of psychiatric control. Chapter 3 is a detailed study of the committal process that brought women to the Provincial Hospital for the Insane and shows that not only did families and other members of the non-psychiatric community hold pre-eminent roles in determining how and when women arrived at the PHI, but also that Doherty's views of mental illness and its causes were not widely shared by either the lay or the non-psychiatric medical community at large.

Doherty, therefore, had little influence over broad societal perceptions of mental illness. The next chapter assesses the dominance of asylum staff over patient behaviour and internal relations of the institution by focussing on the ways that female inmates either conformed or subverted asylum discipline and the extent to which patients and their families were able to influence the treatment women received at the PHI.

The sources used in this thesis were primarily institutional records of the period. The PHI's records contained the following information: inmate vital statistics usually recorded in the admission books upon the patient's arrival; committal forms; the results of a psycho-biological exam which was conducted by the Assistant Medical Superintendent involving the results of blood and urine tests, a physical examination and a study of the patient's personal and pathological history; ward notes compiled on a daily or weekly basis for the first few months of an inmate's confinement usually diminishing in content as the patient lingered within the asylum; and, finally, autopsy reports and death certificates if the patient died while incarcerated. As well, these records included correspondence about the patient between her family, friends and asylum doctors. Finally reports of any unusual occurrences during the patient's stay were also found in these records.

Three sampling techniques were used to study these files. First, all admission books were coded for cross-referencing and tabulation by computer. Second, a random sampling was done of all patients, male and female who entered the PHI in this period in order to determine the possible effects of commonly experienced 'modernized' treatments such as blood and urine tests. Third a ten per cent sampling of all women patients was used to qualitatively study the contents of individual case files. Through these sources, as well as coroner's records of those women who subsequently

committed suicide, letters regarding patient treatment found in Provincial Secretary Correspondence and newspaper articles, the lives of women patients has been reconstructed to show the roles the PHI played in them.

These sources are, however, imperfect. Admission books, for instance, do not provide a census of the institution and thus information gleaned from them about patient population is statistically skewed to favour recent arrivals. As well, information about patient life garnered from case notes is limited. These records were created by the institution to follow the course of patient life towards either recovery or chronicity. Patient histories were recorded for diagnostic purposes and were meant only to provide a chronology of inmate pathology. Similarly, the records of patient institutional life include only those areas which specifically related to treatment. Case notes tend to be scanty about those patients who become chronic, for instance, because asylum officials believed there was little hope for recovery and therefore little call for interventive treatment. Psychiatric records themselves limit the voices of the incarcerated by their view of the language of madness.<sup>53</sup> The words of patients are quoted only in so far as they are indicative of re-surfacing rationality or persistent delusion. Indications of patient sub-culture appear only on the periphery of these notes and for this reason, generalizations about such a culture must be tentative.

Thus case notes provide a view of the asylum which emphasizes the role of institutionalization within the context of the family and community at large. As well they grant a limited or censored view of life within a mental hospital. Nevertheless, despite these limitations, asylum records do bring the patient closer to the historical surface and add insight into the practice of mental therapeutics far beyond that of standard studies of prescriptive

psychiatric literature and of prominent alienists. Finally, the Provincial Hospital's case notes may also contribute to a greater understanding of the lives of girls and women in the Canadian west in the early decades of the twentieth century, the dynamics within the Western Canadian family and the relationship between family crisis and state intervention.

<sup>1</sup>The only major exception to this is Richard Fox's work on a San Franciscan mental institution. See Richard Fox, So Far Disordered in Mind: Insanity in California 1870-1930. (Berkeley: University of California Press, 1978.)

<sup>2</sup>Only two recent graduate theses deal at all with the West. Harvey Stalwick's "A History of Asylum Administration in Pre-Confederation Canada" (Ph.D. thesis: University of London, 1969) briefly mentions British Columbia and Ian H. Clarke, "Public Provision for the Mentally Ill in Alberta, 1907-1936," (M.A. thesis: University of Calgary, 1973). A further Western account of asylum building is John D. Griffin and Cyril Greenland, "The Asylum at Lower Fort Garry, 1874-1886" The Beaver 310 (4) (Spring, 1980): 18-23 which focuses on the transformation of the Hudson's Bay Post to asylum. Other than these, the majority of work on Canadian psychiatry has focussed on Ontario, Quebec and the Maritimes.

Examples of Whiggish accounts are: T. J. W. Burgess, "A historical sketch of our Canadian institutions for the insane" in The Royal Society of Canada Proceedings and Transactions; 2nd series, vol. 4 (section 4)(1898): 3-117 and T. J. W. Burgess, "Presidential Address--The Insane in Canada" American Journal of Insanity vol. 62, (July, 1905): 1-36; Henry M. Hurd, The Institutional Care of the Insane in the United States and Canada, vol. 4 (Baltimore: The Johns Hopkins Press, 1917); Valerie Adolf, One hundred years at Woodlands (Victoria: Mental Health Branch, 1978); David Davies, "A History of the Mental Health Services of B. C." (unpublished manuscript, 1984); Richard A. Foulkes, "British Columbia Mental Health Services: Historical Perspectives to 1961" The Leader vol. 29 (no. 5): 25-34; Richard A. Foulkes, "One Hundred Years in the lives of B. C.'s mental patients," (unpublished pamphlet, 1972); Robert Henry Thompson, A summary of the growth and development of mental health facilities and services in B. C., 1850-1970 (Victoria: Mental Health Branch, Department for Health Services and Hospital Insurance, 1972.)

<sup>3</sup>Burgess was Medical Superintendent of the Protestant Hospital for the Insane in Montreal and President of the American Medico-Psychological Association in 1905; Hurd edited that Association's journal The American Journal of Insanity for some years.

<sup>4</sup>Adolf, One hundred years; ii

<sup>5</sup>The same is true to a greater or lesser extent among other Canadian and Anglo-American scholars who approach the history of psychiatry from a Whig perspective. See for example M. Baker, "Insanity and Politics: the establishment of a lunatic asylum in St. John's Newfoundland, 1836-55," Newfoundland Quarterly 77 (summer-fall, 1981): 27-31; Norman Dain, Concepts of Insanity in the United States, 1789-1865 (New Brunswick, N. J.: Rutgers University Press, 1964); Albert Deutsch, The Mentally Ill in America: A History of Their Care and Treatment, 2nd ed., (New York: Columbia University Press, 1949); Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," Acadiensis 1977, 6(2): 23-38; Kathleen Jones, A History of Mental Health Services (London: Routledge and Kegan Paul, 1972); Alfred Lavell, "The Beginnings of Ontario Mental Hospitals," Queen's Quarterly 49 (Spring, 1942): 59-67

<sup>6</sup>Michel Foucault, Madness and Civilization: A History of Insanity in the Age of Reason (New York: Random House, 1965). Foucault has been criticized for his "fuzzy abstractions" and "slipshod research" but his ability at myth-making and the influence

of his work is seldom challenged. No introduction to the history of psychiatry is complete without mention of Foucault, so summaries and critiques of his work abound. Still the most trenchant criticisms of his theories, style and methods are: H. C. Erik Midelfort, "Madness and Civilization in Early Modern Europe: A Reappraisal of Michel Foucault," in After the Reformation: Essays in Honour of J.H. Hexter, ed. Barbara C. Malament (Philadelphia, University of Pennsylvania Press, 1980), 247-65; Lawrence Stone, "Madness", The New York Review of Books, 29 (16 December, 1982): 28-30; Lawrence Stone and Michel Foucault, "An exchange with Michel Foucault", The New York Review of Books, 30 (31 March, 1983), 42-4.

<sup>7</sup>Andrew Scull, Museum of Madness: The Social Organization of Insanity in Nineteenth Century England (Harmondsworth: Penguin Books, 1979). Scull has also published a number of articles but most of his argument can be found in the above cited book. Klaus Doerner, Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry (Toronto: Oxford University Press, 1981). David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston: Little, Brown and Co., 1971). See as well: D. J. Mellett, The Prerogative of Asyludom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth Century Britain (New York: Garland Publishing, 1982); Christopher Lasch, "Origins of the Asylum" in The World of Nations: Reflections on American History, Politics and Culture (New York: Alfred Knopf, 1974): 3-17; Michael Katz, "Origins of the Institutional State" Marxist Perspectives (Winter, 1978): 6-22. see also Michael Ignatieff, "Total Institutions and the Working Classes: A Review Essay" History Workshop Journal 15 (Spring, 1983): 167-72.

<sup>8</sup>George Rosen, Madness in Society: Chapters in the Historical Sociology of Mental Illness (New York: University of Chicago Press, 1967): 154.

<sup>9</sup>Michael Donnelly, Managing the Mind: A Study of Medical Psychology in Early Nineteenth-Century Britain (London: Tavistock Publications, 1983); Andrew Scull, "Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry" Psychological Medicine 9 (1979): 421-8; Andrew Scull, "Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry," Rice University Studies 67 (1) (1981): 21-41; Andrew Scull, "The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic," in Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era, ed. Andrew Scull. (Philadelphia: University of Pennsylvania Press, 1981): 144-165; Andrew Scull, "Madness and Segregative Control: The Rise of the Insane Asylum," Social Problems 24 (3) (Feb., 1977): 337-351.

<sup>10</sup>Andrew Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," European Journal of Sociology 17 (2) (1976): 279-305.

<sup>11</sup>Peter L. Tyor and James S. Zainaldin, "Asylum and Society: An Approach to Institutional Change" Journal of Social History 1979 13(1): 24. Brevity requires an overview approach perhaps resulting in a reductionist summary of the social control perspective.

<sup>12</sup>W. F. Bynum, Roy Porter and Michael Shepherd, "Introduction," The Anatomy of Madness: Essays in the History of Psychiatry, vol. 1 (London: Tavistock Publications, 1985): 3. These authors cite the work of Thomas Szasz, The Myth of Mental Illness

(London: Paladin, 1972) and The Myth of Psychotherapy (New York: Anchor Press, 1978) as particularly seminal.

<sup>13</sup> Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830-1980 (New York: Viking Penguin Books, Inc., 1985).

<sup>14</sup> Barbara Ehrenreich, Dierdre English, Complaints and Disorders: The Sexual Politics of Sickness. (Old Westbury N.Y.: The Feminist Press, 1973); Barbara Ehrenreich and Deirdre English, For Her Own Good: One hundred and Fifty Years of the Experts' Advice to Women. (Garden City N.Y.: Anchor Books, 1978); Sara Delamont and Lorna Duffin ed. The Nineteenth-Century Woman: Her Cultural and Physical Worlds. (London: Croom Helm, 1978); Carroll Smith-Rosenberg, Disorderly Conduct: Visions of Gender in Victorian America. (New York: Alfred A. Knopf, 1985).

<sup>15</sup> Smith-Rosenberg, Disorderly Conduct: Visions of Gender in Victorian America. (New York: Alfred A. Knopf, 1985).

<sup>16</sup> The fact that the 'social control' school has been the focus of most critical essays rather than the 'gender control' element of feminist scholarship is perhaps the result of the perception that feminist psychiatric literature is more properly categorized as a 'sub-field' of women's history rather than an alternate approach within psychiatric history.

<sup>17</sup> Thomas E. Brown, "Foucault Plus Twenty: On Writing the History of the 1980's", Canadian Bulletin of Medical History, 2(Summer, 1985): 30.

<sup>18</sup> Joseph Featherstone, "Understanding Schools in Capitalist America: A Commentary", History of Education Quarterly, 17 (2) (Summer, 1977): 140.

<sup>19</sup> Ignatieff, "Total Institutions", 173.

<sup>20</sup> Harvey G. Simmons, "The New Marxist Orthodoxy," Canadian Bulletin of Medical History, 2 (Summer, 1985): 102-3.

<sup>21</sup> Ignatieff, "Total Institutions", 172.

<sup>22</sup> Nancy Tomes, "'The Anatomy of Madness': New Directions in the History of Psychiatry." Social Studies of Science, 17(1987): 358. Loic J. D. Wacquant argued for an understanding of Marxist theory which included three heuristic models: base superstructure, organic totality and dialectical development in his article "Heuristic Models in Marxian Theory" Social Forces, 64(September, 1985): 17-45. In his view, "synthetic reconstruction of the whole...is *the* mandatory task of ... the unitary social science" (p. 27).

<sup>23</sup> Anne Digby, "The Quantitative and Qualitative Perspectives on the Asylum," in Problems and Methods and the History of Medicine ed. Roy Porter and Andrew Wear, (London: Croom Helm, 1987): 153-171 and Michael MacDonald, "Madness, Suicide and the Computer" in Problems, ed. Porter and Wear, 207-229.

<sup>24</sup> Mark Finnaine, Insanity and the Insane in Post-Famine Ireland, (London: Croom Helm; Totowa, N.J.: Barnes and Noble, 1981): 162, 122 and Mark Finnaine, "Asylums, Families and the State", History Workshop Journal 20 (1985): 135; MacDonald, Mystical Bedlam, 75-84, 88-104; Nancy Tomes, Generous Confidence, chapter 3; Constance McGovern, "The Myths of Social Control and Custodial Oppression: Patterns of Psychiatric Medicine in Late Nineteenth Century Institutions," Journal of Social History 20 (1) (1986): 3-23; McGovern, "The Community, the Hospital and the Working-

Class Patient: the Multiple Uses of Asylums in Nineteenth Century America" Pennsylvania History 54 (1) (1987): 17-33.

25 J. Walton, "Casting out and Bringing back in Victorian England: Pauper Lunatics, 1840-70," in Anatomy of Madness, ed. Bynum, Porter, Shepherd, vol.2, 138 This study, however, should be contrasted with Richard Fox's work which argues that in the cases of single male immigrants the opposite was the case. See Richard W. Fox, So Far Disordered in Mind: Insanity in California 1870-1920 (Berkeley: University of California Press: 1978).

26 Anne Digby, Madness, Morality and Medicine: a Study of the York Retreat, 1796-1914 (Cambridge: Cambridge University Press, 1985): 174-5.

27 Digby, "Quantitative," 160

28 Tomes, A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883, (New York: Cambridge University Press, 1984), 109

29 Tomes, A Generous Confidence, 123.

30 McGovern, "Myths of Custodial Oppression," 11-14

31 Lawrence J. Ray, "Model of Madness in Victorian Asylum Practice," Archives Européennes de Sociologie 22 (1981): 229-265.

32 Tomes, A Generous Confidence, 12-14 and chapters 3 and 5. See also Phyllis Chesler, Women and Madness (New York: Avon Books, 1972): 136-159.

33 Walton, "Casting," 141

34 Roy Porter, A Social History of Madness: Stories of the Insane. (London: Weidenfeld and Nicholson, 1987); Roy Porter, Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency. (London: Athlone Press, 1987).

35 Michael MacDonald, "Madness, Suicide and the Computer," in Problems, ed. Porter and Wear, 210.

36 Wendy Mitchinson, "Hysteria and Insanity in Women: a Nineteenth-Century Perspective," Journal of Canadian Studies, 21 (3): 88; Rainer Baehre, "The Ill-Regulated Mind: A Study in the Making of Psychiatry in Ontario, 1830-1920," (Ph.D. thesis, York University, 1986): 3

For instance Baehre and Brown both see Grob as important in the development of their perspectives. see Baehre, "Ill-Regulated Mind," 20 and Thomas E. Brown, "Living with God's Afflicted: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911," (Ph.D. thesis, Queen's University, 1980): 9

37 Thomas Brown, "The Origins of the Asylum in Upper Canada, 1830-1839," Canadian Bulletin of Medical History, vol.I (1) (Summer, 1984): 27-58

38 Brown, "Origins," 42-44

39 Brown, "Foucault plus twenty," 33, 36, 37.

40 Simmons, "The new Marxist orthodoxy," 99, 100, 102, 105, 106

41 Mitchinson, "Hysteria," 87-105; Wendy Mitchinson, "Historical Attitudes towards Women and Childbirth," Atlantis, 4(2) (Spring, 1979): 13-34; W.L. Mitchinson, "Causes of Disease in Women: The Case of the Late Nineteenth Century English Canada," in Health, Disease and Medicine: Essays in Canadian History, ed. Charles Roland (Toronto: Hannah Institute, 1984): 381-95; Wendy Mitchinson, "The Medical View of Women: The Case of the Late Nineteenth Century Canada," Canadian Bulletin of Medical History, 3 (Winter,

- \* 1986): 207-224; Wendy Mitchinson, "Medical Perceptions of Female Sexuality: a Late Nineteenth Century Case," Scientia canadensis, ix (June/juin, 1985): 67-81.
- \* 42 Wendy Mitchinson, "Gynecological Operations on the Insane," Archivaria 10 (1980): 125-44; "A Medical Debate in Nineteenth Century English Canada: Ovariectomies" Social History 17 (1984): 133-47.
- 43 Angus McLaren, "The Creation of a Haven for Human Thoroughbreds: The Sterilization of the Feeble-Minded and the Mentally Ill in British Columbia," Canadian Historical Review 67, 2 (June 1986): 127-150.
- 44 S.E.D. Shortt, Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry. (New York: Cambridge University Press, 1986).
- 45 Shortt, Victorian Lunacy, 48-9.
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- \* 47 Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum: The Case of Toronto," in Essays in the History of Canadian Medicine, ed. Wendy Mitchinson and Janice Dickin McGinnis, (Toronto: McClelland and Stewart, 1988): 88-109
- 48 Thomas Brown, "Shell Shock and the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry and the Great War", in Health Disease and Medicine: Essays in Canadian History ed. Charles Roland, (Toronto: Hannah Institute of Medicine, 1984): 308, 323; see also Thomas E. Brown, "Dr. Ernest Jones, Psychoanalysis, and the Canadian Medical Profession, 1908-1913," in Medicine in Canadian Society ed S.E.D. Shortt, (Montreal: McGill-Queen's University Press, 1981): 315-60
- 49 Brown, "Foucault", 39
- 50 G.F. Bodington was the only other asylum superintendent not to experience either a commission of inquiry or a disgraceful resignation, but he came to asylum practice in British Columbia as a very old and esteemed physician and stayed with the PHI for only three years from 1895 to 1898. <sup>2</sup> r
- 51 Richard Irvine Bentley the first medical superintendent of the PHI who served the institution from 1882 to 1895 was condemned for his inability to control his staff and was forced to resign as a result. See "Proceedings before a Commission appointed to enquire into certain matters connected with the Provincial Lunatic Asylum at New Westminster, 1894," Government Record 1732, British Columbia Archives and Records Service, Victoria, British Columbia.
- 52 BCSP, 1907, ARMS, 1906.
- 53 Lawrence J. Ray, "Models of Madness," 230.

**Chapter 2**  
**Charles Edward Doherty,**  
**the Provincial Hospital for the Insane,**  
**and the Treatment of Women.**

By all contemporary and historical accounts, Charles Edward Doherty was the most important medical superintendent the Provincial Hospital for the Insane had ever known. Yet a brief study of these histories does not provide any real sense of why Doherty has been so highly esteemed within the British Columbian psychiatric profession.<sup>1</sup> The treatments he "pioneered" were not new and even Doherty, himself, recognized that he was not an innovator.<sup>2</sup> He was, however, a model civil servant, adept at building alliances with the provincial government and the medical profession. As well, Doherty was the first British Columbian asylum superintendent to participate in the dialogues and debates within psychiatry's international community. As a result, he was able to bring the treatment of insanity in British Columbia up to international standards. His 'modernization' program involved 'new' methods of institutional care for the insane, the adoption of which further added to his control over psychiatric services in the province. It did not, however, significantly advance the treatment of women at the PHI.

*women & treatment*

Doherty's attempts to 'modernize' the care of the insane did, however, affect the lives of women patients in two ways. First, as senior asylum officials became increasingly removed from the treatment of women, untrained asylum nurses filled the void. Given Doherty's emphasis on "improving" asylum facilities, it is significant that he made no effort to develop training programs for nurses until quite late in his tenure. Meanwhile, the appointment of attendants remained, largely, in the realm of political patronage. In most cases, nurses were not hired on the basis of

their proven ability to handle the insane nor did many of them intend to remain with the PHI and establish themselves in asylum nursing careers. Although it is impossible to be sure whether untrained nurses detrimentally affected the care of patients, it is important, nonetheless, that nurses' training was one area of asylum therapeutics which fell through the cracks in Doherty's 'modernization' program. It is especially important to this study since women's treatment increasingly fell into their hands. Second, since Doherty spent much of his time implementing 'new' therapies that would affect only men, he expended relatively little effort in developing 'advanced' treatments for women. While men were handled with hydrotherapy and agricultural work, women's treatment remained one of 'moral control,' a more traditional therapy involving the regulation of the physical health and the social habits of patients.<sup>3</sup> Thus the therapeutic philosophy that guided the treatment of women at the PHI and the nurses who enacted it remained untouched by Doherty's institutional rejuvenation.

By the time of his appointment as Medical Superintendent, Charles Edward Doherty was well-suited for the job. Graduating from Trinity Medical College in 1898, Doherty emigrated to British Columbia the following year and was appointed superintendent of Kootenay Lake General Hospital in Nelson, where he remained until 1902.<sup>4</sup> In May of that year, he became Assistant Medical Superintendent at the PHI.<sup>5</sup> His early involvement with the institution, however, was short-lived. Although Medical Superintendent G.M. Manchester described him as "entering upon his work with enthusiasm and vim," by November 1902, Doherty was sufficiently dissatisfied with his pay to resign.<sup>6</sup> During the next three years, he served as the coroner in Ymir but was unable to successfully establish himself in private practice.<sup>7</sup> In

January 1905, Manchester was himself profoundly dissatisfied with work at the PHI and resigned. Doherty was appointed to fill his place. His reasons for returning are obscure, but it would appear that he wished to relocate in the Lower Mainland partly for personal reasons, for, in the same year, he married New Westminster resident Eleanor Martin, daughter of cannery entrepreneur Samuel Barclay Martin.<sup>8</sup>

Doherty's early medical career prepared him well for his work as Medical Superintendent. From the beginning, he had gained experience both with medical administration and mental therapeutics. Although he received little formal training in the latter, this was not uncommon. Most asylum superintendents in this period came to psychiatry without any substantial education in the field.<sup>9</sup> Therefore his prior appointment to the PHI made him a strong candidate for its senior administrative post. This previous experience with the PHI also gave him insight into the pitfalls of asylum practice in British Columbia. Doherty's predecessor, Manchester, had been embittered in his relations with the government from the time of Doherty's initial employment and was explicit about the disadvantages of his position in his letter of resignation. Manchester wrote:

The superintendent stands in a crossfire of disapproval, first from his patients who are unable to discriminate, secondly from undesirable and inefficient employees and thirdly from an uncomprehending public. It will, at any rate, be easily understood that from none of the above sources does he get the aid and encouragement which he as a human being requires.<sup>10</sup>

Doherty realized that these feelings were not unique to Manchester. The history of the PHI was filled with scandal, unhappy staff relations, governmental underfunding and public suspicion.<sup>11</sup> Of all of Doherty's

predecessors, only one, G.F. Bodington, had not resigned in disgrace and he died very soon after his retirement. Doherty's success lay, in part, in his ability to avoid such pitfalls and improve the PHI's reputation.

In doing so, the superintendent was aided by the fortuitous timing of his appointment and his ability to exploit these promising circumstances. At the turn of the twentieth century, British Columbia experienced a boom economy which engendered governmental enthusiasm for social service development and undercut financial restraint. Doherty successfully exploited the prevailing sense of optimism in official circles and in 1908, Provincial Secretary Henry Esson Young announced that \$2,000,000 was to be spent on improved asylum care for the insane.<sup>12</sup> Indeed, the amount of money spent annually on the PHI (including the mental hospital at Essondale after 1913) rose from \$84,561 in 1904 to \$357,710 in 1914.<sup>13</sup> Moreover, Doherty shared a positive working relationship with his government superiors. Not only was he a personal friend of Premier Richard McBride, but Young's medical background undoubtedly encouraged him to support Doherty when facing patient complaints.<sup>14</sup> Furthermore, his willingness both to receive support based on patronage and dispense personal favours to politicians also enhanced his popularity. In 1910, for instance, Doherty accepted the Dewdney Conservative Association's gift of an experimental orchard to be placed on the Colony Farm.<sup>15</sup> In return, the produce from the Colony Farm made its way to the table of the Provincial Secretary on at least one occasion during the economic downturn of the early 1910's.<sup>16</sup> Certainly, Doherty recognized that his alliance with the government was advantageous. In 1906, he wrote that:

such relations [with the government] stimulate a Superintendent's interest, lighten his labour and lessen his care, and, in doing so, make of his official duties a pleasure, in the enjoyment and memory of which he forgets the disagreeable features of a life that otherwise would be one of irking stress and never-ending strain.<sup>17</sup>

But politicians were not Doherty's only allies. In the same period, the province's medical profession had begun to show a keen interest in social affairs and the superintendent recognized the importance of gaining their support.<sup>18</sup> By speaking to them on matters that pertained to mental illness within their own practices and inviting them to tour the PHI, he successfully broke down the barrier of mistrust that had grown up between some doctors in the province and the institution.<sup>19</sup> He also became actively involved in their professional group, the newly-formed British Columbia Medical Association. Twice, he was elected to executive positions within the association; first as vice president in 1910 and the following year as treasurer.<sup>20</sup> His years on the BCMA executive were, however, entirely unremarkable. Ultimately, his attempts to advance himself within the BCMA were thwarted by the constraints of his duties at the PHI. During his year as treasurer in 1911, for instance, he attended only one executive meeting.<sup>21</sup> The affiliation with the BCMA did, nevertheless, help to build an alliance with the medical profession and granted him an opportunity to establish working relationships with the province's most prestigious physicians.

Finally, the psychiatric profession as a whole was entering a period of renewed optimism which Doherty shared and with which he imbued his own plans for the institutional care of the insane in British Columbia. While some psychiatrists continued to despair over the science's continuing ignorance on many matters associated with insanity, others saw cause for hope.<sup>22</sup> Some placed their confidence in improved research and therapeutic

techniques, while others anticipated that new institutional forms would gradually lessen their reliance on the asylum.<sup>23</sup> Doherty sought to benefit from this time of growing experimentation within the field by becoming involved in the American Medico-Psychological Association.<sup>24</sup> In 1906, he attended his first meeting of the group, setting out to "learn many advanced ideas in caring for the insane, which, by their application to our Local Institution will repay the Government for its expense."<sup>25</sup> Although Doherty never became a prominent member of the AMPA, his involvement provided opportunities to consult with his senior colleagues elsewhere.<sup>26</sup> As well, he used the endorsements he received from his more prominent counterparts to impress his allies closer to home. In 1913, the superintendent boasted in his annual report that the visiting Chicago alienist, Dr. Bayard Holmes had judged Doherty's ideas to be "...undoubtedly correct, and far in advance of the time-dishonoured methods of caring for the insane."<sup>27</sup> Such approving comments from Eastern alienists no doubt added to Doherty's reputation and stood in stark contrast to the disapprobation meted out to most of his predecessors.<sup>28</sup> Doherty had arrived at the PHI both in a position to serve the institution well but also at time when governmental, medical and psychiatric confidence was high.

By building alliances with all three of these groups, he gained their support. The government increased the money he could spend on his institution while supporting his hegemony over it. For the most part, the medical profession ceased suspecting that "all was not right" with the institution and did not call for public inquiries into its operation as it had before.<sup>29</sup> Finally, Eastern alienists consulted with their lesser colleague, praised his willingness to listen to their suggestions and supported his

implementation of them.<sup>30</sup> In turn, Doherty provided his allies with a 'modernized' system of mental health care of which they could all approve.

Because most of Doherty's 'improvements' to the PHI did not involve women, discussion of them will be brief. These 'progressive' additions to asylum practice included: hydrotherapy and agricultural work treatment, the planning and construction of the new site at Essondale, and the establishment of a pathological laboratory.

→ Hydrotherapy was a form of treatment that used water as a therapeutic agent. At the turn of the twentieth century, it was hailed as a breakthrough that would eliminate the use of mechanical restraint.<sup>31</sup> Its reputation as an 'advanced' technique made it a treatment of choice at many psychiatric institutions in this period.<sup>32</sup> Accordingly, Doherty requested that the province purchase equipment that would produce "continuous baths", "rain and needle showers," and "steam baths", to sedate violent or destructive patients. Hydrotherapy at the PHI used steam cabinets in which perspiration was induced, followed by lukewarm showers and massages to quiet patients.<sup>33</sup> This procedure was applied to most agitated male patients upon their arrival at the PHI, but few women appear to have undergone hydrotherapy.<sup>34</sup> Indeed, hydrotherapeutic apparatus was not installed in the female wards until 1911 and then only in the refractory ward.<sup>35</sup> While the reasons for the gender-specificity were never stated, it may be that women were not seen to be as violent or as dangerous as male inmates.<sup>36</sup>

A similarly praised treatment from which women were excluded was the agricultural work therapy provided at the Colony Farm, a 1000 acre agricultural colony of the PHI, situated at the confluence of the Fraser and Coquitlam rivers. Although the land was purchased by Doherty's predecessor, G.M. Manchester, upon the recommendation of C.K. Clarke, the

farm first flourished under Doherty's management.<sup>37</sup> From the beginning, the Colony Farm had two functions: to create a pleasant work atmosphere for a select group of well-behaved male patients whom it was believed would benefit from "regular employment in the open air," and to reduce the per capita costs of the PHI by providing farm and dairy products.<sup>38</sup>

As Cyril Greenland has pointed out, occupational therapy was a favoured therapeutic approach of alienists precisely because it combined economic gain with therapeutic and social rehabilitation.<sup>39</sup> Moral treatment advocates of the first wave of psychiatric reformism had long touted the benefits of work as a means of distracting the insane from their demented thoughts.<sup>40</sup> Patient labour continued at most asylums during the late nineteenth century, and the interest in work as therapy was revived in "progressive circles" in the early twentieth century.<sup>41</sup> The emphasis was not only on distraction but also on the moral benefit of instilling in the insane discipline and pride in their accomplishments.<sup>42</sup> While psychiatrists believed that women could also benefit from work therapy, all agreed that women could be satisfied with domestic tasks on the wards of psychiatric institutions. Because the male wards of the PHI were more seriously overcrowded than the female, thus requiring alternate accommodation for some men and because domestic work therapy could be accomplished in the larger institution, women were not sent to the Colony Farm.<sup>43</sup>

Overcrowding in the PHI also prompted Doherty to search for more extreme solutions. By 1906, he recognized that the situation could be alleviated by nothing less than construction of a new hospital community on a larger site. In that year, he wrote that all future expenditure should be concentrated on building at the Colony farm and the construction of a new "complete, modern asylum."<sup>44</sup> Two years later when Provincial Secretary

Young announced that \$2,000,000 would be spent on the building of a new facility for the insane, calls for architectural submissions were placed in the newspapers of Vancouver, Victoria and New Westminster and the B.C. Gazette.<sup>45</sup> On 25 November, 1908, Toronto architect H.S. Griffiths was awarded the contract for the new buildings.<sup>46</sup> Construction began the following year and on 1 April, 1913 the male chronic care building was opened. Again, women were excluded from the new site as they had been from the Colony Farm and hydrotherapy. Until 1930 when the female chronic building was opened, women patients remained in the original institution which Doherty had argued should receive no more funding.<sup>47</sup>

The final element of Doherty's 'rejuvenated' asylum practice was the establishment of a pathological laboratory. Encouraged by testing which revealed a connection between syphilis and general paresis and motivated by theories of 'auto-intoxication', alienists during this period advocated extensive testing of patient blood and urine in the hopes of finding further links between the content and flow of the body's circulating fluids and insanity, particularly manic-depression.<sup>48</sup> Again in an effort to keep "abreast of the times," Doherty cited the establishment of a pathological laboratory as one of the PHI's "most urgent needs," in 1907, and the following year, the government agreed to his request that a pathologist be added to the asylum's staff.<sup>49</sup> A program of regular blood and urine tests was instituted in 1908. The results of these tests, however, were disappointing and few patients seem to have benefitted from them.<sup>50</sup>

Thus Doherty's 'modernization' program did little to improve the treatment of women at the PHI. In fact, since comparatively little money was spent on the main structure at New Westminster, the area of the institution which housed women, it may be that the material conditions of female

inmates actually deteriorated in this period.<sup>51</sup> One central aspect of treatment at the PHI did change as a result of Doherty's successes, that is doctor- patient contact. The time Doherty spent building alliances with provincial physicians and Eastern psychiatrists, coupled with his efforts to lobby the government for increased expenditure, took him away from the PHI and its patients.<sup>52</sup> His medical assistant, James E. McKay, was called on to oversee operations at the Colony Farm, so that he too spent much of his time away from the main institution at New Westminster.<sup>53</sup> Finally as Bursars M.J. Knight and Gowan McGowan more closely monitored the institution's accounts, the responsibility of ordering supplies, administering the kitchen and laundry fell more directly to Matron Maria Fillmore, taking her away from her patients.<sup>54</sup> With these senior officials variously engaged, much of the responsibility for handling patients fell to the attendants.

Asylum superintendents, including those at the PHI, recognized the importance of the attendants' work with patients. The author of the Rules and Regulations Handbook in use at the PHI during this period wrote: "Attendants hold in their hands the welfare of each under their care, and the whole future life of many a patient will depend on the **manner in which attendants do their duty.**"<sup>55</sup> Recognition of the importance of proper attendants led many psychiatrists to recommend the establishment of training schools for asylum nurses, in part to bring their level of training up to the standards of general nurses. In 1888, Charles K. Clarke opened the first training school for asylum nurses in Canada at Rockwood, and the members of the AMPA made the establishment of similar facilities a major priority in 1907.<sup>56</sup> Doherty also agreed that "proper nurses" were "the first great factor in the treatment of the insane," but no institute for asylum nurses was established in British Columbia until 1919.<sup>57</sup> Until that time,

attendants at the PHI were untrained and received their positions primarily on the basis of political patronage.<sup>58</sup>

Throughout the period under study here, the majority of asylum attendants came through the recommendation of the Provincial Secretary, Henry Esson Young, Premier Richard McBride and Thomas Gifford, Legislative Assembly member for New Westminster. Doherty apparently accepted their input.<sup>59</sup> Since each year, an average of 25% of the male attendants and 35% of the female attendants did not return to the PHI, their suggestions probably helped to ease the effects of these high turnover rates.<sup>60</sup> The constant flow of appointments suggested by political patrons alleviated what otherwise may have developed into a situation of chronic labour shortage within the PHI. As well, since the supply of applicants frequently exceeded the demand, Doherty was enabled to dismiss disloyal or abusive attendants promptly.<sup>61</sup> Each year, one or two attendants were fired for allegedly striking patients, using too much force in restraining them, or for being a "menace to discipline."<sup>62</sup> More often though, attendants simply resigned because the work itself was arduous and demanding.

The lives of asylum workers are more obscure from the historian's vantage point than those of patients. The personnel records from the PHI have vanished and what is known about their work has been gleaned from official correspondence, public accounts, patient records and the Rules and Regulations handbook. Attendants worked twelve-hour days beginning at 6:30 am, were allowed to leave the institution in the evening, but were locked in each night at 10:30 pm.<sup>63</sup> The wage scale in use at the PHI in 1905 began male attendants at a salary of \$35 per month with a maximum of \$40 if they stayed in asylum service for more than two years. Women received an

initial salary of \$25 per month which could be raised to \$30 when they were considered "experienced" two years later.<sup>64</sup>

Since attendants were responsible for ward maintenance and leading the patients in work activities, Doherty preferred that attendants have some skill. He was particularly pleased when he hired one nurse because her knowledge of dressmaking qualified her "to intelligently direct the female patients in their work..."<sup>65</sup> Yet the low wages, long hours and restricted life that attendants were forced to lead meant that many of his appointments were less than satisfactory. Few women stayed after other options emerged. Some left to be married<sup>66</sup> and others used the asylum as a training ground for careers in private nursing, leaving to establish themselves elsewhere.<sup>67</sup> In Doherty's view, too few women saw mental nursing as a career and female turnover rates remained higher than those among men throughout the period.<sup>68</sup>

For those who stayed, relationships between attendants and patients sometimes developed. Certainly, on the female wards bonds of friendship and common interest grew between patients and nurses. Doherty, for instance, blamed one nurse for the relapse of her patient Florence S. (#2598, 2906) because she had complied with her Florence's request to read theosophic literature, a direct contradiction of Doherty's express wishes. Other patients wrote fond letters to their nurses at the PHI after their release.<sup>69</sup> Friendships between patients and nurses were, however, discouraged.

Within the authoritarian structure of the asylum, the nurse was to act only upon the physician's command. Doherty described the doctor-nurse relationship:

When the primary purpose of the nurse is other than to carry out the directions of the physician in charge, and to see that the treatment is as he intended, it is high time to discharge such nurse, and if he, the Superintendent, does not possess such absolute power, it is time that he himself passed in his resignation in the interests of the patients of the Hospital.<sup>70</sup>

As nurses became increasingly important implementors of Doherty's therapeutic plans for his patients, their loyalty became crucial. Particularly on the female wards, nurses were more active in treatment than either of the PHI's physicians. And just as the superintendent was to have "absolute power" over his nursing staff, patients were to conform completely to asylum routine and discipline. Doherty's therapeutic philosophy of 'moral control', administered in his absence by nurses, remained the central treatment of women throughout this period, despite the supposedly changing nature of PHI care.

When treating women at the PHI, Doherty combined medical and moral means. In both cases, his primary concern was with regulating patient life. Like many of his contemporaries, Doherty believed that insanity was the mental symptom of various physiological disorders "which may be referred to the nervous tissue, the blood, the lymphatics, locked secretions, or pathological conditions of any of the vital organs which control or modify nutrition."<sup>71</sup> The medical portion of Doherty's therapeutic regime primarily involved regulating patient diet and elimination in order to promote stable physical health which in turn would cultivate mental and emotional balance.<sup>72</sup>

Doherty's medical therapies did not involve surgical intervention. He was opposed to ovariectomies and for the most part preferred to treat women's gynecological problems topically.<sup>73</sup> In offering such treatments,

however, he did not believe he was attacking the source of mental illness, rather to his mind, he was simply responding to painful and dangerous physical conditions among his women patients. Gynecological treatments were not central to his medical therapy.<sup>74</sup> Instead asylum staff focussed on providing their patients with a balanced diet of well-cooked food. When severely debilitated women entered the PHI, they were given a dietary supplement of extra milk, eggs and beef tea. Regular evacuation was facilitated by hot and cold packs as well as the administration of laxatives such as cascara and calomel.<sup>75</sup>

Yet these therapies were seldom effective on their own. One such case was that of Lucy L. (#2299). In 1908, Lucy was admitted with a form of insanity initially diagnosed as hystero-mania. Two to three times each day she suffered from paroxysmal pseudo-epileptic seizures lasting as long as ninety minutes. Doherty admitted never having seen such a case but eventually concluded that its organic base was a tetanus infection brought on by pneumonia. He could not, however, discover any way to treat Lucy effectively. His attempts to manipulate diet and promote elimination in order to lessen the production and retention of 'toxic' gastro-intestinal substances proved futile in preventing the seizures and he noted that his treatment was purely palliative. By 1914, Doherty was particularly frustrated with the case and began to believe that Lucy was "shamming and exaggerating" the extent of her physical discomfort. During the next year, her seizures increased and were accompanied by repeated escape attempts as well as violent and destructive behaviour. But abruptly in the late fall of 1915, Lucy symptoms stopped. She no longer required sedation and began to "behave herself well." Four months later, she was discharged; her recovery as inexplicable as the persistence of her illness. Doherty's inability

to provide a medically-provable cure to this and other cases did not undermine his view that insanity was somatically-based. He did, however, recognize that medical treatment was only one part of a successful therapeutic plan. Along with the regulation of diet and elimination, Doherty also sought to regulate the habits of the insane in the hope that their own senses of discipline and control would be aroused.<sup>76</sup>

Just as regulating the body's circulating fluids created a more efficient and well-adjusted body, a well tuned body governed by a disciplined will comprised the mentally stable individual.<sup>77</sup> Yet Doherty realized, as did many of his contemporaries, that creating a disciplined individual required more than control and restraint. The insane also needed a "moral", encouraging environment, removed from the temptations and worries of regular life. Asylum officials could remove the physical causes of their distress while re-educating the insane in habits that would prevent further breakdowns.<sup>78</sup> The non-medical elements of Doherty's therapeutic practice were termed 'moral control'. This involved adherence to asylum routine through regular domestic labour and the regulation of personal habits enforced through an informal system of rewards and punishments.<sup>79</sup> In this way, the PHI sought to curb the dysfunctional behavioural components of what was perceived to be somatically-based mental illness.

Like many alienists of the time, Doherty believed that environmental factors were only the 'exciting' elements which produced outbreaks of deviant behaviour. Yet it was precisely these elements from which the insane needed to be removed in order for recovery to take place.<sup>80</sup> Insane women, in particular, needed to be taken out of the home, not because it was believed that the domestic sphere was psychologically unhealthy for women but because, it seemed to Doherty, that relatives were reluctant to exert a

healthy measure of control over women. The completeness with which the asylum could 'morally control' its female patients was, in Doherty's view, one of its greatest advantages. As he wrote to one concerned husband who was experiencing his wife's relapse, "The trouble according to your letter seems to be that you lack the control of her that strangers would have and so she does pretty much as she pleases which in her mental condition is not conducive to the best results."<sup>81</sup> Thus women who were mentally ill required control and therefore needed to be sent to asylum where discipline could be most easily applied.<sup>82</sup> One method of exerting control was through a strict regimen involving domestic labour.

Regular ward work was an essential element of 'moral control' therapy at the PHI. As a therapeutic practice, however, occupational therapy also had the advantage of contributing to the asylum in three ways. First, since occupational therapy was seen as a particularly progressive form of treatment, its use at the PHI bolstered the hospital's reputation as a curative institution.<sup>83</sup> Second, work therapy helped to dispel the notion that the institutionalized insane were an unreasonable financial burden upon the state.<sup>84</sup> Their labour made a significant contribution to the fiscal solvency of the PHI.<sup>85</sup> Third, work helped to maintain a level of discipline and regularity on the wards that was seen as beneficial not only to patients whom staff believed were curable but also for those patients who had become chronic.<sup>86</sup> In the case of Ida B. (#1799), Doherty wrote her father that she was working well on the ward and though she would never be "cured" she was, however, "now very amenable to discipline...and [soon] would be sufficiently recovered to be discharged...and become a useful member of society." For the sake of these benefits, asylum staff were urged to make their wards as productive as possible.

The necessity of ward productivity was emphasized in the Rules and Regulations Handbook of the PHI. Nurses were reminded that: "All should do something".<sup>87</sup> Attendants were told that they "were not doing their whole duty [if they did] not continually and systematically try to interest every one under their care in something that will occupy the mind or body, or both, in a helpful way."<sup>88</sup> Furthermore, attendants were to lead their patients in the work at hand by "setting them a good example." The Rules and Regulations handbook emphasized that patients should be encouraged to work because it diverted their thoughts and instilled self-discipline.<sup>89</sup> Regular work contributed to the asylum's more general effort at controlling female deviance by inducing conformity to asylum routine which, it was hoped would, contribute to a patient's recovery or, in cases where recovery was unlikely, limit the parameters in which aberrant behaviour was expressed.<sup>90</sup> Occupational therapy was an important part of the behaviour modification process which emphasized routine and discipline.

Institutional life, partly, by necessity, was routinized. In 1912, two hundred and ninety nine women were housed in two wards of the PHI which was the home of over one thousand patients in total.<sup>91</sup> While these crowded conditions did not entirely eliminate the possibility of some individualized treatment, much of the day-to-day functioning of the institution relied heavily on the ability of patients and staff to carry out normal activities at specified times. Each morning the patients were awakened between 7:15 and 7:30 and breakfast was served either in the dining areas on each ward, or in individual patients' rooms. From 8:00 to 8:30, patients were dressed, rooms were cleaned and soiled linen was collected to be sent to the laundry. These tasks were performed primarily by nurses, but patients on the women's wards frequently assisted. From 9:00 to 10:30, women were

encouraged to engage in some form of domestic labour either on the ward or in the tailor shop, kitchen or laundry. At 10:30, patients who were willing and able were conducted to the airing court to take light exercise for thirty minutes, at which time they were returned to the wards and lunch was prepared. After noon, the cycle was repeated, although if weather permitted, some women were allowed to take their mending or embroidering outside with them.<sup>92</sup> At 5 p.m., the evening meal was served, followed by bathing until the entire ward retired at 7pm. As each nurse was responsible for ensuring the safety and health of thirty five patients, the ability of the ward to follow this routine affected the lives of all the women, nurses and clients alike, who spend their days on the wards.<sup>93</sup>

But asylum officials were well aware of how difficult it could be to ensure that all ward residents, some of whom were quite mentally afflicted, carried on their lives within that routine. When asylum staff were unable to induce women to conform to asylum routine, they were faced with a situation that was not only disruptive and disorganized but also potentially dangerous. In addition, as the asylum became more interested in seeing itself as a curative and care-giving hospital, nurses became responsible for the physical and mental welfare of their patients.<sup>94</sup> One of the ways that asylum officials integrated their need for order with the desire not to be seen as repressively custodial was to make the ability of patients to conform obediently to the routine on the wards an element of the curative process.<sup>95</sup> Discouraging disruptive behaviour through chemical and mechanical restraint, transfer to the refractory ward, and the denial of privileges could thus be seen as therapeutic.

To the public, Doherty and his staff preferred to downplay their use of mechanical and chemical restraints. While, Doherty wrote that the use of

sedatives impeded mental recovery and that the advent of hydrotherapy eliminated the need for restraint, in fact, drugs such as paraldehyde, hyoscine and sulphonal were often used to sedate disruptive patients.<sup>96</sup> Most frequently, sedatives were used only at bedtime to induce sleep and to prevent noisy behaviour that woke others. The cases of Ciril M. (#2181), Lizzie G. (#3695), and Sophia M. (#2650) who were all administered shots of hyoscine before retiring were typical. Some patients such as Annie M(#3582) requested sedatives in order to sleep. Other cases, predominantly those involving unpredictable and injurious seizures were kept under constant sedation. Emma K. (#1907), for example, was given potassium bromide regularly for the last year of her life after she sustained bruises and broken bones during paretic fits.

In instances, where patient behaviour could not be contained chemically, physical restraint was used. Women, such as Sarah K. (#1758), Mildred W. (#1988) and Mary L. (#1653), who attempted to escape, destroyed their clothing or threatened violence were held in camisoles or restraining chairs until they behaved properly. When threats of violence or suicide were realized, women were first confined to single rooms on the general ward G. There inmates such as Lucy L. (#2999) and Mary H. (#1784) were watched closely and denied privileges of taking communal meals, walking on the grounds, and attending the weekly concerts staged by the hospital orchestra.<sup>97</sup> Although amusement and recreation were seen as vital elements in relieving mental anguish, they were nonetheless available only to those who worked regularly and for whom "the various forms of amusement [came] as a variety and relaxation from some more useful employment."<sup>98</sup> Similar restrictions were placed on women in the refractory wards of the hospital.

Patients who persisted in violent, or destructive behaviour were transferred to Ward J, the refractory ward. Elizabeth S. (#2131) was sent there when she broke a window. Meta B. (#2048) was similarly transferred after she attacked a fellow patient. When they became quieter and more compliant both were returned to G Ward and their privileges re-instated.

The extent to which chemical and physical restraint and ward transfers were used punitively is difficult to assess. Certainly, the hospital rules forbade the use of 'excessive' force in containing outbreaks of violence. Nurses were reminded that responding angrily to patient behaviour was equally inappropriate, for as they were told, "an angry person is no better than an insane person, for reason is gone in both cases." <sup>99</sup> Nurses accused of unfairly secluding or restraining patients were often summarily dismissed. When one attendant confined a patient to the screened balcony after the woman allegedly struck her on the way back from the airing court, Doherty questioned the inmate whose strenuous denials were corroborated by others. The nurse was immediately fired.<sup>100</sup> In many cases, it does not appear that restraint was used excessively. Laura C. (#3143) was described as 'troublesome and resistive' for two months before being given sedatives and Meta B. (#2048) was not confined or sedated in any way until she struck a fellow patient although she had been troublesome for two years.

In contrast, short term seclusion in a single locked room was used to contain a variety of less severe forms of disruption including incontinence and snoring as well as more serious or threatening behaviour. Mary H. (#1794) was first sent to a single room on Ward G when her snoring began to annoy other patients and Flora C. (#2932) was periodically secluded when her habits were described as 'filthy'. Mary H. (#1794) was released from the single room when it appeared that she could not help snoring but was

returned when she assaulted patients who complained. In some instances, then, ward transfer and seclusion appear to have been used to contain or discourage behaviour deemed inappropriate, dangerous or disruptive. While the rules of the institution prohibited the punitive use of restraint, seclusion or ward transfer, the disciplinary effects of measures were widely recognized. One psychiatric textbook noted that the "removal from one ward to another, according to the patient's condition, will often be appreciated by the patient, to some extent, as discipline, though it is necessitated by his conduct or his physical and mental condition."<sup>101</sup> Since ward classification at the PHH was based on patient behaviour, and since the denial of privileges accompanied single-room seclusion or residence on the refractory ward, transfers within the institution acted as part of a process in which appropriate behaviour was encouraged and destructive, dangerous or disgraceful behaviour discouraged.<sup>102</sup> The slowness with which such behaviour was punished or restrained suggests that the PHH staff attempted to live up to their claims that they had abolished mechanical and chemical restraint.

One form of disruptive behaviour which was treated promptly, however, was the refusal to eat. In some cases women refused asylum food because they feared poison.<sup>103</sup> Margaret M(#1784) and Mary L.(#1653) both believed that asylum personnel were in league with their husbands whom they accused trying to poison them. Both women were forcibly fed by nasal tubes which introduced light fluids such as milk, raw eggs and beef tea into the stomach via the nasopharynx. All forms of artificial feeding required physical restraint as patient interference could send the tube into the trachea and lungs resulting in aspiration pneumonia.<sup>104</sup> When patients were particularly agitated, sedatives could also be administered with the

food as in the case of Lizzie G.(#3695). Some women agreed to eat when they saw the artificial feeding apparatus. Edith F. and Mary O(#3542) had refused food, but ate when the nasal tube arrived. Although artificial feeding was used primarily to maintain women's physical health, it could also work as a form of suggestive therapeutics.<sup>105</sup> Thus chemical, physical restraint, ward transfers and artificial feeding were used both as practical responses to disruptive or dangerous patient behaviour as well as methods to induce conformity to asylum routine that were seen as therapeutic in itself.

The treatment of women at the PHI in this period emerges as one of 'moral control'. Asylum staff tried to produce women who were physically healthy and mentally stable, by using therapies designed to control patient behaviour supplemented by medical strategies to regulate inmates' bodily functions. The constant supervision needed to carry out this treatment and run the institution efficiently, coupled with the increased absence of senior asylum officials from the female wards, left women's care predominantly to asylum nurses. Despite Doherty's recognition of the crucial role nurses played, he appears to have done little to support them. Their hours were long, their pay low and few stayed in the service very long. Yet while Doherty complained that women seldom chose mental nursing careers, he did nothing in this period to advance their professionalization by, for instance, providing training. This aspect of 'modernization' did not fit immediately into Doherty's plans.

Indeed, neither did the treatment of women patients. Throughout this period, women remain absent from the therapies of which Doherty was so proud, just as they are largely invisible in the official reports and commentaries on the PHI. For this reason, the treatment of women only

emerges from study of case files. And as it becomes visible, forms of therapy which Doherty said he had eliminated, such as chemical and mechanical restraint appear, in fact, to have been widespread. Other elements of asylum practice also become apparent. While Doherty emphasized that his ability to control women patients was crucial to their recovery, it soon appears that his power in this regard was constrained. Patients and families continued to play important roles in deciding when and how to use the asylum. It is to these elements that this thesis now turns.

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<sup>1</sup>Val Adolf, The History of Woodlands. (Victoria: Mental Health Branch, 1978); David Davies, "A History of Mental Health Services of British Columbia" (unpublished manuscript, 1984); Richard Foulkes, "British Columbia Mental Health Services: Historical Perspectives to 1961", The Leader, vol. 20(5): 27; Richard Foulkes, "One hundred years in the lives of British Columbia's mental patients." (unpublished pamphlet, 1972); Henry M. Hurd, The Institutional Care of the Insane in the United States and Canada, vol. 4, (Baltimore: The Johns Hopkins Press, 1917); Horace Sheridan-Bickers, "The Treatment of the Insane: Farming as a Cure for Madness -- British Columbia's Novel experiment," Man to Man, 6(12)(December, 1910):1050-9; see also Robert Henry Thompson, A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia, 1850-1970. (Victoria: Mental Health Branch, Department of Health Services and Health Insurance, 1972)

<sup>2</sup>British Columbia Sessional Papers ( hereafter BCSP), 1909, Annual Report of the Medical Superintendent ( hereafter ARMS), 1908

<sup>3</sup>Michael Donnelly, Managing the Mind: A Study of Medical Psychology in Early Nineteenth Century Britain ( London: Tavistock Publications, 1983): 44

<sup>4</sup>"Charles Edward Doherty, M.D.," in F.W. Howay and E.O.S. Scholefield, British Columbia Biography, vol. III (Vancouver: S.D. Clark Publishing Co., 1914): 288; "Charles Edward Doherty," Vertical File, British Columbia Archives and Records Service [hereafter BCARS]; College of Physicians and Surgeons, The Register of the British Columbia Medical Council, 1905, British Columbia Medical Association Archives [hereafter BCMA Archives]

<sup>5</sup>Manchester to Fulton, 22 May, 1902, "Correspondence," Provincial Secretary [hereafter PSC], GR 1330, b4536, file 852, BCARS

<sup>6</sup>Manchester to F.J.Fulton, 31 May, 1902, PSC, GR 1330, b4536, file 891, BCARS; Doherty to Fulton, 20 November, 1902, PSC, GR 1330, b4536, file 1909, BCARS

<sup>7</sup>Doherty to Fulton, 3 January, 1905, PSC, GR 1330, b 4540, file 5, 16, BCARS

<sup>8</sup>Charles Edward Doherty, Vertical File, BCARS; Samuel Barclay Martin, Vertical File, BCARS.

<sup>9</sup> Stephen Garton, "The Melancholy Years: Psychiatry in New South Wales, 1900-40," in Australian Welfare History: Critical Essays, ed. Richard Kennedy (South Melbourne: The MacMillan Co. of Australia Ltd., 1982): 139; Gerald N.Grob, Mental Illness and American Society: 1875-1940, (Princeton, N.J.: Princeton University Press, 1983): 32

<sup>10</sup>Manchester to Fulton, 27 January, 1905, PSC, GR 1330, b4540, file 266, BCARS

<sup>11</sup>E.A. Sharpe was forced to resign in 1876 after staff at the Provincial Lunatic Asylum charged him with drunkenness, inappropriate behaviour and theft: "Correspondence Relating to the Lunatic Asylum," BCSP, 1876, p672; James Phillips was also forced to resign after a commission of inquiry found him to be incompetent and autocratic; "Commission to Inquire into the Management of the Provincial Asylum, New Westminster, 1885," GR 693, BCARS; Since both of these men had no medical training, it was thought that the appointment of a resident medical superintendent would solve the problems they found at the Lunatic Asylum, but a commission in 1894 found the first Medical Superintendent, Richard Irvine Bentley incapable of handling asylum affairs and requested his resignation as well, "Proceedings before a Commission appointed to enquire into certain matters connected with the Provincial Lunatic Asylum at New Westminster," GR 1732, BCARS

<sup>12</sup>Vancouver Daily Province, "Home for the Insane to Cost \$2,000,000." 22 December 1908, 4

<sup>13</sup>"Comparative Statement of the Receipts and Expenditure of the Province of British Columbia, from 1 July to 31 March 1914," "Public Accounts," 1914, BCSP, 1915, B4

<sup>14</sup>George H. Perley to Percy Thacker, 11 August 1917, Overseas Ministry, RG 9, III, vol. 265, file 10-D-98, National Archives of Canada; see also Chapter 4.

<sup>15</sup>Dewdney Conservative Association to Henry Esson Young, 1 August 1910, PSC, GR 1330, b4550, file 1159, BCARS

<sup>16</sup>In November 1912, Young wrote Doherty the following letter: "My dear Doherty: It looks as if we are going to have a long cold winter; times are hard and money is scarce. Could you send me over a few sacks of potatoes, not too many, and a sack or two of the other roots." Young to Doherty, 12 November 1912, PSC, GR 542, box. 12, file 6, BCARS

<sup>17</sup>BCSP, 1907, ARMS, 1906

<sup>18</sup>C.E. Doherty, "The Care of the Mentally Defective," Royal Commission on Mental Hygiene, GR 865, Box. 1, file 11, p.10, BCARS; F.J. Brydone-Jack, "Presidential address-BCMA," Dominion Medical Monthly, vol. XXV, 201,205; see also Margaret Andrews,

"Medical Services in Vancouver, 1886-1920: a study in the interplay of attitudes, medical knowledge and administrative structures." (Ph.D. thesis, University of British Columbia, 1979): 176

<sup>19</sup>C.E. Doherty, "Diagnosis of Insanity by the General Practitioner and the Consequent Duties Which Must Necessarily Devolve Upon Him." paper presented to the British Columbia Medical Association, Annual Meeting, held in New Westminster, B.C. on August 1-2, 1906, reprinted in BCSP, 1909; "Proceedings of Societies--BCMA", Dominion Medical Monthly, vol XXVII (Sept., 1906): 140-1; BCSP, 1907, ARMS, 1906

<sup>20</sup>"News," Dominion Medical Monthly; vol XXXVIII (Jan., 1912): 35

<sup>21</sup> Doherty to Monroe, 13 January, 1911, 13 July 1911, 8 June 1912, "Executive committee correspondence," vol. 11, files 5-6, BCMA Archives

<sup>22</sup> Some of the more pessimistic observers noted that in contrast to the advances made in hospital treatment and more general medical science, the asylum and its doctors had stood virtually still intellectually. See Grob, Mental Illness, 31, 108.; David Rothman, Conscience and Convenience: The Asylum and Its Alternatives in Progressive America. (Boston: Little, Brown, 1980):326; S.E.D. Shortt, Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry. (New York: Cambridge University Press, 1986):124; see also Clarence B. Farrar, "On the Methods of Later Psychiatry." American Journal of Insanity, [hereafter AJI] vol. LXI (Jan., 1905):437; Andrew MacFarlane, "The Duty of the State to the Insane," The Popular Science Monthly, vol. XLIII (May-October, 1893): 745

<sup>23</sup>George Bancroft, "Hopeful and Discouraging Aspects of the Psychiatric Outlook," AJI, vol. LXV, (July, 1908): 1-2; A.R. Urquhart, "The Progress of Psychiatry in 1902: Great Britain," AJI, vol. LIX, (April, 1903): 593-99; see also Rainer Baehre, "The 'Ill-Regulated Mind': A Study in the Making of Psychiatry in Ontario, 1830-1920," (Ph.D. thesis: York University, 1986): 374-5.

<sup>24</sup>Doherty to Fulton, 20 April 1906, PSC, GR 1330, b4542, file 1099, BCARS

<sup>25</sup>Doherty to Fulton, 11 May 1906, PSC, GR 1330, b4543, file 1283, BCARS

<sup>26</sup>Doherty attended AMPA meetings in 1906, 1907, 1910, 1911, 1912. "Proceedings: American Medico-Psychological Association," AJI, vol. LXIII (July, 1906):95; "Proceedings," AJI vol. LXIV (July, 1907):165; "News," Dominion Medical Monthly, vol. XXIV (August, 1910):76; "Proceedings," AJI vol. LXVII (October, 1911):304; AJI vol. LXVIII (July, 1912)105.

<sup>27</sup>BCSP, 1914, ARMS, 1913

<sup>28</sup>For an example of Eastern psychiatrists' disapproval of the PIII see "Report of Commission into the Hospital for the Insane, 25 January 1901," Provincial Secretary, GR 731, BCARS

<sup>29</sup> This was the rationale for the commission of inquiry into asylum affairs in 1894 which was headed by two British Columbian physicians, Dr. Charles Newcombe and Dr. Edward Hassell. "Proceedings before a Commission appointed to enquire into certain matters connected with the Provincial Lunatic Asylum at New Westminster, 1894," Provincial Secretary, GR 1732, BCARS

<sup>30</sup> For instance when the Canadian National Committee on Mental Hygiene inspected the PIII they commented on the "whole-hearted co-operation" of Doherty and his "intelligent conception of the advances being made in the field and [his preparation] to

accept modern dictums on the subject." Canadian National Committee on Mental Hygiene to Young, n.d. "Correspondence," Provincial Secretary, GR 1665, box. 6, file 2

<sup>31</sup>George T. Tuttle, "Hydrotherapeutics," AJL, vol LXI (October, 1904): 179

<sup>32</sup>Gerald Grob discovered that hydrotherapy was the most frequent treatment used in American institutions in the early twentieth century; Grob, Mental Illness, 122

<sup>33</sup>BCSP, 1910, ARMS, 1909

<sup>34</sup>Random sampling of male and female patients admitted between 1908-1914, "Patient Registers," RR, GR1754, BCARS

<sup>35</sup>BCSP, 1912, ARMS, 1911

<sup>36</sup>Interview with David Davies, instructor and staff historian, Riverview Hospital, Coquitlam, British Columbia, 1 May 1989; though mechanical restraint was used on violent female inmates, none of the patient files I examined showed any indication of hydrotherapy being used as a sedative.

<sup>37</sup>BCSP, 1906, ARMS, 1905

<sup>38</sup>BCSP, 1906, ARMS, 1905

<sup>39</sup>Cyril Greenland, "Work as Therapy in the Treatment of Chronic Mental Illness," Canadian Psychiatric Association Journal, vol. 7(1): 11-14

<sup>40</sup>Michael Donnelly, Managing the Mind: A Study of Medical Psychology in Early Nineteenth-Century Britain. (London: Tavistock Publications)

<sup>41</sup>L. Vernon Briggs, Occupation as a Substitute for Restraint in the Treatment of the Mentally Ill: A History of the Passage of Two Bills Through the Massachusetts Legislature. (reprint ed., New York: Arno Press, 1973): 4

<sup>42</sup>W.E. Taylor, "Farming as a Cure for the Insane," Charities and the Commons, vol. XVII (October 1906-April 1907): 943

<sup>43</sup>Evidence of Charles Edward Doherty, "Inquisitions", 1913, British Columbia Attorney General, GR 3231, b2391, file 112, BCARS; though Tanzi stated that women could certainly be given traditionally female agricultural tasks, most institutions continued to populate their farms with men, the women performing ward maintenance, sewing, needlework and other domestic duties. see Eugenio Tanzi (trans. W. Ford Robertson, T.C. MacKenzie) A Textbook of Mental Diseases. (New York: Ribman Co., 1909): 784. see also Rothman, Conscience, 347

<sup>44</sup>BCSP, 1906, ARMS, 1905

<sup>45</sup>Victoria Daily Colonist, 13 May 1908, p. 7, 24 March 1908 p.3; Vancouver Daily Province 22 December 1908, p.4; 11 June 1909, p.12; Young to Doherty, 11 April 1910, PSC, GR 542, box. 12, file 5, BCARS; To ensure that the new site would meet international standards, the New York State Lunacy Commission adjudicated the architectural submissions; see Doherty to Young, 6 August 1908, PSC, GR 1330 b4547, file 2488, BCARS

<sup>46</sup>Young to Griffiths, 25 November 1908, PSC, GR 540 file 2482, BCARS

<sup>47</sup>David Davies, "Our History in a Nutshell," n.d., mimeographed, 3,4.

<sup>48</sup>Grob, Mental Illness, 108; Auto-intoxication involved the derangement of physical and mental condition by the accumulation of toxic substances within the body.

<sup>49</sup>BCSP, 1908, ARMS, 1907, BCSP, 1909, ARMS, 1908

<sup>50</sup>BCSP, 1911 ARMS, 1910,

<sup>51</sup>Certainly while the government expenditure for the PIII rose massively during this period, in 1908, Doherty argued that only \$8000 was needed to keep the main institution

in an adequately maintained state. The same year \$74,874.64 was spent on maintaining the Colony Farm and the PHI. Since expenditure figures were not broken down to reveal how much money was spent on each part of the institution, it is impossible to tell if Doherty lived up to his cost-cutting expectations. BCSP, 1909, ARMS, 1908.

<sup>52</sup>Doherty to Monroe, 8 June 1912, "Executive Correspondence," vol. 11, file 6, BCMA Archives

<sup>53</sup>Val Adolf, "Woodlands History: interview with Dorothy Kane", Tape 4172.2, BCARS

<sup>54</sup>Rules and Regulations to the Employees of the Provincial Hospital for the Insane of British Columbia (Victoria: Richard Wolfendon, 1901): 10

<sup>55</sup> Rules and Regulations, 33, emphasis theirs.

<sup>56</sup>Baehre, "Ill-Regulated," 379; "Report on the Committee on Training Schools for Nurses", AJI vol. LXIII, (July, 1907): 119-140; C.P. Bancroft, "Reconciliation of the Disparity Between Hospital and Asylum Trained Nurses," AJI, vol LXI, (October, 1904): 199-209

<sup>57</sup>Val Adolf, Woodlands, 30

<sup>58</sup> Political patronage was also the source for the appointment of attendants in Great Britain. See Mick Carpenter, "Asylum Nursing Before 1914: A Chapter in the History of Labour," in Rewriting Nursing History, ed. Celia Davies (London: Croom Helm, 1980):127

<sup>59</sup> See for examples: PSC GR 1330 b4540, files, 160, 890, 916, 1896, BCARS

<sup>60</sup>Ontario, American and British had similarly high turnover rates. See: Shortt, Victorian Lunacy, 43, Rothman, Conscience, 353, Carpenter, "Asylum Nursing," 137

<sup>61</sup> For instance when Gifford submitted the application of Annie Reid, Doherty wrote that he had no vacancies but would give her the first opening; see Doherty to Fulton, 19 July 1905, PSC, GR 1330, b4540, file 1896, BCARS

<sup>62</sup>See for example the cases of James Devlin, 21 March 1905, PSC, GR 1330, b4540, file 793, BCARS; George Henry, 30 January 1906, PSC, GR 1330 b4542, file 280, BCARS; Nurse Huff, 16 July 1906, PSC, GR 1330, b4543, file 1761, BCARS; S.A. Bailey, 9 May 1906, PSC, GR 1330, b4544, file 1451, BCARS; Attendant Bettles, 18 November 1907, PSC, GR1330, b4545, file 3106, BCARS

<sup>63</sup> Rules and Regulations, 29; see also T. Gifford to Fulton, 2 May 1904, PSC, GR 1330, b4539, file 1011, BCARS

<sup>64</sup>By comparison to some other Canadian mental institutions, attendants at the PHI received higher wages and worked shorter hours. Doherty was proud of the wages his employees received in comparison to their Eastern counterparts and believed that his was a better institution as a result; see "Schedule of wages," 3 March 1905, PSC, GR1330, b4540, file 605, BCARS; for New Brunswick's schedule of wages and hours see 26 May 1905, GR 1330, b4539, file 1201, BCARS; for Nova Scotia Hospital for the Insane schedule see Hattie to Fulton, 28 May 1905, PSC, GR 1330, b4539, file 1187, BCARS; for Ontario's schedule see Christie to McBride, 27 May 1905, PSC, GR 1330, b4539, file 1229, BCARS

<sup>65</sup> Doherty to Young, 4 April 1905, PSC, GR 1330, B4540, file 916, BCARS

<sup>66</sup>See for instance the resignation of Bella Firth to get married: Doherty to Fulton, 9 January 1905, PSC, GR 1330, b4540, file 1927; see also Doherty to Fulton, 14 March 1905, PSC, GR 1330, b4540, file 748, BCARS

<sup>67</sup>A former nurse at the PHII later went on to care for the wife of a government agent when she was released from the asylum; see Doherty to Young, PSC, GR 1330, b4546, file 748, BCARS

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68 Testimony of Charles Edward Doherty, "Inquisitions," 1913, British Columbia Attorney General, GR 1323, b2391, file 112, BCARS

69 Eliza S. #2131, "Patient files," Riverview Records [hereafter RR], G-87-024, BCARS

70 BCSP, 1914, ARMS, 1913

71 BCSP, 1913, ARMS, 1912

72 BCSP, 1907, ARMS, 1906, BCSP, 1908, ARMS, 1907

73 see Case # 2592, 3789, "Patient files," RR, G 87-024, BCARS

74 BCSP, 1907, ARMS, 1906

75 BCSP, 1907, ARMS, 1906

76 Anne Digby has noted that "attempts to regulate food consumption may be seen in part as the product of [a] more thoroughgoing medical approach to treatment that sought to control physical inputs, circulating fluids and evacuations in a mechanistic model of the body...dietary management was one way back to the moral world of sober living and thus to health and sanity." see Anne Digby, Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914 (Cambridge: Cambridge University Press, 1985):132

77 Charles Edward Doherty, "The Care of the Mentally Defective", Royal Commission on Mental Hygiene, GR865, Box 1, file 11, p. 14, BCARS

78 Rules and Regulations, 25

79 Other more prominent alienists also gave 'habit-training' a central role in treatment. Adolph Meyer who popularized Kraepelin in the United States emphasized the notion that psychogenic factors made it difficult for patients to adapt to their environment and so relied on the asylum and popular education to teach the insane to be more commodious to their surroundings; see Grob, Mental Illness, 115; See also T.S. Clouston, Clinical Lectures on Mental Diseases. (Philadelphia: H.C. Leas and sons and co., 1884):130

80 BSCP, 1913, ARMS, 1912

81 Case # 1198, "Patient files," RR, G 87-024, BCARS

82 Both alienists and patients recognized that asylums were environments of control. Daniel Brower and Henry Bannister wrote that "There is, we might say, a sort of atmosphere of discipline and control about the [asylum]..." and a patient at the Colney Hatch asylum is reported to have said that there was a "sense of...power and authority" about the institution. See Brower and Bannister, A Practical Manual, 130, and; Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830-1980 (New York: Penguin Books, 1985): 102

83 Horace A. Sheridan-Bickers, "The Treatment of the Insane: Farming as a Cure for Madness--British Columbia's Novel Experiment." Man to Man, vol. 6 (December, 1910): 1050-1059; L. Vernon Briggs, Occupation as a Substitute for Restraint in the Treatment of the Mentally Ill: A History of the Passage of Two Bills Through the Massachusetts Legislature. (reprint ed., New York: Arno Press, 1973).

84 Cyril Greenland, "Work as Therapy," 12, 14.

85 see Chapter 4.

86 Lawrence J. Ray, "Models of Madness," 229-264; Donnelly, Managing the Mind, 37.

87 Rules and Regulations, 13

88 Rules and Regulations, 29.

<sup>89</sup>Rules and Regulations, 18.

<sup>90</sup>Ray, "Models of Madness", 254-5.

<sup>91</sup>BCSP, 1913, ARMS, 1912

<sup>92</sup> Though the practice of allowing women to take their work outside had been common during the days when Flora Ross was Matron, overcrowding at the PHI disallowed it until Manchester re-opened the female airing court in 1905 to, in his words, "allow a little respite for the patients from the usually hated ward where so many distressing influences exist if it is crowded." Manchester to Fulton, 21 January 1905

GR 1330, B4540, file 766, BCARS

<sup>93</sup> Testimony of Annie Thomas, charge nurse, "Inquisitions," 1906, British Columbia Attorney General, GR 1323, reel b2382, file 151, BCARS; On particular evenings, for instance there was only three nurses on duty to handle over 150 patients. See case # 2999, "Patient files," RR, G 87-024, BCARS

<sup>94</sup> At the PHI, this transformation was more apparent than real in the sense that the female ward was always run in a way which was far less custodial than the male wards. see "Proceedings before a Commission appointed to enquire into certain matters connected with the Provincial Lunatic Asylum, 1894," Provincial Secretary, GR 1732, BCARS

<sup>95</sup> Nancy Tomes has used the phrase to describe the process by which women were cured under the moral therapeutics of Thomas Story Kirkbride. I have adopted its use because women at the PHI appear to have experienced recovery in similar ways to those women Tomes described. Tomes, A Generous Confidence, 188.

<sup>96</sup>BCSP, 1907, ARMS, 1906 ; BCSP, 1910, ARMS, 1909

<sup>97</sup>Rules and Regulations, 27

<sup>98</sup>Rules and Regulations, 29

<sup>99</sup> Rules and Regulations, 26

<sup>100</sup> Doherty to Fulton, 16 July 1906, PSC, GR 1330, reel B4543, file 1761, BCARS

<sup>101</sup> Brower and Bannister, A Practical Manual, 129, 131. Commentators later in the twentieth century have noted that ward transfers are particularly useful as control mechanisms. See Erving Goffman, Asylums: Essays on the social situation of mental patients and other inmates, (Garden City: Anchor Books, 1961): 361; Nancy Malony, "Patterns of Psychiatric Patients' Perceptions of Hospitalization," (Ph.D. thesis: Simon Fraser University), 8

<sup>102</sup> Lawn House was reserved for trusted chronic or convalescent female patients, Ward G was used as the general female ward and Ward J as the refractory ward.

See testimony of Charles Edward Doherty, "Inquisitions," 1913, British Columbia Attorney General, GR 1323, reel b2391, file 112, BCARS; Shortt also found that ward classifications were based on level of co-operation rather than on diagnosis, see Shortt, Victorian Lunacy, 57.

<sup>103</sup> Poisoned food seems to have been a very common delusional fear. As well (and perhaps for this reason), resisting food has been found to be a particularly female form of disruptive behaviour; see Tomes, A Generous Confidence, 236.

<sup>104</sup> Adolf Meyer, "On Some Terminal Diseases in Melancholia," AJL, vol LIX, (July, 1902): 83-9.

<sup>105</sup> The 'moral' effect of artificial feeding was also recognized by psychiatrists. See Brower and Bannister, A Practical Manual, 115.

### Chapter 3

## The Admission of Women to the Provincial Hospital for the Insane

As Medical Superintendent of the Provincial Hospital for the Insane[PHI], Dr. Charles Edward Doherty raised the status of the institution and his position and attained an unprecedented level of control over the PHI and its external relations. But how much did this influence extend to his female patients and their families? This chapter will begin to answer that question by assessing the process by which women entered the PHI. In doing so, female committal will be examined from the perspective of asylum officials, the family, the community and local doctors.<sup>1</sup> The reactions of mentally ill women to insanity, family conflict and asylum admission are obscured because the records used here were not designed to capture their response. Instead, institutional commitment papers reveal the relationships between the non-psychiatric community and the insane, illuminating the mental hospital's role in containing unresolvable family conflict and socially unacceptable behaviour and the attitudes of the lay community and family physicians towards the female insane, the nature of female mental illness and its causes.<sup>2</sup> As well, committal records are an important historical source because they document, albeit imperfectly, the lives of the insane and their families prior to institutional psychiatric involvement and reveal the extent to which popular beliefs about mental illness reflected or deviated from professional ideas.

Like most of his contemporaries, Doherty realized that his psychiatric authority resided almost entirely within the walls of the Provincial Hospital. Ultimately, the control over the rate and character of admissions to the PHI remained beyond his grasp. Despite his influence with medical and

governmental allies, the lay public continued to sustain its own interpretations of the appropriate uses of the mental institution. As a result, Doherty and other institutional psychiatrists were seldom pleased with the kinds of patients they received. Eastern alienists presumed that their facilities held so many essentially harmless inmates because their asylums were seen as "good boarding houses".<sup>3</sup> Doherty complained that the cure rate of his institution could not be compared with Eastern mental hospitals because his asylum, as the only one in the province, was forced to take all cases of mental derangement including incurables such as epileptics and 'idiots'.<sup>4</sup>

The more crucial problem, however, as asylum administrators saw it, was the tendency of families to delay committal so long that cure became impossible. This failure was cited as one of the main reasons for the rise of custodial conditions within asylums.<sup>5</sup> Not only was treatment too often delayed, it was often postponed indefinitely and concerned physicians feared that many insane were still at large, untreated, and uncontrolled. For instance, the British Columbian psychiatrist Ernest A. Hall estimated that for every person admitted to asylum, twenty more were still in the community, "their moral sense lowered and their capacity for work lessened."<sup>6</sup> The concerns of medical authorities over the inappropriate nature of asylum admissions and the "insane at large" arose in part because they acknowledged their inability to control what they saw as the most crucial point in the lives of curable lunatics: the committal decision.

Physicians and psychiatrists were right to see the choice to commit as one aspect of mental health care largely beyond their authority. They could encourage families to seek medical care for a disturbed relative, but except in cases of criminal conduct, they could not force psychiatric intervention.

Patient records show that families resolved to send women to asylum in private, with reluctance, and frequently independent of medical advice. When they could afford it, they sought to delay asylum committal by seeking alternate treatments, home care, and extended travel. The needs of the working-class family, however, often prevented such strategies. The inability of working-class men to care for insane wives and children while maintaining sometimes itinerant employment meant that working-class women arrived at the asylum sooner in the course of their mental illness than their middle-class counterparts.<sup>7</sup> In both cases, however, physicians were consulted only as a means of postponing committal by offering extra-institutional treatment, or to provide validation for a decision already made. The mental hospital and the expertise of its physicians were called upon only as a last resort.<sup>8</sup>

Some cases of medical or state intervention did occur, however. Although the by-laws of Vancouver General Hospital forbade the admission of "lunatic persons", some insane women did end up there and in other general hospitals.<sup>9</sup> But as Doherty reported to a coroner's inquest, "general hospitals [were] anxious to get rid of insane patients."<sup>10</sup> Single women or women who came into conflict with the law were also more directly placed under asylum control. Lilli S. and Bertha H. were both arrested for prostitution and when they became disruptive in their cells, they were quickly transferred to the PHI.<sup>11</sup> But such cases were far outweighed by instances of family-generated committal.

Once the decision to commit a woman was made, families faced a legal process that required medical and judicial corroboration. First the lunatic was to be examined by two duly qualified physicians who had to agree on a diagnosis of insanity. Then the committal agent, whether a family member

or not, filled in a form stating the particulars of the case, and answering questions about the patient that ranged from age and sex to symptomatic delusions, behavioural propensities and pecuniary circumstances. Finally, the committal agent proceeded to a Justice of the Peace, Stipendary Magistrate, or a Court of Record Registrar with the completed forms and the supposedly insane individual to obtain official agreement that the person was "a Lunatic and a proper person to be taken charge of and detained under care and treatment..."<sup>12</sup> The patient was then ordered to be admitted to asylum.

The legal committal process brought non-kin into what had been a family crisis, sometimes for the first time. As such, it served as a transitional phase between the family's private efforts to contain the effects of female insanity and the decline of that control with asylum incarceration. As will be argued in subsequent chapters, family input into the care and control of insane women did not end with incarceration but rather took less direct, more manipulative and negotiated forms. Still the committal process was a watershed in the lives of many families and the women involved.

But what of those that did not choose asylum care? Locating how these people viewed mental hospitals and why they chose not to use institutional psychiatric services cannot be accomplished using hospital records. We can only speculate on why some families committed women with suicidal tendencies and some did not.<sup>13</sup> Subsequent censuses of the 'mentally defective' in British Columbia show that a number of individuals whom the medical profession thought needed institutional care, had managed to maintain themselves in society without incident.<sup>14</sup> As the eugenics era approached, psychiatrists increasingly tried to discover the reasons for the persistent disinclination of some families to use mental hospitals. Partly, they decided, it was because of the stigma still associated

with asylum committal.

Some psychiatrists thought that families and the insane themselves were reluctant because asylum admission was unnecessarily complicated and legalistic. James Russell of the Hamilton Mental Hospital asked "Is it any wonder, in view of the vigorous methods of admission, that the people postpone the ordeal as long as possible, and only consent under the direct necessity?"<sup>15</sup> Russell and others advocated the establishment of psychopathic wards in general hospitals so that some mentally distressed individuals and their families could circumvent "all the red tape formalities" inherent in asylum admission.<sup>16</sup>

Doherty, himself, did not support the establishment of psychopathic wards, but he did agree that the PHI was not being used appropriately. In Doherty's view, general practitioners were crucial players in the committal process. Family physicians were often the first non-relatives to be consulted about an insane person's behaviour and since provincial legislation required medical certification, Doherty sought to alert his fellow physicians to their duty to refer mentally distressed patients promptly to the Provincial Hospital. In August 1906, Doherty presented a paper to the British Columbia Medical Association's annual meeting, emphasizing the need to diagnose and treat insanity in its early stages. He also outlined what he saw as the appropriate methodology for the mental exam conducted by the certifying physician.<sup>17</sup> Yet apart from educating his fellow physicians and assuring that the PHI was portrayed by the press in a positive light, Doherty could do little to convince a family that an insane relative required committal. Only in future decades could psychiatrists in private practice or associated with schools and hospitals have direct access to the pre-institutionalized insane and their families.

Families' decisions to commit women to the PHI were commonly the result of a number of behavioural and environmental factors. These included the appearance of delusional beliefs and hallucinations, outbreaks of violent, suicidal or embarrassing behaviour, and families' inability to cope with the level of care or control that women required. Families' preference for home care declined with the onset of destructive or self-destructive behaviour and when women became increasingly helpless and in need of constant care.<sup>18</sup> In many instances, kin had endured periodic attacks of hallucinations or chronic dementia for years and only decided to commit female relatives after alternatives or previously-used care networks were exhausted.

'Abnormal' behaviour was often presaged by delusional beliefs and hallucinations, most involving male violence and family dissolution. Augusta W. (#1782) believed that her husband had sold their daughter to "Chinamen" for "immoral purposes", and that these men were now following her. She also felt that her cannery co-workers were all against her. Sarah K. (# 1773) feared that men were following her and that women were conspiring against her, sending her husband false reports about her fidelity. Fears of desertion, family breakdown and male brutality were natural for these women. The migration of nuclear families, which was part of many inmates' experience, intensified the marital relationship and increased the negative effects of a husband's death or desertion on women and their children.<sup>19</sup> Similarly, fears of male violence, lost reputation and 'white slavery' all speak to real problems in turn-of-the-century British Columbia.<sup>20</sup> Clearly some women expressed fears that were out of proportion to their personal lives, but nevertheless were rooted in the myths and realities of the time. When families disproved these notions to no avail, they began to suspect insanity.

Religion and royalty were other pervasive themes in women's delusions. Although belief in exalted birth, as queens and princesses, was usually harmless, some women did get into trouble. Mamie W. (#1836) was sent to the PHI when she went to the police claiming that her money had been stolen. The investigating constable subsequently discovered that Mamie believed herself a princess and the state, the thief. While these delusions may have been evidence of women's profound dissatisfaction with their real lives, these beliefs were generally not taken seriously enough, in most situations, to warrant confinement. Conversely, religiously-based delusions were often not so benign and the punitive nature of the Judeo-Christian tradition granted much fodder for women's fears. The single most frequently cited delusion, next to those concerning the family, involved sin and damnation. Edith L. (#1938) became increasingly depressed because she believed that she had committed a mortal sin and would be punished. Despite the 'feminization' of religion in previous decades, the elements of condemnation to be found in Christianity continued to be metaphoric for the extreme social consequences of inappropriate behaviour for women.<sup>21</sup> Whatever the source of such beliefs, few families committed women simply for holding them. When violent or self-destructive behaviour resulted, however, many families felt compelled to intervene.

When forced to act, middle-class or multi-generational families were frequently more able to delay asylum committal by using alternate strategies than their working-class counterparts. For instance, when Helen H. (#3364) became insane after an attempted sexual assault, her middle-class family first tried to cure her by sending her to the Burrard Sanitarium run by Dr. Ernest A. Hall. Dissatisfied with his treatment of Helen's case, her mother removed her from his care, and returning Helen to her home, hoped

that musical study and reading would distract Helen from her mental anguish. But when Helen began to wander and attempt suicide, the H. family decided that it could delay no longer and sent her the PHI. Similarly, the family of Margaret C. (#1505) tried to confine her at home after her mental breakdown. Her adult daughter cared for her until Margaret struck her during an escape attempt. Her husband then tried to spend more time with her until he too became the victim of her violence. Having exhausted their own facilities to care for Margaret, they then turned her over to the PHI.

Working-class nuclear families were not able to employ such tactics. As in the case of Isabella G.(#3452), admission to asylum came shortly after the first indications of destructive behaviour. A mere five days before entering the asylum, Isabella became delusional and depressed. Mr. G reported that she neglected her appearance, her housework and their baby. Three days later, upon returning from work to their east Vancouver home, Mr. G found his pregnant wife in the street, clothed only in her night dress, threatening to take poison and burn the house around her. Mr. G proceeded to the nearest doctor and demanded that she be given appropriate treatment for her mental condition. Isabella entered the Provincial Hospital for the Insane on the eleventh of October, 1912 and died there in 1936.

Violence and attempted suicide were not the only forms of behaviour that prompted families to admit their women. After many years of care, some relatives decided to send women to asylum because their needs became too great to be handled at home. Mr. W committed his 19 year old daughter Mildred (#1988) when she became incontinent and resisted home confinement. When Martha H.(#2727) failed to recover from a bout of melancholia, lost interest in her surroundings and became suspicious of her family, her father decided that he could no longer care for her. Ultimately he

concluded that she was "so depressed ... it was better to have her committed." The fact that he had previously sent his stepson to the PHI in 1894 probably aided him in making his decision.

Other families found women's behaviour embarrassing or morally unacceptable. When Ethel F. disgraced her family at their annual New Year's Eve party, she was immediately confined to her room. Within a few days, despite their desire to "keep [Ethel's condition] quiet", they reluctantly sent her to the PHI, "as the only place likely to do her any good."<sup>22</sup> Others found inappropriate behaviour not only embarrassing, but dangerous, especially to young children. Helena F.'s husband (#1536) wrote that his wife had not been thoroughly cured by a previously performed operation and that he was obliged to hire a woman to look after his home and children. He did not begin to consider sending her to asylum, however, until Helena's behaviour took an immoral turn. He explained that "At times, she acts something shameful with strange men--I am obliged to watch her for my little girl's sake."

Still, few families committed women simply for socially inappropriate behaviour. Certainly some such cases existed, but generally the vital economic and child-rearing roles that women played within the home prevented families from committing them for anything less than seriously dangerous or disruptive behaviour. Daughters, wives and mothers often continued to perform their domestic functions despite delusions, depression and intermittent bouts of mania for years before a change in behaviour or family circumstances precipitated committal.<sup>23</sup> As will be seen in the next chapter, asylum admission was not an easy solution to family crisis. Clearly, families that resorted to committal, did so because they felt they had no other choice.

Relatives also realized that, while caring for insane women within the home was difficult and private nursing or treatment was expensive, non-institutional care allowed them more control over the role the medical profession played in their lives. Many families felt that asylum admission would end that control.<sup>24</sup> Their experiences with the police and non-psychiatric institutional medicine confirmed that impression.

Occasionally, medical and police officials intervened to prompt relatives to commit a woman. Such non-family committal agents did not have to receive consent from families or legal guardians but the law recommended that relatives be notified, primarily to facilitate financial support.<sup>25</sup> Usually police and doctors became involved in admitting women to the PHI when women had already been committed to a general hospital, came into conflict with the law or had no family within the province.

Such was the case when women were admitted to general hospital for physical illness or as a result of a suicide attempt. Sarah K (#1759) stayed at the Royal Columbia Hospital only briefly in 1906 to recover from drinking carbolic acid. She said that she knew that she was "going insane", but could not help it. She asked to "go away for a while" and hospital staff and her family decided that the asylum was the most appropriate destination.

Women in conflict with the law were especially vulnerable to state intervention. Lilli S. (#2570), a prostitute, was arrested for assault and remanded to the Vancouver jail on 2 January 1910. While incarcerated she broke a radiator, a chair and a bucket in her cell and smeared feces on the walls of the police toilet. Examining doctors and the jailer signed the final committal form to have her admitted immediately.

Women without family in the province could also find themselves in the care of those less likely to tolerate deviant behaviour. Lucy L (#2299)

was presumed to be an orphan when she arrived at a convent in Cranbrook in 1898. Ten years later, she began to destroy convent property during periodic seizures and even when lucid absolutely refused to work. The sisters sent her to the Provincial Hospital, six months after the first seizure.

Not only did institutional psychiatrists fail to gain control over the committal process, it also appears that current psychiatric theory on the nature and causes of mental illness were not widely known or accepted among the non-psychiatric community. These lay conceptions of insanity are expressed in committal forms. Although Doherty's annual reports including his assessments of the predominant causes of insanity were published in local newspapers, most British Columbians who sent women to the PHI sustained their own interpretations.

By the turn of the twentieth century, asylum doctors were beginning to see heredity as the primary cause of insanity. Based on their own asylum populations, however, they often had some difficulty proving it.<sup>26</sup> In the absence of hard evidence of heredity, Doherty resorted to speculating about its presence. He believed that many patients and families refused to acknowledge hereditarian taint, but that their vehement refusal was itself proof. He wrote that: "The doggedness with which members of some neurotic families will deny the heredity of insanity to the physician is only equalled by the readiness with which they divulge it."<sup>27</sup> At the PHI, suspected or inferred heredity was consistently ranked as the most prevalent cause of insanity among women throughout the ten years under study here. In some cases, Doherty's reasons for suspecting hereditarian insanity are entirely obscure, as there are no indications in the family histories he compiled or in committal forms of any previous family member's madness.

Even in cases where committal forms or diagnostic interviews uncovered an insane ancestor, most committal agents came to different conclusions on the origins of mental illness. Husbands, fathers, brothers and policemen continued to identify women's reproductive functions as primary causes of insanity. Some families traced the origins of a woman's long-standing mental illness to the birth of child years earlier. For instance, Annie M's father (#628, 3582) traced existing difficulties to "womb trouble, since the birth of her child six years ago." Others noted that it was the strain of labour that caused mental derangement, commenting on the length and nature of the birthing process. Mr B (#2048) explained that Meta's insanity was the result of her physical and nervous prostration at the time of delivery and Elizabeth G's husband (#3789) cited her sixty-one hour labour as the source of his wife's nervous collapse.

Non-family committal agents also blamed pregnancy for female insanity. When a native woman named Tilly(#3601) was found in allegedly "the worst hovel in Vancouver", covered in blood and seven months pregnant, a constable who found her immediately attributed her derangement to pregnancy. Despite a diagnosis of imbecility which would suggest a more congenital basis and a host of environmental factors such as abject poverty and her husband's desertion, Vancouver General Hospital's examining physician concurred and submitted pregnancy as the root of Tilly's mental disorder.

Next to conditions associated with childbirth, menopause was another prevalent cause cited by male family committal agents. Margaret C's ten year mental illness (#1505, 2232) was brought on by "the change of life" or so her husband believed. Catherine S's spouse (#3272) wrote that she was copying her mother by becoming insane at menopause. He stated that her

first attack came during her last menstrual period over a year before, but also noted that Catherine was extremely upset by her daughter's death in childbirth. Despite such tragedy, he concluded that menopause was ultimately to blame for her paranoia.

To some fathers and husbands, menstruation itself, or the lack of it could cause insanity. Ida B's father (#1799) believed that the source of Ida's immodest and melancholic behaviour was the "onset of womanhood." Mr. H. noted that his wife Mary(#1794) had never menstruated during their entire 18 year marriage, attributing her repeated attacks of delusions and violence to this fact. Helena F's husband(#1536) speculated that his wife's mania was the result of "some female complaint" and wondered if an operation would cure her. Apparently, most men who committed women to the PHI viewed women's reproductive functions as potentially insanity-causing. Certainly many contemporary psychiatrists would have agreed.

Although by the turn of the twentieth century, heredity was seen as a predisposing factor in both male and female insanity, disorders of the female reproductive organs were considered significant 'exciting' factors in the onset of mental illness in women.<sup>28</sup> Such ideas were also current in British Columbia. Dr. Ernest Hall of the Burrard Sanitarium based his entire career on the notion that female insanity lay rooted in disordered reproductive organs and treated his patients with ovariectomies. Within British Columbia, he was an influential commentator on matters pertaining to mental illness. Local newspapers followed his career, noting when he travelled to Johns Hopkins for further training or when he published articles in medical journals.<sup>29</sup> Furthermore, five percent of my admission sample had already been treated by Hall. Clearly, if only through Hall's work and reputation, British Columbians encountered psychiatry's notion of reproductive causes of

female insanity. When these so-called 'scientific' explanations for women's insanity fitted neatly into popular notions of women's inherent weakness caused by their reproductive functions, the stage was set for their widespread acceptance.<sup>30</sup>

Not all men, however, concurred. Some turned inward and searched their own circumstances and the lives of their women for the root of insanity. In these cases, the most frequently cited environmental cause was domestic worry accompanied by overwork. Often this was associated with a husband's absence and isolation from extended family members. Mr. M, for instance, committed his wife, Margaret (#1784) when he returned home from a logging camp to find her depressed, delusional, and emaciated. He explained that she frequently overworked and was suffering the effects of isolation. Psychiatric literature admitted environmental factors, as well, but most alienists asserted that they were 'exciting' causes affecting only those with hereditarian predispositions for insanity.<sup>31</sup> The men who viewed these factors as essential to their wives' mental breakdowns, however, believed they were primary causes.

Women who committed women also disagreed with contemporary psychiatry's assessment of the causes of female insanity. More than any other group of committal agents, women attributed insanity to male desertion or brutality. For instance, the sister of Mary Ann F (#2825) and the female cousin of Sarah K (#1773) both ascribed their relatives' mental illness to spousal desertion. When Jean T. (#2592) tried to smother her one week old baby, her friend and nurse Amy Martin was very clear where the blame lay. Citing childbirth as only the third possible cause, Miss Martin contended that Jean's breakdown came from years of abuse at the hands of a drunken husband and the fatigue that arose from trying to care for four children

during her husband's frequent binges. The doctors who examined Jean disagreed, endorsing pregnancy as the only cause. The asylum admission books, in turn, stated that the cause was unknown.

Despite the fact that most decisions to commit women originated in the home, the committal process itself required medical and judicial corroboration. Although the judicial component of the process appears to have been primarily one of arbitrary assent, physicians were required by law to examine all asylum committals. It would appear, however, that general practitioners understood very little about what they observed in the cases they encountered. As a result, the certifying physicians were frequently unable to substantiate their diagnoses of insanity with anything more than subjective observations and non-scientific judgements. Their role was often more corroborative than interventive, as families and friends remained the primary decision-makers when admitting women to asylum. But the evidence gathered by general practitioners while certifying women as insane is important to historians because it belongs to an often undocumented area of medical ideology: the way that family physicians distinguished the mad woman from the sane.

The first stage of this process of examination and interrogation involved the description of how women communicated. Physicians were requested to record patients' words in the space provided on the Medical Certificate. Some women made this task easy for their doctors by speaking incessantly. Their incoherence and delusions were clear indications of mental breakdown and doctors confidently recorded these ramblings verbatim as evidence.<sup>32</sup> Similarly, vile or profane language, particularly that of a sexual nature, was seen as evidence of insanity.<sup>33</sup>

Just as often, however, physicians frequently found women who were

unable or unwilling to speak. Sometimes a woman knew what lay behind the doctor's interest and refused to answer him. For instance, examining physicians could find nothing odd about Florence W (#2427) but since her husband had threatened to send her to asylum if "she did not do better," they assumed that she understood why they were there and "watched herself carefully". In some instances, a language barrier prevented women from expressing themselves as in the cases of Julia(#3299) and Fanny S.(#2261), who were unable to understand or speak English. Others simply refused to communicate for reasons that remain known only to themselves.<sup>34</sup> It is impossible to discern whether muteness was indeed symptomatic of a particular mental disorder or whether women adopted it for some other reason, but the language used by physicians to describe their silence frequently implied conscious resistance. Physicians portrayed speechless women as "stubborn", "suspicious", "obstinate", "cunning" and "disobedient."<sup>35</sup> Non-compliance to medical authority by the insane was seen as one of the major reasons for advising asylum treatment, and when that behaviour was exhibited by women, it also became a major symptom of insanity.<sup>36</sup>

When faced with women who did not verbally exhibit signs of breakdown, certifying physicians based their diagnoses on a variety of observations about personal appearance and manner. Frequently physicians noted that a woman appeared slovenly, unkempt, flushed, or agitated.<sup>37</sup> Sometimes, physicians noted only that a woman had the appearance "of a person of unsound mind."<sup>38</sup> One doctor was quick to assert that his medical training allowed him to make such an assertion with authority. He wrote that Mary S.(#3670) "looked normal" but that his "medically trained eye could easily detect the insane eye." In still other instances, physicians found

no evidence of insanity, but proceeded with the committal process based on the testimony of relatives and other on-lookers. One Salmon Arm physician wrote: "Although I have personally not caught [the] patient in one of her 'bad spells' I am firmly convinced that all statements of [her] husband and neighbours are correct and true and that *treatment* in an asylum is the proper and only thing for [the] patient."<sup>39</sup> The physicians who certified Ivy F. (#3899) also noted that she spoke and behaved rationally in their presence but since she had admitted to "being paid for her immorality", they complied with her mother's wishes that she be sent to asylum since "moral perversion was clearly present." Accepted indications of insanity were sufficiently flexible to permit committal for a wide range of behaviour, even that which can only be described in retrospect as "immoral" or even merely annoying. In most cases, certifying physicians were called in to validate a decision that families had already made and realized that one visit did not necessarily qualify them to dispute that decision. In fact, given the often long history of deviant behaviour that preceded the committal decision, the weight accorded such testimony was probably understandable. Indeed, as patient records indicate, few families seem to have undertaken that decision lightly.

Certainly, the family was the source of the majority of female committals to the Provincial Hospital for the Insane during the period 1905-15. Few of the cases examined here indicate that the role of the family was entirely usurped by the mental institution, the state or the medical profession. Nor was the 'popular' view of mental illness dominated by psychiatry's theories. Contemporary alienists' notions of insanity and its causes interacted with the values and observations of the non-psychiatric

community to shape their decisions about disruptive individuals. And these decisions were most often made privately by the family, after sometimes lengthy attempts to contain the crisis of female insanity within the domestic sphere. In doing so, they employed visiting nurses, home confinement, travel, intermittent stays in voluntary institutions such as general hospitals and sanitariums, and frequently succeeded in putting off asylum committal for months, even years. Working-class, nuclear families did not often have access to the personal and financial resources needed to delay admission once women became extremely disruptive or destructive, so their women sometimes arrived at the asylum earlier in the course of their mental illness. Yet the crisis of female insanity for British Columbian families did not necessarily end with incarceration. As the next chapter will show few families simply abandoned their women to the PHI. By persistently pressing Doherty with their demands and concerns, they remained forces with which he had to reckon, thus diminishing his authority even within his own institution.

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<sup>1</sup> Community in this sense involves individuals such as friends, acquaintances and the police who were sometimes involved in committing women to the PHI.

<sup>2</sup>By lay community, I mean non-institutional and non-medical individuals

<sup>3</sup>Province of Ontario, Sessional Papers, Vol. 19, no. 24, 1861, cited by Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth Century Ontario Insane Asylum: The Case of Toronto." In Essays in the History of Canadian Medicine, ed. Wendy Mitchinson and Janice Dickin McGinnis (Toronto: McClelland and Stewart, 1988): 90.

<sup>4</sup>BCSP, 1906, ARMS, 1905; The term 'idiots' in this period meant, of course, the congenitally mentally disabled.

<sup>5</sup>Nancy Tomes, A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1882, (Cambridge: Cambridge University Press, 1984):105

<sup>6</sup>Ernest A. Hall, The Truth about Alcohol, (Victoria, B.C.: Free Lance Publishing Co., 1916), 8; see also "The Insane at Large," The Canada Lancet, vol XLII (7) (March, 1909): 481-2

<sup>7</sup>Wendy Mitchinson also found this to be the case in Ontario. Wendy Mitchinson, "Reasons for Committal," 102

<sup>8</sup>Charlotte MacKenzie has found this to be true among middle-class admissions at the

Tycehurst Asylum. See Charlotte MacKenzie, "Social factors in the admission, discharge and continuing stay of patients at Ticehurst Asylum, 1845-1917," in The Anatomy of Madness: Essays in the History of Psychiatry, vol 2. ed. W.F. Bynum, Roy Porter and Michael Shepherd, (London: Tavistock Publications, 1985): 147-173

<sup>9</sup>"Vancouver General Hospital Guidelines," PSC, GR 1330, b456, file 2095, BCARS

<sup>10</sup>Testimony of Charles Edward Doherty, "Inquisitions," 1913, British Columbia Attorney General, GR 1323, b2391, file 112, BCARS

<sup>11</sup>Cases #2288, 2478, 2570, 2678, "Patient Files," RR, G-87-024, BCARS

<sup>12</sup>British Columbia, Statutes of the Province of British Columbia, An Act to amend and consolidate the Law relating to Lunatic Asylums and the Care and Custody of the Insane, Chapter 17, (1897), 184,196-199

<sup>13</sup>Susan Johnston, who is working on female suicide in British Columbia, 1878-1918 has discovered 136 cases of female suicide investigated by coroners. Of these only five had been previously admitted to the PHI and a further 8 had received some form of hospital treatment for melacholia

<sup>14</sup>C.E. Doherty, "The Care of the Mentally Defective," "Royal Commission on Mental Hygiene," Provincial Secretary, GR 865, box, 1, file, 11, pgs 2,3,6, BCARS

<sup>15</sup>James Russell, quoted in Frank P. Northbury, "The Duty of the Community to Incipient Cases." Charities and the Commons, Vol. 15, (October 1905-March 1906): 210-11

<sup>16</sup>Northbury, "The Duty," Charities and the Commons, 211; Frederick Lyman Hills, "Psychiatry--Ancient, Medieval and Modern," Popular Science Monthly, Vol. 60 (November 1901-April 1902): 47; see also "The Care of the Insane in General Hospitals," in Notes and Comments, American Journal of Insanity, [hereafter AJI] vol 59, (October, 1902): 529-30; Stanley Abbott M.D. "A Few Remarks about Observation Wards and Hospitals," AJI, vol. 61, (October, 1904):211-221; Adolf Meyer, "Reception Hospitals, Psychopathic Wards and Psychopathic Hospitals," AJI, vol 54, (July 1907): 221-30; Campbell Meyers, "Neuropathic Wards in General Hospitals," AJI vol 65 (January, 1909): 533-540; H.P. Alan Montgomery, "Suggestions and Plans for Psychopathic wards, Pavillions and Hospitals for American Hospitals," AJI, vol 61 (July, 1904): 1-10. See also: Gerald N. Grob, Mental Illness and American Society, 1875-1940 (Princeton, N.J.: Princeton University Press, 1983), 129-142 and David J. Rothman, Conscience and Convenience: The Asylum and its Alternatives in Progressive America, (Boston: Little, Brown and Co., 1980): 302-375

<sup>17</sup>C.E. Doherty, "Diagnosis of Insanity by the General Practitioner and the Consequent Duties which Must Necessarily Devolve upon Him," paper presented to the British Columbia Medical Association, Annual Meeting, held in New Westminster, British Columbia on August 1-2, 1906, reprinted in BCSP, 1910, ARMS, 1909

<sup>18</sup>Nancy Tomes has found this as well among families that sent patients to the Pennsylvania Hospital for the Insane. Nancy Tomes, A Generous Confidence, 103

<sup>19</sup>Of course, the absence of extended family also resulted in the formation of non-kin community networks among women and between families. In cases where this did not work because of geographic or social isolation, the spousal relationship became even more important. See Carrol Smith-Rosenberg, Disorderly Conduct: Visions of Gender in Victorian America (New York: Alfred Knopf, 1985): 34

<sup>20</sup>Terry L. Chapman "Women, Sex and Marriage in Western Canada, 1890-1920, Alberta History, vol. 33 (August, 1985): 5-7; prostitution was also circumscribed by municipal authorities to exist within Vancouver's Chinatown, thus perpetuating the popular links

between 'white slavery' and the Chinese community; see Deborah Nilson "The 'Social Evil': Prostitution in Vancouver, 1900-1920" in In Her Own Right: Selected Essays on Women's History in B.C. ed. Barbara Latham and Cathy Kess (Victoria: Camosun College, 1980): 210-11

<sup>21</sup> On the importance of religion in women's lives see Margaret Conrad "'Sundays Always Make Me Think of Home': Time and Place in Canadian Women's History," in Rethinking Canada: The Promise of Women's History eds. Anita Clair Fellman, Veronica Strong-Boag, (Toronto: Copp Clark Putnam, Ltd., 1986): 73,77; Medical views of women's deviancy emphasized physiological retribution in ways that were similar to religious sanctions against such behaviour. Carroll Smith-Rosenberg Disorderly Conduct: Visions of Gender in Victorian America, (New York: Alfred A. Knopf, 1985): 25; Wendy Mitchinson also found these kinds of delusions among her patient population "Reasons for Committal," 102; for an instance where the church judged a woman's deviant and insane behaviour to also be sinful see the case of Ethel F; Charles to Millie Hayward, "Correspondence," 18 Jan., 1913, Charles Hayward Family Records, Additional Manuscript 503, vol. 9, BCARS

<sup>22</sup> Charles to Millie Hayward, "Correspondence," 18 Jan, 1913, 22 Feb, 1913, Charles Hayward Family Records, Additional Manuscript 503, vol. 9, BCARS

<sup>23</sup> For instance Rosa J. worked around the home and her father's nursery until her withdrawal from family members prompted her parents to commit her despite the fact that she was described as "backward since childhood." Case # 1569, 1768, "Patient files." RR, G 87-024, BCARS

<sup>24</sup> See for example family letters to Doherty in the cases of Edith L., #1938, and Meta B. #2048, "Patient files," RR, G 87-024, BCARS.

<sup>25</sup> British Columbia, An Act to amend, 185

<sup>26</sup> Brower and Bannister claimed that forty per cent of all the insane had family histories of it, if all the facts were known. Daniel R. Brower and Henry M. Bannister, A Practical Manual of Insanity for the Medical Student and General Practitioner (Philadelphia and London: W.B. Saunders and Co., 1902), 19

<sup>27</sup> BCSP 1907, ARMS, 1906

<sup>28</sup> For an overview of these ideas in Canada see Wendy Mitchinson, "Hysteria and Insanity in Women: A Nineteenth-Century Perspective," Journal of Canadian Studies, 21 (3): 87-105; Mitchinson, "Causes of Disease in Women: The Case of Late Nineteenth-Century English Canada," in Charles Roland ed. Health, Disease and Medicine: Essays in Canadian History (Toronto: Hannah Institute, 1984): 381-95; Mitchinson, "Gender and Insanity as Characteristics of the Insane: Nineteenth-Century Study," Canadian Bulletin of Medical History, 4 (1987): 99-117; see also S.E.D. Shortt, Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth Century Psychiatry. (New York: Cambridge University Press, 1987); Rainer Baehre, "Victorian Psychiatry and Canadian Motherhood," Canadian Women's Studies, 2 (1980): 44-6; see also Sara Delamont and Lorna Duffin, eds. The Nineteenth Century Woman: Her Cultural and Physical World. (London: Croom Helm, 1978); Barbara Ehrenreich and Dierdre English, Complaints and Disorders: The Sexual Politics of Sickness. (Old Westbury New York: The Feminist Press, 1973); Elaine Showalter, The Female Malady: Women, Madness and English Culture, 1830-1980. (New York: Penguin Books, 1985); Some contemporary exponents of this were: Sir Thomas Clouston, Richard Krafft-Ebing, William Bevan Lewis, Henry Maudsley, Charles Mercier and George Savage among many others; see: Sir Thomas Smith Clouston, Clinical Lectures on Mental Diseases, 6th ed. (Philadelphia: Leas and Brothers and Co.,

1904); Clouston, "The Psychological Dangers to Women in Modern Social Development," in ed. Sir Oliver Lodge, The Position of Women: Actual and Ideal. (London: James Nisbet, 1911) 103-117; Richard Krafft-Ebing, A Text-book of Insanity, based on Clinical Observations, trans. by Charles Gilbert Chaddock (Philadelphia: F.A. Davis, 1905); William Bevan Lewis, A Text-book of Mental Diseases with Special Reference to the Pathological Aspects of Insanity. (London: C. Griffin and Co., 1899); Henry Maudsley, The Pathology of the Mind: A Study of Its Distempers, Deformities and Disorders. (London: Macmillan and Co., 1895); Charles Mercier, Sanity and Insanity. (London: Walter Scott, 1890); Mercier, A Text-book of Insanity. (London: Swan, Sonnenschein and Co., 1902); George Savage, Insanity and Allied Neuroses. (London: Cassell and Co., Ltd., 1886)

<sup>29</sup> For example, "Dr. Hall's Vacation," The Daily Colonist, 15 March 1899, 5; . Advertisement, Vancouver Daily Province, 19 January 1915, 11

<sup>30</sup> Mary Daly, Gyn/ecology: The Metaethics of Radical Feminism (Boston: Beacon Press, 1978) 234-40; Sara Delamont and Lorna Duffin, "Introduction" to The Nineteenth Century Woman: Her Cultural and Physical World, eds. Sara Delamont and Lorna Duffin (London: Croom Helm, 1978):10-16; Carroll Smith-Rosenberg, Disorderly Conduct, 48-9, 196; see also Bram Dijkstra, Idols of Perversity: Fantasies of Feminine Evil in Fin-de-Siecle Culture. (New York: Oxford University Press, 1986)

<sup>31</sup> Brower and Bannister, A Practical Manual, 29-37, George H. Savage, Insanity, 34, 35, 49

<sup>32</sup> Cases #2346, 1615, 1766, 1569, 1768, 1988, 2048, "Patient files," RR, G 87-024, BCARS

<sup>33</sup> Cases # 1784, 1907, 2570, 2678, "Patient files," RR, G 87-024, BCARS

<sup>34</sup> see for examples: Cases #1704, 1782, 1536, 2088, 2261, 2383, 2384, 2451, 2650, 2727, 2932, 3034, 3038, "Patient files," RR, G 87-024, BCARS

<sup>35</sup> see for examples: Cases # 1808 , 2383 , 2863 , 2932 , 3034 , 3622, "Patient files," RR, G 87-024, BCARS

<sup>36</sup> George T. Faris, "The Management of Disturbed Mental Cases Prior to Commitment," Dominion Medical Monthly, 134; Daniel R. Brower & Henry M. Bannister, A Practical Manual, 102; Elaine Showalter has found that unco-operative women were frequently seen as profoundly psychotic and in need of strict discipline. see Elaine Showalter, The Female Malady, 154; Editorial writers for Dominion Medical Monthly questioned the British suffragettes sanity because of their rebelliousness against male authority and the adoption of the hunger strike as a prison tactic. See Comment from Month to Month, editorial, "Are the British militant suffragettes insane?" Dominion Medical Monthly, vol XL, (June, 1913): 205-6

<sup>37</sup> Cases: # 1784, 1799, 2131 , 1505, 2232, , 2383, 2384, 2825, "Patient files," RR, G 87-024, BCARS

<sup>38</sup> Cases # 3364, 3756, , 1766, 661, 790, 1803, 1907, 1536, 2088, 3383, "Patient files," RR, G 87-024, BCARS

<sup>39</sup> Case #2427, "Patient files," RR, G 87-024, BCARS

**Chapter 4**  
**Doctors, Patients and Families:**  
**The Internal Dynamics of the**  
**Provincial Hospital for the Insane.**

Most families sent women to the Provincial Hospital for the Insane because it seemed their only option. These people hoped that the asylum would succeed where they had failed and that their women would be returned to them with restored sanity. Others combined their hopes for cure with the fear that prolonged asylum stay would further damage their women's mental health and sought release at the first sign of improvement.<sup>1</sup> All felt that at least short-term asylum care was necessary.

Doherty agreed that his institution provided essential care, particularly for the temporarily mentally distressed. The treatment of female patients established a curative process that was to facilitate their re-entry into the outside world. But successful completion of this process required patient and family co-operation. Patients had to be both willing and able to conform to asylum discipline and kin were obliged to support the institutional staff in all matters. Such unanimity of purpose was not always forthcoming.

The superintendent recognized that his authority was incomplete even within the PHI. While some patients would still pass through the hospital, ultimately returning to the community as living testimonials to the asylum's efficacy, others' disorders remained resistant to cure. Some women were unwilling or unable to aid in their rehabilitation and defied efforts at controlling their behaviour. In these cases, patients made their unhappiness known to asylum personnel by disrupting the wards and complaining to their families.

Many families continued to be involved in the lives of women, pressing Doherty with concerns and demands in meaningful, if deferent ways. While Doherty was able to limit the effect that patient and familial complaints had on his reputation with the provincial government, such grievances did force him to justify his asylum practice to extra-institutional individuals. Family input, whether intended to redress perceived grievances or to improve a woman's individual care, had some impact within the asylum. As a result, the internal environment of the PHI emerges as a negotiated and conflictual space, determined as much by patient behaviour as by therapeutic goals. Certainly, it was "a life apart," in many ways, but seldom an existence completely isolated from the outer context of family and community.<sup>2</sup>

Between 1905 and 1915, fifty-eight percent of the women admitted to the PHI left within one year. For these women, a stay in the PHI was only one phase in their lives, one which frequently passed within a few months. Although the actual reason for their recoveries is as difficult to assess as the initial cause of the breakdowns, certainly asylum officials and many families believed that these women's restorations were evidence of the PHI's success. Whatever the reason, at some point in the course of their institutional lives, these women began to behave in ways that convinced asylum officials that they were improving. This 'curative process' began with patients' acceptance of the asylum as the fit place for them on account of their mental instability. They eventually rejected their delusions as false beliefs or unwarranted fears, and took renewed interest in the lives of their families and of the other patients around them. After being assessed as 'behaving and working well', they were released on probation to individuals, usually but not always family members, who agreed to provide adequate care and vigilance and to

report regularly to the medical superintendent for six months. If they showed no sign of relapse, women were then discharged in full. After probation, the patient's mental health was largely out of the hands of asylum staff.

To begin the 'curative process', the individual had to accept that she was sick and in need of treatment, trusting the asylum as the source of care and cure. Not surprisingly, some alienists wrote that gaining the patient's confidence was a necessary first step.<sup>3</sup> The PHI strove to ensure patient confidence right from the start by instructing nurses to give each newcomer special treatment. During the first week of confinement, for example, attendants on Ward G kept detailed notes on the sleeping patterns of new patients, recorded the exact nature of their diet as well as the time of elimination and watched their new charges for signs of suicidal or violent propensities. These practices were used to assess the patient's condition, but they were also designed to make the PHI seem more like a hospital from which cure and release were possible. Nurses were ordered to encourage patients to enter into the life of the ward, work and participate in amusements. Finally they were to ensure that inmates understood the rules of the ward and to make them feel "that they ha[d] come among friends."<sup>4</sup>

Although committal was often a very frightening experience, some women nevertheless accepted it.<sup>5</sup> Edith G. (#3789), for instance, told the nurses on Ward G that "since she was ill, she did not mind being in hospital." Women who exhibited a belief in their own ill-health were viewed by asylum officials as fitting into a 'sick role'. In these cases, insanity was seen a transitional phase and the prognosis for recovery was good.<sup>6</sup>

Having accepted the asylum, women who were eventually regarded as cured then began to assume an active part in the life of the ward, working

well, taking a renewed interest in their personal appearance and exhibiting efforts to behave properly. Helena F(#2088), Mary Anne B(#3343), Sarah K(#1758) and Mary H.(#1794) were all described as "working and behaving well" just prior to their release. Since work was seen as therapy in itself, the ability to engage happily in domestic labour suggested to officials not only that these women were regaining their sanity but also that occupational therapy was indeed efficacious. Matron, Maria Fillmore characterized a recovering female mental patient when she wrote of Agnes B. (#3722): "She is quiet, pleasing in her manner and is quite industrious."

But conforming to the asylum's routine, being resigned to confinement and working well formed only part of the curative process. Recovering patients were also expected to confront and ultimately dismiss their delusions. Doherty was particularly encouraged by Mary B.'s progress (#3179) when he wrote: "This morning while making rounds she spoke of her delusions and stated they they must have been imaginary and she is now very glad that she was committed to this institution." One month later she was discharged on probation to her husband. Such was the case, too, of Florence S. (#1536) who attributed her insanity to her study of theosophy.

Finally, asylum officials believed that a woman's recovery was nearly complete when she began to take an interest in family and in her fellow patients. Officials were particularly encouraged by women's interest in their children, especially since the threat of infanticide often played a crucial role in their families' decision to commit them in the first place.<sup>7</sup> Attention to fellow patients was further evidence of restored sanity. In 1913, Doherty reported that "it is very often the case the minute a patient shows signs of recovery, she very often takes interest in those around her and occupies herself to their advantage."<sup>8</sup> As a result, he noted it was asylum policy to

place suicidal patients in the care of convalescents who were instructed to watch over them.<sup>9</sup> A fully recovered patient communicated all these desirable characteristics.

But not all patients fully recovered. Psychiatrists recognized that there was a certain class of patients for whom treatment proved ineffectual.<sup>10</sup> While earlier alienists viewed chronicity as a challenge to their authority over mental illness, by the twentieth century, degenerationist theories placed the burden of blame for chronic insanity on patients and their kin rather than on the asylum environment or ineffective treatment.<sup>11</sup> Custodial care for chronic patients, while a source of psychiatric concern during the mid-nineteenth century eventually came to be regarded as acceptable, even profitable, in later decades.<sup>12</sup>

By the end of the nineteenth century, some psychiatrists began to see the economic benefits of housing a permanent population of highly-functioning chronic patients.<sup>13</sup> Eugenio Tanzi, an Italian alienist whom Doherty cited at length in his annual reports, described the contributions of permanent inmates:

It is the chronic, quiet, diligent patients, habituated to an automatic existence, who constitute the muscular system of an asylum. They are the instruments of order, financial profit, and salutary example to the other patients...When the 'Old Guard' of chronic patients is well represented, the general atmosphere of the asylum is healthier, and its credit balance larger, because the work of its inmates provides unlooked-for profits which lessen expenditure.<sup>14</sup>

Doherty found a similarly important work force among his permanent female residents. Between 1905 and 1915, 32% of the women admitted to the PHI stayed for an average eleven years, leaving the institution only through death. Like those patients who engaged in the curative process, many permanent residents conformed to the asylum routine, accepted their

impairment but showed little indication of any desire to leave.<sup>15</sup> Their work contributed to the financial health of the institution and they often became pseudo-staff members performing a variety of functions, including the care of other patients and even of administrators' children. Not surprisingly, psychiatrists, having foisted the responsibility for incurability onto the patients themselves, defended the custodial aspects of the asylum as not only acceptable in some instances but also as very profitable.<sup>16</sup>

Certainly, in the case of the PHI, female patient labour, most consistently performed by permanent inmates, reduced operating costs. Each year women patients sewed and mended thousands of articles of clothing and linen for use in the institution. In 1906, for instance, 2220 articles were made on the women's wards, 143 in the tailor shop, and 25,640 articles were mended on the wards. As well, 150,072 woman-hours were spent in the kitchen and, in the autumn of that year, 731 quarts of preserves and 67 bottles of raspberry vinegar and catsup were canned. By 1911, the work of predominantly female patients in the tailoring department saved the PHI \$5,914.52 in making and mending clothing for patients, linen and nurses' uniforms. The sewing and mending performed by female patients and attendants was partly responsible for lowering the per capita cost of clothing asylum inmates and employees to \$5.16 in 1906, the lowest since 1892.<sup>17</sup>

Female chronics also performed other functions within the asylum. Although the Doherty children had a nanny, the children of assistant physician James McKay, were cared for by a number of long-term residents. One such patient was Lizzie who cooked the children's meals and cleaned the McKay apartment.<sup>18</sup> Finally, women who stayed in the asylum for long periods also assisted in the care of other patients. Ivy F. (#3899) lived and

worked on B Ward after it was vacated by male chronics in 1913. There she assisted with ward work and was actively involved in nursing the more incapacitated patients.

Not all patients, whether perceived as curable or not, however, were either willing or able to adapt to asylum life. In fact, most women behaved at some point in their institutional lives in ways that were described as 'resistive'.<sup>19</sup> Such women refused to submit to the asylum's efforts at 'moral control'. Whether their resistance stemmed from insanity itself, or was a conscious effort to maintain some form of personal autonomy in a controlling environment, non-compliance reveals two interrelated elements. First, not all women were passive about either the diagnosis of insanity or incarceration. Second, patient resistance underscores the relationship between asylum practice and patient behaviour. For instance, despite the alleged importance of therapeutic control, it is clear that patient behaviour sometimes defied coercion and affected treatment at least as it was meted out on the wards. Women could disrupt the asylum routine by refusing to eat or sleep at the appointed times. Most often incarcerated against their will, women patients at the PHI were not surprisingly dissatisfied with treatment. The asylum staff had to respond to unhappiness that was exhibited either on the wards or through correspondence with their families or with other extra-institutional individuals. In these ways, some women maintained a modicum of control over their environment.<sup>20</sup>

Frequently these attempts began by disputing both the nature of their illness and the reasons for which they were committed.<sup>21</sup> While some women eventually accepted that they were both mentally ill and in need of asylum treatment, most began institutional lives by rejecting both notions. Most were described as having "little insight into the nature of their illness"

and others simply stated that they were not insane. Catherine S(#3272) vehemently denied her insanity, insisting that, in fact, she was the only sane person in the place, patients and staff included. Since these women believed that they were sane, and yet incarcerated, it was obvious to them that they were wrongfully confined. Mary L(#1653) told her father that her husband had spitefully confined her because she had told other people about his persistent beatings. Believing that they were unjustly institutionalized, women also persistently lobbied asylum officials for their release. .

Some inmates attempted to obtain release either by manipulating what they saw as asylum prerequisites for discharge or by trying to force officials to grant it by direct means. Ida B (#1799) told her father that she was writing to him only because Doherty said it would mean swift release. Others attempted to hide delusions assuming that if they did, they would be discharged sooner. Nurses were advised that "Symptoms and peculiarities are often manifested before attendants which the patient would carefully conceal in the presence of the doctor."<sup>22</sup> Patients who claimed no longer to experience hallucinations but who continued to behave improperly were believed to be liars. Doherty observed of Mary O (#3542) that, although "She states that she no longer hears voices talking to her... her behaviour would not lead one to believe that such had entirely disappeared."<sup>23</sup> In these cases women attempted to manipulate the asylum's perception of them in order to achieve discharge.

Other women used more direct strategies or attempted to escape. One form of manipulation that was particularly frightening to families was self-starvation. While many women would not eat for reasons that were clearly a result of delusions or more general mental incapacitation, others did so primarily to get their families to meet their needs and, less successfully, to

win concessions from asylum nurses and doctors. Edith F., for instance, refused to eat until her family removed her from the PHI. When her sisters arrived for a visit, unaware of the situation, they found her looking quite ill. They frantically promised that if she would take food and follow the doctor's orders they would not only bring her out of hospital but would allow her to accompany them on a tour of England. As a friend of the family noted, the sisters' promise "had an immediate and beneficial effect of breaking up the hunger strike and leading her to dress decently."<sup>24</sup> She was released six weeks later. In another instance, however, self-starvation was far less successful. When Mary O (#3542) ceased taking food she stated explicitly that this would force her father to remove her. She pledged not to take another bite of food until "it was served to her in freedom." In this case, however, Doherty forbade her father from visiting until Mary was more appropriately under control. Two days later, when preparations to forcibly feed her were made, Mary ate voluntarily. Although her efforts to obtain discharge did not cease during her entire three year stay, it was not until she contracted tuberculosis and her father agreed that she be transported to California to die, that Mary left the PHI.

Some women simply tried to leave the PHI on their own accord. There were no successful female escapes during this period, but that was more the result of the vigilance of nurses and police than for a lack of effort by women.<sup>25</sup> Some escapes were somewhat symbolic or at least profoundly ill-conceived as in the case of Edith G. (#3789) who was found with her legs and arms through the bars of a window stating that she wanted to get out but that the fresh air and sunshine on her legs was probably enough. Other women simply ran away every chance they got, whether while walking on the grounds or by bolting through doorways each time the passage was

made clear. In such instances, women were caught and either restrained or denied grounds privileges for a time.<sup>26</sup>

In the one instance where a woman actually made it off asylum grounds, other patients had helped her. On the night of 17 October, 1913 at 5:55 pm Lucy L. escaped. For some months, she had been denied a nightdress due to suicidal tendencies. On that evening, since she had complained of being cold, and had refrained from self-destructive tendencies, for some time, her nightdress was returned. Despite increased vigilance by ward nurses, by 6:00 pm it was apparent that Lucy had eluded them. They found the cleats supporting the front sash of a bathroom window removed and Lucy gone with a change of clothing and a supply of food. The police were notified, and at 9:15 St. Annes orphanage phoned to say that Lucy had arrived there looking for shelter.

Although Doherty's official report stated that both nurses had been in their own rooms, this was, in fact, not the case. At least one nurse had been in the bathroom washing another patient who appeared to become quite disturbed everytime the door opened. As this patient occupied her attendant, four other patients smuggled in Lucy's escape supplies. Although the nurses insisted that the escape was only possible with the cooperation of other patients, "[telling] each other when anyone was coming," Doherty reported that the nurses had neglected their duties, taking tea at the time.<sup>27</sup> The assistance of other patients was obviously crucial since Lucy's escape was the only one to be even momentarily successful. While such examples of inmate co-operation are rare in the case notes as were other such clearly articulated protests, less dramatic forms were quite common.

Patients used disruptive behaviour to affect their treatment on the ward. Women could anticipate increased nursing care by refusing to

participate in the ward routine. Margaret Jane V. (#3840) complained perpetually and in this way received nearly constant attention as nurses tried to quieten her by remaking her bed, replacing her pillows or changing her nightdress. Edith G.(#3789), Lizzie G.(#3695) and Ellen M(#3622) refused to eat unless nurses spoonfed them. Certainly inmates who tore their clothing or smeared feces on themselves received more attention than the more compliant, and some appear to have liked causing tumult. Ida B(#1799) for instance, was recorded as enjoying "mak[ing] herself as objectionable as possible to the nurses" by singing loudly and yelling "when she [did] not get her own way." Since some patients such as Ida were not restrained, at least initially, it may be that she was successful in getting 'her own way' when she misbehaved in annoying but not dangerous ways.

Still other women acted by writing to their families and others for release. In one case, a woman's presentation of her case was convincing and successful. Ivy F. (#3989) obtained release when she wrote Burnaby's Police Chief and gained his sympathy and co-operation. He forwarded her letter to Doherty, saying that he not only believed that she was cured but also that he knew that the F. family was planning to return to England. He underlined the section of Ivy's letter that he believed made the best case for her release. In her words, she realized that she:

caused a lot of trouble and worry to my mother but God knows I am sorrier than my heart can tell you. I am wiser and wiser every day and I understand what I have done in my past as been [sic] the wickest [sic] thing a girl can do but please help me. I have had a great punishment with being in this place and the greatest of all is that I was not allowed [sic] to see and kiss my brother for the last time before leaving for the front...my mother is not working the work was to [sic] hard for her and I am glad she gave it up but what can we do and who is there to earn money to keep us alive?

By appealing to wartime patriotism and exhibiting evidence that the PHI had, in fact, done its job well, Ivy got her release. The fact that her family planned to emigrate certainly helped matters. Still such cases of successful patient lobbying for release were extremely rare.

Many women informed relatives and others about what they regarded as the cruelty of their treatment. Catherine S. (#3272) begged her brother to see through the asylum's claims that she was insane and to come to her aid. Florence S. (#2906) wrote to Dr. Lyle Telford, complaining of ill-treatment at the asylum. Neither of these letters reached their intended recipients, because Doherty seized them as indicative of the women's mental ill-health. When such complaints did reach outside ears, as with Ivy's letter to the Burnaby police chief, Doherty was forced to justify his asylum practice, give in to patient demands or attempt to undermine their validity.

When women voiced their dissatisfaction to individuals outside the PHI, Doherty could refute their complaints simply by pointing out that the women were, after all, insane. When Ida B. (#1799) wrote to her father that she could not see how the asylum was helping her since she had nothing to do or read and had been placed with people who used foul language, he raised these concerns with Doherty. Mr. B. worried "I cannot believe my daughter is placed with such characters, without occupation and without literature. Therefore I ask you if I may be allowed. Is Ida telling the truth?" Doherty responded "I beg to state that I was very much surprised not at the fact that your daughter has made such statements...but because of the fact that you apparently put some belief in them." He went on to describe Ida's condition as one which not only prevented her from discerning truth from fabrication but also created a "desire to manufacture willful and malicious untruths." He then went on to assert that there was an

abundance of good reading material available to Ida. Nevertheless, Mr. B sent Ida a parcel of her favorite books with his next letter.

When unflattering patient portrayals of asylum life reached governmental ears, Doherty faced the possibility of a more serious lack of confidence. Still, the belief in degeneracy theory which Doherty shared with Provincial Secretary, Dr. Henry Esson Young enabled him to dismiss complaints. In 1908, Young wrote Doherty saying that he had heard that a patient named Bertha H. (#2288, 2478) claimed that she had had sexual relations with several of the PHI's male staff. Doherty responded that "I might say that Miss. H. presents a well-marked case of moral degeneracy, the most marked symptom of which is an inherent tendency to lie."<sup>28</sup> Notwithstanding Young's concern, Doherty's response appears to have placated him, because the incident went no further than a brief exchange of letters. Primarily because these women were deemed to be insane, their public complaints were largely ineffectual in undermining Doherty's psychiatric authority.

Despite Doherty's assertions that patient complaints were unfounded, some families sought to investigate and ameliorate their source. Other families never received the unhappy letters of their relatives. Even those families who remained suspicious of the PHI's reputation, had little choice of institutions if they could not care for their women at home. When families were convinced that their women were not receiving adequate or humane care, they were legally entitled to demand discharge. When the sisters of Helen H. (#3364) arrived to visit her shortly after her committal in 1913, they found her restrained in a camisole and severely bruised. When they questioned Helen about the bruises, she told them that the nurses had beat her. They demanded to see Doherty who told them that if they were

convinced that Helen was receiving brutal treatment then they had best remove her. Helen was discharged to her father on a Special Discharge stating that it was against the superintendent's wishes and advice.

The H. family then informed Provincial Secretary Young about what they saw as the horrendous conditions at the PHI. This time Young was alarmed and explained that he had recently received other demands for investigation.<sup>29</sup> On this occasion, Doherty was able to note that Helen had, in the meantime, been readmitted to the PHI by her family who found her impossible to handle. He went on to note that she appeared to have deteriorated physically, thus contradicting the H family's claim that she was better at home. Whatever the reason, such complaints did not lead to a formal investigation. Young did, however, inform Mrs. H that she need not fear that her previous dissatisfaction with the PHI and subsequent demands for an inquiry would adversely affect Helen's care or treatment on re-admission. To ensure that Doherty understood this to be the case, both Young and Mrs. H forwarded a copy of this letter to the PHI.

Despite Doherty's ability to quell these complaints before they resulted in investigations, such public expressions of dissatisfaction forced him to defend his practice to the government. As well, families such as Helen's were not entirely without power to affect the lives of their incarcerated women. Most families, however, chose remedies circumscribed by their deference to Doherty as a perceived expert in handling insanity. They pressed Doherty with their concerns and demands to assist them in coping on the outside and to release their women promptly. When these demands seemed reasonable and did not undermine his authority, Doherty frequently acquiesced. When he could not grant requests, families often yielded to his opinions and continued to solicit advice.

Most families committed women to the PHI because they had been unable to cure them. The decision to commit was often borne of desperation but also carried with it a measure of cautious hope that the asylum would help. Many sought to aid PHI physicians by suggesting specific forms of treatment of which they had heard or, in cases where the family resided outside of the province or country, by proposing that the woman be transferred to an appropriate facility nearer their home where they could be more involved in her treatment. When such suggestions were in line with asylum or provincial policy, or did not require too much extra effort, officials tended to comply. For instance, when Meta B's husband (#2048) requested that she be watched closely at 3 pm on the 10 November, 1914 because this was the seventh anniversary of her delusions, acting superintendent James McKay wrote back that he had done as requested but had observed nothing unusual. When six years earlier, Mr. B had suggested that Meta be given a full examination of her reproductive organs, Doherty complied and repaired a torn perineum. However, when Mr. B asked that Meta be given an ovariectomy, Doherty refused.<sup>30</sup> Mr. B. wrote that "he did not want to appear to be interfering" but hoped that surgery might allow them to "send a poor helpless woman home to her little family, [and] I hope no more children." Mr. B went on to request a second opinion from Dr. Ernest Hall, to which Doherty also consented, but when Meta died, her autopsy showed that her reproductive organs remained intact. Doherty was willing to go along with Mr. B's requests so long as they did not require action which contradicted Doherty's view of appropriate asylum therapeutics.

Similarly, when families asked that their women be deported home, so that they could provide care, Doherty was also obliging. The revised federal legislation of 1906 simplified the deportation of insane aliens but provincial

legislation and asylum policy prevented the release of inmates without someone willing to take responsibility for them for at least six months. Having a family who wanted to look after a patient in the country of their birth made deportation possible. This suited Doherty, since he believed that provinces should not be made to provide for those whom the federal immigration authorities should have kept out in the first place.<sup>31</sup> Thus when the family of Carrie S. (#1808) asked that she be sent to them in England, Doherty promptly began the necessary procedures. The S family wrote that although they had no complaints with the PIII's treatment, they nevertheless hoped that if she were in an English asylum, they would at least be able to visit and dispel her delusions. When Carrie arrived home two months later, their hopes were realized and she experienced a "speedy deliverance". As in the case of Ivy G (#3899), the possibility of emigration aided patients and families' in obtaining release.

Sometimes, families used the negative impact on them of a woman's incarceration to prompt the early release of someone whom asylum officials believed to be improving. Sarah K (#1758, 1990) was discharged before she was designated fully recovered because a friend in Chilliwack wrote that while Sarah's eldest daughter was caring for the younger children as best she could, her schooling would be disrupted if her mother did not return soon. Since Sarah had improved dramatically, Doherty agreed that caring for her family might work to further her recovery.

Not all families, however, used their influence to get women released. The father of Ida B. (#1799), for instance, reacted strongly to Doherty's suggestion that Ida would soon be sufficiently cured to be returned home. He wrote that he believed that the asylum's "discipline and restraint [were] the dam which h[eld] back the flood [of Ida's insanity]," and that Ida would

certainly become entirely immoral if she were released. His constant argument that Ida would never be recovered enough to maintain herself effectively delayed her release for six months until finally Ida's sister agreed to take charge of her.

Women whose husbands refused to sign their discharge papers experienced similar delays. Mary Anne V(#1871) improved considerably within the first three weeks at the PIII but when Doherty wrote her husband that he could come and take her out, he absolutely refused. He explained that he would be doing himself and his children an injustice by bringing Mary home and that, when she left, it was understood that she would not return. Doherty was appalled by this response, observing: "My idea of a husband's proper course in such a case and one that would be adopted by ninety nine white men out of a hundred, would be to take your wife home on trial, forgetting the past as excusable on account of your wife's mental derangement at the time." He also noted, however, that if Mr. V did not consider it his duty to do so, he had no means of compelling him. Mary Anne remained at the PIII for another five months until a friend finally agreed to the conditions of discharge.

Most families were, however, very anxious to have inmates resume the roles they had played as wives and mothers. Indeed the impact of even short-term confinement of mothers could be devastating. Husbands frequently asked Doherty for advice in how to deal with their children and pressed him with their fears about the future. The husband of Meta B(#2048) fretted over his ability to care for his children and told Doherty that he was often "overcome by his loneliness and the helplessness of his little ones." Most men, however, found combining childcare with regular or itinerant labour ultimately too burdensome, indeed impossible, and boarded

their children out.<sup>32</sup> Eliza M's husband(#1766) sent his children to boarding school and orphanages on the coast, but his inability to find employment there meant that he could only visit his family once or twice a year. Ultimately, he realized that his family could only be united if Eliza was discharged and three months before her death in 1910, he wrote that he was "still living in hopes of learning...that she [was] making some improvement towards recovery." As with many such men, his hopes were never realized.

The other major problem which husbands faced was the cost of their wives' stay in the PHI. Although it was a public institution, families were expected to pay what they could and were regularly billed. Most families, whatever their financial situation attempted to supply women with, at least, their own clothes.<sup>33</sup> Many others provided sporadic funds and those that could not often wrote that they found their debt humiliating. Eliza M's husband (#1766) wrote that he was "disagreeably surprised" by a bursar's bill of \$780.00 since he had already told asylum officials that the cost of boarding out his children left very little cash and he was already trying to pay the asylum all he could. The husbands of Florence W.(#2427) and Edith C(#2863) described similar circumstances, the latter pointing out that his wife's six month stay at the PHI had cost him a year's income.<sup>34</sup> Clearly, even a relatively short confinement resulted in extreme financial, emotional, and social strain on families.

The burden was that much greater for the relatives of women who became permanent inmates. The son of Mary Anne F(#2825) wrote in 1953 that he had spent the remainder of his childhood shunted from one foster home to the next. When the brother-in-law of Isabella G.(#3452) returned from WWI, he got the Department of Soldier's Re-establishment to find his brother's son. The child was living at a Nanaimo boarding school supported

by a charitable organization that hoped to gain the \$1500 which the boy would receive upon majority. He was shocked to discover that, since the Soldiers' pension plan had refused to contribute to Isabella's upkeep after her husband had been killed in France, that the PIII was also vying for the boy's inheritance.

While the effects of such family crises undoubtedly had their greatest impact on the children they involved, women who left the PHI were also faced with trying to pick up the pieces of broken relationships. The very few who left the institution after long stays experienced this most profoundly. When Mary S(#3670) left the PIII in 1930 after seventeen years, she immediately set about to search for her children. She found, however, that the twins to whom she had given birth just before her committal were dead and her other two sons had been adopted, their whereabouts withheld. When she returned home to Georgia, she wrote Maria Fillmore that "there [was] nothing left for her outside" and hoped to someday return to the PHI.<sup>3</sup> Mary's case is, of course, unique since most women who stayed at the PHI for more than five years never left the institution. But even those women who had stayed for only a matter of months faced similar strains upon leaving.

Some women were faced with re-assembling their families. On their way home, Helena F(#2088) and Mabel T.(#2346) both had to pick up infants from boarding homes. Others such as Edith C(#2863) returned to find precarious financial situations. During her six month stay, her husband had to re-finance their cherry orchard at Kaslo creating economic stresses until the loans could be repaid. Many more women returned home to care for the demanding needs of young infants and several other children, the very circumstances cited as causing their breakdowns. Not surprisingly, given

these predicaments, some were re-committed. Undoubtedly, some women were incapable of being cured in any permanent way while others experienced the stigma of mental illness, as their families watched them closely for signs of relapse. Once a family had incarcerated a woman, they showed a greater willingness to do so a second time. Seventeen percent of those women who were admitted to the PHH during this period, returned at least once more within the ten years under study. Twenty-eight per cent had been incarcerated previously either at the PHH or elsewhere. Such recidivism was due, in part, to the fact that some women had forms of mental illness that could be ameliorated but never entirely cured. For instance, though various family members tried to keep Josephine W. (#660, 890, 1550) at home, primarily it seemed to Doherty, because of the work she could be made to do, all eventually found her too hard to handle and admitted her three times in ten years. Others however, scrutinized their women closely for signs of relapse and with it promptly returned them. Mary Anne V's husband (#1198, 1871) re-committed her when she seemed to be "on the road to insanity [because] she would not content herself with her work and children". Similarly, when Annie K(#3494) refused to follow her husband to Butte Montana, he wrote McKay that he feared her refusal was a new sign of mental illness and wondered what his rights were *vis-à-vis* his children. The relative speed with which these men were willing to re-incarcerate their women suggests that they did not view the asylum as a particularly brutalizing place.<sup>35</sup> Indeed some families re-admitted their women because they believed that if the PHH could cure them once, it could do so again.

Some historians have argued that the one positive element of the renewed interest in the asylum was its re-emergence in the public eye as a

curative hospital.<sup>36</sup> Certainly Doherty's 'modernization' program was widely publicized and praised, and may have engendered confidence in the PHI. The extent to which this was actually the case is, of course, unclear, since we know nothing about those who chose not to use the asylum, but some families were pleased with the services the PHI provided and were willing to re-admit their women if the need arose. Rosa J's mother (#1569, 1768) thanked Doherty for "his special good treatment of her case," but within six months wrote that Rosa's dementia had re-appeared. Her confidence in the PHI unshaken, she re-admitted Rosa "hoping for the same success." Some women, themselves, appear to have believed that the PHI had benefitted them in some way during a previous stay and requested re-admission with the onset of a further attack. When Margaret Cooke(#1505,2232) became increasingly distraught over her foster daughter's proposed emigration, she specifically asked to go back. Clearly to some women and their families, the PHI served important functions and were willing to use it on more than one occasion.

Of course, not all the women and their families who used the PHI ever had to express their confidence in this way. Women who were released from the PHI as recovered stood as living testimonials to the institution's success over mental illness. One man was sufficiently impressed with the PHI's work with his friend Edith F. that he wrote his sister that "no one would suspect that she had once been under a cloud."<sup>37</sup> The husbands of Edith C.(#2863) and Mary Ann B(#3343) both thanked Doherty for restoring their wives' sanity. Elizabeth S.'s(#2131) husband reported to Doherty that she had arrived home safely, was eating and sleeping well, was cheerful and "much against her wishes ha[d] gained ten pounds." Obviously not all asylum stories had such happy endings but, when they did, all agreed that Doherty

and his institution were creditable.

In contrast, when cure did not happen or relapse occurred, the PHI was rarely blamed. Although Ida B's father (#1799) was relatively scathing in his commentary on his daughter's stay at the PHI, he still wondered whether Ida should return to the PHI, this time as a nurse.<sup>38</sup> Obviously, Doherty took a calculated risk when he released a woman from the PHI and, in some cases, his decision appears ill-advised. Still, when tragedy befell a recently released woman, Doherty could easily deflect criticism from himself and his institution to the woman herself for being unable to 'maintain' her cure or onto families who did not exert enough control or vigilance. He responded to Mr. B's comments by reminding him that Ida's mental instability was the result of heredity, thus excusing the PHI from failing to cure her and effectively casting aspersions on Mr. B's own mental constitution. Similarly when Janet Ann H committed suicide shortly after her discharge, Doherty blamed her daughters for not taking her directly home with them but rather placing her in the Salvation Army home without notifying its officials either of her recent decarceration or of her suicidal tendencies.<sup>39</sup> Clearly, in some instances, the women that the PHI treated did have difficulty coping with adversity. They may have seemed cured at the time of release, but maintenance of 'normalcy' or at least its appearance was not guaranteed. After Sarah K.'s husband (#1758, 1990) left her and her son lost his job, she made her third and ultimately successful suicide attempt, by drinking carbolic acid.<sup>40</sup>

In many cases, the PHI performed its function as stated, relieving mental illness where it could and providing safe custodial care for those it could not. Despite an emphasis on "control and restraint", the internal environment of the PHI and Doherty's practice as a whole, however, were

negotiated phenomena. Doherty certainly had the upper hand, particularly as far as the provincial government was concerned, but patients and families could make their needs and feelings known on the wards and in their correspondence. Through resistance and manipulation, female patients affected the level of care they received. Although the controlling nature of the asylum environment and Doherty's authority often ultimately prevailed, the PHI was, in Michael Macdonald's words, " a marketplace in which concepts of insanity were bartered and compromises between the expert knowledge of the physician and the lay knowledge of families and patients were struck."<sup>41</sup> As well, the external realities of family response further affected the lives of institutionalized women. Many relatives maintained contact with their women inside the PHI, and this interaction as well as that between asylum officials and kin had an undeniable impact on incarcerated women. Similarly, female institutionalization affected family life outside. The importance of the female familial role is underscored by the fact that many families simply could not survive without their women. When women were released from the institution, they had also to deal with the crises that their relatives had faced in their absence. These added strains, combined with a willingness on the part of the family to re-use the institution probably accounts, more than any feminine predisposition towards mental illness, for the high rate of recidivism among female patients. Thus, insanity emerges as a tripartite relationship: involving women, their doctors and their families.

<sup>1</sup>see for example the case # 2775 "Patient files" RR, G-87-024, BCARS.

<sup>2</sup>"a life apart" is Doherty's term--see BCSP, 1911, ARMS, 1910 ; Gerald Grob, S.E.D. Shortt and Nancy Tomes have all noted that the administrative and therapeutic control over the internal environment of asylums was mediated by the demands of patrons and the behaviour of patients. Gerald N. Grob, Mental Illness and American Society, 1875-1940 (Princeton, N.J.: Princeton University Press, 1983): 17 see also S.E.D. Shortt, Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry (New York: Cambridge University Press, 1986): 42-3; Nancy Tomes, A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883 (Cambridge: Cambridge University Press, 1984): 188-9, 263

<sup>3</sup>Tomes, A Generous Confidence, 213; "The Sick and the Mentally Defective," Charities and the Commons, vol. XV (October 1906-March 1906): 240-1; Daniel Brower and Henry M. Bannister, A Practical Manual of Insanity for the Medical Student and General Practitioner (Philadelphia and London: W.B. Saunders and Co., 1902): 84.

<sup>4</sup>Rules and Regulations to Employees of the Provincial Hospital for the Insane of British Columbia (Victoria: Richard Wolfenden, 1901): 29

<sup>5</sup>Some women obviously found committal to the asylum a frightening experience. Margaret C. (#1505) wept bitterly on the way to her room and Elizabeth G. (#3789) refused to associate with her fellow patients, hiding in corners for the first days of her confinement.

<sup>6</sup>For instance Doherty wrote to the husband of Sarah K (#1758) that her insight into her precarious mental condition and her understanding of her need for treatment coupled with the absence of a family predisposition to insanity gave her a good chance of recovery; Lawrence Ray has noted a similar phenomenon in his study of 'sick roles' and impaired identity models in asylum practice; see Lawrence J. Ray, "Models of Madness in Victorian Asylum Practice," European Journal of Sociology 22(2)(1981): 248.

<sup>7</sup>Nancy Tomes found this to be the case as well; see Tomes, A Generous Confidence, 216

<sup>8</sup>Evidence of Charles Edward Doherty, "Inquisitions," 1913, British Columbia Attorney General, GR 1323, b 2391, file 112, BCARS.

<sup>9</sup>Evidence of Charles Edward Doherty, "Inquisitions," 1913, British Columbia Attorney General, GR 1323, b 2391, file 112, BCARS.

<sup>10</sup>George Savage, Insanity and Allied Neuroses (London: Cassell and Co., Ltd., 1886): 222,

<sup>11</sup>Nancy Tomes, writing on the asylum practice of Thomas Storey Kirkbride an advocate of 'moral treatment' of an earlier era, categorizes chronic patients with those who resisted the asylum in other ways, indicating that failure to cure patients was seen as undermining the alienist's authority. By the late nineteenth century, psychiatrists took less responsibility for unrecoverable cases. Shortt writes that "Degeneration theory, in effect, lifted from the alienist the stigma of therapeutic defeat..."; S.E.D. Shortt, Victorian Lunacy, 103; see also Grob, Mental Illness, 39-40; Ray "Models of Madness", 257; Richard W. Fox, So Far Disordered in Mind: Insanity in California, 1870-1930 (Berkeley: University of California Press, 1978): 31; see also Andrew MacFarlane, "The Duty of the State to the Insane," The Popular Science Monthly vol XLIII, (May-October 1893): 750

<sup>12</sup>Ray, "Models of Madness," 258

<sup>13</sup>Savage, Insanity and Allied Neuroses, 221

<sup>14</sup>Eugenio Tanzi, A Textbook of Mental Diseases, trans. W. Ford Robertson and T.C. Mackenzie (New York: Rebman Co., 1909): 784

<sup>15</sup>In the case of chronic patients, the ability to work and behave well was not seen as indicative of release as in the case of patients perceived to be cured. Chronic patients while exhibiting some elements of the curative process often continued to be seen to be insane because they continued in their 'false beliefs', were co-operative but child-like or when released on weekend passes, lapsed into immoral, intemperate or otherwise dysfunctional behaviour. Ivy F. (3899) for example consistently ran away to Vancouver and returned to prostitution every time she was released to her mother for a weekend. As well, asylum doctors realized that conformity and good work habits in the asylum was not necessarily indicative of cure but rather of their ability to adapt to asylum life. John Walton makes this point in J.K. Walton, "Casting out and bringing back in Victorian England: pauper lunatics, 1840-70." in The Anatomy of Madness: Essays in the History of Psychiatry, vol 2. eds. W.F. Bynum, Roy Porter and Michael Shepherd, (London: Tavistock, 1986): 142. Creating an environment which closely approximates 'real life' within a mental institution in order that such adaptation is not counter-productive to cure remains an issue. See Nancy E. Malony, "Patterns of Psychiatric Patients' Perceptions of Hospitalization," (Ph.D. thesis: Simon Fraser University, 1986):16, 18.

<sup>16</sup>Mark Finnaine notes that while chronic patients were still viewed as disruptive to the curative asylum, they were also very important to the financial health of an institution. See Mark Finnaine, Insanity and the Insane in Post-Famine Ireland (London: Croom Helm; Totowa N.J.: Barnes and Noble, 1981): 188

<sup>17</sup>BCSP, 1907, ARMS, 1906, BCSP, 1912, ARMS, 1911

<sup>18</sup> Interview with Dorothy Kane, James McKay's daughter, Val Adolph, "Woodlands History," Audio Record, Tape 4172:1, BCARS; It is unclear whether Lizzie was paid for this work but at least one male patient was paid for acting as hall porter; Manchester to Henry Esson Young, 1 March 1904, PSC GR 1330, B4540, file 604, BCARS

<sup>19</sup> 78% of my sample were described as 'resistive' at least once in their institutional lives.

<sup>20</sup> Goffman and Brehm call this psychological reactance, in which patients attempt to demonstrate self-will through resistance to imposed prohibitions. They note that when 'reactance' fails, patients frequently adopt a strategy of compliance (or are forced into it). Since few female patients were able to maintain a level of resistance throughout their stays and either engaged in the curative process or became compliant chronic patients suggests that this theory may be true of them as well. See Erving Goffman, J.W. Brehm, A Theory of Psychological Reactance, (New York: Academic Press, 1966): 9

<sup>21</sup> As Nancy Tomes has pointed out, the psychiatrist-inmate relationship is unique within the medical profession because it is the only one in which the patient has a vested interest in refuting the doctor's diagnosis; Tomes, A Generous Confidence, 189

<sup>22</sup>Rules and Regulations, 34

<sup>23</sup> Mark Finnaine notes that patients who did not discuss their delusions were not perceived to be cured but merely resistant. It is, of course, possible that women like Mary really were **not** plagued with further delusions but because they refused to conform to asylum discipline were perceived to be feigning recovery. Without patient autobiographies it is impossible to really assess such situations; see Finnaine, Insane in Ireland, 186

<sup>24</sup> Charles to Millie Hayward, 01/13/13 Charles Hayward Family Correspondence, Additional Manuscript 503, vol.9, BCARS

<sup>25</sup> Nurses were to be fined a \$10 lost uniform fee for each successful escape. This was

equal to slightly less than half their monthly salary and probably gave them an increased incentive to prevent escapes.

<sup>26</sup>Cases # 1653, 3272, 3452, "Patients files," RR, G 87-024, BCARS

<sup>27</sup>"Attendant's report on Unusual Occurrences", Lucy L. #2299, RR, G-87-024, BCARS

<sup>28</sup>Doherty to Young, 27 November 1908, PSC, GR 1330, reel B 4547 file 3384, BCARS

<sup>29</sup>In these instances, Doherty noted that insanity was primarily an inherited condition and pointed out that the tone of these letters indicated that the parents were suffering from conditions of mental unsoundness. See Doherty to Young, 27 November 1908, PSC, GR 1330, B 4550, file 1246

<sup>30</sup>Doherty appears to have agreed that reproductive surgery was not a cure for insanity. This may have resulted simply because he entered psychiatry during a time when such treatment was passing out of vogue. Grob, Mental Illness, 122-3

<sup>31</sup>Doherty to Young, 10 June 1906, PSC, GR 1330, b 4544, file 1728, BCARS; W.D. Scott to Young, 9 July 1907, PSC, GR 542, box 12, file 4, BCARS

<sup>32</sup>Bettina Bradbury has pointed out a similar fragility among the families of the working poor in Eastern urban centres and discovered that boarding children out was a common strategy used by families during crises; see Bettina Bradbury, "The Fragmented Family: Family Strategies in the Face of Death, Illness, and Poverty, Montreal, 1860-1885," in Childhood and Family in Canadian History, ed. Joy Parr (Toronto: McClelland and Stewart, 1982): 109-128

<sup>33</sup>The asylum charged \$5/week for provincial patients; Knight to Young, Hospital Lettersbook, Records held by the Riverview Hospital Historical Society.

<sup>34</sup>The cost of staying at the PHH varied somewhat. Doherty attempted to get any money that the woman held on her own and oversaw the sale of any property she may have held or commandeered any money she may be left by a relative. For instance, the PHH received \$3,596.14 from the estate of Mildred W.'s uncle (#1988) for payment towards her thirteen year stay. Two years later, a further \$1100 was applied to her account.

<sup>35</sup>Constance McGovern has found this to be true among the working-class community of Harrisburg, Pennsylvania; See Constance McGovern, "The Community, the Hospital and the Working Class Patient: The Multiple Uses of the Asylum in Nineteenth Century America," Pennsylvania History, 54(1)(1987): 28; it could also be true that they sought to punish their women for deviant behaviour by re-committing them especially since the evidence suggests that the behavioural criteria for re-admission decreased in severity with each subsequent committal. Certainly, current ex-psychiatric patients find that they and their families begin to see every sign of dissatisfaction as symptomatic possibility and a threat of relapse. See Chamberlin, "Women's Oppression," in Women Look at Psychiatry, eds. Dorothy Smith, Sara Diamond (Vancouver: Press Gang Publishers, 1975): 43. Inferring these motives, however, may not grant due justice to the other factors stated in this chapter.

<sup>36</sup>Tomes, Generous Confidence, 233

<sup>37</sup>Charles to Millie Hayward, 11 April 1913, "Hayward Family Correspondence" Additional Manuscript 503, vol. 9, BCARS

<sup>38</sup>He wrote that "It seems cruel that a girl should be broken down in a 'charitable institution' and then cast out like a dead dog," but he was still convinced that Ida was on her way to a life of immorality which only the asylum could stop.

<sup>39</sup>Doherty to Deputy Attorney General, 13 December 1912, "Inquisitions", British Columbia Attorney General, GR 1323, reel b2082, file 10167-7-12

<sup>40</sup>Testimony of Charles Edward Doherty, "Inquisitions", 1913, GR 1323, reel b2392, file

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427, BCARS; Mark Finnaine found a similar variety of post-release outcomes among the Irish insane; See Finnaine, Insanity in Ireland, 169.

<sup>41</sup> Michael MacDonald "Madness, Suicide and the Computer." in Problems and Methods in the History of Medicine ed. Roy Porter and Andrew Wear. (London: Croom Helm, 1987):211.

The received wisdom on the nature of psychiatry in North America has been, until very recently, that asylums, alienists, and their ideology controlled how mental illness and its victims were seen and treated. This conclusion was shared by Whig, 'social control' and feminist historians despite the obvious differences in their perspectives. In part, this view was drawn from the fact that these historians generally relied on documents written by men and women with perceived authority on the subject of mental illness.

A similar conclusion would be drawn about the asylum practice of Charles Edward Doherty if similar sources were consulted about his work at the Provincial Hospital for the Insane between 1905 to 1915. This period would appear to have been one of unprecedented 'progress' in the care of the insane in British Columbia. From official documents, Doherty emerges as an alienist who had ultimate control over asylum services. This dominance arose both from his ability to curry favour with the provincial government and the local medical profession, and from his application of 'new' therapies which further consolidated his hegemony over public psychiatric services. By 1915, the Provincial Hospital for the Insane, if viewed only from the perspective of the official literature, seems to have become a 'modern', 'progressive' institution. The mentally ill were restored to sanity through pleasant farm labour in the open air, and were calmed by 'humane' hydrotherapy. As well, the PHI, according to its annual reports, contributed to a more scientific understanding of mental illness through laboratory tests and the planning and construction of a new model institution.

While this description of the PHI would be an accurate reflection of official sources, it does not tell us very much about the experience of the mentally ill in British Columbia. This glowing portrayal of the PHI is incomplete. The absence of women patients from the official view of the institution is striking. While male patients are described in examples of the ameliorative effects of hydrotherapy or the Colony farm, women are seldom mentioned at all. This is because women were excluded from the 'progressive' treatments of which Doherty and other observers were so proud. As a result, the treatment of women seemed uninteresting and unworthy of comment.

But beyond these official accounts lies a picture of asylum life in which the treatment of women is important. Recognizing that women's care was not 'progressing', it becomes clear that much of the asylum's life was not reflected in Doherty's reports. Women's experience of the PHI was affected by its modernization only in that programs for men took much of the attention of senior officials away from their wards. Instead, their treatment rested largely in the hands of nurses who sought to carry out 'moral control' therapy. The role of nurses and the lives of women inmates, though invisible in official accounts, is revealed when the focus of study is narrowed to the day-to-day functioning of the women's wards.

This focus is possible through the use of patient files. Despite the imperfections of these sources, they do offer information on the lives of women on the PHI's wards and the forms of treatment meted out there. It becomes clear that mechanical and chemical restraint were used, despite Doherty's claims to the contrary, and that ward transfers, single room confinement and denial of privileges functioned to discourage deviant behaviour. Thus patient files provide an account of asylum life that goes

beyond generalizations about the PIII and speaks more of psychiatric practice than propaganda.

This study also examined how asylum authority was mediated by patients and their families. First committal records reveal how relatives made the decision to admit women to the PIII. Frequently they delayed committal as long as possible and chose the asylum as a last resort. As well, it appears that they made this decision autonomously, seeking corroboration from physicians only after the choice to commit was made. Thus Doherty's attempts to urge physicians to admit insane patients were undermined by the continued control families had over the committal decision. The state or medical authorities intervened, in only a few cases where relatives were either absent, or had placed women under the care of non-kin individuals. Finally, committal forms show that the non-psychiatric community sustained its own views of insanity's causes. Although Doherty attempted to disseminate his views on the hereditarian origins of mental illness through the publication of his annual reports, these appear to have had little impact on the minds of the non-psychiatric community at large. Thus Doherty's influence over the insane, their families and their communities was limited to those actually resident within the PIII.

Once admitted to the asylum inmates lost much of their autonomy. Yet even there, women and their families maintained influence. Inmates could either comply with the asylum rules and routine and thereby gain release, or they could subvert that control by refusing to conform. Patients, then, could affect their treatment on the wards by being disruptive, refusing to eat or trying to escape. When profoundly dissatisfied, women could also write their kin and other non-institutional individuals, and force Doherty to justify his practice. Similarly, families could also influence asylum staff by

pressing them with their concerns and demands. In some instances, they were able to get women released before Doherty thought they were fully 'recovered'. Thus the internal environment of the PHI's women's wards emerges as a negotiated space where the demands of patients and families interacted with asylum practice and psychiatric authority. Here too, Doherty's control was incomplete.

This thesis has argued two points. First, that Doherty's work to 'modernize' the PHI did not advance women's treatment. It remained characterized as 'moral control', a therapeutic form which had been in use since the nineteenth century. Second, despite Doherty's emphasis on the efficacy of asylum control in curing mental illness, his influence was mediated by patient resistance and family input. This argument challenges the Whig interpretations of amateur studies of British Columbian psychiatry and questions the assertions made by social and gender control historians who argue that psychiatry was successful in enforcing behavioural conformity. Finally, this study contributes to the field of Canadian psychiatric history by focussing on a province that has not previously been examined by professional historians.

But does this thesis tell us anything about the lives of British Columbian girls and women? First, it underscores the importance of women's roles in the family. These women were not redundant.<sup>1</sup> Had they been so, husbands and fathers would not have sought to delay committal by employing alternate curative strategies, or by waiting until women's behaviour was no longer simply annoying but profoundly dangerous. Similarly, if women's roles were unimportant, men would not have been so anxious to have their women released. This point is made even clearer by examining the impact that female institutionalization had on families.

Without their women, many families simply dissolved. Children were boarded out to strangers and sometimes eventually adopted. Husbands wrote to Doherty of their grief and fears for the future. Sometimes the articulation of these fears, combined with a woman's mental improvement, encouraged Doherty to discharge a woman sooner than he would have otherwise. When women were not released, families faced perpetual instability.

Part of the reason that families simply could not cope without women undoubtedly rests, in part, with the migration experience.<sup>2</sup> Only 7.9% of the women admitted to the PIII between 1905 and 1915 had been born in British Columbia. Most had come from Great Britain, either arriving in the province directly or moving to the coast after living for short periods in other parts of Canada. A significant minority were born elsewhere in North America.<sup>3</sup> Since extended family migration was uncommon by this time, and since it appears from the letters of relatives that few had relocated in areas where kin already lived, the nuclear family was forced to be self-reliant.<sup>4</sup> As a result, the spousal relationship intensified and many families were incapable of handling the incapacitation of so crucial a member as the wife or mother. While infrastructural improvements may have facilitated family visiting during periods of crisis, these could not replace permanent extended family networks.<sup>5</sup>

The trauma of female insanity and incarceration were only two kinds of crises that could befall families in this period. By examining how communities and relatives handled these situations historians can begin to study how they coped with other circumstances brought on by economic, social and spatial dislocation<sup>6</sup>. Certainly, a study which focusses on a public institution will highlight those families with limited strategies. Further

research into those people who chose not to put mentally ill relatives in asylums will illuminate other tactics and the family decision-making that lay behind that choice. In doing so, institutions will be placed more firmly into their community contexts and the study of the insane will be brought out from behind asylum walls.

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<sup>1</sup> See for a contrast to my conclusions, Cheryl Krasnick Warsh, "The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and the Commitment of Women to the Private Asylum, 1883-1923," Historical Papers (1988): 145-167.

<sup>2</sup> Recent work on western families reveals that insanity was, in fact, a common experience among first generation migrants. See Lillian Schlissel, "Family on the Western Frontier," in Western Women: Their Land, Their Lives, ed. Lillian Schlissel, Vicki L. Ruiz and Janice Monk (Albuquerque: University of New Mexico Press, 1988):86-7. The reasons for this are unclear. Rosalinda Gonzalez, for instance, argues that mental illness was a result of community dislocation which resulted from economic disruption and spatial relocation. See Rosalinda Mendez Gonzalez, "Commentary," in Western Women, 99-106.

<sup>3</sup> 26.1% had been born in Canada and 10.8% had been born in the United States

<sup>4</sup> Bruce Elliott has noted that while chain migration predominated among Irish migrants both during emigration and internal migration, the coming of the railroad facilitated single family mobility even among this group. Bruce Elliott, Irish Migrants in the Canadas: A New Approach, (Kingston and Montreal: McGill-Queen's University Press, 1988): 185-191; see also Schlissel, "Family," 88

<sup>5</sup> Elliott, Irish Migrants, 191

<sup>6</sup> Bettina Bradbury's work is an example of study in this area. See Bettina Bradbury, "The Fragmented Family: Family Strategies in the Face of Death, Illness and Poverty, Montreal, 1860-1885," in Childhood and Family in Canadian History, ed. Joy Parr (Toronto: McClelland and Stewart Ltd., 1982): 109-128.

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