"The only place likely to do her any good": The Admission of Women to British Columbia's Provincial Hospital for the Insane*

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In the reminiscences of ex-psychiatric patients, the day they entered the hospital looms large. While their institutional lives may be blurred by the grinding routine of the wards and the somnambulism of drug-induced states, the circumstances of committal stand out in vivid memory.[1] As two recent writers described it, arriving at the mental hospital was, itself, a dizzying jolt:

> My mother called the police because she was so out of herself she didn't understand what was going on. She brought the police into it... It was an eighteenth-century horror show. All the doors were locked ... Just the shock of it brought me somewhat to my senses ...[2]
>
> When we arrived at the [mental hospital] ... Dr. Blau said "Rosette, dear, one day you will thank me for bringing you here ..." But then I thought, in sudden shock, I am really [to be] shut up in an asylum ... do they actually think I am insane?[3]

Given the significance of committal to those who have lived it, the circumstances surrounding it deserve attention and understanding. Yet in spite of an expansion in psychiatric history over the past twenty years, only a handful of scholars have examined how this process worked in the past.[4]

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1 See for example, Persimmon Blackbridge and Sheila Gilhooly, *still sane* (Vancouver: Press Gang Publishers, 1985); "It was an Eighteenth Century Horror Show," as told to Marsha Enomoto, in Sara Diamond, and Dorothy Smith, eds., *Women Look at Psychiatry* (Vancouver: Press Gang, 1975): 47-52; Judi Chamberlain "Struggling to be Born," *Women Look*, 53-58; Clifford Beers, *A Mind that Found Itself* (Garden City: Doubleday and Co., 1907); Lucy Freeman, *Too Deep for Tears* (New York: Hawthorne and Dutton Press, 1980).

2 "It was an Eighteenth Century Horror Show," 48.

3 Lucy Freeman, *Too Deep For Tears*, 144-45.

4 Mark Finnaine, "Asylums, Families and the State," *History Workshop Journal* 20 (1985): 134-48; J. Walton, "Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50," *Journal of Social History* 13 (Fall 1979): 1-22; Charlotte MacKenzie, "Social Factors in the Admission, Discharge and Continuing Stay of Patients at Ticehurst Asylum, 1845-1917," in W. F. Bynum, Roy Porter and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry*,

Instead, much of the work on the history of "insanity" has defined the world of the mad by the walls of the asylum. Whether using the prescriptive literature of medical journals, the theories of prominent psychiatrists or institutional case files, historians have seldom been able to extend their studies beyond the confines of psychiatric thought and practice. For the most part this emphasis has resulted from the kinds of sources available to historians and the ways in which they have been used. Psychiatric literature was designed to advance and defend hypotheses about the nature and cause of insanity, to establish standards of care and to disseminate acquired "knowledge" to interested practitioners and policy makers. Institutional records were equally self-serving, concerned as they were with observation, diagnosis, treatment, and success. Yet there are glimpses of the insane in these sources which can be used to understand their experience outside the mental institution. When examining these sources, we are reminded that psychiatrists did not have control over all of the insane, nor were they able to exert authority over their patients at all stages of mental illness. The events leading to admission, for instance, remained largely out of their hands. So too was the perception of mental illness by the non-psychiatric community.

The lives of the "insane"[5] before intervention and the ways in which they were viewed outside of the asylum will be examined here using the institutional records of the 586 women who were committed to British Columbia's Provincial Hospital for the Insane [PHI] from 1905 to 1915.[6] Female committal will be studied from the perspective of asylum officials, the family, the community, and local doctors. 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 responses. Instead, institutional commitment papers show the relationships between

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vol. 2 (London: Tavistock Publications, 1985), 147-73; Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (New York: Cambridge University Press, 1984); Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth Century Ontario Insane Asylum: The Case of Toronto," in Wendy Mitchinson and Janice Dickin McGinnis, eds., *Essays in the History of Canadian Medicine* (Toronto: McClelland & Stewart, 1988); 88-109.

[5] No attempt will be made here to conduct psychiatric autopsies on the women committed to asylum. It will be accepted that these women were deemed "insane" by the cultural, social, and medical standards of the time.

[6] Three sampling techniques were used to study the patient files of the Provincial Hospital for the Insane. First, all records contained in the admission books were coded and cross referenced by computer. Second, a random sampling of male and female patients was taken, primarily to determine gender difference in treatment. Finally, a 10 per cent sampling of all women patients files was taken to facilitate a qualitative study of their contents.

the non-psychiatric community and the insane, illuminating the ways in which families came to use the mental hospital to contain conflict and socially unacceptable behaviour. Further, these documents reveal the attitudes of the lay community and family physicians towards the female insane, as well as the nature of mental illness and its causes.[7] By highlighting these attitudes, committal records reveal the extent to which popular beliefs about mental illness reflected or deviated from professional ideas.

Women were chosen as the focus of this case study for two reasons. First, scholars have argued that the asylum reforms of the mid-nineteenth century coupled with the growing belief in women's natural proclivity to insanity favoured the institutionalization of women so that women outnumbered men in asylum admissions well into the twentieth century.[8] Studies of asylums in Canada have confirmed this view, finding that women were over-represented in inmate populations.[9] This was not the case in British Columbia. Here women were underrepresented (see table 1).

TABLE 1

Asylum Admissions by Gender and Marital Status Compared to Total British Columbia Population[10]

	B.C. population 1911		*PHI admissions 1911*		*PHI admissions 1905-1915*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Men:						
Single	160,218	40.8	158	42.1	1,093	47.1
Married	83,096	21.2	75	20.0	463	19.9
Widowed	4,079	1.0	8	2.1	38	1.6
Divorced	215	.6	1	.3	2	.1
Unknown	4,011	1.0	5	1.3	135	5.8
Total	251,619	64.1	274	73.1	1,763	74.7
Women:						
Single	71,585	18.2	33	8.8	156	6.7
Married	61,359	15.6	63	16.8	390	16.9
Widowed	178	1.6	5	1.3	38	1.0
Divorced	156	.04	0	.0	1	.04
Unknown	1,583	.4	0	.0	15	.6
Total	140,861	35.9	101	26.9	586	25.3

[7] By lay community, I mean non-institutional and non-medical individuals.

[8] Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Penguin Books, 1985), 51-73, 121-44; Phyllis Chesler, *Women and Madness* (New York: Avon Book, 1972); 32-48.

[9] S. E. D. Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth Century Psychiatry* (New York: Cambridge University Press, 1986), 53;

Secondly, while historians studying eastern Canadian private institutions have found that social redundancy was a major factor in the admission of women, at the PHI single, widowed, or deserted women comprised only 23 per cent of all women entering asylum in this period (see table 2). When the definition of social redundancy is narrowed to include only those women who were without means of support other than the good will of family or neighbours and who lacked a social role, the percentage drops to 15 per cent.[11] Contrasting this figure with the 53 per cent found to be the proportion of socially superfluous women sent to a private institution in Ontario, social redundancy appears to have been less a factor in British Columbia than in more established societies in the east.[12] Thus the case of British Columbian women provides a unique case deserving of particular attention.

TABLE 2

Stage in Lifecycle at Time of Admission for Women Entering the PHI, 1905-1915[13]

Lifecycle stage	*No.*	*%*
Young, single, not living at parental home	3	4.6
Young, single, living at parental home	8	12.3
Young, married, without children	3	4.6
Married, with infant (under age 1)	17	26.2
Married, with children (ages 2-13)	16	26.2
Single, menopausal	2	3.1
Married with adult children	9	13.8
Elderly with spouse	5	7.7
Widowed	2	3.0

Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal and Kingston: McGill-Queen's University Press, 1989), 78-79.

[10] Canada, *The Fifth Census of Canada*, vol. 1 (Ottawa: C. H. Parmelee, Printer to the King's Most Excellent Majesty, 1912): 512-13; "Admission Books," Riverview Records [hereafter RR]. Volumes 10-13. Government Record [hereafter GR] 1754. British Columbia Archives and Records Service [hereafter BCARS].

[11] "Patient Files," RR, G-87-024. BCARS.

[12] Cheryl Krasnick Warsh, *Moments of Unreason*, 78-79.

[13] "Patient Files," RR G-87-024. BCARS. Ten Percent Sampling of all Female Admissions including Recidivists, 1905-1915.

The period under study corresponds to the tenure of Medical Superintendent Dr. Charles Edward Doherty at the Provincial Hospital. Doherty was praised at the time for his skilful administration of the institution and his ability to treat the insane through "moral control."[14] Yet, 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 asylum remained beyond his grasp, and 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. 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."[15]

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.[16] Not only was treatment too often delayed, it was often postponed indefinitely, and concerned physicians

[14] Doherty's tenure has been seen as an important and progressive turning point in the development of asylum services in British Columbia both by his contemporaries and historians. See 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, "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): 1050-59; 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); further, Doherty's role in improving the PHI was praised by the British Columbia Medical Association and the Canadian National Committee on Mental Hygiene. "Proceedings of Societies — BCMA," *Dominion Medical Monthly* XXXVII (Sept. 1906): 140-41; Canadian National Committee on Mental Hygiene to Henry Esson Young, n.d. "Correspondence," Provincial Secretary [hereafter PSC], GR 1665, box 6, file 2. Doherty described his therapeutic technique as "moral control" in his address to the BCMA in 1906. 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 *British Columbia Sessional Papers* (hereafter *BCSP*), 1909, Annual Report of the Medical Superintendent (hereafter ARMS), 1908.

[15] *BCSP*, 1906, ARMS, 1905.

[16] James Russell, cited in Frank P. Northbury, "The Duty of the Community to Incipient Cases," *Charities and The Commons* XV (October 1905-March 1906): 210-11; W. H. Hattie, *Dominion Medical Monthly and Ontario Medical Journal* XXVI (March, 1906): 117.

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."[17] Such claims, no doubt, were partly propaganda, designed to aid in the psychiatric profession's attempt to consolidate its position while recognizing the unfulfilled expectations of the asylum.[18] But they also show the anxiety of alienists over 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. As a group, they played a role in forming public perceptions of insanity, but they were unable to ensure that their view predominated. As individuals, they could encourage families to seek the service of the asylum 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 based on their own criteria, frequently independent of direct medical advice. Families decided what behaviour was "insane" and how that behaviour was best treated.[19] When they could afford it, they sought to delay asylum committal by seeking alternative treatments such as home care and extended travel. The needs of the working-class family, however, often prevented such strategies. The inability of labouring men to care for insane wives and children while maintaining sometimes itinerant employment meant that their women arrived at the asylum sooner in the course of their mental illnesses than did their middle-class counterparts.[20] In both

[17] 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* XLII (7) (March 1909): 481-82.

[18] Gerald Grob convincingly argues that in the late nineteenth and early twentieth centuries the psychiatric profession was undergoing an extreme crisis of faith. Surrounded by medical practitioners and scientists whose knowledge, technical skills, and social role were expanding, psychiatrists found themselves trapped in their own asylums, losing scientific ground to the pathologists and social relevance to the neurologists. Canadian psychiatrists felt similarly constrained and sought new institutional forms, techniques, and theories to renew their legitimacy. See Gerald N. Grob, *Mental Illness and American Society: 1875-1940* (Princeton, N.J.: Princeton University Press, 1983), 24, 30-31, 36, 39-43, 52-65, 108-43; 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.

[19] Cheryl Krasnick Warsh similarly finds the role of the family important, but attributes this, in part, to the financial exigencies of the private institution. Cheryl Krasnick Warsh, *Moments of Unreason*, 91.

[20] Wendy Mitchinson also found this to be the case in Ontario. Wendy Mitchinson, "Reasons for Committal," 102.

cases, 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 staff were called upon only as a last resort.

Some cases of medical or state intervention did occur. Although the bylaws of Vancouver General Hospital forbade the admission of "lunatic persons," some insane women did appear there and in other general hospitals.[21] But as Doherty knew, "general hospitals [were] anxious to get rid of insane patients," and so such individuals were promptly transferred to the Provincial Hospital.[22] Single women or women who came into conflict with the law were also placed promptly under asylum control. Women who were arrested for prostitution and who became extremely disruptive in their cells were transferred to the PHI.[23] But such cases were far outweighed by instances of family-generated committal.

Once the decision to commit 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 patients 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, Stipendiary 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 . . ."[24] 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. 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. For many it was also the first admission that their efforts to care for or cure a troubled female family member had failed. As much as it acknowledged defeat, committal

21 "Vancouver General Hospital Guidelines," PSC, GR 1330, b456, file 2095, BCARS.

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

23 Cases #2288, 2478, 2570, 2678, "Patient Files," Riverview Records [hereafter RR], G-87-024, BCARS.

24 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, 196-99.

also signified, in some instances, the hope that asylum treatment would succeed and that women would be returned to them cured. Once in the asylum, few families completely abandoned their women, and many were able to influence conditions and treatment from the outside.[25] Whatever the hopes of the family, the committal process was an important watershed in their lives and those of the women involved.

But as Ernest Hall and others pointed out, not all those perceived to be insane ever saw the inside of a mental institution. This was a major source of concern for psychiatrists because it revealed that their confidence in the profession's expertise was not widely shared by all echelons of society. There appeared to be a persistent prejudice against using the mental institution, and psychiatrists of the time insisted on finding out why. One of the sources of this prejudice, they concluded, was the stigma associated with committal.

Many concerned psychiatrists believed that the reluctance to seek asylum care shown by the families of prospective patients was the result of a committal process that 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?"[26] 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 formal institutionalization. As well, these wards promised voluntary admission so that if the mentally distressed could be convinced that treatment might ameliorate their condition they could simply check themselves into the hospital, as was the case with physical illnesses.[27]

[25] Mary-Ellen Kelm, "'Please Tell Emma that I have not forgotten her': Women, Families and the Provincial Hospital for the Insane, 1905-1915." Paper presented to the Western Canadian Studies Conference, 16-18 February 1990, Banff, Alberta.

[26] James Russell, quoted in Frank P. Northbury, "The Duty of the Community to Incipient Cases," *Charities and the Commons*, 15 (October 1905-March 1906): 210-11.

[27] Northbury, "The Duty," *Charities and the Commons*, 211; Frederick Lyman Hills, "Psychiatry — Ancient, Medieval and Modern," *Popular Science Monthly* 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*] 59 (October, 1902): 529-30; Stanley Abbott, M.D., "A Few Remarks about Observation Wards and Hospitals," *AJI* 61 (October 1904): 211-21; Adolf Meyer, "Reception Hospitals, Psychopathic Wards and Psychopathic Hospitals," *AJI* 54 (July 1907): 221-30; Campbell Meyers, "Neuropathic Wards in General Hospitals," *AJI* 65 (January 1909): 533-40; H. P. Alan Montgomery, "Suggestions and Plans for Psychopathic wards, Pavillons and Hospitals for American Hospitals," *AJI* 61 (July 1904): 1-10. See also: Gerald N. Grob, *Mental Illness and American Society*, 129-42 and David J. Rothman, *Conscience and Convenience: The Asylum and its Alternatives in Progressive America* (Boston: Little, Brown and Co., 1980): 302-75.

Doherty, himself, did not support the establishment of psychopathic wards, but he did agree that the PHI was not being used appropriately.[28] 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 such 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.[29] Yet apart from educating his fellow physicians, Doherty could do little to facilitate 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.

So the committal decision rested predominantly with individual families who, as psychiatrists feared, had their own ideas about when and under what circumstances relatives would be sent to the asylum. In making that decision, families considered the seriousness of the inappropriate behaviour exhibited as well as their own social and economic circumstances. In the case of the women who eventually entered the PHI, the appearance of delusional beliefs and hallucinations, outbreaks of violent, suicidal, or embarrassing behaviour were crucial factors leading to asylum admission. Yet these had to be combined with the families' acceptance that they could no

TABLE 3

Delusions: Female Admissions, 1905-1915[30]

Major Theme of Delusion	*No.*	*%*
Family violence and dissolution	25	46.3
Religion	11	20.4
Royalty	10	18.5
Gossip and persecution	8	14.8

[28] After his return from war service with the Canadian Medical Corps, Doherty was more enamoured of psychiatric wards. When he was consulted about the establishment of such a ward at Vancouver General Hospital and promised some control over how it would be run, Doherty became much more enthusiastic. *BCSP*, 1919, ARMS, 1918.

[29] 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 1-2 August 1906, reprinted in *BCSP*, 1910, ARMS, 1909.

[30] "Patient Files" RR G 87-024, BCARS.

longer care for these women in their present condition. In many instances, kin had endured periodic attacks of hallucinations or chronic dementia for years and only decided to use the asylum after alternatives or previously used care networks were exhausted.

Yet such circumstances seldom arose without warning. "Abnormal" behaviour was often presaged by delusional beliefs and hallucinations (see table 3). Nearly half of those mentioned in committal records involved male violence and family dissolution. For instance, Mary L. (#1653) was convinced that her husband attacked her each night while she slept and arose each morning to inspect her body for signs of these noctural beatings. 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.[31] Similarly, fears of male violence and "white slavery" all speak to real or perceived problems in turn-of-the-century British Columbia. As various American studies attest, domestic violence was neither uncommon or entirely invisible in early twentieth century communities. In Canada, women had little legal recourse when victimized by men and were extremely vulnerable.[32] In addition to real threats to their safety, British Columbia women shared in the collective paranoia which associated the Chinese community with the traffic in women.[33]

[31] 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.

[32] Linda Gordon, *Heroes of their own Lives: The politics and history of family violence, Boston, 1880-1920* (New York: Viking, 1988). In the American West, women who experienced spousal abuse might receive divorces with relative ease. Robert L. Griswold, "Anglo Women and Domestic Ideology in the American West in the Nineteenth and Early Twentieth Centuries," in Lillian Schlissel, Vicki L. Ruiz and Janice Monk, *Western Women: Their Land, Their Lives* (Albuquerque, New Mexico: University of New Mexico Press, 1988), 26-29; Glenda Riley, *The Female Frontier: A Comparative View of Women on the Prairie and the Plains* (Lawrence, Kansas: The University Press of Kansas, 1988), 21-22, 80-81, 96; Terry L. Chapman "Women, Sex and Marriage in Western Canada, 1890-1920," *Alberta History* 33 (August 1985): 5-7.

[33] 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.

Some of these concerns were coupled with anxieties about the damaging nature of other women's gossip. Augusta W.'s co-workers, and the subject of some of her suspicions, were all women, and like Sarah K., Florence W. (#2427) feared that neighbour women were conspiring against her, in this case spreading rumours about her eating habits, flirting with her husband, and poisoning her livestock. While historians have cited women's back-doorstep conversations as important ways of passing on community information and building female networks, some women's fears about gossip underscore its malicious potential as well. It would appear that these women were keenly aware that gossip constituted a form of social control in which women were the arbiters of community behaviour.[34] Whether focused on male violence, "white slavery," or women's gossip, some women expressed anxieties that were exaggerated. Nonetheless, these fears were rooted in the myths and realities of the time.

Religion and royalty were other 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, they 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 despondent 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.[35] Still, few families chose to commit women simply for expressing unreasonable fears or

[34] Susan Mann Trofimenkoff makes this point in her presidential address to the CHA. Canadian Historical Association. *Historical Papers* (1985): 7.

[35] 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*, ed. 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*, 25.

"strange" beliefs. When violent or self-destructive behaviour resulted, however, many families felt compelled to intervene.

When forced to act, middle-class and multi-generational families could use a number of strategies to delay committal. For instance, when Helen H. (#3364) became depressed after an attempted sexual assault, her middle-class family first tried to help her by sending her to the Burrard Sanitarium run by Dr. Ernest A. Hall.[36] 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 she began to wander and twice tried to kill herself, the H. family decided that it could delay no longer and sent her to the PHI. Similarly, the family of Margaret C. (#1505) tried to confine her at home after her mental breakdown. Though in this case, the family was not well-off financially, they were able to cope with Margaret's illness with the help of an adult daughter who still resided at home.[37] This situation began to break down, however, when Margaret struck her daughter during an escape attempt. Her husband then tried to spend more time with her until he too became the target of her attacks. Having exhausted their own facilities to care for Margaret, they 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 lethargic. 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 treated. Within two days Isabella was admitted to the Provincial Hospital for the Insane.

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 nineteen-year-old daughter Mildred (#1988) when she became incontinent and resisted home confinement. He noted that with a number of other children

[36] Hall's Sanitarium was used in a number of instances by families seeking to delay recourse to the Provincial Hospital. However, this alternative must have been prohibitively expensive to some families since it charged between $10 and $20 a week for accommodation and care. *Henderson's City of Vancouver Directory*, 662.

[37] Letters from Mr. C. to Doherty indicate that Mr. C. was an unemployed machinist. Case file # 1505, "Patient Files," RR, G87-024, BCARS.

to support, he could not afford to provide the care that she required, nor could he keep any of his older children at home to look after her. The exigencies of their financial situation required him to send Mildred to the PHI as a "public" or free patient. 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 the 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."[38] Others found inappropriate behaviour not only embarrassing but also dangerous, especially to young children. Helena F.'s husband (#1536) wrote that earlier attempts to treat his wife had failed and now he was obliged to hire a woman to look after his home and children. Yet he did not begin to consider sending her to asylum 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."

When the behaviour exhibited by women did not appear physically dangerous, privileged families could utilize yet another option: extended travel. The father of Mary O. (#3542) sought to relieve her persistent depression by taking her on a tour of the Pacific Coast. By the time they reached Victoria her behaviour had worsened and she was found informing fellow tourists that they were travelling as husband and wife. After a number of letters passed between Mr. O. and another daughter in California, they decided that the trip could proceed no further and that Mary had to be committed immediately.

Still, few families sent women to the asylum 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

[38] Charles to Millie Hayward, "Correspondence," 18 Jan. 1913, 22 Feb. 1913, Charles Hayward Family Records, Additional Manuscript 503, vol. 9, BCARS.

or family circumstances precipitated committal.[39] Finally, the extent to which families attempted to delay committal further corroborates that argument that, in British Columbia, the asylum was not used as a place to dump socially redundant women. 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.[40] 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.[41] 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 appeared mentally distressed while in hospital because of physical illness or when they had tried to commit suicide. Elizabeth S. (#3789) entered Royal Jubilee Hospital in a severely debilitated state following the birth of a child. When her physical condition began to improve without a corresponding lift in her spirits, the nurses there demanded that she be sent to the PHI. 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.

Finally, hospitals were reluctant to admit any patients for whom recovery was unlikely. Individuals who tried to use them as means to delay asylum committal for a family member frequently found their efforts thwarted. Richard K. had used a number of general hospitals to care for his chronically ill wife Emma (#1907) when his employment took him away from

[39] 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.

[40] 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.

[41] British Columbia, *An Act to amend*, 185.

home. As her illness worsened, many of these refused her re-admittance. Finally, when the last hospital that had been willing to offer him respite ordered him to find other accommodation for Emma in future, Richard was forced to send his wife to the PHI.

Women in conflict with the law were especially vulnerable to state-initiated psychiatric confinement. 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. Such behaviour warranted, in the eyes of examining doctors and the jailer, swift transfer to the PHI Similarly, Bertha H.'s bold assertions that she had had intercourse with a number of prominent Vancouver businessmen, coupled with a dishevelled appearance and disoriented manner, led police to jail and subsequently commit her on two occasions (#2288, 2478).

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, refused to work. The sisters sent her to the Provincial Hospital six months after the first seizure. Sara K. (#1773) also found herself without friends when her husband abandoned her in Vancouver during a supposed stopover on their way to South Africa. Left alone in a strange city, awkwardly with the relatives of her now disappeared husband, Sarah could not conceal her despondency and began to drink heavily. Within a few days of Mr. K.'s departure, Sarah's annoyed hosts sent her to the asylum.

Even when casual acquaintances were concerned for the safety and mental health of the women around them, they were often unable to help. Carrie S. (#1808) became profoundly depressed when she emigrated to Vancouver to work as a nurse and found that such employment was not readily available. Suffering from homesickness, worried about money, she became convinced that others believed she was immoral and on the path to prostitution. When a fellow boarding house resident became concerned that she was suicidal, he arranged for a local physician to examine her and together they decided that she belonged in a mental institution since she was without family to see her through an obviously difficult time.

Very few of the committal decisions made about women in this case study involved the kinds of criteria that psychiatrists considered to be important. Psychiatrists, physicians, and other advocates of asylum care argued that relatives should commit the insane both to ensure the best

chances for cure in the individual but also out of a sense of social responsibility. "Mistaken affection" was not to get in the way of psychiatric control.[42] Yet few committal agents cited either of these reasons as sole motivating factors in their decisions. Families frequently sought asylum admission not simply because women were clearly under mental duress and in need of psychiatric treatment, but because they could no longer cope with the kinds of behaviour exhibited without assistance. While many families hoped that the asylum would do some good for their female relatives, few saw it, in the first instance, as a preferred curative strategy. Most had tried to deal with female insanity privately, with their own resources, and turned to the institution when all else seemed to fail. Similarly, non-family committal agents seldom turned women over to the asylum merely out of regard for their mental health. Most, including police and nurses, were concerned that insane women would disrupt their own institutional environments and sought to remove them to a more appropriate place. Even concerned friends and acquaintances regarded the asylum as the place for those mentally disturbed persons who did not have access to other care-giving options. Clearly, despite the psychiatric profession's attempts to portray the asylum as a curative institution if used promptly, the broader community was not entirely convinced that this was so.

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 was not widely known or accepted among the non-psychiatric community. These lay conceptions of insanity were 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 maintained their own interpretations.

At the end of the nineteenth century, psychiatrists were concluding that insanity was an inherited condition. Yet asylum statistics seldom supported this view. Textbook authors Henry Bannister and Daniel Brower claimed that 40 per cent of all asylum admissions had family histories of insanity if all the facts could be ascertained.[43] But the PHI's doctors found that only 21 per cent of the women and 13 per cent of the men who crossed the threshold into that institution had forms of insanity attributable to heredity.[44] Fewer still were the cases where individuals saw themselves as bearing

[42] "The Insane at Large," *The Canada Lancet* XLII (7) (March 1909): 481-82.

[43] 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.

[44] "Admission Books," RR vols 10-13. GR 1754, BCARS.

the taint of lunacy in their family. Only 10 per cent of those admitting women to the PHI cited heredity as the cause and, significantly, all but one of these were husbands, and therefore not blood relatives.[45] Doherty expected this and argued that kin denial of ancestral lunacy was itself a symptom of insanity and proceeded to attribute most of his cases to "inferred" or "suspected" heredity.[46] Doherty's examination techniques included the compilation of a family history, and the committal forms were designed to elicit information about past incidents of insanity among relatives.[47] In some instances, an insane ancestor was discovered, but in most, there were no indications in any of the records of a lineage of mental illness.

Even in cases where a family history of insanity was known, most committal agents came to different conclusions about the origins of mental illness (see table 4). 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 cause cited by male family committal agents. Margaret C.'s ten-year

[45] "Patient Files," RR G 87-024, BCARS.

[46] *BCSP*, ARMS, 1906.

[47] Doherty followed the examination techniques outlined by Emil Kraeplin in *Lehrbuch der Psychiatrie*. Allen Ross Diefendorf. *Clinical Psychiatry: A Text-Book for Students and Physicians*, abstracted and adapted from the 7th German edition of Kraeplin's "Lehrbuch der Psychiatrie" (New York: Macmillan and Co., 1907), xxvi.

mental illness (#1505, 2232) was brought on by "the change of life" according to her husband. 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 eighteen-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, many men who committed women to the PHI viewed women's reproductive functions as potentially insanity-causing. Certainly some contemporary psychiatrists would have agreed.

TABLE 4

Causes of Insanity In Women Cited by Committal Agents[48]

Cause	*Male Committal Agent* No.	%	*Female Committal Agent* No.	%
Reproductive Functions:				
Menstruation	8	12.3	0	0
Pregnancy and childbirth	16	24.6	4	6.2
Menopause	6	9.2	1	1.5
Total reproductive functions	30	46.2	5	7.7
Environmental Causes:				
Domestic worry	3	4.6	0	0
Financial worry	3	4.6	1	1.5
Overwork	3	6.2	1	1.5
Male abuse and desertion	0	0	6	9.2
Other:				
Intemperance	3	4.6	0	0
Heredity	6	9.2	1	1.5
Unknown	2	3.0	1	1.5

[48] "Patient Files," RR, G 87-024, BCARS.

By the turn of the twentieth century, the role of malfunctioning reproductive organs in producing female insanity was no longer hotly debated in North America. The controversy which Richard Bucke faced over his gynecological treatment of women psychiatric patients was not an isolated incident, but the majority of professional opinion had turned against such surgical solutions.[49] Indeed, by 1916, one American psychiatrist noted that the opinion of his colleagues was that the belief in genital disorder-based insanity was a "superstition which needed to be lived down."[50] Yet practices associated with these theories continued. In British Columbia, Dr. Ernest Hall based his entire career on the notion that female insanity lay rooted in reproductive disorders and treated his patients with ovariotomies. Hall was well-known in Vancouver and Victoria and was an influential commentator on matters pertaining to mental illness, temperance, and social policy.[51] Local newspapers followed his career, noting when he travelled to Johns Hopkins for further training or when he published articles in medical journals.[52] Not only was Hall influential among élites, but his establishment, the Burrard Sanitarium, provided an alternative place of care for families with insane women. Five per cent of those women ended up at the PHI from 1905 to 1915 had already been patients at the Burrard Sanitarium. Clearly, at least some individuals accepted Hall's treatment as appropriate, and given the high incidence of reproductive causes cited by men in committal forms, some accepted his theories as well.

Discovering the reason for the persistence and popularity of these theories requires some speculation. Such ideas may have seemed applicable because they gave "scientific" sanction to widespread assumptions about women's inherent mental and physical weakness.[53] Male committal agents

[49] S. E. D. Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth Century Psychiatry* (New York: Cambridge University Press, 1986), 152-55.

[50] Gerald N. Grob, *Mental Illness and American Society, 1875-1940*, 123.

[51] E. A. Hall, "Gynecological Treatment in the Insane," *Canadian Practitioner* 33 (3) (1908): 147-51; idem. "Melancholia versus Ovarian Cystoma." *Canadian Lancet* 38 (10) (1905), 904-5; idem. "Experiences in the Treatment of Pelvic Diseases in the Female Insane," *Canada Lancet* 37 (3) (1903), 301-12; idem. "The Surgical Treatment of the Insane in Private Practice," *Dominion Medical Monthly* 12 (1) (1899), 1-18; idem. "Pelvic Disease and Insanity," *Canadian Medical Review* 8 (4) (1898), 105-14; idem. *The Truth About Alcohol* (Victoria, B.C.: Free Lance Publishing Co., 1916).

[52] For example, "Dr. Hall's Vacation," *The Daily Colonist*, 15 March 1899, 5; advertisement, *Vancouver Daily Province*, 19 January 1915, 11.

[53] 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*, ed. Sara Delamont and Lorna Duffin (London: Croom Helm, 1978), 10-16; Carroll Smith-Rosenberg,

observed that their women became insane precisely when their reproduction organs appeared to be asserting themselves either through pregnancy, menstruation, or menopause. To them, the alleged connection between reproduction and insanity seemed logical. The fact that they rooted this in biology rather than social circumstances or emotional or physical fatigue suggests that they fitted their observations into the framework of the existing social and medical ideology of sex difference. Alternatively, men might have found reproductive theories much more hopeful in outlook than hereditarian ones, since the former held out the possibility of treatment and recovery. For those men who wanted or needed their women returned to them, reproductive theories must have been attractive. That some prominent psychiatrists, including Doherty, viewed these notions as obsolete appears to have had little impact on the minds of these men.[54]

Others came to different conclusions. 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.[55] The men who viewed these factors as essential to their wives' mental breakdowns, however, believed they were primary causes.

Women who committed also disagreed with psychiatry's assessment of the causes of female insanity, citing neither heredity or reproduction. 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

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Disorderly Conduct, 48-49; 196; see also Bram Dijkstra, *Idols of Perversity: Fantasies of Feminine Evil in Fin-de-Siecle Culture* (New York: Oxford University Press, 1986).

[54] Doherty concurred with the position of his more prestigious central Canadian and eastern American counterparts in renouncing theories of reproductively based insanity. In two cases, Doherty refused to perform ovariotomies even when husbands requested them. Cases #2048 and 1536, "Patient files," *RR*, G87-024, BCARS.

[55] Brower and Bannister, *A Practical Manual*, 29-37, George H. Savage, *Insanity and Allied Neuroses* (London: Cassell and Co., Ltd., 1886): 34, 35, 49.

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.

While the family controlled the decision to commit, general practitioners were required by law to corroborate it.[56] It would appear, however, that these doctors 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. Still the evidence they gathered during the course of their examinations and the opinions they expressed in the process contributed to the popular and non-psychiatric ideology about female mental illness at the time.[57]

TABLE 5

Symptoms of Insanity Cited by Certifying Physicians[58]

Symptom	*No.*	*%*
Language:		
Incessant, incoherent speech	22	13.6
Abusive, profane language	10	6.2
Delusional speech	21	13.0
Silent	19	11.7
Total:	72	44.4
Appearance:		
Agitated	28	17.3
Untidy, incontinent, lethargic	30	18.5
Exhibitionistic	7	4.3
"Insane appearance"	25	15.4
Total:	90	55.5

[56] They were also paid, from Provincial Hospital accounts to do so, usually $10 per patient. See *BCSP* 1906-1916, "Public Accounts," 1905-1915.

[57] Further, this is one area of opinion which remains undocumented in the psychiatric historical literature.

[58] "Patient Files" RR, G 87-024, BCARS.

The first stage of this process of examination and interrogation involved the description of how women communicated (see table 5). 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 appeared to be clear indications of mental breakdown, and doctors confidently recorded these ramblings verbatim as evidence.[59] Similarly, vile or profane language, particularly that of a sexual nature, was seen as evidence of insanity.[60]

At other times, physicians 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 remained known only to themselves.[61] 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," "obstinate," "cunning," and "disobedient."[62] 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 was also interpreted as a symptom of insanity.[63]

[59] Cases #2346, 1615, 1766, 1569, 1768, 1988, 2048, "Patient files," RR, G 87-024, BCARS.

[60] Cases #1784, 1907, 2570, 2678, "Patient files," RR, G 87-024, BCARS.

[61] See for examples: Cases #1704, 1782, 1536, 2088, 2261, 2383, 2384, 2451, 2650, 3737, 2932, 3034, 3038, "Patient files," RR, G 87-024, BCARS.

[62] See for examples: Cases #1808, 2383, 2863, 2932, 3034, 3622, "Patient files," RR, G 87-024, BCARS.

[63] 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: Women, Madness and English Culture, 1830-1980* (New York: Penguin Books, 1985), 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* (June 1913): 205-06.

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 (see table 5). Frequently physicians noted that a woman appeared slovenly, unkempt, flushed, or agitated.[64] Sometimes, physicians noted only that a woman had the appearance "of a person of unsound mind."[65] 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."[66] 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. Still when women such as Hannah A. (#3389) and Florence W. (#2427) believed that their husbands and the doctors were conspiring against them, the willing corroboration of these physicians appeared to confirm such impressions. The absence of information from doctors who refused to certify women on the basis of family testimony prevents us from determining if physicians ever allied themselves with patients against families who were trying to wrongfully confine women. With the records that do exist, however, it appears that physicians seldom took an independent role in the deliberations of families on sending women to the Provincial Hospital.

[64] Cases #1784, 1799, 2131, 1505, 2232, 2383, 2384, 2825, "Patient files," RR, G 87-024, BCARS.

[65] Cases #3364, 3756, 1766, 661, 790, 1803, 1907, 1536, 2088, 3383, "Patient files," RR, G 87-024, BCARS.

[66] Case #2427, "Patient files," RR, G 87-024, BCARS.

Certainly the evidence suggests that 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 within the family, sometimes after lengthy attempts to contain the crisis of female insanity within the domestic sphere. In doing so, they employed visiting nurses, home confinement, travel, and 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 mental illness. In both cases, physicians seldom exerted much influence in the committal decision. Their corroborating testimony was used by families to validate these decisions because the law required it. The nature of the records used here does not permit a study of individuals who successfully resisted confinement in the pre-committal stages or whose families were able to avoid using the asylum indefinitely. Still the admission documents found in institutional case files do allow us a glimpse of the lives of the insane leading up to incarceration. Some light is cast on the context of the committal decision, a momentous event in the lives of psychiatric patients. And with insight into the extra-institutional lives of the insane, the study of mental illness is extended beyond the walls of the asylum.