

**Depression and The Depression:
An Analysis of the Patient Ledgers of the Saskatchewan Hospital
North Battleford from 1929 to 1939**

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Abstract

Studies of the Great Depression in Saskatchewan tend to focus on the unsurpassed poverty, unemployment and general suffering that characterize this period. Little research, however, has been conducted on how this suffering may have contributed to the increasing rates of committals in provincial mental hospitals throughout the 1930s. The Saskatchewan Hospital North Battleford (SHNB) not only experienced increasing populations, but serious overcrowding throughout the Depression era. The growth and overcrowding of SHNB demonstrates that Saskatchewan society utilized the hospital to fill their needs.

This thesis analyses the patient ledgers of SHNB to determine what role mental hospitals played in Saskatchewan society during the Depression. Whether concerned for relatives with perceived mental illness, or apprehensive of their deviant behaviour, families were often the primary actors in initiating committal. Once within the walls of SHNB, patient labour was utilized to ensure both the treatment of the insane and the survival of the hospital. Lastly, SHNB also played a role in shaping Canadian society through the deportation and incarceration of unwanted elements. Through an analysis of patient ledgers, it is clear that SHNB was part of a complex set of strategies used by families, hospital staff and society to both house the insane and deviant and to provide treatment in hopes of returning the deemed ill to sanity.

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Introduction

We must not wait...until a person has gone completely over the cliff into insanity and then send him or her to a mental hospital. We can all do a little preventative work by holding out the hand of friendship¹

-Violet McNaughton

The Great Depression of the 1930s represents a period of widespread poverty, where individuals and families struggled to survive. Rural families dealt with low commodity prices for wheat coupled with the environmental devastation of dust storms, droughts, and insect infestations. Towns and cities throughout the province experienced increasing unemployment and reliance on the municipality for relief. Transience was not only common for single men who rode the rails in search of work, but of the rural and urban families who thought they could succeed elsewhere. From 1931 to 1941, Saskatchewan was the only province to experience a drop in population, declining from 921,785 to 887,747. Violet MacNaughton, activist and editor of the “Mainly for Women” page of the Western Producer wondered whether the devastation that she had witnessed personally and through the lives of the women who wrote her letters would drive women to the mental asylum. Though the madhouse has always been a spectre for women on the brink, MacNaughton’s fear was not entirely unfounded.² Sociologist Harley Dickinson’s study of psychiatry in Saskatchewan shows that there was a sharp increase in the patient

¹ The Western Producer, 30 May 1935, 10 quoted in Christa L. Scowby, “‘Divine Discontent’: Women, Identity, and the Western Producer” (MA Thesis, University of Saskatchewan, 1996), 86-87.

² See Linda Rasmussen, Lorna Rasmussen, Candace Savage, and Anne Wheeler, eds., *A Harvest Yet to Reap*. (Toronto: Toronto Women’s Press, 1976), 22.; S. Leigh Matthews, *Looking Back: Canadian Women’s Prairie Memoirs and Intersections of Culture, History and Identity* (Calgary: University of Calgary Press, 2010), 177.

population of Saskatchewan's mental hospitals in 1922, and that this rise continued well into the 1930s.³

Saskatchewan's historiography has been mainly concerned with the homesteading period, as it is one of the hallmarks of Canadian prairie history. Historians have focused on the rigours of settlement, the famed sod house, settlement patterns among immigrant farmers, and on those who lost the 'prairie gamble.' The campaign for female suffrage and the rise of political activism on the prairies has attracted a significant amount of attention, covering the late 1910s, 1920s and 1930s, but seldom focusing on the cause for such involvement. In addition, western Canadian history is most often presented in anthologies; contributing articles are collected from throughout large regions such as 'western Canada' and 'the prairies,' while attempting to cover vast periods of time.⁴ Furthermore, throughout the early twentieth century, women are stereotyped as either "gentle tamers, sunbonneted helpmates, hell-raisers, [or] bad women," while men are condensed into being irrepressible farmers.⁵ The men and women who were committed to the Saskatchewan Hospital North Battleford (SHNB) during the 1930s represent an entirely different group of people. They are those who did not cope, for various reasons, and were committed to a mental hospital. The Depression was bleak for many families and individuals, but what happened when

³ Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: Canadian Plains Research Centre, University of Regina, 1989), 38.

⁴ Examples of historical work presented in anthologies include: *The Prairie West: Historical Readings*, eds. R. Douglas Francis and Howard Palmer (Edmonton: Pica Pica Press, 1992); *"Other Voices": Historical Essays on Saskatchewan Women*, eds. David De Brou and Aileen Moffatt (Regina: Canadian Plains Research Centre, 1995); *Unsettled Pasts: Reconceiving the West Through Women's History*, eds. Sarah Carter, et. al. (Calgary: University of Calgary Press, 2005), *Telling Tales: Essays in Western Women's History*, eds. Catherine A. Cavanaugh and Randi Warne (Vancouver: University of British Columbia Press, 2000). For anthologies with an international perspective, see: *The Women's West*, eds. Susan Armitage and Elizabeth Jameson (Norman, OK: University of Oklahoma Press, 1987); *Writing the Range: Race, Class and Culture in the Women's West*, eds. Susan Armitage and Elizabeth Jameson, eds. (Norman, OK: University of Oklahoma Press, 1997).

⁵ Joan M. Jensen and Darlis A. Miller. "The Gentle Tamers Revisited: New Approaches to the History of Women in the American West," *The Pacific Historical Review* 49 2 (May 1980): 178. An example of the "irrepressible farmer" is found in Sinclair Ross, "The Lamp at Noon," in *The Lamp at Noon and Other Stories* (Toronto: McClelland and Stewart, 1988), 7-17.

family members could not muddle through? From 1929 to 1939, 2474 men and 1582 women were admitted and readmitted into SHNB. These stories have not been told.

In order to understand the Saskatchewan Hospital North Battleford and the patients within its walls, mental illness has to be understood as a fluid term, influenced by medicine, science, society and more specifically, by the person or persons who initiated committal proceedings. How mental illness is defined determines the lens through which those deemed mentally ill are viewed. Mental illness as a social construction, influenced by gender, has been hotly debated by scholars. Elaine Showalter, in *the Female Malady*, argues from a fiercely feminist standpoint that suggests that women were deemed ill because of the perceived nature of the female body. Encapsulating the Victorian era to 1980, Showalter outlines the medical and societal connections that were made between mental illness and women in England. Seen as weak and mysterious, a woman's own body was her enemy. Puberty, menstruation, childbirth and menopause placed women in heightened hormonal states, placing them dangerously close to the edge of mental illness. Insanity, Showalter asserts, is the female malady. In an earlier article, Showalter wrote: "we learn from the study of Victorian women and insanity that definitions of both insanity and femininity are culturally constructed, and that the relationship between them must be considered within the cultural frame."⁶ Women were lambasted by medicine, non-conformists were treated as hysterics, unmarried women as a social problem, and post-menopausal women as sexless beings without purpose. Like Showalter, Canadian historian Wendy Mitchinson suggests that doctors saw the womb as the site of mental illness in the female body. They believed that "gynaecological disease could show up as symptoms elsewhere and, if

⁶ Elaine Showalter, "Victorian Women and Insanity," *Victorian Studies* 23 2 (Winter 1980): 179.

left untreated, [would] become the origin of disease in any part of the body.”⁷ Furthermore, “by focusing on the very part of the body that made women female, doctors deemed the poor health of women natural and something they could not escape.”⁸

The arguments of Showalter and Mitchinson are compelling. They both use powerful rhetoric, defended by extensive use of medical texts, journals and patient files, coupled with fictional novels, to flesh out their argument in the cultural milieu of the period. In recent years, however, historians have suggested that looking at mental illness as a socially defined female malady is an unbalanced and biased way of looking at women’s experience with mental illness. Sociologist Joan Busfield, one of the first to challenge mental illness as being a female malady, suggested that male stereotypes of insanity were equally represented in Victorian culture: masturbatory insanity, the mad genius, and the criminal lunatic. Looking solely at statistics, Busfield shows how admission rates reflect the fact that commission was much more evenly matched between the sexes.⁹ Historian David Wright also challenges the theme of the feminization of mental illness as it has become evident that men frequented asylums as well as women for similar symptoms.¹⁰ By suggesting that women were committed simply because of their social non-conformity suggests that all persons in charge were conspiring to control women. In his study of the Buckinghamshire Pauper Lunatics Asylum, Wright noted that there were safeguards in place to ensure against wrongful imprisonment. Alienists, or early psychiatrists, were not part of the process of committal; rather it was between family members

⁷ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991), 51.

⁸ *Ibid.*

⁹ Joan Busfield, “The Female Malady? Men, Women and Madness in Nineteenth Century Britain,” *Sociology* 28 1 (February 1994): 268.

¹⁰ David Wright, “Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England,” in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (New York: Editions Rodopi B. V., 2004), 151.

and Poor Law officers.¹¹ Wright argues that the seemingly gendered diagnoses arose from the fact that those were the illnesses of the people who presented themselves at the gates of the asylum.¹² He contends that manifestations of these illnesses may have been gendered, but not the illness itself.¹³

Viewing the asylum or mental hospital as an institution which solely sought to suppress deviance from societal norms discounts the experiences of those who were legitimately sick. This viewpoint characterizes psychiatrists, doctors and hospital staff as villains, and not as human beings who dedicated their efforts to the treatment of the ill. Historian Richard Fox suggests that looking at the mental hospital through the social control perspective “flattens out...vital structural developments by positing an abstract conflict between a group of controllers and their victims, and then by moralistically upbraiding the controllers for their alleged inclination to dominate.”¹⁴ Furthermore, solely looking at the feminization of mental illness provides only a portion of the story and dramatizes exceptions. Historians have shown that women have occupied positions of power when courts considered the confinement of a husband or father. They acted as legitimate sources of information, whether by being a witness in a court proceeding or by being charged with the responsibility of administering the affairs of the household in their husband’s mental absence. In analyzing madness and families in nineteenth-century Québec, historian Thierry Nootens describes the legal changes that had to be made to the family structure when male adults were suffering from mental illness. Wives and other family members would approach the court to have power of attorney, or curatorship, transferred to another person. This legal situation challenged family norms, especially when curatorship was

¹¹ *Ibid.*, 152.

¹² *Ibid.*, 153.

¹³ *Ibid.*, 169.

¹⁴ Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 14.

given to the wife. Being deemed curatrix gave women power that did not exist in the traditional family sphere.¹⁵

Historians have also started to look at the environment as a cause of mental illness. It has been suggested that family dynamics and stressors influenced the committal and length of stay of family members. The relationship between taxing circumstances and insanity is reinforced by Marjorie Levine-Clark's study of the admission records of the West Riding Asylum in England. Levine-Clark created a sample of seven-hundred-and-sixty (760) cases, through which she makes some interesting observations on the relationship between poverty and insanity. Out of this sample, 101 cases list poverty, unemployment and other related factors as key causes for insanity.¹⁶ The director of the West Riding Asylum commented that poverty was "a source from which insanity first originates..." as well as "the cause of relapses."¹⁷ Women raved about the stressors in their lives. For example, one patient "talk[ed] about her debts and want[ed] to pay them but [was] unable: her privations weigh[ed] heavily on her mind."¹⁸

Oonagh Walsh found similar results in her study of the Ballinasloe Asylum in Ireland. She found that only eight out of a total of nineteen tabulated causes of insanity in 1872 were biological. The rest were based on "highly individualized circumstances."¹⁹ Biology appeared to be less important in admission than factors such as family disputes, economic strain and various

¹⁵ Thierry Nootens, "For Years We Have Never Had a Happy Home': Madness and Families in Nineteenth-Century Montreal," in James E. Moran and David Wright, eds. *Mental Health and Canadian Society: Historical Perspectives*. (Montreal: McGill-Queen's University Press), 49-68.

¹⁶ Marjorie Levine-Clark, "Embarrassed Circumstances': Gender, Poverty, and Insanity in the West Riding of England in the Early-Victorian Years," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (New York: Editions Rodopi B. V., 2004), 132.

¹⁷ *Ibid.*, 129.

¹⁸ *Ibid.*

¹⁹ Oonagh Walsh, "Gender and Insanity in Nineteenth-Century Ireland," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (New York: Editions Rodopi B. V., 2004), 75.

other environmental pressures.²⁰ Historian Geoffrey Reaume, based on his research of the patient records of the Toronto Hospital for the Insane from 1870 to 1940, found that:

the emotional turmoil was not some biologically induced state for most of the people considered here. Distress had to do with the depredations brought on by poverty, social isolation, loss of status and income, and abuse from people in positions of power.²¹

Another form of stress, though not mutually exclusive from the above, was that experienced through living within proscribed roles. Mitchinson argues that hysteria was a physiological reaction to the boundaries society had placed on women and that “added to this pressure was the lack of alternative roles for women outside the home.”²² Wives were responsible to marry, bear, raise and educate children, undertake the major responsibility of maintaining a home, and support and serve their spouses. There were few opportunities for employment and education was discouraged. Historian Lara Campbell suggested that the Depression laid “bare the unstable association of economic interdependence and masculinity, and the anxiety contained within that hegemonic definition of manhood.”²³ Men, confounded by unemployment, coped as best as they could. According to Campbell, the fear of the loss of status in the community and as providers caused many unemployed men to be on the precipice of a nervous breakdown.²⁴ In addition, Campbell’s research cautiously indicates that suicide rates did

²⁰ *Ibid.*

²¹ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Don Mills, Ont: Oxford University Press, 2000), 53.

²² Mitchinson, 280-1.

²³ Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario’s Great Depression* (Toronto: University of Toronto Press, 2009), 57.

²⁴ *Ibid.*, 64.

increase in the first few years of the 1930s. In fact, the rate of suicides among men aged thirty to thirty-five in 1930 doubled the 1924 rate.²⁵

Family structure and economic roles determined the way a relative deemed mentally ill was treated. Looking at legal records, historians André Cellard and Marie-Claude Thifault discuss how families used asylums to take care of their ill relatives in nineteenth-century Québec. Living in an urban centre with a mentally ill relative was comparatively more difficult than in rural settings. If the illness was mild enough, ill relatives could be included in rural household labours, but not in urban areas where most people went out to work. Proximity to neighbours made inappropriate outbursts and behaviours something that challenged the dignity and standing of the family. Cellard and Thifault postulate that “asylums may have had the usefulness of providing a respite or short rest for exhausted families unable to provide adequate supervision of their loved ones,” as they found that many families petitioned for the release of their relatives within a few weeks of committal.²⁶ Families used asylums to care for their ill relations whenever their behaviour got to be too much for them to handle.²⁷ Furthermore, the authors suggest that families “made strategic use of asylums and were by no means poor victims...Over the course of the twentieth century, families developed their own patterns for using asylums to compensate for resources lacking within the family.”²⁸ Being released from an asylum was largely dependent on having supportive friends and family who would have a place for them to stay as they would need assistance in reintegrating themselves into the community.²⁹ Most inmates who did not have family petitioning for their discharge stayed until their death.

²⁵ *Ibid.*, 65.

²⁶ André Cellard and Marie-Claude Thifault, “The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-Century Quebec,” in *Mental Health and Canadian Society: Historical Perspective*, eds. James E. Moran and David Wright (Montreal: McGill-Queen’s University Press), 109.

²⁷ *Ibid.*, 111.

²⁸ *Ibid.*

²⁹ Reaume, 193-4 and 49.

Cellard and Thifault also suggest that when family members were taken home from asylums, it could have been due to their acknowledgement that the asylum may not have been the best place for their family member to recuperate, and that the family home might be more ideal.³⁰

While most historians have analysed the treatment of the mentally ill in the Victorian era, whether in Canada, England or America, many connections with the Great Depression can be made. Canada and England shared similar laws concerning the poor and little had changed since the nineteenth-century. The Poor Law in Victorian England created the Dickensian workhouses, whereas relief policy during the Depression in Canada created work for relief projects and work camps. Each period had an idealized work ethic where initially “(u)nemployment was regarded as the fault of the worker, not something integral to the capitalist system.”³¹ Those relegated to live in workhouses felt the same stigma as those who were called ‘reliefers’ in the Depression era.³² Eviction from home left many families scrambling to collect their real and psychological baggage. It attacked the dearly held ideals of middle- and working-class families, while leaving them dependent on relief, family and charity. In addition, surviving on the wages of one provider was unattainable for anyone below high-middle-class, yet it remained an unrealistic goal throughout the late nineteenth- and early twentieth-century. In reality, family sustenance depended on female labour, though neither era outwardly approved. The glorification of women as mothers and homemakers finds place in the Depression period as it did in the Victorian era.³³ Though women had previously enjoyed occupations in a handful of industries, the financial stresses of the Depression challenged their already tenuous position in the workforce. Female

³⁰ Cellard and Trifault, 110.

³¹ Levine-Clark, 126. The commonality of this sentiment is illustrated in Margaret Hobbs, “Gendering Work and Welfare: Relationship to Wage Work and Social Policy in Canada During the Great Depression” (PhD Diss., University of Toronto, 1995), 304.

³² *Ibid.*, 127; Healy, 87

³³ Mitchinson, 8-9.

‘reliefers’ also bore the humiliation of relief as it was women who purchased groceries and collected coal and wood from city depots. Relief policy spelled out the attitude of the era by designating women to be either dependents of their fathers or of their spouses, and thus not valid relief recipients.³⁴ Married women were relegated back to the home, facing the same prescribed roles occupied by their Victorian mothers and grandmothers.

Historians have largely studied the Victorian era because it was then that the transformation in the treatment of the mentally ill occurred. Institutions for the insane in Great Britain evolved from punitive, decrepit institutions to palatial quasi-villages. Treatment moved from shackles and straitjackets to work therapy, hydrotherapy and social events. This process was influenced by the development of the field of psychiatry and utilized the advances and theories that accompanied it. As this process continued into the twentieth century, in Canada in particular, provincial institutions were being built to divert the mentally ill away from jails. Though the mentally ill still appeared before a magistrate prior to committal, the 1922 Mental Diseases Act of Saskatchewan recognized that “a disease process is being dealt with, [not] a criminal prosecution.”³⁵

The Saskatchewan Hospital North Battleford (SHNB) was built upon these precepts. In 1907, Premier Walter Scott sent Dr. David Low to tour mental hospitals in the eastern United States and Canada in preparation for a future hospital in Saskatchewan. Low recommended that a cottage system would work best, and that all physical restraint should be abandoned. However noble his intentions, they were largely ignored. On the bank of the Battle River in North Battleford, a large pavilion-style hospital was built from 1911-1913.³⁶ Until this time, mentally

³⁴ Hobbs, 143.

³⁵ Dickinson, Table 1.

³⁶ *Ibid.*, 20-22.

ill residents of Saskatchewan were either jailed or institutions in Manitoba.³⁷ Dr. James Walter MacNeill became the Superintendent of SHNB, and applied the progressive trends being adopted in the field of psychiatry and the treatment of the mentally ill. Changing terms such as “asylum” to hospital, banning the use of mechanical restraints and establishing a hospital farm demonstrated MacNeill’s view of mental illness.³⁸

The hospital, however, faced major challenges. Overcrowding placed increased strain on the institution as it dealt with epidemic illness, short food supplies, and high patient-to-staff ratio. As a result, patients did not receive the kind of attention they required which stalled the healing process.³⁹ Moreover, though the hospital was located in North Battleford, it was still quite a distance from the town itself. Staff largely resided on premises, working twelve-hour shifts six days a week.⁴⁰ Hiring experienced staff was near impossible as the stigma of working at a mental hospital eventually drove employees to seek jobs elsewhere. Meanwhile, the shifts were so long that it was not possible to secure additional training and education. There was continuous turnover among on-site physicians as they often went elsewhere to find better opportunities.⁴¹ Hydrotherapy and work therapy were the main forms of treatment, though the latter had fallen out of favour among psychiatrists. Care was mainly custodial and as a result, almost all patients left the hospital either by parole or death, not because they were considered to be cured.

It was in these conditions that patients entered SHNB in the 1930s. This thesis will look at the main historiographical debates in the history of psychiatry while looking at the

³⁷ *Ibid.*, 19-20.

³⁸ Delores Kildaw, *A History of the Saskatchewan Hospital, North Battleford, Saskatchewan*. (Saskatoon: University of Saskatchewan, 1990-91), 14-17.

³⁹ Dickinson, 37-8.

⁴⁰ *Ibid.*, 47.

⁴¹ *Ibid.*, 36-37.

Saskatchewan Hospital North Battleford. It will argue that the stress of the Depression was a key factor in the committals of men and women. Furthermore, it will contend that families utilized the hospital to assist in times of need, either as a dumping ground of undesirable relations, for treatment, or a short-term form of respite. It will show that work inside and outside the hospital was a measure of worth and respectability in men and women. Finally, though gendered social control or moral regulation did not function in the majority of experiences of hospital life, it did play a role in the lives of a significant few. Race, class and morality influenced labels of insanity. To ensure that Canada was made up of the “best stock,” restrictive immigration policy, deportation (including that of the mentally ill) and incarceration of persons considered deviant was utilized.

Absolutely central to this thesis are the patient ledgers of SHNB. The archival collection is comprised of the General Register, Admission and Discharge, Daily Record, and Index and Ward Location Ledgers. These were authored by hospital staff and the majority (Admission and Discharge, Daily Record and Index and Ward Location ledgers) were used to help staff keep track of the number of patients admitted and discharged and where they were placed in the hospital wards. The General Register ledger contains patient numbers, names, race, residence, sex, age, civil condition (marital status), number of children, occupation, degree of education, religion, habits of life, number of admissions, date of admission and date of discharge, information on their disorder, mental diagnosis, result, supposed cause of death, and any observations. This particular ledger formed the majority of the primary research for this thesis. It is clear that the information found on the General Register ledger was derived from forms filled out upon a patient’s arrival at the hospital, but it is not known who filled out these forms.

Furthermore, how the information on the forms was interpreted and summarized by hospital staff when filling out the General Register is unclear.

Daily Records were tally sheets indicating how many came in and out of the hospital each day. These ledgers helped to track admission and discharge rates. Admissions (on one page) included the date, name of patient, place (where patient came from), who they were accompanied by, notes, while Discharges (on the opposite page) noted the date, name of patient, who they were paroled to and other notes. This particular ledger was discontinued in 1935. Index and Ward Location Ledgers kept track of patient numbers, names, dates of admission and discharge, disposal (by death, parole, elopement, deportation, or transfer) and their ward location in the hospital. This collection of ledgers has never before been studied, and has been depersonalized by the Saskatchewan Archives Board to remove all identifiable personal data, specifically, names. Only records from January 1, 1929 to December 31, 1939 were utilized in the research for this thesis so that the Depression era could be fully encapsulated. When the depersonalization of the ledgers was completed, photocopies were sent to the Saskatoon branch of the Saskatchewan Archives for the author's, and only the author's, use. Worksheets were created in Microsoft Excel to replicate each ledger's headings and columns. The information contained in the ledger was entered into these worksheets exactly as it was seen on the ledger, including spelling mistakes and terms that are no longer used in contemporary parlance, including the racial terms 'Negro,' 'Red Indian,' and 'French half-blood,' and geographic regions like Czechoslovakia and Yugoslavia.

After the ledgers had been entered into the excel workbook, each as a separate worksheet within the workbook, tables were created in order to generate graphs. Some of the tables were created directly from the data, for example, table 1 and 3.1a-3.11b (appendix). The majority,

however, were derived from a rudimentary ‘bean counting’ approach, where each patient who fell under a particular heading was counted and compared with those who did not. Table 2 (appendix), for example, was created by counting each patient whose length of stay fell within certain parameters and compared with groupings of other patients whose length of stay was shorter or longer. Tables 5 and 6.1-6.2 (appendix) were created by similar means; each patient was counted whose occupation or diagnosis fit certain categories developed by the author and then compared in large groups. Using this simple process, sixty-six graphs were generated, twenty-seven of which are included in the appendix. Statistics other than those presented in these graphs were created by the same process. Each grouping was calculated as a percentage of the whole number of patients, unless otherwise specified. Anecdotal evidence, illustrated through reference to a specific patient number, was gleaned from a thorough reading of the General Register ledger and was deemed noteworthy by the author. These patients stand out from the large body of patients for several reasons: a piece of information was recorded about the patient which was considered unique, for example: behaviour which deviated from the good-fair-bad paradigm often used by ledger authors, recurrent alcoholism or drug use, single motherhood, spousal abandonment, committed siblings, diagnosis labels which could denote social maladjustment or deviance rather than mental illness, patients transferred from jail or sent to the hospital by order in council, and early deaths, suicide, or death resulting from lack of care or due to treatment. These records were highlighted in yellow in the excel workbook for easy location. As a result, the data collected provides statistical, as well as anecdotal, evidence that shed light on the important issues debated in this thesis. Patients will be identified by patient number, and details on when they were committed, their occupations, marital status, diagnoses, and any other details gleaned from the General Register will be included where relevant.

Chapter One will discuss how family dynamics played a role in the committal process and will test Cellard and Trifault's theory that families utilized the asylum to relieve pressure in their homes. As access has not been granted to view patient files, to answer this question, statistics from admissions and discharges will be utilized. Readmission statistics will be employed, and length of stay will be determined from the admission and discharge records, to demonstrate the spectrum of ways that families utilized the hospital. One notable trend derived from the ledgers is the increased paroles and decreased admissions of women in December in most years between 1929 and 1939. From these statistics, it is hard not to conclude that families were taking their female relatives home for the holidays. For many other families, the asylum was a source of shame. Reaume's study of the patient files of the Toronto Hospital for the Insane show that many relatives requested anonymity.⁴² Requests for privacy were received by the hospital, some asking that any outgoing mail be sent in plain envelopes with no official seal, while others asked that only certain approved persons be allowed to visit. North Battleford was no different. Historian of SHNB Delores Kildaw, recorded a visit from a middle-aged woman inquiring whether her mother was a patient there. She was, and she was still alive. The woman had been told at the age of three that her mother was dead.⁴³ Those forgotten or forsaken by family had difficulty not only getting adjusted in society when paroled, but faced major obstacles in getting released in the first place. As when committed, family involvement was essential to being paroled. Some never came back to retrieve their relatives. In one area of the SHNB stand 1500 steel crosses over graves of those "unclaimed by their families."⁴⁴

⁴² Reaume, 197.

⁴³ Kildaw, 61.

⁴⁴ *Ibid.*

Chapter Two will address work and its social trappings. Work was a highly important theme in this period: the lack of work, work for relief, work as the right of and main characteristic of men, and the invisible work of women. Masculinity and citizenry were tied into work and the lack thereof presented obstacles for male identity. Aged persons still continued to identify themselves with their former occupations, and those unable to work were in danger of being considered socially redundant. Women entered in and out of the job market as need dictated, which suggests that their identity had little to do with formal employment. For men, employment was considered a rite of passage. Unemployment challenged this major bulwark of identity. Was urban unemployment a greater cause for insanity, or year after year of failed crops? Admissions from rural and urban settings will be compared as well as the occupations for each person admitted in the 1930s. Using the ‘habits of life’ column of the General Register, the importance of being industrious will be discussed. For example, one thirty-five-year-old female inmate was recorded in the ‘habits of life’ column as: “used to like work, now neglects work.”⁴⁵ The importance in recording this change in behaviour demonstrates that shirking work in the outside world was considered unusual behaviour and was defined as a symptom of mental illness.

Work therapy was still a major form of treatment at SHNB. Though it was no longer considered the best form of therapy among psychiatrists, patient labour reduced costs and provided free food and labour for the hospital. Gender-appropriate occupations reinforced the ideals held inside and outside the hospital walls. Patients worked in the laundry, kitchens or grounds throughout their incarceration, and considering the level of unemployment experienced outside the walls of the hospital, it is possible that many found meaning and identity in their

⁴⁵ General Register, Ledger 9 Folder 2, North Battleford Patient Ledgers, Saskatchewan Archives Board.

work.⁴⁶ As patients undertook the maintenance, renovation and beautification of the hospital, the question arises as to whether such hard labour was appropriate for patients. In Reaume's analysis of the Toronto Hospital for the Insane, he notes that "the constant demands of these labour-intensive jobs, with men and women working as long as possible, meant that patient work was much more intense than any light duties that the architects of moral reform had envisioned."⁴⁷ Yet, Reaume notes that patients who agreed to work were given privileges that other inmates were not.⁴⁸ In this chapter, work conditions, expectations, identity and rewards at SHNB will be compared with the concept of work in the outside world.

Chapter Three will look at how the obsession with creating an ideal society influenced deportation, immigration, and the definition of mental illness. In this period, those considered unable to assimilate, or who exhibited characteristics that were not in keeping with the Canadian ideal of a moral, white, Anglo-Saxon citizenry, were in many cases, deported or committed. A significant number of male patients were deported from SHNB between 1929 and 1937. Alcoholics and drug users were being sent to SHNB instead of jail, and were being treated there. Based on the number of readmissions, it appears that this treatment was largely ineffective though patients continued to return. In addition, women whose sexual practices did not meet the acceptance of their families or community were vulnerable to committal. In the patient ledgers there are records of women who were committed because they did not meet social norms (as Showalter and Mitchinson have suggested). Despite their minority, their incarceration at SHNB is telling. Did these women exhibit psychotic behaviours? Legal historian Constance Backhouse's study of Violet Bowyer and her incarceration in the Orillia Asylum illustrates how

⁴⁶ Reaume, 169.

⁴⁷ *Ibid.*, 180.

⁴⁸ *Ibid.*, 152, 166.

her recalcitrance and lack of shame were reasons enough to keep her incarcerated though no psychosis was found. These women, however, were few and far between, and it is important not to lose sight of the vast majority of women who were legitimately sick.

Much of the work on the history of Canadian medicine, specifically mental illness, has focused on Victorian Canada.⁴⁹ By covering a smaller period of time, and a particular province, this thesis is better able to see how the stressors of society, particularly during the Great Depression, can manifest themselves through higher admission rates, lower discharge rates, shorter length of stay, and admittance of those whose crimes were frequently moral, not legal. This thesis is groundbreaking; it utilizes records that have never before been viewed outside the hospital. It connects with and debates the historical work on family dynamics, gender, deviance and labour that have been put forth in Canada, Great Britain and the United States. Furthermore, this thesis engages in a broad and complicated debate surrounding the hospital and its function in society, either as an institution of social control or a centre for benevolent treatment. In this debate, there are no easy answers because the hospital often acted and was acted upon causing seemingly contradictory positions. The Saskatchewan Hospital North Battleford received persons who were considered mentally ill by their families, while at the same time, the hospital essentially incarcerated those who exhibited deviant behaviours. The hospital retained patient labourers to ensure the institution's survival, yet it was powerless to stop the consistent influx of patients that caused severe overcrowding. In addition, without patient files, it is impossible to stake a position in this debate. However, though a more complete picture might be painted by an analysis of patient files, due to the level of detail contained within these files, the patient ledgers

⁴⁹ One of few exceptions, Erika Dyck's research on the use of LSD and psychedelic drugs at the Weyburn Hospital from 1940-1970 published in her book *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins Press, 2008).

are still an invaluable resource. The statistics gleaned from the ledgers illuminate trends in admission, discharge, diagnosis, and length of stay patterns which reinforce the arguments posed in this thesis, and pose many additional questions. By analysing the way in which the hospital was an active and inactive actor in Saskatchewan society sheds light on a larger issue: how society has taken care of its ill, how it has viewed them, and how the definition of illness has changed over and over, depending on the definer.

Chapter One

Family Dynamics in the Epicentre of the Great Depression

“My family don’t [sic] live anymore we only exist,” Mrs. Otto Brelgen confessed in a letter to Prime Minister R.B. Bennett. “I know I’m very near a nervous wreck. If we allowed suppose [sic] the doctor would tell me I had a nervous breakdown as it is I have to keep trudging along trying to make the best, but I don’t think I could stand the strain any longer...”¹ On April 15, 1935, when this letter was penned, Mrs. Brelgen found her family in dire circumstances. Her youngest baby was underdeveloped due to lack of nutrition, her family had little food and clothing, and their relief had been cut back. In addition, her family was sent from Saskatoon to settle in Dempster as part of a government relief plan. Typical of many women in Saskatchewan, Mrs. Brelgen muddled through as best as she could, but it was often more than she could bear. The devastation of the Great Depression reduced many families to the depths of poverty, much like the Brelgen family. Not only was Saskatchewan the “first casualty of the Great Depression”² but was at “the epicenter of [this] economic earthquake.”³ After a visit to the Little Saskatoon and Tamarack settlements in 1932 Reverend A. R. Taylor recorded that he was surprised by the suffering of the new settlers, “hinting that some were one step away from the asylum.”⁴ These accounts suggest that the spectre of mental illness loomed large in the minds of those humbled by the problems of the 1930s. For many, the threat became real as the Great Depression and the hardships that accompanied it proved to be too much.

¹ Mrs. Otto Brelgen to Prime Minister R.B. Bennett, April 15, 1935, *The Wretched of Canada: Letters to R.B. Bennett 1930-1935*, eds. L.M. Grayson and Michael Bliss (Toronto: University of Toronto Press, 1971), 143-4.

² Bill Waiser, *Saskatchewan: A New History* (Calgary: Fifth House Ltd., 2005), 281.

³ G.P. Marchildon, “Chapter 4: The Great Divide,” in *The Heavy Hand of History: Interpreting Saskatchewan's Past*, ed. G. P. Marchildon (Regina: Canadian Plains Research Centre, 2005), 56.

⁴ Waiser, 300.

In many cases during the 1930s, the increased level of stress exacerbated existing mental vulnerabilities, which led to being deemed mentally ill. In addition, economic trouble, combined with the growing acceptance of institutionalizing the insane, increased a family's willingness to utilize the mental hospital as a place for their relatives. Lastly, due to flexible and malleable provincial legislation surrounding committal, families were able to have family members committed under their own criteria. Since the early 1920s committals to the Saskatchewan Hospital North Battleford (SHNB) were on the rise and this trend continued unabated throughout the Depression era. Table 1 (appendix) illustrates that from January 1929 to December 1939, the female population at the hospital increased from 314 to 525, while the male population ballooned from 635 to 1008. This graph illustrates the increased willingness of Saskatchewan families to commit their ill relations. This consistent population growth led to severe overcrowding, the height of which was experienced in 1937. Yet patients continued to arrive. From the Daily Record ledger, it is clear that at least one patient per day was admitted during most months between 1929 and 1939. Fifty-two patients, the highest monthly total, were admitted in May 1936. Only eleven were paroled.⁵ Reinforced by anecdotal and statistical evidence from the patient ledgers of SHNB, this chapter will show how the financial and physical pressures of the Great Depression led to increased committals in the 1930s. The ways in which Saskatchewan families viewed SHNB, and how they utilized it as a pressure-valve for their homes will also be demonstrated.

The Brelgen family, among thousands of other families, were recent transplants to Saskatchewan. This young province was settled by successive waves of immigrants. The early prairie experience was a form of hardship for these new arrivals. Many new frontier families

⁵ Daily Record- Saskatchewan Provincial Hospital, Ledger 4 Folder 1, North Battleford Patient Ledgers, Saskatchewan Archives Board.

started prairie life cut off geographically from the well-spring of their culture, lineage and support systems. Minority groups who settled close to one another tried to re-establish their traditions, cultural practices, and religions in order to maintain some semblance of the homeland.⁶ Census statistics show that Saskatchewan's population had doubled in the twenty years before the Depression hit; in 1911 there were 492,432 citizens and by 1931, 921,785 citizens claimed Saskatchewan as their home. Of this number, 68.4 percent lived in rural areas.⁷

“King Wheat” dominated Saskatchewan agriculture and was largely responsible for its economic prosperity and downfall throughout the early twentieth century. In 1925, Saskatchewan experienced a full-fledged boom in wheat prices that spread beyond the farms to the rural towns and cities, filling its citizens with optimism.⁸ Six short years later, wheat prices severely declined and when coupled with droughts, dust storms, insect infestations and crop failures, would lead to the worst depression Saskatchewan had ever seen. This decline decimated the previous optimism and caused provincial net farm incomes to hit a record low of *minus* \$36 million in 1937.⁹ Declining prices meant that farmers were getting paid less for the products of their labour, while everyday farm implements became more expensive.¹⁰ Taking a gamble for their survival, rural families left failed farms and either moved north or to the city, while urban families tried their hands at farming as part of a provincial relief strategy. The children of many families accepted jobs to give support, while many youths fled to the city, or rode the rails in search of work. Older relatives, who lived with their married sons or daughters,

⁶ See Lesley Erickson, “The Interplay of Ethnicity and Gender: Swedish Women in Southeastern Saskatchewan,” and Anna Feldman, “‘A Woman of Valour Who Can Find?’: Jewish-Saskatchewan Women in Two Rural Settings, 1882-1939,” in *“Other Voices”: Historical Essays on Saskatchewan Women*, eds. David De Brou and Aileen Moffatt (Regina: Canadian Plains Research Centre, 1995) pp. 27-40 and 60-75.

⁷ Dominion Bureau of Statistics, *1931 Census of Canada* (Ottawa: J.O. Patenaude, Printer to the King's Most Excellent Majesty, 1933), 141.

⁸ Marchildon, 55.

⁹ *Ibid.*, 57.

¹⁰ Waiser, 282.

assisted the family by providing child care and helping in home production. According to historian Cynthia Comacchio, the Great Depression “necessitated a return to the ...interdependent family economy.”¹¹ Those who were able contributed what they could. Not all family members, however, were able to help with the family economy. Ill relatives who could not or would not work placed pressure on the home. Moreover, the care of small children, elderly relatives and ill family members added additional stress to a family which was barely making ends meet.

Relief policy during the Depression was essentially an experiment in early public welfare. Traditionally, local municipalities were responsible for providing relief to their struggling constituents, but it quickly became apparent that this situation could not continue. Declining incomes led to fewer taxes being paid, which was then compounded by failing businesses and deserting families. The provincial government stepped in, offering direct and indirect forms of relief to struggling families. In addition, drought-stricken farmers headed to the drought-free crown lands of North Saskatchewan.¹² In the cities, municipal councils created relief boards in an effort to handle the ballooning demand for assistance. As the Depression continued, provincial and municipal debts continued to rise as did the number of Saskatchewan citizens needing help. Giving relief to needy families was new terrain for the government at both federal and provincial levels. Saskatoon, in particular, attempted a number of relief strategies which were generally unsuccessful. Retrenchment and stinginess were found at each level of government. According to historian Theresa Healy, the Mayor of Saskatoon condescendingly remarked that relief was not necessary if people would learn to be thrifty. Relief was understood

¹¹ Cynthia R. Comacchio, *The Infinite Bonds of Family: Domesticity in Canada, 1850-1940* (Toronto: University of Toronto Press, 1999), 123.

¹² Waiser, 299-300; Marchildon, 57.

not to support, but to rehabilitate.¹³ As a result, relief recipients hardly had enough to live on and were forced into livelihoods which were almost impossible to maintain.

Applying for relief struck at the heart of masculinity as it seemed to affirm men's inadequacy as providers. Some men believed that they had "signed away [their] manhood."¹⁴ After work for relief programs were discontinued, direct relief in the form of a voucher system was put in place. Removing men even further from the realm of work, the "dole" placed men in a state of limbo. Providing and earning was a socially mandated requirement of men. While women experienced higher levels of stress because of the extra work that was required of them, men were disoriented as they remained in the female sphere, not knowing what to do with themselves. In "next year country," farmers hoped against hope for a better yield at harvest time, as is demonstrated in Myrtle G. Moorhouse's memoir:

Cliff would sometimes put in 200 acres of crop, and a three day blow would send the sand flying and cut off the small tender blades. He would walk from window to window crying, with his lungs full of sand that he had breathed in while seeding...He couldn't take it any longer and he turned to drink.¹⁵

Women living on relief dealt with both the humiliation and inadequacies that followed. They navigated the program as best as they could through a number of ways: they established an underground economy and relied upon or supported local women's charities and organizations. Talented women used whatever means they could to support their families, which became the norm for most who were not upper or middle class. Women would provide room and board, take

¹³ Theresa Healy, "Prayers, Pamphlets and Protest: Women and Relief in Saskatoon, 1929-1939" (MA Thesis, University of Saskatchewan, 1989), 13.

¹⁴ Waiser, 289.

¹⁵ Myrtle G. Moorhouse, *Buffalo Horn Valley* (Regina: Banting, 1973), 31-32, quoted in S. Leigh Matthews, *Looking Back: Canadian Women's Prairie Memoirs and Intersections of Culture, History and Identity*, (Calgary: University of Calgary Press, 2010), 199.

care of children, take in laundry or other cleaning services, sew and make clothes, or cook, bake and style hair.¹⁶ Ensuring that their family was well-taken care of caused women to simplify, economize and even learn new skills. They darned and sewed until there was nothing but holes, and turned left-over materials, like flour sacks, into much-needed articles of clothing. Women helped in the fields when farm labourers became a luxury, and on top of this, women were encouraged to safeguard their husband's feelings about their poverty by not complaining or quarrelling.

Other members of the family were adversely affected by the Depression. Daughters delayed leaving home indefinitely as opportunities for employment and education became scarce and expensive. They laboured in various kinds of informal work including care for ailing family members, assisting with home production or in the fields. Young men also stayed in the family home and worked in order to contribute to the struggling family economy. Some adventured beyond the farm and hometown by riding the rails in search of employment. Children's life courses were interrupted as families in indigent circumstances kept them home due to the lack of food and clothing.¹⁷ According to Cynthia Comacchio, at the age where young people would be considering school, starting careers or forming marriage relationships, they "were forced into a waiting zone," which made them feel "trapped in a limbo of frustrated expectations."¹⁸ While the youth of Saskatchewan delayed future prospects, aged family members worried how their lives would continue when faced with few options to provide for themselves. Before Old Age pensions came into being in 1928, elderly people lived on whatever savings they had, and when that was exhausted, lived on support from their families or charity. These pensions, however

¹⁶ Healy, 102.

¹⁷ Comacchio, 147.

¹⁸ *Ibid.*, 147.

offered only \$365 per year and any additional income or help from family members was deducted from this amount.¹⁹ Rural families still passed land titles from father to son, which in many cases, safeguarded elderly patriarchs from being poorly treated by their descendents. In urban settings, familial obligations were no longer enforced by the inheritance of family property, which made aging relatives vulnerable by their dependence.²⁰ Yet families utilized elder relations to provide services to the household. Assistance in child care and household production was considered invaluable because it allowed wives and mothers to seek outside wages when necessary. For others, the economic downturn of the Great Depression caused those already threatened by the prospect of poverty to be more insecure than ever.

Did these factors contribute to the deterioration of mental health? Modern scientific research has suggested that many mental diseases are biologically based, and yet, studies have been conducted on the effects of stress and of the vulnerabilities to mental illness that are situated in life experience. Sociologist Joan Busfield, in her study of Men, Women and Madness, notes that a pivotal study on ‘vulnerability factors’ (which were derived from the similar experiences of several female interviewees) provides “strong evidence of the importance of situational factors in explaining the origins of depression.” Of course, the biochemistry of the brain is part of this equation, but according to Busfield, it is not enough to explain the incidence of depression.²¹ In addition, Karen Smoyer-Tomic et. al. in their geographical-medical study of the Canadian prairies, found farming to be the most stressful of occupations.²² The highest causes of stress in farmers, as discovered by their study, included bad weather and financial

¹⁹ *Ibid.*, 143.

²⁰ Jane Synge, “Work and Family Support Patterns of the Aged in the Early Twentieth Century,” in *Aging in Canada: Social Perspectives*, ed. Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), 135.

²¹ Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (New York: New York University Press, 1996), 198.

²² Karen Smoyer-Tomic, et. al. “Health Consequences of Drought on the Canadian Prairies,” *EcoHealth Journal* Volume 1, Supplement 2 (2004), SU150.

pressure.²³ While Busfield and Smoyer-Tomic have a contemporary focus, their findings can be extrapolated back to the 1930s as no other period experienced such environmental devastation coupled with crippling financial depression.

Historical research has illustrated that devastating circumstances including the death of a loved one, loss of finances or severe disappointment, were causes of insanity. Historian Geoffrey Reaume's analysis of the Toronto Hospital for the Insane between 1870 and 1940 concludes that for many patients, the extenuating circumstances of their lives were far more responsible for their illness than anything that could be diagnosed by a doctor.²⁴ Historian Cheryl Krasnick Warsh discovered in her work on the Homewood Retreat in Guelph that "mental health was...affected by physical or external factors such as puerperal disorders and other illnesses, overwork...grief at the loss of a close family member and household disruption accompanying death."²⁵ Certainly, biochemical processes play a role in the manifestation of mental illness. For many, however, it is clear that the onset of suspect behaviour which led to committal could also be triggered by environmental and emotional factors.

By the 1930s, societal attitudes about mental illness had transitioned from attributing insanity to criminality to accepting it as a medical condition. Beginning with the construction of SHNB in 1911, and the 1922 Mental Diseases Act which replaced the 1919 Dangerous Lunatics Act, it is obvious that the viewpoints of policy makers were changing. Modern science, historiography and policy aside, it was how the common man or woman defined mental illness that mattered most. By classifying behaviour as 'sane' or 'insane' determined how families

²³ *Ibid.*

²⁴ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Don Mills, Ont: Oxford University Press, 2000), 53.

²⁵ Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989), 83.

treated those who they considered mentally unstable.²⁶ Pre-conceived notions of mental illness or feeble-mindedness existed in every community and in every family. Historian Geertje Boschma suggests that the formerly popular term ‘feeble-mindedness,’ was often applied “to a wide range of socially unacceptable behaviours, reflecting a reproduction of cultural beliefs and inequalities as much as an application of a medical term in the literal sense.”²⁷ According to historian James Moran’s study of Victorian Ontario, certain behaviours were considered indicators of failing mental health and could lead to requests for committal. These were: violence to family or community, taking off clothes, filthiness of appearance and vocabulary, “or to display other forms of behaviour considered embarrassing or unacceptable.”²⁸ Cheryl Krasnick Warsh proposes that breaches of family standards, including sexual promiscuity, refusal to work, and any behaviour that disturbed “family harmony,” motivated family members towards committal.²⁹ Family standards reinforced appropriate conduct and scrutinized that which was not. Shame and embarrassment may have been enough reason to commit a relative who exhibited this behaviour.

Setting also played a major role in what was considered grounds for committal. Historians André Cellard and Marie-Claude Thifault note that “caring for a mentally disturbed relative was enough of a challenge in the country, but this role encountered special obstacles in an urban setting.”³⁰ On the farm, persons deemed mildly ill could still assist in household duties.

²⁶ James E. Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen’s University Press, 2000), 99.

²⁷ Geertje Boschma, “A Family Point of View: Negotiating Asylum Care in Alberta, 1905-1930,” *Canadian Bulletin of Medical History* 25, no. 2 (2008): 372.

²⁸ Moran., 120.

²⁹ Warsh, “The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923,” *CHA Historical Papers* (1988): 150; Warsh, *Moments of Unreason*, 10.

³⁰ André Cellard and Marie-Claude Thifault, “The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-Century Quebec,” in *Mental Health and Canadian Society: Historical Perspectives*, eds. James E. Moran and David Wright (Montreal: McGill-Queen’s University Press), 98.

In the cities, when an outburst of socially inappropriate behaviour became public, it challenged the standing of the family in the community. Supervision was next to impossible as many city dwellers worked outside the home. Even a lack of resources, whether of caregivers or finances, caused families to “identify a member as insane, neurotic or addicted and seek outside accommodation for them.”³¹

The General Register, contained in the patient ledgers of SHNB, includes a column entitled ‘habits of life’ where a short description of the patient’s conduct was included. Because it was such a small space, patient behaviour was boiled down to short, often one-word sentences. Some patients were labelled as “dirty,” “lazy,” “drinks,” “intemperate,” “shiftless,” “violent temper,” “wanderer,” “indolent,” and “will not work.”³² Others had more positive labels, such as “industrious,” “temperate,” “liked her work,” “good worker,” or “hard worker.”³³ From these labels, it is apparent that Saskatchewan society’s definition of insanity varied little from that held in other provinces and communities across the country. People were expected to keep themselves clean and tidy, abstain from alcohol or drugs, work, and put down roots in their community. It is important to note that in a period where work was one of the most important themes, being labelled “industrious,” “lazy,” or “will not work” was a notable characteristic used to classify those deemed mentally ill.³⁴

The financial cost of caring for an ill relative, or the shame of having such a relation are not the only reasons why families sought committal. Asylums were a fairly new invention and did not immediately supplant the traditional methods families and communities had for handling

³¹ Warsh, *Moments of Unreason*, 10.

³² Habits of Life column, General Ledger, Ledgers 8-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

³³ *Ibid.*

³⁴ *Ibid.*

individuals who were deemed insane. Family and community care, treatment by local physicians, and incarceration in local jails were some of these methods. These forms of treatment continued to be part of the spectrum of viable alternatives for families even after an asylum or mental hospital was built. Some families wanted to continue caring for their relative at home. Even when committal was sought, it may not have been because the family felt the asylum would offer better treatment, but because the caregivers could no longer take care of their ill relation due to age, their own failing health, meagre resources, or the death of the caregiver.³⁵

When families considered committal, they and the relative they deemed mentally ill had to appear before a magistrate. According to the provincial Insanity Act of 1906, a magistrate had to order committal for a person deemed to be too insane and dangerous to be at large.³⁶ The Mental Diseases Act of 1922 altered the connection between insanity and criminal conduct, and began to recognize it as mental disease. Though this transition in the legal definition of mental illness is important, as it began to divert the ill from jails to hospitals, it did not necessarily change societal and familial definitions of mental illness and criminal behaviour. Furthermore, committal proceedings changed little, as committals remained under court order, and acquiring a warrant was fairly simple.³⁷ Similar processes existed throughout Canada and the United States.³⁸ The person suspected to be mentally unstable would appear before a magistrate or Justice of the Peace who would order them to the care of the mental hospital if they were declared insane. Some proceedings began from jail, where the allegedly insane would be

³⁵ Moran, 119; Boschma, 381.

³⁶ Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: Canadian Plains Research Centre, 1989), Table 1.

³⁷ Eric Kempthorne, "Social Control and the Mentally Ill: Towards a Theory of Deinstitutionalization" (MA Thesis, University of Saskatchewan, 1995), 34.

³⁸ Moran, 98.; and Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 44. In California, persons had to be deemed "so far disordered in mind" that they were considered dangerous to themselves and others.

examined by the jail physician. If they were considered to be ill, legal proceedings were initiated.³⁹

Playing upon the vague nature of the legal interpretation “dangerous” was one way families manoeuvred to achieve their chosen outcome. Historian James Moran suggests that some families, in their haste to have a family member committed, would have them declared to be too “dangerous to be at large” and then would have them confined in the local jail until they were transferred to the hospital by court order. This strategy was one way of speeding up the process.⁴⁰ Historian Richard Fox, in his study of insanity in Northern California from 1870 to 1930, agrees with Moran: many people were committed on weaker definitions of “danger” and were deemed insane based on a varying range of symptoms and concerns.⁴¹ Oftentimes, the family’s definition of dangerous was what the court upheld. Historian Mary-Ellen Kelm, in her study of women and the British Columbia Provincial Hospital for the Insane, showed that families committed female family members “based on their own criteria, frequently independent of medical advice.”⁴² Fox argues that committal proceedings were started because “relatives, doctors, police, or neighbours decided they could no longer tolerate [their ill relative’s] deviant behaviour.”⁴³ Thomas Scheff’s sociological work in Wisconsin confirms this finding. Scheff discovered that urban courts were so inundated with various court cases that they essentially rubber-stamped the “prior judgment of family members or other petitioners that the disturbed person required hospitalization.”⁴⁴

³⁹ Moran, 104.

⁴⁰ *Ibid.*, 98.

⁴¹ Fox, 44.

⁴² Mary-Ellen Kelm, “‘The only place likely to do her any good’: The Admission of Women to British Columbia’s Provincial Hospital for the Insane,” *BC Studies* 96 (Winter 1992-93): 71.

⁴³ Fox, 137-8.

⁴⁴ *Ibid.*, 98.

Several examples from the North Battleford Patient Ledgers illustrate that family members committed relatives that may have shown peculiar or inappropriate behaviour, but not necessarily symptoms of mental illness. Patient 6092, a rural, fifty-one-year-old housewife was committed in February 1934. Once in the hospital however, she was found to be ‘without psychosis-not insane’ and was paroled seven days after her arrival.⁴⁵ Patient 5009, a thirty-eight-year-old Austrian housewife lived at SHNB from her committal in February 1931 until October 1934 when she was finally paroled. She was assessed as “undiagnosed- not psychotic.”⁴⁶ Though she was eventually paroled, she resided at the hospital for three years without being diagnosed.

Once within the walls of the institution, families chose the type and amount of contact they had with their committed relation. Some would visit, some would write letters, some neither. Geoffrey Reaume notes that in some cases families would request anonymous mail from the asylum, with no seal or any obvious markings, as they feared the shame that would prevail when the community at large discovered their secret. In addition, some would request that only approved people be allowed to see their committed relation, fearing the prying eyes of their community.⁴⁷ Where possible, a number of families got involved with the care being given to their family members. Toronto, like SHNB, employed work therapy as a form of treatment for their patients. Reaume discovered that some patients were fortunate to have their families demand their exemption from such labour. Others requested compensation for the free labour provided by their relative.⁴⁸ Various families requested discharge or parole shortly after committal, possibly due to a resurgence of feelings of familial duty, or because time away made

⁴⁵ Patient 6092, General Ledger, Ledger 9 Folder 2.

⁴⁶ Patient 5009, General Ledger, Ledger 9 Folder 2.

⁴⁷ Reaume, 197.

⁴⁸ *Ibid.*, 151.

their previously intolerable behaviours less so.⁴⁹ According to Kelm, families suffered when their female relations were committed. Fathers would have to work, run the household and raise their children alone. In these circumstances, families tried to convince hospital officials to parole or discharge their loved ones, even when their female relations were not considered healed.⁵⁰ Cellard and Thifault note that in other cases, when families were not completely convinced of the merits of the mental hospital, they would petition release based on the fact that they did not feel that it was doing any good.⁵¹ While it is hard to determine the level of contact between families and their ill relations at SHNB based on the patient ledgers alone, it is clear that not all families acted the same way. The readmissions, paroles and short-stays of patients illustrate that families remained in some form of contact with their ill relatives. Due to the increased population size SHNB experienced in the 1930s it is possible that many paroles were granted to those whose families saw “overcrowding as an obstacle to healing.”⁵² Opting to remove their relative rather than allowing them to stay demonstrates that some families continued to hope that their ill relation would be cured, though perhaps not at the hospital. Permanent admissions and subsequent deaths of patients at the hospital paint a bleaker picture. Though it cannot be said with surety that all these patients suffered abandonment by their families, it is plausible that a great number did. Behind SHNB stand 1500 steel crosses which mark the graves of patients who died at the hospital. Only identified by a number, these patients faced the shame of their families in death as they had in life.

⁴⁹ Cellard and Thifault, 109.

⁵⁰ Mary-ellen Kelm, “Women, Families and the Provincial Hospital for the Insane, British Columbia, 1900-1915,” *Journal of Family History* 19, 2 (1994): 187.

⁵¹ Cellard and Thifault, 110.

⁵² Dickinson, 37-8.

An analysis of the admission and discharge ledgers contained in the SHNB collection confirms that there were diverse ways in which families utilized the mental hospital. According to Table 2 (appendix), a significant majority of patients stayed at the hospital for less than one year (seventy percent of men and seventy four percent of women).⁵³ The largest group of patients resided at the hospital for an even shorter period of time, between 31 to 100 days. Families of these patients could have utilized the hospital for only brief periods for several reasons: having an ill relative diagnosed was the primary goal of incarceration, the family needed a short respite from the strain placed on the home by the ill relative, or because the dependence of the family on the ill relative ranked higher than the relative's need for treatment. An interesting trend is reflected in the admission and discharge totals per month per year, as is seen in Tables 3.1a-3.11b (appendix). By tracking these monthly totals, admission and discharge trends are created which illustrate that in 1929, 1930, 1932, 1935, 1936, and 1937, female admissions decreased and paroles increased in the latter months of these years, and reversed in the early months of the following year. From these statistics it is possible that families were taking their female relatives home for the holidays, or waiting until the New Year to have them committed. It is also clear that this trend was more common among female patients as female relations, especially wives and mothers, kept the family together. Their work was most essential as they took care of the immediate needs of the family and the home. While male admissions commonly decreased in November and December, paroles continued throughout each year on a fairly steady pace, seldom peaking in the winter months. This trend could suggest that though families postponed committal of their male relatives until after the holiday season they were less

⁵³These statistics were based on a patient population of 2033 male and 1358 female patients. These patients were those that had a clear admission and discharge date, and all those without clear dates (443 male and 224 females), or where one was not filled out, were not included in this set of statistics. Categories were developed by the author in order to underline the large group of short-stay patients in comparison with the smaller body of long-term or permanent-stay patients.

likely to have one paroled to their care than they were their female relations. Whether by postponing committal or having a relative paroled for Christmas, these trends illustrate that many families viewed the hospital at best, as the finest care they could receive, or at worst, a place of respite for families overburdened with work and financial stress.

Admission records of SHNB indicate that families who had committed a relative once had less reluctance to commit that same relative again. Out of the 1582 female patients committed between 1929 and 1939, twenty-six percent (26%) were readmissions. Of the 2476 male admissions, twenty percent (20%) were readmissions. These numbers could actually be larger as the General Register, from which these statistics were gleaned, was seldom completed for readmissions. These percentages are based on the number of patients to which 'readmission' was indicated somewhere on the register. Some returning patients had only their new patient number and sometimes the 'number of admissions' completed in the General Register. Of all the patients that resided at SHNB under 200 days, twenty-one percent (21%) of females and fifteen percent (15%) of males were readmissions. There were several interesting readmission cases at SHNB: twin fourteen-year-old rural Danish girls, patient numbers 7126 and 7127, were committed in September 1936 and were diagnosed as having schizophrenia agitated catatonia, and schizophrenia catatonia, respectively. Seven months later, patient 7127 died of tubercular pneumonia and pulmonary tuberculosis. Interestingly, her sister was paroled two weeks earlier. Exactly seven months from the date of her parole, she was returned to the hospital for another five months. The records are not clear if she ever returned again.⁵⁴ Patient 8217, a fifty-three-year-old housewife with a diagnosis of schizophrenia hebephrenia was committed in July 1939 for the ninth time. She was then released in December, only to be committed again that same

⁵⁴ Patient 7126 and 7127, General Register, Ledger 10 Folder 1.

month for the tenth time and remained at SHNB until July 1940.⁵⁵ Patient number 5447, a number given him on his seventh admission to SHNB in June 1932, would return to the hospital twenty-two more times in the next seven years. A grocer from North Battleford, this patient was almost always diagnosed as an alcoholic without psychosis. His time in the hospital would range from two to twenty-seven days. His alcoholism caused him to be readmitted over and over. By his twentieth admission, his family must have known that the treatment received in the hospital was not curing him. For this family as well as many others, committing relatives they deemed mentally ill for short periods of time relieved pressure on their homes.

The first admission and subsequent release of a family member deemed mentally ill set a precedent. In some situations, when home care was not proving effective, or when the recidivism of their relative was exhausting resources and causing strain, families readmitted these relations for longer periods or permanently. Twenty percent (20%) of females and nineteen percent (19%) of males readmitted stayed over two years. Patient 4453, a twenty-seven-year-old rural mother was committed sometime in May or June 1929. She was never diagnosed and was subsequently released. She appears on the General Register ledger again as a readmission on March 10, 1930, now patient number 4688. Diagnosed with dementia praecox, she remained at the hospital for ten years. She died on March 20, 1940.⁵⁶ Patient 5137, a forty-six-year-old rural mother of two, was readmitted for the second time and was diagnosed with involuntal melancholia. She was readmitted on July 7, 1931 and remained in the hospital for almost fifteen years until her death on June 5, 1946.⁵⁷ Patient 5387, a fifty-four-year-old farmer from rural Saskatchewan was readmitted for the second time in April 1932. Though he was

⁵⁵ Patient 8217, General Register, Ledger 10 Folder 2.

⁵⁶ Patient 4453, General Register, Ledger 9 Folder 2.

⁵⁷ Patient 5137, General Register, Ledger 9 Folder 2.

diagnosed as pre-senile, he remained at the hospital until his death in May 1947. Patient 6215, a twenty-four-year-old farm labourer, was readmitted for the third time in June 1934 with a diagnosis of epilepsy. Though his illness might have been mild, or one that did not require continuous hospitalization, he remained in the hospital until his death in October 1945. These examples illustrate that once suspect behaviours or symptoms of mental illness re-emerged, many families opted to leave their ill relatives permanently to the care of SHNB.

To achieve discharge from the hospital, families had to be directly involved, whether by petitioning the superintendent themselves, or through their assurance to the superintendent that their ill relation would be cared for.⁵⁸ When patients were paroled from SHNB, the discharges portion of the Admissions/Discharges ledger most often included the person they were paroled to.⁵⁹ Whether to a husband, wife, parent, or in-law, these patients were considered to be in the care of their family members. Families had a significant amount of power in the decision to have a relative discharged or paroled, as they did in their initial committal. Cheryl Krasnick Warsh notes that “the wishes of the family--not the diagnoses, nor the success or failure of drugs, or rest cure-- were primarily responsible for discharge.”⁶⁰ Families were seldom forced to pick up ill relations whose conditions were not severe enough to need hospitalization. If families, however, severed ties with the relative, an ill relation could face lifelong incarceration, regardless of diagnosis. Some relatives were considered well enough to be discharged by hospital staff, but if family members did not come to retrieve them, they often stayed until their death. Patient 6671 was a forty-year-old Hungarian housewife with four kids who remained undiagnosed at SHNB

⁵⁸ Reaume, 211.

⁵⁹ Admissions/Discharges, Ledger 1, North Battleford Patient Ledgers, Saskatchewan Archives Board.

⁶⁰ Warsh, *Moments of Unreason*, 95; Reaume, 211.

from August 1935 to March 1946.⁶¹ Patient 6236, a forty-four-year-old rural blacksmith admitted in June 1934, resided at the hospital until he died from pulmonary tuberculosis in June 1945. He was never diagnosed.⁶² A lack of diagnosis could suggest that the symptoms presented by these two patients did not match any of the contemporary illnesses understood by hospital psychiatrists. However, the fact that a diagnosis was not determined within eleven years could indicate that they were not insane to begin with.

The other side of the equation was how the patient behaved at the hospital and whether or not the family considered the relative ready for home life. According to Warsh and Reaume, patients who worked within the asylum demonstrated to their families that they were willing and able to work, and assured them that this behaviour would continue after discharge.⁶³ Once a patient returned home, families were essential in getting them re-established in society. The social stigma of once being certified insane made it difficult for paroled patients to readjust in society without familial help, especially if their stay in the hospital was of any great length. This relationship became strained, however, when symptoms re-emerged, as families did not know what else to do other than to return the relative to the hospital. Mary-Ellen Kelm noted that once female patients were released, they were thrown back into the lives they had before incarceration. The pressures that surrounded these women, whether familial or economic, waited for them when they got home, which increased the possibility of relapse. After being committed once already, these women were now watched more closely by their families.⁶⁴

Lack of familial involvement after committal guaranteed that the patient would remain in the hospital for the rest of their lives. Some families would sever ties after their relative's future

⁶¹ Patient 6671, General Register, Ledger 10 Folder 1.

⁶² Patient 6236, General Register, Ledger 10, Folder 1.

⁶³ Warsh, *Moments of Unreason*, 97.; Reaume, 217.

⁶⁴ Kelm, "Women, Families and the Provincial Hospital for the Insane," 187.

was sealed by the magistrate. Patients without means or financial support had difficulty securing release as charitable homes and shelters were reluctant to receive those who had previously been treated in a mental hospital.⁶⁵ Historians David Wright, James Moran and Mat Savelli concede that “in some situations, the asylum was used in a manner that could be characterized as familial abandonment,”⁶⁶ or in a less delicate way, a “dumping ground.” Wright, Moran and Savelli suggest that not all families “exhausted every means of coping with the demented and deranged, and had thus resorted to the asylum as a final, and possible shameful, escape from their domestic crisis.”⁶⁷ Comparing patient deaths with admission records show that of the 281 female patient deaths that occurred at SHNB during the Depression, eighty-two percent (82%) were first-time admissions. Of the 556 male patient deaths, eighty-eight percent (88%) were first-time admissions. In addition, thirty percent (30%) of female and thirty-nine percent (39%) of male patients had lived at the hospital an average of six to seven years before their death. From these statistics, it is hard not to conclude that while some of these patients had symptoms which warranted such an extended stay, it is possible that for many families SHNB functioned as a place to hide family members who were deemed mentally ill. Patient 4647, a forty-year-old single woman, was committed in January 1930 and diagnosed with dementia praecox on a defective base. She lived out the remainder of her days, fifteen years of them, at the hospital.⁶⁸ A sixty-seven-year-old Belgian widow, patient number 6004, was committed in November 1933 with arteriosclerosis as her diagnosis. This illness would eventually take her life, but it took twelve years to do so.⁶⁹ Patient number 4736, a forty-three year old rural labourer, was

⁶⁵ Reaume, 193-4.

⁶⁶ James Moran, David Wright and Mat Savelli, “The Lunatic Fringe: Families, Madness, and Institutional Confinement in Victorian Ontario,” in *Mapping the Margins: The Family and Social Discipline in Canada, 1700-1975*, eds. Nancy Christie and Michael Gauvreau (Montreal: McGill-Queen’s University Press, 2004), 296.

⁶⁷ *Ibid.*, 297.

⁶⁸ Patient 4647, General Register, Ledger 9 Folder 2.

⁶⁹ Patient 6004, General Register, Ledger 9 Folder 2.

committed in April 1930 and diagnosed as a mental deficient of low grade imbecile type. He would spend the remaining twenty-five years of his life within the walls of the hospital. Another patient, number 4566, was diagnosed as a mental deficient after his admission in October 1929 and dwelt at the hospital until his death in 1947. Considering both men were employed as labourers before their committal, suggesting that they must have been able to work in some capacity, the reason that they needed to remain at the hospital is unclear. After patients died, many families did not come to claim their bodies. The 1500 steel grave markers behind SHNB and the statistics above demonstrate that SHNB was a 'dumping ground' for relatives who were deemed mentally ill and whose behaviour was considered too reproachable to return to the family unit.

It was also the lack of family connections which played a role in the development of symptoms of mental illness in immigrant or recently naturalized patients as well as determining the length of their committal. In their psycho-historical review of early immigration to Canada, G. N. Smith et. al. noted that the incidence of schizophrenia among British and European immigrants at the British Columbia Provincial Hospital for the Insane between 1902 and 1913 was higher than among the Canadian-born population.⁷⁰ They suggest that immigrants, due to the cultural and familial separation they experienced, were vulnerable to the additional stressors of discrimination, loneliness and isolation. They remark that this "increased sensitivity to stress... [would make them] more likely to develop symptoms in the face of stress."⁷¹

⁷⁰ G. N. Smith, et al. "The Incidence of Schizophrenia in European Immigrants to Canada," *Schizophrenia Research* 87 (2006): 208.

⁷¹ *Ibid.*, 209.

Through an analysis of the General Register, where Canadian-born patients (1606) are divided from the foreign-born (1775) patterns in diagnosed illnesses are discovered.⁷² Schizophrenia is by far the most diagnosed illness among both Canadian-born and foreign-born populations, yet it is markedly higher among the former (thirty-three percent versus twenty-four percent). While these statistics contradict Smith et. al. and their findings, the assertion that foreign-born or immigrant populations were vulnerable to committal is not lost. Senility-related diseases, including senile dementia and senile psychosis, are higher among these populations than among Canadian-born patients (eleven percent versus six percent). Arteriosclerosis is another mental illness which was diagnosed in greater numbers among foreign-born patients (ten percent versus six percent). Because aging immigrant populations were largely displaced from family, kin and community networks, their appearance at SHNB is not surprising. While family connections made managing a perceived mental illness at home possible, the absence of family relationships assured incarceration. Support through providing room and board, funds for medical treatment, and physical safety would not be available, and thus the higher incidence of foreign-born patients diagnosed with age-related mental diseases at SHNB.

As is evidenced by Mrs. Brelgen's letter to Prime Minister Bennett, poverty, destitution, shame, and uncertainty characterized the Depression for most Saskatchewan citizens. While some were able to survive these difficult years because of their resilience, creativity and determination, others could not. The Depression also increased pressure on those who may have already been vulnerable to mental illness. In addition, financial pressures may have caused families to zero in on relatives whose behaviours they defined as mentally ill, and for their own

⁷² For this set of statistics, six-hundred-and-seventy-seven (677) patients were excluded because their nativity or race was unclear on the ledger. Among these exclusions are readmissions, Battleford Jail inmates, or patients whose record was not legible. This created a sample size of 1606 Canadian-born and 1775 foreign-born patients. General Register, Ledgers 9-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

reasons, considered committal. Furthermore, whether this behaviour was considered dangerous, shameful or annoying, tight budgets or lack of care options caused various families to look to the hospital as a survival strategy. From there, how their committed relatives were treated depended largely on the committing family. Short-term stays were common perhaps because the illness was minor, the behaviour tolerable after a short respite, or because the family could not survive without the help that the relative provided. Some of these families committed time and time again when symptoms re-emerged, or when another break was needed. Other families had their family members committed for life. The absence of family relationships, whether through shame or through immigration, assured the committal of those deemed ill when they were no longer able to provide for themselves. Through initiating the committal of a relative, determining the relative's subsequent level of contact with the outside world and whether or not they were paroled demonstrates that families exercised a great deal of power in the lives of its members. The patient ledgers of SHNB provide significant evidence that families utilized the hospital to suit their needs and did so increasingly as the Depression continued.

Chapter Two

Ennobled by Work?: The Intrinsic Value of Work Inside and Outside the Walls of the Saskatchewan Hospital North Battleford

The Great Depression was a period that reinforced work as a fundamental part of life for both men and women. As unemployment skyrocketed and relief became part of life for many Saskatchewan families, work and the lack thereof became the *conversation du jour*. Finding pride in being a husband and provider declined with limited wage and work opportunities. At the same time, informal female labour increased as families needed to make ends meet. The Great Depression required more of women: more hours of work, more ingenuity, and more determination. Men and women who found the pressures of unemployment or working with little reward too great found themselves in a situation where their mental health was tested, even unto subsequent committal. Age added complexity to the relationship between work and gender. When their ability to work became diminished, aged bachelors, spinsters, widows and widowers were all vulnerable to incarceration at Saskatchewan Hospital North Battleford (SHNB) due to their increased financial dependence on their families and community.

The SHNB reinforced the importance of being industrious and willing to work, as these qualities presented themselves as the most noteworthy quality recorded in the 'habits of life' column of the General Register. This small column could have housed any description of new patients, yet being industrious, or not, appears often. In addition, the hospital utilized patient labour in many of their operations. Used as a form of therapy, though the concept was

significantly out of date by the 1930s,¹ patient labour helped the struggling hospital in a time of increased patient populations. Historians have suggested that patients who willingly worked were more likely to be discharged.² Other scholars have argued that patient workers were considered to be an asset to the hospital, and the institution was more reluctant to parole them.³ By comparing Depression era society with SHNB, this chapter will discuss how work, either through engaging in it or shirking it, informed identity. In this era, being industrious was considered one of the most essential personal characteristics, and neglecting work was a sign of deviance or mental illness. The ways in which age- and gender- based conceptions of work were reinforced by relief policy, society and by hospital staff will be illustrated throughout this chapter.

Male and female roles as provider and homemaker were enshrined in society. The desire and engagement with work characterized both men and women. As historian Joe Cherwinski noted, “every able-bodied individual over the age of fourteen was expected to work; unemployment was viewed as a personal disgrace.”⁴ Married men were responsible for earning an income, whether through an occupation outside the home or through farming, while married women managed household affairs, cooked, cleaned, and raised children. Single men were encouraged to prepare for marriage through saving money, working up through the ranks, by acquiring their own land, or preparing to assume land titles from their fathers. In preparation for their future role as homemakers, young women stayed home on the farms to learn what they

¹ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*. (Don Mills, Ont: Oxford University Press, 2000), 159-60.

² 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), 97.

³ Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984*. (Regina: Canadian Plains Research Centre, 1989), 28.

⁴ Joe Cherwinski, “Early Working-Class Life on the Prairies,” in *The Prairie West: Historical Readings*, eds. R. Douglas Francis and Howard Palmer (Edmonton: Pica Pica Press, 1992) 551.

could from their mothers. Others flocked to the cities, taking an increasing number of jobs in teaching and in the clerical and service industry. These jobs were temporary; as soon as women married they were expected to resign, especially when the new wife became pregnant. These generalized descriptions of work based on gender and age depicts an organized, delineated society. However, in reality, the social structure of Saskatchewan was much more complicated. Few families fit the breadwinner/homemaker family role. Historian Margaret Hobbs points out that many families below what was considered middle and upper-middle class could not exist if they followed the 'male-as-sole-breadwinner' myth. Despite the unrealistic nature of this myth, it pervaded Canadian culture and was defended by anti-feminists and feminists alike.⁵

Women's work has recently become a much contested area of women's historiography. Informal female labour was not recorded in early census records, and women's dependence was codified through land ownership and dower legislation. In addition, many women did not value their work as 'employment.' Historian Eliane Leslau Silverman conducted a year of meticulous research where she interviewed 150 women who had experienced the prairies first-hand. Silverman found that despite the fact that women's work was gruelling, whether raising children and poultry, baking, cooking, canning, cleaning and assisting in the fields, these women accepted these duties as part of their role as housewives. For these prairie women "work was not ennobling...it was, instead, merely what one had to do."⁶ The definition of labour has subsequently been expanded to include other types of informal labour. Historians, such as

⁵ Margaret H. Hobbs, "Gendering Work and Welfare: Women's Relationship to Wage-Work and Social Policy in Canada During the Great Depression" (PhD Diss., University of Toronto, 1995), 304; Christa L. Scowby, "Divine Discontent: Women, Identity and the Western Producer," (MA Thesis, University of Saskatchewan, 1996), 59; Eileen Boris and Peter Bardaglio, "Gender, Race, and Class: The Impact of the State on the Family and the Economy, 1790-1945," in *Families and Work*, eds. Naomi Gerstel and Harriet Engel Gross. (Philadelphia: Temple University Press, 1987), 141.

⁶ Eliane Leslau Silverman, *The Last Best West: Women on the Alberta Frontier, 1880-1930*. (Montréal: Eden Press, 1984), 73-74.

Christa Scowby, and Lara Campbell, and sociologists like Sandra Rollings-Magnuson, state that the 'invisible' work of women made sure that households continued to function.⁷ Their labours went beyond cooking and cleaning, and included efforts to economize in order to fit the household income. These efforts included sewing, canning, making cheese, selling eggs and sharing their skills with the local community. Many women developed new skills, including beekeeping, dairying, tanning calf skin for leather, and using flour sacks to make various clothing items.⁸

Urban mothers, in many cases, continued to work after children were born. Historian Veronica Strong-Boag has asserted that most women, even if they wanted to, could not leave work because "general economic uncertainty, low male wages, and hopes for a better life in general always drove some to search out a second income."⁹ Women's work outside the home was officially recognized by the passing of the Factories Act in 1909 and Minimum Wage Act of 1919-20 in Saskatchewan. Herein, women were given shorter days, better pay, and separate bathrooms. It also enforced a minimum wage that employers would be forced to pay. However, while women had opportunities to work, the number of industries accepting female employees was limited. This legislation made getting jobs harder for women as employers had to follow more restrictive rules than if they had hired men.¹⁰ Yet, many women were desperate for any wage, and employers took advantage of their dependence. For them, women represented a 'reserve labour force' because they were effortlessly hired and fired. Women were also not

⁷ Sandra Rollings-Magnuson, "Canada's Most Wanted: Pioneer Women on the Western Prairies," *Canadian Review of Sociology and Anthropology* 37 2 (May 2000) 225; Scowby, 59.; Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario's Great Depression* (Toronto: University of Toronto Press, 2009), 23.

⁸ Scowby, 110.

⁹ Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Markham, Ont.: Penguin Books, 1988), 49.

¹⁰ Sandra Rollings-Magnuson, "Hidden Homesteaders: Women, the State and Patriarchy in the Saskatchewan Wheat Economy, 1870-1930," *Prairie Forum* 24 2 (Fall 1999): 178-9.

included in union membership.¹¹ While men could apply for and work in a wide range of jobs, Strong-Boag has found that women's occupations were condensed into six of the twenty-five categories contained in the census: "textiles and clothing, retail and wholesale trade, education, health and welfare services, food and lodging, and personal recreational services."¹² According to Strong-Boag, by 1931, forty-seven percent (47%) of women aged twenty to twenty-four, twenty-four percent (24%) of those between twenty-five and thirty-four, and thirteen percent (13%) of women between thirty-five and sixty-four were active in the labour force.¹³ Indeed, these rates indicate that women participated in the work force, but they also demonstrate that the majority of women working were young women, arguably single.

To women, their entrance and exit from the job market reinforced the fluidity of their employment: they would start working as young women, leave their jobs to have babies, and then return at any time when needed. This type of employment did not define their roles as women. However, when a man entered into the workforce, whether through paid employment or farming, he was considered to have successfully transitioned into masculinity. Men worked in a wide range of occupations, and according to historian Bill Waiser, early Saskatchewan society was dominated by a large young male workforce. This trend would continue into the 1930s.¹⁴ In 1931, 17.1% of Canadian single men in rural settings were unmarried, and 11.5% of Canadian men were unmarried in urban centres.¹⁵ Many young urban men, like author James Gray in 1920s Winnipeg, were able to move from job to job, seeking higher wages and greater job

¹¹ Theresa Healy, "Prayers, Pamphlets and Protest: Women and Relief in Saskatoon, 1929-1939" (MA Thesis, University of Saskatchewan, 1989), 89.

¹² Strong-Boag, 51.

¹³ *Ibid.*, Table I, 43.

¹⁴ Bill Waiser, *Saskatchewan: A New History* (Calgary: Fifth House Ltd., 2005), 64.

¹⁵ *Ibid.*; Strong-Boag, 82.

satisfaction.¹⁶ On the farms, bachelor men working as labourers filled a temporary need in the community. Working to save up for land of their own, and the familial trappings associated with it, reinforced the farm labourer's position in the community.¹⁷ According to historian Cynthia Comacchio, "the male-breadwinner ideal was the most powerful factor shaping the roles and relations of gender and family during the early twentieth century."¹⁸

The end of one's career depended on whether or not one could afford to retire. Before pensions and social services, aged men were expected to work until they could no longer physically do so and during their working years, they were to save up for their retirement. On farms, land titles often moved from father to son. Most often the son and his family would live on the family parcel until his father died. According to sociologist Jane Synge, before pensions, "elderly people lived from their own work, from their savings, from support given to them by their families, from private charity, and from public aid."¹⁹ In 1927, the federal Old Age Pensions program was developed and disbursed \$365 per year to approved recipients. Essentially one-dollar per day, this wage appears grossly insufficient in comparison with a provincial average wage of \$0.45 per hour paid to urban common labourers who worked between eight to ten hours per day.²⁰ Old Age Pension would be further reduced if family or charitable support had also been received. Editors and historians Beth Light and Ruth Roach Pierson suggest that society strongly believed that all persons should save up for their own

¹⁶ James Gray, *The Winter Years* (Toronto: MacMillan of Canada, 1966), 10-13.

¹⁷ Cecilia Danysk, "'A Bachelor's Paradise': Homesteaders, Hired Hands and the Construction of Masculinity, 1880-1930," in *Making Western Canada: Essays on European Colonization and Settlement*, eds. Catherine Cavanaugh and Jeremy Mouat (Toronto: Garamond Press, 1996), 161.

¹⁸ Cynthia Comacchio, "Bringing Up Father: Defining a Modern Canadian Fatherhood, 1900-1940," in *Family Matters: Papers in Post-Confederation Canadian Family History* eds. Lori Chambers and Edgar-Andrew Montigny (Toronto: Canadian Scholars' Press, 1998), 293.

¹⁹ Jane Synge, "Work and Family Support Patterns of the Aged in the Early Twentieth Century" in *Aging in Canada: Social Perspectives* ed. Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980) 135.

²⁰ Dominion Bureau of Statistics, *The Canada Year Book 1931* (Ottawa: F. A. Acland, 1931), Table 3, 795.

retirement. For most, however, saving for retirement was “a great difficulty not only for the urban proletariat, both male and female, but for all working women given their generally low earnings.”²¹ Furthermore, it was expected that children and other family relations would take care of aging relatives, leaving unmarried and childless women vulnerable as they had fewer kin members to depend on.²²

Being a housewife was a mark of middle-class respectability because it was a gender-appropriate occupation. Spinsters, on the other hand, were considered redundant because they offered nothing but dependence to the family economy.²³ Empty-nesters and widows who had at one time occupied this role found themselves lumped in with spinsters as they had no spouse or children to care for, and thus had to rely on family for support. This dependence and redundancy could lead to institutionalization when symptoms of mental illness presented themselves. Historian Cheryl Krasnick Warsh found in her analysis of the Homewood Retreat in Guelph from 1883 to 1923, that socially redundant females outnumbered males five-to-one.²⁴ At SHNB, 108 widows and ten spinsters over sixty (the average age of widowhood among patients) were recorded in the ‘civil condition’ column. While comprising only seven percent (7%) of admissions between 1929 and 1939, eighty percent (80%) of spinsters and sixty-three percent (63%) of widows were committed and left until their death. Out of the sixty-eight widows who lived and died at the hospital, fifty-four were over sixty. Men did not fare much better, however. Sixty-two percent (62%) of widowers and seventy-six percent (76%) of aged bachelors remained at the hospital until their death. These numbers reinforce Warsh’s conjecture that widows and

²¹ *No Easy Road: Women in Canada 1920s to 1960s*, eds. Beth Light and Ruth Roach Pierson (Toronto: New Hogtown Press, 1990) 314.

²² *Ibid.*

²³ Cheryl Krasnick Warsh, “The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923,” *CHA Historical Papers* (1988), 160.

²⁴ *Ibid.*

spinsters were at risk of being committed by their families due to their financial dependence and their assumed redundancy. This concept of redundancy, however, needs to be extended to widowers and aged bachelors, as they were committed in almost equal numbers and met the same ends. In addition, referring back to Table 2, the number of men residing in the hospital longer than two years was the second most common length of time. For women, residing at the hospital for longer than two years was a distant third. Tables 3.1a-3.11b show that the combined increase in paroles and decrease in committals of female patients in 1929, 1930, 1932, 1935, 1936, and 1937 seldom appeared in male patient statistics. Though male admissions decreased, fewer were being paroled than females. From these statistics, it would appear that when work ceased for men they were also considered redundant, and they were just as vulnerable to incarceration as women.

Rising rates of unemployment and inadequate relief support directly challenged masculinity as it reduced work and replaced it with dependence. Historian Denyse Baillargeon has noted that “the Great Depression has appeared, both at the time and in retrospect, as an essentially “masculine” crisis...because it undermined the breadwinner status that constituted the foundation of male power and identity.”²⁵ Unemployment was a direct threat to the essence of man; conversely, if a married woman worked, her femininity was defiled. A married woman worker was portrayed as indulgent, seeking “pin money” for her excesses. Many such women were demoted, forced into lower wages or asked to resign.²⁶ Floating in the abyss between

²⁵ Denyse Baillargeon, “Indispensable But Not a Citizen: the Housewife in the Great Depression,” in *Nation and Society: Readings in Post-Confederation Canadian History*, Volume 2, eds. Margaret Conrad and Alvin Finkel (Toronto: Pearson Education Canada, 2008), 257.

²⁶ The case of a young woman working for the Imperial Bank of Canada in Saskatoon is recorded. She is given a letter which asks for her resignation citing the existence of male workers in lower positions that have been there for several years. “Their development is retarded by the fact that ladies are occupying the positions that should be filled by young men.” G. D. Ritchie to Miss _____, 16 September 1935, reprinted in “Discrimination Against Women in Banks,” *The Business and Professional Woman* (December 1935): 2, quoted in Hobbs, 278.; Healy, 90.

women's work and masculinity were single women. The employment of single women did not attack their gendered role, but was considered a half-way house between the home of their father and that of their future spouse. Historian Margaret Hobbs analyzed Toronto relief policies and contended that the pressures of the Great Depression "seemed to be redrawing the boundaries between masculine and feminine territory" as they utilized and reinforced a gender-based criteria of dependence.²⁷ Single women, for example, were denied relief as they were expected to be dependent upon their male relations for support.²⁸ Denyse Baillargeon notes that the government went to great lengths to "confirm the privileged access [that] men had to a source of income, a proof of both their independence and their status as citizens."²⁹ Cynthia Comacchio suggests that Canadian fathers "needed the protection of the state, of...experts and of their wives because their domestic presence was crucial to the all-important preservation of the family's traditional form."³⁰

Author James Gray, a survivor of the 1930s, described the Depression: "It was a decade that destroyed men's faith in themselves, mocked their talents and skills, blighted their initiative, and subverted their dedication to the cultivation of their land."³¹ Gray himself had stood in the relief line, and felt the shame and disappointment in having to beg to provide for his family.³² According to Hobbs, married men like Gray who were receiving relief "were thought to need all the incentive the state could muster to counter the softening, feminizing influence accompanying the severing of paid employment — that life blood of masculinity."³³ As a result, work-for-relief programs were attempted for the first few years of the Depression. Gray experienced the work

²⁷ Hobbs, 201.

²⁸ Waiser, 286.

²⁹ Baillargeon, 258.

³⁰ Comacchio, 303-4.

³¹ Gray, 6.

³² *Ibid.*, 13.

³³ Hobbs, 201.

for relief programs in Winnipeg. These make-work projects, as James Gray attested, were menial jobs such as picking dandelions or sweeping streets. He lamented that though there were lots of areas that needed repair, roads for example, these jobs were not given to relief labourers. In Saskatoon, public works projects were utilized for the first few years of the Depression, but soon proved too costly. Direct relief was subsequently put in place. Relief in the form of vouchers or cash removed men even further from the realm of work, leaving them to stagnate in the female sphere.

Comacchio suggests that “the Depression emergency...did not strike at the heart of feminine identities in the way that the loss of provider status affected men,” yet Bill Waiser contends that women seemed to be more adversely affected than their partners.³⁴ Rural women helped in the fields as hired help became a luxury, while maintaining the home with less technology than their urban sisters. In an effort to economize, women went without more store-bought items, opting to make food stuffs themselves.³⁵ Christa Scowby has found in her analysis of the Western Producer’s “Mainly for Women” section, that many women looked to this page for information on a variety of topics. Women requested information on labour-saving devices, household hints, water supply and recipes. Little interest was paid to “reading, book reviews and home decorating.”³⁶ Women learned new skills and utilized existing skills to barter and trade for others. Theresa Healy discovered that Saskatoon women developed an underground economy, “providing board and lodging, child minding, laundry and cleaning services, in-home hair styling, sewing or dressmaking, [and] cooking.”³⁷ In dealing with inadequate relief, many women found ways to top it up, though if found out, they could have been barred from future

³⁴ Comacchio, 294; Waiser, 296.

³⁵ Waiser, 296.

³⁶ Scowby, 78.

³⁷ Healy, 102.

relief payments.³⁸ Saskatoon women, for example, in getting around the voucher system, would buy other goods within the cash value of the voucher as long as they had made an agreement with shop owners.³⁹ Women increasingly took in boarders in the Depression era. The 1931 Census Monograph on the Family shows that nearly ten percent (10%) of all Canadians lived in residences which did not belong to persons within the family circle.⁴⁰ Fifty-four percent (54%) were lodgers.

Married women in the workforce were persecuted during the Great Depression because many politicians and activists felt they were taking jobs from unemployed fathers. Married women were asked to leave their white collar jobs, or were pressured by the media and political groups to vacate. Blue collar industries, meanwhile, continued to hire women as they could pay them less than they could men. Single women, according to Hobbs, “could be more easily assimilated into the male conceptual models of employment and unemployment...their need for self support was not scrutinized to the same degree as married women worker’s need.” Yet, but not officially, many were asked to leave their jobs and return home to their fathers. Their proper role as dependent daughter was demonstrated by the fact that relief policy was not extended to single women and they were left to depend on charitable organizations, like the YWCA, for their survival.⁴¹ The areas where women continued to find employment were in areas where men did not want to work, for example, in domestic service.⁴² In fact, some women were castigated for not taking domestic work when it was available.⁴³ Low wages combined with underemployment contributed to the “ghettoization” of women, which interestingly, kept many women employed.

³⁸ *Ibid.*, 112.

³⁹ *Ibid.*

⁴⁰ *No Easy Road*, 131.

⁴¹ Healy, 175.

⁴² Hobbs, 284.

⁴³ Healy, 143.

By relegating women into lower-status jobs like domestic service, historian Veronica Strong-Boag asserts that:

the Great Depression retarded the long-term decline in personal service, especially domestic service, slowed the growth of the professional and clerical sectors, and slightly accentuated the long drop in the number in manufacturing and mechanical occupations.⁴⁴

The Great Depression exposed existing fault lines in both social policy and in family relationships. While relief policy floundered and failed over and over, family harmony had to ride the waves as best as possible. They were living in a world which was far from the ideals they worked to obtain. James Gray noted that the most difficult experiences occurred when “household articles wore out or broke and had to be replaced...In any rooming house, these spats could be heard erupting like firecrackers.”⁴⁵ In families where relief was being received, women who were responsible for ensuring that their family was being fed and clothed, had their hands tied by men who spent it on alcohol or other non-essentials. As the relief money or vouchers came in the name of the husband, women were unable to maintain their households without help from the courts.⁴⁶ In addition, according to historian Lara Campbell, the Great Depression “exposed the phenomenon of temporary desertions, where men left for extended periods of time to look for work, often leaving women unsure as to when, or if, they would return.”⁴⁷ Work patterns in these families would differ from the ideal, as single mothers and wives with dissolute spouses would have to do more to ensure that their family survived. Women’s primary role of nurturing their children was extended to encompass discouraged spouses. According to Byrne Hope Sanders, editor of *Chatelaine* in the 1930s, wives were encouraged to show more

⁴⁴ Strong-Boag, 51.

⁴⁵ Gray, 30.

⁴⁶ Campbell, 132-133.

⁴⁷ *Ibid.*, 49.

“thoughtfulness and tenderness toward men.”⁴⁸ Emotional support towards husbands was essential in an era which challenged the foundation of male identity. Families who worked together, survived together. Comacchio asserts that family harmony during the Depression was found in families “where domestic roles were clearly defined and accepted, and where family relations were founded on mutual respect and complementarity.”⁴⁹ In agreement with Comacchio, Campbell suggests that “...the institution of the family held possibilities for conflict, but it also embodied relationships of mutual economic support.”⁵⁰ Not only did it take work to survive financially, but also to ensure harmony within the household.

As noted in the previous chapter, the ‘habits of life’ column of the General Register of SHNB reveals much about how society defined upright citizens. Outside the appraisals of behaviour considered ‘good’, ‘fair’, ‘excellent’, ‘poor’, or any combination of these, it was the descriptive attributes like ‘idle’, ‘lazy’, or ‘industrious’ which shed greater light on what constituted good or bad behaviour. Patient 4797, a Hungarian farmer who was committed in June 1930 at sixty-seven years of age, was characterized as “fair, though lazy.”⁵¹ Patient 5816, a married twenty-three-year-old store clerk, was brought to the hospital in May 1933, and subsequently described as being “good- no occupation.”⁵² Characterizing patients by the way they engaged with work is interesting. Being good or fair was not enough when being lazy or jobless was considered problematic. Patient 4719, a twenty-seven-year-old Polish rural housewife, was committed in December 1930, and was described as “does not work.”⁵³ Patient

⁴⁸ *No Easy Road*, 135; Campbell, 27.

⁴⁹ Cynthia R. Comacchio, *The Infinite Bonds of Family: Domesticity in Canada, 1850-1940* (Toronto: University of Toronto Press, 1999), 125.

⁵⁰ Campbell, 99.

⁵¹ Patient 4797, General Register, Ledger 9 Folder 2, North Battleford Patient Ledgers, Saskatchewan Archives Board.

⁵² Patient 5816, General Register, Ledger 9 Folder 2.

⁵³ Patient 4719, General Register, Ledger 9 Folder 2.

5596, a thirty-five-year-old housewife who “used to be good, now neglects work,” was committed in November 1932.⁵⁴ Again, these women were defined by their work habits, as if these behaviours were symptomatic of mental illness. Though patients with these unique characterizations remain in the minority, they provide insight into how work was used to define good or bad behaviour during the Great Depression.

Another column of the General Register which sheds light on the theme of work during the Depression was the ‘occupation’ column, where each patient’s job title was noted. Table 4 (appendix) illustrates the breakdown of occupations among male and female patients from 1929 to 1939.⁵⁵ Similar to the ‘habits of life’ column, the ‘occupation’ column made special note of the twenty-four unemployed patients, the ninety-nine who had no occupation, or the one patient on relief. As the ledgers were filled out by hospital staff, it is hard to determine what information was given by the patient and what was an interpretation made by staff. However unclear, the occupation column defined patients according to their engagement with work. Twenty-six patients, the youngest being fifty-five, were defined as being “retired farmers.” Though not actively engaged in farming, their former livelihood was considered to be an important part of their identity. This trend was also true for the retired school teacher, patient 4583, and the retired engineer, patient 5247.⁵⁶ Sixty percent (60%) of all female patients were identified as housewives, and nearly fourteen percent (14%) were domestic labourers, a distant second. The prevalence of these two categories of female labour reinforces the fact that first, women were expected to marry and raise children, and secondly, the most appropriate form of female labour outside the home was in domestic service. In addition, forty-one widows over age

⁵⁴ Patient 5596, General Register, Ledger 9 Folder 2.

⁵⁵ Occupational data was collected for first-time admissions only as the patient ledgers were seldom completed for readmitted patients. As a result, 495 male and 405 female patients were removed to calculate this set of statistics. Categories were created by the author who used the 1931 Canadian census as a guideline.

⁵⁶ Patient 4583 and Patient 5247, General Register, Ledger 9 Folder 2.

sixty were classified as housewives, thus illustrating that these women were assumed to identify with their former role, despite their husband's death and long after children were raised.

Many occupations placed labourers under stress, though some were worse than others. Karen Smoyer-Tomic, et.al., concluded that farming was one of the most stressful occupations in society and that financial difficulties and bad weather were some of the highest causes of stress among farmers.⁵⁷ When the severe drought, dust storms and low wheat prices of the Depression are taken into consideration, a defensible connection between farming and mental illness in the 1930s can be made. During the Depression era, single farm labourers, who were once readily accepted into homesteading culture as necessary labour, were now seen as un-ambitious, shiftless, and disregarded as drifters.⁵⁸ Bachelor hired hands lived a lonely existence, since they were less likely to marry due to their high degree of mobility and job insecurity.⁵⁹ Domestic service, according to Veronica Strong-Boag was “the oldest and largest of female occupational groups. It was also among the most assiduously avoided and the lowest in status.”⁶⁰ Female domestic labourers often found themselves at the mercy of the family they served, forced through their dependence on wages to accept long hours, difficult work and even to have to deal with unwanted sexual advances.⁶¹ Housewives sacrificed their dreams, their material possessions, food and even clothing to ensure the survival of their family. According to Waiser, women bore “the brunt of these years more heavily than their partners... they worked alongside their husbands, all the while providing encouragement and support.”⁶² Lack of funds to purchase

⁵⁷ Karen Smoyer-Tomic, et. al. “Health Consequences of Drought on the Canadian Prairies,” *EcoHealth Journal* Volume 1, Supplement 2 (2004), SU150.

⁵⁸ Danysk, 168.

⁵⁹ *Ibid*, 167-8.

⁶⁰ Strong-Boag, 54.

⁶¹ Campbell, 33.

⁶² Waiser, 296.

or repair time- and labour-saving household implements, while avoiding store-bought food stuffs through home production, increased the housewife's work day significantly.⁶³

Occupational stressors, combined with Depression-related poverty and unemployment, could have caused the development of symptoms deemed akin to mental illness. Some turned to drink, others to drugs, and some refused to work any longer. It was acceptable to be frustrated with work or unemployment, but not to shirk work. Patient 4590, a Romanian farmer, was committed in November 1929 and his habits of life completed with the phrase "will not work."⁶⁴ Refusing to work was also the sole characteristic given to patient 4736, an American labourer committed in April 1930.⁶⁵ Patient 4719, a Polish rural housewife, was committed in March or April 1930 and defined as someone who "does not work." Patient 5596, whose habits of life were summarized as "used to be good, now neglects work," reinforced the fact that when these patients refused to engage in the world of work, their behaviour became considered symptomatic of mental illness. Considering refusal to work as a symptom of illness coincides with historian David Wright's research on identification and diagnosis of mental illness by families and civil authorities. He concluded that:

it was not the *absence* of a desire to fulfil sex-specific roles that warranted attention in the certificates of insanity...but rather the sudden and unexplained *cessation* of former sex-specific activities that alerted family members that something was wrong.⁶⁶

⁶³ *Ibid.*; Veronica Strong-Boag, "Pulling in Double-Harness or Hauling a Double Load: Women, Work and Feminism on the Canadian Prairie," in *The Prairie West: Historical Readings*, eds. R. Douglas Francis and Howard Palmer (Edmonton: Pica Pica Press, 1992), 407.

⁶⁴ Patient 4590, General Register, Ledger 9 Folder 2.

⁶⁵ Patient 4719, General Register, Ledger 9 Folder 2.

⁶⁶ David Wright, "Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (New York: Editions Rodopi B. V., 2004), 165-6.

When patients arrived at the hospital, they did not leave the world of work behind. In fact, for patients who were unemployed or retired, life at the hospital symbolized a return to full-time labour. Dr. J.W. MacNeill, superintendent of SHNB throughout the 1930s employed patient labour in the hospital. Both skilled and unskilled labour was utilized. Patients worked in the kitchen, laundry, and the wards. They also worked as plumbers, tailors, barbers, electricians, shoemakers and blacksmiths, and on the farm, irrigation farm and the experimental orchard. Specialty shops produced furniture, mattresses, clothing items, blankets, quilts, and toys, just to name a few.⁶⁷ In 1929, 552 men and 314 women worked in various occupations throughout the hospital and its grounds. By September 1930, there were 682 male and 358 female patients residing at SHNB when the hospital's annual report was submitted to the Department of Public Works. While each of the annual reports gave an account of the success or failure of the hospital farm, the 1930 *Annual Report* was the most thorough of all reports submitted during the 1930s, because it included the number of patients employed at each of the shops and occupational therapy groups that the hospital had. No other report included this information. From the 1930 report, it is evidenced that eighty-one percent (81%) of men and eighty-eight percent (88%) of women who were committed were engaged in some form of patient labour between 1929 and 1930.⁶⁸ While this report only represents one year and though this annual report was filed early in the Depression, it is likely that these numbers climbed due to increased levels of overcrowding and decreasing operating funds throughout this period.

⁶⁷ For a more comprehensive list, see *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1930*. (Regina, SK: J.W. Reid, King's Printer, 1930)

⁶⁸ To calculate this statistic, the numbers given in the 1930 *Annual Report* (66) were compared with the total number of patients residing at the hospital, according to the Daily Record Ledger, at the end of the month preceding the day the report was submitted (September 5, 1930). *Annual Report of the Department of Public Works, 1930*; Daily Record- Saskatchewan Provincial Hospital, Ledger 7, North Battleford Patient Ledgers, Saskatchewan Archives Board.

Even in the hospital, gender roles continued to be enforced through engaging in appropriate forms of labour. Male patient labourers were employed in more physically taxing areas including handling coal, maintaining the septic tank, servicing roads, stone work, plastering, electrical work, plumbing and not surprisingly, farming. Other than the road crew, which employed sixty, the largest contingency of patients employed in one area, at forty-eight, was on the farm. The mandate of the farm at SHNB was to feed only the residents of the hospital, and even that was a lofty task.⁶⁹ Table 6 (appendix) shows that each year, the farm produced thousands of pounds of milk, beef, pork, chicken, eggs, turkey, lamb and mutton. Wheat, oats, corn, sunflowers, barley, and in some years, alfalfa and sweet clover, were planted and harvested for the hospital's use. The irrigation farm was harvested for the first time in 1938 and produced a large and varied grain and vegetable crop despite the drought which was decimating crops in the area. The experimental orchard planted apple, cherry, and crab-apple trees. Acres were cleared for berry patches including strawberries, raspberries, gooseberries and red currants. The vegetable garden contained multiple types of vegetables, the most common being potatoes, tomatoes, turnips, cabbage, onions, carrots, peas, beans and beets. It varied every year, but most years, especially when the irrigation farm was started, swiss chard, spinach, corn, lettuce, green onions and celery were planted. Like many other farms in the area, the farm and gardens of SHNB were vulnerable to drought, especially in 1937 and 1938. However, the hospital farm had an almost endless supply of free labour where local farmers did not.

Male patients who were former craftsmen applied their skills making handmade furniture and accessories. According to the 1930 *Annual Report* submitted by SHNB to the Department of Public Works, from 1929 to 1930, men employed in the basket shop made many items including

⁶⁹ Delores Kildaw, *A History of the Saskatchewan Hospital, North Battleford, Saskatchewan* (Saskatoon: University of Saskatchewan, 1990-91), 39.

lamps, foot stools, tables and chairs. The toy shop fashioned hundreds of toys including wagons, carved animals, cradles and hobby horses for sale. The tailor shop contributed their skills to sewing the attendants' coats, shirts and trousers and hundreds of overalls. Female patients worked in domestic areas. In 1929-30, the largest contingent of female patients employed, assisted in maintaining the wards. Women also worked in the sewing class doing fancy handiwork, in the flower garden, and in the laundry. The Occupational Therapy Class contributed hundreds of articles of clothing from bloomers, kimonas and smocks to scarves, dresses, night dresses and pyjamas. From the variety of occupations in which men were employed, and the short list of jobs available to female patients, it is clear that male patients could utilize the breadth of their talents while women were streamlined into domestic service or sewing. Much like the outside world, except with no threat of unemployment, men and women were employed in areas considered proper for them to occupy. Patients who engaged in work therapy showed to the hospital staff and their families that they were on the road to recovery.⁷⁰ As sociologist Harley Dickinson has noted, "the ability to work...was considered the *sine qua non* of sanity and the most likely route by which a person would be returned to that state."⁷¹

Recovery was hoped for through patient labour. J.W. MacNeill stated in his report to the Department of Public Works in 1931 that he and his staff endeavoured to "keep every patient occupied whom we possibly can, and in this way, we improve both their mental and physical health."⁷² MacNeill and others believed that both physical and psychological improvement resulted from 'work therapy', as he termed it. They worked every able-bodied patient to ensure

⁷⁰ Reaume, 217.

⁷¹ Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984*. (Regina: Canadian Plains Research Centre, 1989), 25.; this is also suggested in James E. Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario*. (Montreal: McGill-Queen's University Press, 2000) 92.

⁷² *Annual Report of the Department of Public Works, 1931*, 61.

“they were physically tired at the end of the day and ready for normal sleep.”⁷³ The Saskatchewan Hospital North Battleford published a small pamphlet which conveyed to new patients the purpose behind work therapy:

Occupation keeps the troublesome thoughts away, keeps you interested in useful things and gives the necessary exercise to your mind and body...to take an interest in some occupation is the best and surest way to convince the physician that you are well enough to be home.⁷⁴

Historian of SHNB Delores Kildaw, asserts that through employment patients were given feelings of “accomplishment and self-worth in the ability to show their skills and prowess.”⁷⁵ Patients bonded with the “animals, gardens and fields they cared for and...[gained] rapport with these things, as they were then deprived of close physical or psychological inter-relationships with their families, their fellow patients or the staff.”⁷⁶ Most importantly, Kildaw argues that no pressure was placed on patients to work, and that they were only employed in areas that they were physically able to work in.⁷⁷ Work therapy, however, was a contentious issue among superintendents, government officials, the patients themselves and their families.

Historian Geoffrey Reaume notes that patient labour had been praised as therapeutic throughout the first half of the twentieth century.⁷⁸ These labour-intensive jobs, however, were far more “intense than any light duties that the architects of moral reform had envisioned.”⁷⁹ The harvest produced thousands of pounds of produce and the various shops and classes created hundreds of clothing articles, toys, mattresses and several other items. As eighty-one percent

⁷³ Kildaw, 15.

⁷⁴ J. W. MacNeill, “Why Was I Admitted to a Saskatchewan Hospital: Questions and Answers,” n.d. Saskatchewan Archives Board, quoted in Dickinson, 27.

⁷⁵ Kildaw., 38

⁷⁶ *Ibid.*, 38.

⁷⁷ *Ibid.*, 41; see also Dickinson, 26-28.

⁷⁸ Reaume, 154.

⁷⁹ *Ibid.*, 180.

(81%) of men and eighty-eight percent (88%) of women were engaged in work therapy, it is clear that the hospital relied on this significant and free workforce. Reaume indicates that patient labour cut down on costs, which was true at SHNB. Meat, eggs, milk, produce and clothing, made possible by patient labour, were provided to staff and inmates. In addition, patient labourers did repair work, renovation and general upkeep. In the 1939 Annual Report to the Department of Public Works, 170 jobs were listed under occupational therapy.⁸⁰ This list included building new roofs, windows, fences, basements, an incinerator and a septic tank. Walls were plastered and painted, sinks and doorways were installed, and floors were laid. Some notable jobs were: “trench dug for telephone cables and cables laid in concrete,” “rewired old root cellar,” “put in cribbing and repaired sewer at septic tank,” and “built full basement under nurses’ home.”⁸¹

With such a large workforce at the hospital’s disposal, did the use of such labour ever cross an ethical line? Were there occasions where the use of patient labour could have been considered abuse? Geoffrey Reaume discovered in his study of insane asylums in Victorian Ontario that unpaid inmate labour was worse than the lowest paid jobs as they could not negotiate for wages, hours or better conditions.⁸² While work was deemed to be therapeutic, gender-appropriate labour kept women indoors, unable to enjoy the fresh air that was considered a privilege to male patient labourers. Farm labour and cultivation of vegetables were areas where women outside the hospital laboured, but not at SHNB. Flower gardens were tended by female patients at SHNB, but only six were employed between 1929 and 1930. In addition, Dickinson suggests that the use of patient labourers had major consequences for staff and

⁸⁰ *Annual Report of the Department of Public Works, 1939*, 108-111.

⁸¹ *Ibid.*, job numbers 78, 87, 34 and 57, 109.

⁸² Geoffrey Reaume, “Patients at Work: Insane Asylum Inmates’ Labour in Ontario, 1841-1900,” in *Mental Health and Canadian Society: Historical Perspectives* eds. James E. Moran and David Wright (Montreal: McGill-Queen’s University Press), 89.

inmates. First, it created an incongruous relationship between work and parole. Even though parole was the carrot used by staff to encourage patients to work, it seemed that the better the work of the patient, the less likely they were to be paroled.⁸³ Secondly, private use of patient labour became accepted and widespread.⁸⁴ In 1929-30, eleven women were reported to have worked in employees' quarters, and two others worked in the officers' dining room. Tailors made attendant coats and some men "repapered Dr. Nelson's cottage."⁸⁵ An anonymous letter received by the Department of Public Works conveyed the acceptance of patient labour as necessary and appropriate: "it is...true that I employed patient labour in putting in my garden and painting my cottage- that is a privilege which has been extended to any member of the staff."⁸⁶

Two cases from the fonds of Department Minister John M. Uhrich illustrate how patient labour and its promised rewards were interpreted by patients, the hospital, and families. Patient 6748 addressed a letter to her grandfather in Wymark, begging him to have her discharged. She complained that she was being kept in the hospital so that she would continue to do all the laundry for the staff and patients. She lamented, "for all these we have to do the work for absolutely nothing!"⁸⁷ She called the work "to slave" and that it caused "sufferings."⁸⁸ The Deputy Minister and the Commissioner of Mental Services, who happened to be J.W. MacNeill, investigated her concerns, and found them to be without basis. By virtue of her diagnosis of "mental deficiency without psychosis,"⁸⁹ and the note in her file which stated that "there is no

⁸³ Dickinson, 28.

⁸⁴ See Eric Kempthorne, "Social Control and the Mentally Ill: Towards a Theory of Deinstitutionalization," (MA Thesis, University of Saskatchewan 1995), 50.

⁸⁵ *Annual Report of the Department of Public Works*, 1930, 68; *Annual Report of the Department of Public Works* 1939, job number 42, 109.

⁸⁶ Dickinson, 28; Another case where a staff member had used hospital supplies, and had stolen patient-crafted furniture and toys is found in Dickinson, 65.

⁸⁷ Letter dated April 26, 1937, J. M. Uhrich fonds, Saskatchewan Archives Board.

⁸⁸ *Ibid.*

⁸⁹ Patient 6748, General Register, Ledger 10, Folder 1.

possibility of her getting along outside without a good deal of supervision,” Dr. MacNeill recommended that she should remain in institutional care.⁹⁰ She continued in her letter: “Then the Drs. Here [sic] send letters to the government that we and others are not sane, and if not, why do they keep us here?”⁹¹ This statement brings up an interesting point. If patients were ill, why were they engaged in such hard labour? Conversely, if patient 6748 was determined to be too insane to be at large, and needed ongoing incarceration, then why was she asked to work, if work was an indicator of mental health? The second case was a 1938 request for payment for the work done by a husband, a patient at SHNB who was engaged in work therapy at the storehouse of the hospital.⁹² His spouse’s sole source of income was his \$32.50 monthly pension, hardly enough to raise two teenage children. Minister Uhrich responded that “any work performed by patients is regarded as occupational therapy-a part of their treatment- and under no consideration is payment made therefor.”⁹³ Uhrich added that he doubted that the patient was paying for his accommodation at the hospital.⁹⁴ Obviously, the patient’s wife did not see things this way as she believed she was entitled to the wages she felt her husband should be receiving. The connection between work and wages, not work and wellness, was defended by this destitute wife. From Uhrich’s comments, it is hard not to conclude that patient labour was considered payment for a patient’s maintenance in the hospital. This conflict makes evident that work therapy remained secondary to the ‘payment’ these patients were offering through their labours.

Use of patient labour cut down on contractors fees, grocery bills, and cleaning staff, while allowing the hospital to be maintained during a period of cutbacks and limited funding.

⁹⁰ Letter from Dr. J.W. MacNeill, MD, Superintendent and Commissioner of Mental Services to Dr. R.O. Davison, Deputy Minister of Public Health, dated May 8, 1937. J. M. Uhrich fonds.

⁹¹ Letter dated April 26, 1937, J. M. Uhrich fonds.

⁹² Department Memo from J. W. Estey to Honorable J.M. Uhrich, MD, Minister of Public Health, dated April 5, 1938. J. M. Uhrich fonds.

⁹³ Memorandum for Honorable J. W. Estey, dated April 8, 1938. J. M. Uhrich fonds.

⁹⁴ *Ibid.*

J.W. MacNeill had implored the Department Minister to allow for new buildings to be constructed to house the ballooning population at SHNB.⁹⁵ In 1935-1936, a new building was built to house 120 patients, but that was not sufficient. While work was burdensome, Delores Kildaw argued that work therapy allowed patients to leave the overcrowded and restrictive hospital for the day, which was a boon to staff and patients alike.⁹⁶ Furthermore, not all patients resented work. Reaume argues that for some, work was ennobling.⁹⁷ Working day by day, no matter the task, defined these patients, just as it did outside the walls of the hospital. Furthermore, the patients were able to work for their 'living' and that of others who were too incapacitated to do so.⁹⁸ The produce, handicrafts and furniture made by patients of SHNB were exhibited at annual bazaars. The Field Day on the Hospital Farm and the Battlefords Exposition gave the hospital many awards for the cattle, swine, and horses raised by patients. When the farm was phased out in the 1950s, many patients felt "great anger, hostility, heartbreak and incomprehension" as they had great pride and connection with their work.⁹⁹

Whether ennobling or gruelling, or just something one had to do, the willingness to engage in work was a defining characteristic for men and women in the Depression era. A woman's work was never done, yet masculinity was reinforced by employment. However, women who did not shoulder their part of the burden were condemned equally with men who shirked work. Being unemployed fundamentally challenged the masculine role of provider and breadwinner. Aging men and women were also defined by their ability to work, especially in an era of financial constraint. Widows and widowers, along with bachelor men and spinster

⁹⁵ See *Annual Report[s] of the Department of Public Works* submitted in the years 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, and 1937.

⁹⁶ Kildaw, 38.

⁹⁷ Reaume, *Remembrance of Patients Past*, 169.

⁹⁸ Kildaw, 38

⁹⁹ *Ibid.*, 42.

women, placed pressure on families for their care, leading them to be considered socially redundant, and vulnerable to incarceration in a mental hospital when they became remotely symptomatic of mental illness. Yet retired men and widowed women were still identified by their former occupation or role. The ability to, and the importance of, work did not disappear when a patient arrived at SHNB. Work was considered the best form of therapy, and those who laboured without complaint received rewards such as extra meal items and even the possibility of parole.¹⁰⁰ Industrious patients were vital to SHNB, whose maintenance, clothing and feeding came through their own labours. The question, however, whether work was appropriate for the mentally ill continued to arise in the minds of patients and their families. Despite this, there was an underlying attitude among staff members that they were entitled to patient labour. Some considered patient labour as payment for their treatment at the hospital. Yet, unlike Silverman's prairie women, it is possible that patients felt ennobled by their work. The opportunities afforded patients by the hospital to create items for sale, such as furniture and toys, and to compete in agricultural expositions, provided patients a form of approval and commendation. As the employment rate at SHNB was much higher than outside the hospital walls, men and women were able to remain occupied during their lengthy incarcerations. Whether working to ensure the survival of the family or the hospital, work continued to be essential to identity, survival, and the therapeutic aims of SHNB throughout the 1930s.

¹⁰⁰ Reaume, 152, 165-6.; Kempthorne, 51.

Chapter Three

Political Laboratory, Negotiated Space, and Theatre of Struggle: The Saskatchewan Hospital North Battleford and Canadian Social Reproduction

The reason for her being there was because she allowed a person to deceive her with promises of marriage, should she yield to his desires, and which promise was later broken.¹

In 1939, an eager grandfather wrote to Dr. John F. Uhrich, Saskatchewan Minister of Public Health, requesting the release of his granddaughter, a patient of the Saskatchewan Hospital North Battleford (SHNB). Patient 6748 was committed in November 1935 and diagnosed with mental deficiency without psychosis.² In a follow-up letter he wrote that she would be a “great help in doing the housework as we are both sick most of the time.”³ Minister Uhrich replied “that matters of this nature are quite outside my jurisdiction. They are left to the discretion of the superintendents of the hospitals concerned.”⁴ He suggested that his request be taken up with Dr. J.W. MacNeill, the current superintendent of SHNB, as he would be better able to decide if the granddaughter was recovered enough to be eligible for parole.⁵ As this case illustrates, the mental hospital was, in some cases, a site for social control utilized by families and by society to incarcerate persons they considered deviant. According to her grandfather, patient 6748 was committed because she transgressed social mores by engaging in sexual intercourse outside of marriage and was not really dangerous or insane, as the law required. At the same time, though, the grandfather did not question the original reason for incarceration.

¹Letter from Wymark, SK to Hon. John F. Uhrich, Minister of Public Health, dated April 7, 1939. J. M. Uhrich fonds, Saskatchewan Archives Board.

²Patient 6748, General Register, Ledger 10 Folder 1, North Battleford Patient Ledgers, Saskatchewan Archives Board.

³Letter from Wymark, SK to Hon. John F. Uhrich, Minister of Public Health, dated May 4, 1939.

⁴Reply letter to Wymark, SK from Hon. John F. Uhrich, Minister of Public Health, dated May 9, 1939.

⁵*Ibid.*

The interwar period was characterized by an obsessive fixation on social reproduction. The devastating casualties of the First World War, the declining birth rate among white upper-class women and the rapid urbanization of cities caused Canadians to wonder what sort of society their children would grow up in. Growing working-class populations comprised largely of immigrants and situated in cities, were considered responsible for escalating crime rates, loose morals, and the severing of traditional family ties. Social reformers and politicians enacted legislation that would endeavour to suppress crime, while ‘protecting’ Canadians from the evils of urban society. Drugs and alcohol were prohibited, the latter for only a short period of time, urban working conditions were improved, and children and youth convicted of crime were sent to training schools instead of jail in hopes of curbing their delinquency. Immigration policy was tightened, allowing only those considered ‘fit’ to enter. Hierarchies of races were developed, based on the perceived suitability and likelihood of success in assimilating into Canadian society. Deportation numbers increased as municipal employees became watchdogs for the Department of Immigration, informing them whenever an unnaturalized immigrant applied for relief. The motivation behind this legislative and judiciary involvement in Canadian public life during the early twentieth century was based on an earnest desire to form and mould Canadian society into an image held by the Anglo-Canadian elite. Maintaining this image became complicated yet clung to more fervently during the financial turmoil of the Great Depression. Skyrocketing unemployment, crashing prices, overtaxed municipalities with growing relief expenditures exacerbated underlying concerns about crime, immorality, and their effects on social reproduction.

The anxieties and political climate of the early twentieth-century did not stop at the door of SHNB. Historians Dorothy Chunn and Robert Menzies suggest that:

...while the asylums and hospitals of the late nineteenth and early twentieth centuries were “total institutions” in every respect, they were also political laboratories, theatres of struggle, and “negotiated spaces”, where the reigning social conflicts of the day were played out in the discourses of sanity, (dis)order, morality, and redemption.⁶

Peter Boyle, a veteran psychiatric nurse from Weyburn, stated that the hospital had “hobos, alcoholics and eccentrics mixed in with the genuinely ill. Anybody who didn’t fit in outside was sent here.”⁷ Those considered deviant were at risk of being labelled feeble-minded or psychopathic and subsequently institutionalized. Errant sexuality or drug use and alcoholism brought men and women to the hospital to give penance or receive ‘protection’⁸. In addition, racial minorities who resided at SHNB, regardless of the severity of their illness, were in danger of deportation, due to their continued reliance on the ‘public purse’. By incarcerating or deporting ‘poor stock,’ SHNB acted as a defender of “pure” Canadian society. While social control, or moral regulation, did not function in the lives of the majority of patients committed between 1929 and 1939, it is clear that the reasons for committal and deportation of a significant few can effectively be attributed to these methods. This chapter will investigate the social movements and contributing legislation which strove to mould Canadian citizenry, and how the SHNB functioned in Saskatchewan society in the Depression era.

Before 1914, thousands of immigrants came to Canada, settling on the land or flocking to the cities. Urban populations exploded in the first decade of the twentieth century: Toronto by eighty-one percent (81%), Winnipeg by two-hundred percent (200%), and Edmonton by six-

⁶ Dorothy E. Chunn and Robert Menzies, “Out of Mind, Out of Law: The Regulation of ‘Criminally Insane’ Women Inside British Columbia’s Public Mental Hospitals, 1888-1973,” *Canadian Journal of Women and the Law*, 10 (1998), 315.

⁷ As found in Delores Kildaw, *A History of the Saskatchewan Hospital, North Battleford, Saskatchewan* (Saskatoon: University of Saskatchewan, 1990-91), 59.

⁸ While ‘protection’ denotes safety and security, Geertje Boschma suggests that it resulted in increased surveillance, “reproduced social inequality, racism, and sexual or gender control.” Geertje Boschma, “A Family Point of View: Negotiating Asylum Care in Alberta, 1905-1930,” *Canadian Bulletin of Medical History* 25 2 (2008): 378.; Joan Sangster, *Girl Trouble: Female Delinquency in English Canada* (Toronto: Between the Lines, 2002), 3.

hundred percent (600%).⁹ After the First World War, immigration policy had become increasingly selective, as legislators looked to “the most desirable future members of the country.”¹⁰ Anglo-Canadians continued to worry about the number of immigrants from countries deemed less assimilable, brought to work for railroad companies and other industrial firms. The British majority was declining and the position of Francophones was diminishing. On the prairies, immigrants were more comfortable settling near those with similar customs and language. Immigrant farmers from Central Europe were encouraged to settle the Canadian West by Minister of the Interior Clifford Sifton. They found cold comfort in Saskatchewan, however, as their differing customs and language created barriers between them and other farmers. White Anglo-Canadian men and women were considered to be at the top of the ethnic hierarchy, establishing appropriate behaviour while condemning customs, dress or appearance that they did not approve of.¹¹ Many wives felt their isolation more keenly, not only due to geographic distance from neighbours, but through their lack of exposure to the English language. Urban immigrants were condemned on all sides: labour groups scorned newcomers for driving wages down through taking lower paying and more unskilled jobs, while some employers would refuse employment to men with ethnic surnames, especially those that denoted Jewish descent.¹² Furthermore, when immigrant labourers organized, or became involved in labour unions, they became targets for deportation, as their radicalism was considered criminal. White unemployed men decried the presence of “bohunks”, “dagoes”, “chinks” and “ukes” and were supportive of measures that would remove them from the country. While this rhetoric was not new, the Great

⁹ Ninette Kelley and Michael Trebilcock, *The Making of the Mosaic: A History of Canadian Immigration Policy* (Toronto: University of Toronto Press, 1998), 112.

¹⁰ *Ibid.*, 248.

¹¹ Sheila McManus, “Gender(ed) Tensions in the Work and Politics of Alberta Farm Women, 1905-1929,” in *Telling Tales: Essays in Western Women’s History*, eds. Catherine A. Cavanaugh and Randi Warne (Vancouver: UBC Press, 2000), 124, 128-9.

¹² Kelley and Trebilcock, 218-9.

Depression made it more vitriolic as every evil and hardship was blamed on ethnic communities.¹³

Canada's immigration policy was fairly toothless, at least until 1931. By March of that year, immigration policy was restricted to allow only those of predominantly white heritage including the United Kingdom, the United States, New Zealand, Australia and South Africa. Prospective immigrants were permitted as long as they had money to keep them afloat until they found employment, or until they established themselves on the land.¹⁴ In addition, causes of deportation were enforced above and beyond the definitions laid out in immigration policy. Becoming a public charge, being convicted of a crime with a punishment of one-year or more, or medical unfitness, were the three largest reasons recorded for the thousands of unnaturalized immigrants returned to their mother countries in the Depression era.¹⁵ Newcomers to Canada could be easily deported within the first five years before achieving domicile. It became more difficult after that, but not impossible. From 1930 to 1937, over twenty-five-thousand people were deported from Canada, a significant number which has not been experienced again in Canadian history.¹⁶

Politicians were sympathetic to those who campaigned for deportation as relief expenditures were escalating rapidly, challenging the solvency of both municipalities and provinces. The Immigration Act dictated that municipal officers were to inform the government of any immigrants who had not acquired domicile and who were receiving public assistance.¹⁷ Consequently, countless lists of names were sent to Ottawa, leading to arrests, detentions,

¹³ Barbara Roberts, *Whence They Came: Deportation From Canada 1900-1935* (Ottawa: University of Ottawa Press, 1997), 163.

¹⁴ *Ibid.*, 216.

¹⁵ *Ibid.*, Table IV and V, 46 and 51.

¹⁶ *Ibid.*, 228.

¹⁷ *Ibid.*, 230.

inquiries and deportation. Deportation of those considered a public charge increased five-times between 1928-1929 and 1929-1930, achieving their peak in 1932-33. As immigrant communities became aware of their vulnerability, many stayed off relief, living in near-starvation in order to remain in the country. Historian Veronica Strong-Boag describes a young Chinese widow and mother to nine children in Toronto who “rented out rooms, grew vegetables... worked for the Presbyterian Church...and “ate fish heads for a long time.””¹⁸

Though being unemployed was considered to be the main reason for deportation by the Department of Immigration, being on relief was only one of several ways in which a person was deemed to be a public charge.¹⁹ Those residing in a hospital or mental asylum were triply condemned as they used public funds, could not achieve domicile and were considered to have feigned health as those considered ‘feeble-minded’, epileptic or ill were not permitted to immigrate. Persons who arrived in Canada, but were subsequently committed and remained in hospital were subject to deportation, even after several years of living in Canada. Between 1929 and 1939, ninety-two male and fifteen female patients were deported, according to SHNB’s patient ledgers.²⁰ Patients who were deported came from a variety of countries, including Austria, Czechoslovakia, Ireland, England, Poland, Germany, Hungary, Denmark, Sweden, and Holland. From this contingent of countries, nineteen deportees came from those considered acceptable for immigration in 1931, thirty-three from northern European countries and thirty from eastern European countries. Though these numbers seem to indicate a fairly even spread, it must be noted that patients from England, Scotland, Ireland and the United States represent the majority of the population of Saskatchewan, but the minority of the patients deported. Northern

¹⁸ Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Markham, Ont.: Penguin Books, 1988), 47.

¹⁹ *Ibid.*, 159.

²⁰ General Register, Ledger 9-10.

and Central European patients came from smaller ethnic communities in Saskatchewan, yet represent the vast majority of deportees. For example, nearly six percent (6%) of female and fifteen percent (15%) of male Polish immigrant patients were deported versus less than one percent (<1%) of male and female English immigrant patients.²¹ Historian Robert Menzies, in his analysis of the mass deportation of sixty-five Chinese patients from British Columbia in February of 1935 indicates that great efforts were made by the government and hospital officials to expel a group that comprised only 1.3% of all admissions in that year.²² While Northern and Eastern Europeans did not experience the same level of racist persecution as those of Asian birth did, they did suffer isolation, disapproval, disconnection, and xenophobia.

Single male patients seemed to have been the primary target as sixty percent (60%) of all male deportees were single, while only twenty-one percent (21%) were married with children.²³ In addition, those not tied to land were more liable to be deported as sixty percent (60%) of male deportees were unskilled labourers (forty-seven percent were urban labourers and thirteen percent were farm labourers). By contrast, farmers, whose title denotes ownership, represented only fourteen percent (14%) of male deportations. Employed deportees who worked in white collar jobs comprised four percent (4%), while urban blue collar deportees were at seven percent (7%). From these statistics, it can be concluded that those most vulnerable to deportation were those considered to occupy the lower classes: single men without land, employed in unskilled labourer jobs.

²¹ *Ibid.*

²² Robert Menzies, "Race, Reason, and Regulation: British Columbia's Mass Exile on Chinese 'Lunatics' aboard the *Empress of Russia*, 9 February 1935," in *Regulating Lives: Historical Essays on the State, Society, the Individual and the Law*, eds. John McLaren, Robert Menzies, and Dorothy E. Chunn (Vancouver: UBC Press, 2002), 204-6.

²³ General Register, Ledger 9-10.

Despite the fact that the numbers of female patient deportees total only fifteen between 1929 and 1939, some interesting observations can be made. Female patient deportees ranged from twenty to forty-nine years of age and over half were single. Among the seven single women deported, four out of six were employed in domestic service, either as housekeepers, housemaids, or servants. These women were all young, the oldest being twenty-eight. Most of these women were diagnosed with dementia praecox, an illness with an enormous list of possible symptoms. Like their male counterparts, single women who were employed in unskilled domestic service were vulnerable to deportation as they were not engaged in nation-building through marriage or childbirth, and added to the swelling population of the lower classes. Married female patients comprised a slightly smaller group of female patient deportees. As these women were married to someone outside the hospital, and their deportation would have included husbands and children, one wonders why their deportation was desired? Being a 'public charge' was not necessarily enough to have a woman deported, as women were not considered as contributors to the economy, and thus being a drain on the public purse was not as shameful or denigrating to their status as it would be if they were male. Being diagnosed with a mental illness could have been the main reason, as it negated their fitness for citizenship, thereby making them members of the "prohibited classes" and thus vulnerable to deportation. As it was thought that their progeny would also carry the same disposition to insanity, by this reasoning, the deportation of the entire family would be considered appropriate.

All deportations in this period occurred between 1929 and 1937, the majority occurring in 1930 (twenty-one men, five women) which corresponds with the peak of federal deportations in general.²⁴ Deported patients suffered from dementia praecox to senile dementia, illnesses which

²⁴Roberts, 38; Kelley and Trebilcock, 227.

were reflected in the majority at the hospital. As a result, it can be concluded that these patients were deported not due to the severity of their illness, but due to the simple fact that they were ill, and thus considered unfit for citizenship and a drain on public funds. Furthermore, these patients were not chosen from the population who had been living at SHNB for years. None of the patients deported had been in hospital more than two years; the majority of male deportees stayed between 101 to 200 days, and most female deportees resided in the hospital between 201 to two years before deportation.

Out of all patients whose nativity was not Canadian, who were first-time admittances, only two percent (2%) of female patients and eight percent (8%) of male patients' admissions resulted in deportation. This finding raises the questions as to why more patients were not deported. Overcrowding was a serious problem for the hospital, resulting in a decline in care and an increase in the spread of illnesses like tuberculosis. Dr. J.W. MacNeill lamented to the Department of Public Works each year in his annual reports about the declining condition of the hospital. In 1931, he notes that increased accommodation for the growing patient population is "a growing necessity."²⁵ As the situation worsened, the superintendent pleaded with the Department in 1934: "We have now reached the saturation point and I do not see how we can keep on admitting patients unless your department makes some provision for more space..."²⁶ The hospital experienced the increasing cost of the custodial care of a large number of patients, of which more than half claimed nativity from a country other than Canada. Deportation would have been an advantageous release valve for the institution if used in greater numbers. However, Robert Menzies found that it took nearly fifteen years of bureaucratic parleying between Canada

²⁵ *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1931*. (Regina, SK: J.W. Reid, King's Printer, 1931), 59.

²⁶ *Annual Report of the Department of Public Works, 1935*, 53.

and China to have Chinese patients repatriated. SHNB may have attempted to have patients deported, but bureaucratic relations between Canada and the country of nativity could have delayed or prevented the process.²⁷

First Nations Canadians were equally dependent on the government for relief in these trying times, but “shovelling” them out was not an option.²⁸ Surprisingly, between 1929 and 1939 only ten female and twelve male “Indians” were identified on the ledgers. As the Saskatchewan population of First Nations in 1931 was 15,268, simple mathematics would suggest that the numbers on the ledgers were far lower than the number of people who needed treatment.²⁹ In comparison, those of Austrian descent in Saskatchewan, formed a similarly sized group to that of First Nations, (17,061 persons) and yet one-hundred male and sixty-five female patients came from this group. The reasons for the significantly small number of First Nations patients can be explained by two major factors: how First Nations communities perceived illness, and the dispute between these communities and the federal government as to whether First Nations had the right to free and comprehensive health care through treaty agreements. According to Native Studies Professor James Waldram, et. al., there was little distinction between mental and physical illness as “the mind, body, and spirit were seen as an integrated whole.”³⁰ Since illness for First Nations included “spirit intrusion, object intrusion, soul loss, and sorcery or ‘bad medicine,’” perceptions of illness encompassed a wide variety of symptoms, which were not all strictly physical.³¹ Experiencing lack of success in hunting, for example, or

²⁷ Menzies, 200-8.

²⁸ “shovelling...out” is a phrase Barbara Roberts uses frequently to describe the deportation of the unemployed and persons considered economically redundant throughout her book, *Whence They Came*.

²⁹ Dominion Bureau of Statistics, *1931 Census of Canada* (Ottawa: J.O. Patenaude, Printer to the King’s Most Excellent Majesty, 1933), 294-7.

³⁰ James B. Waldram, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995), 102.

³¹ *Ibid.*

in finding a mate could be symptomatic of illness due to ‘bad medicine.’³² Within their communities, First Nations peoples continued many religious and healing practices, whether through ceremony or by the use of their wide knowledge of herbology. It is plausible that many of those who might be deemed ‘insane’ in white communities were treated in First Nations communities through the support of their family circle. Their belief in other forms of causation would reinforce their reasoning to conduct treatment within the community rather than distancing the ill person from family and friends through placement in a mental hospital. Furthermore, psychiatrist Laurence J. Kirmayer and colleagues suggests that these smaller communities were more tolerant of those who exhibited strange behaviour due to their connection to the community at large.³³

Anglo-Canadian society placed great emphasis on progress through industry, urbanization, and business. Scholars debate whether industrialization and urbanization had an effect on the definition of mental illness. Historian Richard Fox suggests that urbanization in industrial America “reduce[d] middle-class tolerance of “unproductive,” “inefficient” behaviour...and did promote the establishment of institutions and professions devoted to the control of deviant behaviour.”³⁴ If symptoms of mental illness are based on deviance from society’s ascribed beliefs, then the definition of illness would differ between Anglo-Canadian and First Nations communities.

³² *Ibid.*

³³ Laurence J. Kirmayer, Gregory M. Brass, Caroline L. Tait, “The Mental Health of Aboriginal Peoples: Transformations of Identity and Community,” *Canadian Journal of Psychiatry* 45 (September 2000), 611.

³⁴ Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 7. The connection between urbanity and institutionalization is also expressed in Cheryl Krasnick Warsh, “The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923,” *CHA Historical Papers* (1988): 159.

Sociologist Eric Kempthorne has suggested that the inadmissibility of First Nations persons to a mental hospital unless the federal government was willing to pay, infringed upon their right to treatment.³⁵ Indeed, because First Nations persons remained under the jurisdiction of the Department of Indian Affairs, it was up to the Indian agent to determine the medical treatment of those deemed ill. Though two successive medical superintendents in the Department proposed changes to the quality of health care given to First Nations communities, most of their proposed plans failed due to lack of funds. First Nations communities and activists claimed that through treaty agreements, they were entitled to “free and comprehensive health care,” while the government suggested that any health care afforded them was through humanitarian efforts and policy, not by a legal obligation.³⁶ At the high-end of their humanitarian efforts, the Department hired medical officers to provide services, and contracted local physicians to provide care to First Nations communities. Many epidemics, however, like tuberculosis, went unchecked. Further complicating the issue was the role of the Indian agent, who was responsible for all matters including health care. As employees of the Department of Indian Affairs, their primary concern was with cost. For example, to have a First Nations person hospitalized or admitted to a sanatorium (in the case of tuberculosis) would require the permission of the agent and in the case of the latter, from the main office in Ottawa.³⁷ Judging by the way tuberculosis was handled, it is quite plausible that mental illness was entirely ignored. In addition, racist campaigns sought racial segregation by mandating separate wards and separate hospitals for Anglo-Canadians. Bureaucratic processes and racism separated many First Nations persons from the care they needed due to cost.

³⁵ Eric Kempthorne, “Social Control and the Mentally Ill: Towards a Theory of Deinstitutionalization” (MA Thesis, Department of Sociology, University of Saskatchewan, 1995), 35.

³⁶ Waldram, 141, 149.

³⁷ *Ibid.*, 154, 159-60.

Most of the patients from First Nations communities came to the hospital with tuberculosis or epilepsy. These two very visible illnesses would be easier for an Indian agent to diagnose and suggest hospitalization. Of all First Nations persons who were committed, male patients who remained at the hospital stayed over one year; most stayed more than three. Female patients stayed at the hospital for shorter periods of time before parole, most under one year. As the government continued to contend that they were not responsible for health care under treaty agreements, and the poverty of many communities would not be able to provide funds for hospitalization, only a small group came to SHNB. It is possible that many cases of insanity did not come before the Indian agent unless it was a source of criminal activity. Furthermore, an outsider would not necessarily be the most trusted person to handle a family member whose behaviour was deemed as insane. Yet, it is also plausible that those who were considered insane were denied the treatment they required because by living on reserves they were already separate from the population at large, thus defeating the purpose of incarceration. By keeping First Nations populations separate, the federal government was able to focus on filling the country with persons they deemed appropriate through immigration.

The *Immigration Act* reinforced a hierarchy of races that was developed by Canadian “common knowledge.” At the top were British citizens, who were characterized as possessing “a peculiar mixture of social order and individual freedom, [which] function[ed] as a sign of both sexual and civic self-policing.”³⁸ Among those races considered undesirable for immigration were Blacks and East-Indians, who were labelled “savages,” unable to “control their sexual desires and were thus unlikely to lead orderly and civilized lives.”³⁹ These descriptions would be

³⁸ Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland & Stewart, 1993), 105.

³⁹ *Ibid.*

considered “racialization”: a term used by legal historian Constance Backhouse and defined as “the process by which attributes such as skin colour, language, birthplace and cultural practices are given social significance as markers of distinction.”⁴⁰ This “racialization” was fuelled by early twentieth century scientific research, and by the concern over the rapidly growing and largely immigrant working-classes. Moral reformers and social purists, who sought to remedy the ills of urban society by operating on the working-class, connected these ills to immigrant populations. Historian Mariana Valverde suggests that social purists and moral reformers put forth two major themes: one came from Biblical teaching, which reinforced the concept of the body as a temple to be kept clean by abstinence from alcohol, drugs and immorality; the other termed the indulgence in these vices as “unpatriotic.”⁴¹ Abolishing alcoholism, drug use, delinquency and prostitution was the focus of these moral activists who considered the latter to be “*the social evil.*”⁴²

Alcoholism was considered to be a male weakness. According to Valverde, working-class men were seen “as potential alcoholics and criminals [who] acquired masculine virtue by being sober and honest.”⁴³ Social reformers sought to suppress alcohol use, emphasizing its worst features. Alcohol consumption led to family and societal breakdown, which spurred temperance movements to campaign for prohibition until it was legislated in Saskatchewan in 1915. Legal prohibition lived a short life after being repealed in 1924, when it was realized that policing alcohol use was impossible. During the prohibition era, finding alcohol was not difficult as bootleggers and ‘blind pigs’ offered booze to those willing to risk being caught. Historian Craig Heron postulates that the consumption of alcohol had less to do with getting

⁴⁰ Constance Backhouse, *Colour Coded: A Legal History of Racism in Canada, 1900-1950* (Toronto: Osgoode Society for Canadian Legal History, University of Toronto, 1999), 148.

⁴¹ Valverde, 71.

⁴² *Ibid.*, 77.

⁴³ *Ibid.*, 78.

drunk and more to do with working-class male bonding.⁴⁴ The early twentieth-century bar was a defender of working-class masculinity where men could enjoy male camaraderie, engage in boyish disobedience to temperate ideals, and continue to connect with their bachelor past.⁴⁵ Relief policy during the Depression era made another attempt to squelch alcohol use by asking those with a liquor license to surrender it or be immediately cut off from support. The “dole” was barely enough to live on, and as a result, booze became a luxury.⁴⁶ Yet for many, alcohol functioned as a survival strategy to those who found themselves unemployed or in the clutches of another bad harvest.⁴⁷

Though alcohol was difficult to control through legislation, upper- and middle-class social reformers did not surrender their temperate ideals. Despite the fact that alcoholism as a medical condition occupied contested ground between mental illness and moral deviance, temperance was still considered to be a virtue at SHNB. The ‘habits of life’ column of the General Register show that the majority of patients were characterized within the good-fair-bad paradigm often used in this section of the General Register. Of the 260 male patients whose habits of life were described more specifically, 227, or eighty-seven percent (87%), were defined by their positive or negative relationship to alcohol. Considering the vast number of patients whose behaviour was noted simply as good, fair, normal, average, bad or poor, being temperate

⁴⁴ Craig Heron, “The Boys and Their Booze: Masculinities and Public Drinking in Working-class Hamilton, 1890-1946,” *Canadian Historical Review* 86 3 (September 2005), 1.

⁴⁵ *Ibid.*, 1, 6.

⁴⁶ According to James Gray, many men who could no longer afford booze fixated on it. These “beer addicts talked of nothing else...about varieties of beer, how to make it, where to drink it, when they last had it, the difference between Canadian and American beer, [and] the superiority of...one brand over another.” James Gray, *The Winter Years* (Toronto: MacMillan of Canada, 1966), 51.

⁴⁷ Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario’s Great Depression* (Toronto: University of Toronto Press, 2009), 133; S. Leigh Matthews, *Looking Back: Canadian Women’s Prairie Memoirs and Intersections of Culture, History and Identity* (Calgary: University of Calgary Press, 2010), 199. In addition, James Gray remarks that those involved in community block parties would chip in money for a “co-operative half-keg of beer for a neighbourhood party at which the Woodyard (where relief was applied for and received) could be forgotten.” Gray, 29.

or intemperate was clearly worth making a special note. Of this number, eighty-four patients consumed alcohol which was noted even though their behaviour was considered good. Patient 4318, a sixty-six-year-old Norwegian farmer, was labelled as “used liquor freely- good.”⁴⁸ Patient 4626, an American mechanic aged fifty-six-years-old, was characterized as: “drinking-good otherwise.”⁴⁹ A nineteen-year-old labourer, patient 4717, was praised for his work ethic after his alcohol use was noted: “drinks- good worker.”⁵⁰ Seventy-seven patients were classified as “intemperate” or any variation of “drinks too much.” One of these patients, was number 5447, a number given him on his seventh admission to SHNB. This English grocer from North Battleford would be readmitted twenty-two subsequent times up to 1940 because of his alcoholism.⁵¹ How he fared beyond that is outside the scope of this study.

Sixty patients came to SHNB for their first treatment as alcoholics between 1929 and 1939. When readmissions are added, one-hundred cases of alcoholism in total were treated, of which twenty-seven were diagnosed as acute alcoholism without psychosis, with some variation in phrasing. Alcoholics accounted for almost three-percent (3%) of all patients committed during the Great Depression. The next largest group of patients with a common illness were epileptics at four percent (4%). Historian Cheryl Krasnick Warsh has indicated that mental hospitals, asylums and retreats were used to place alcoholics to dry out or to receive treatment.⁵² Most male alcoholic patients (thirty-one in total) stayed at the hospital for less than a month. In very few cases did their stay last longer than a year, unless complicated by illness. Patient 6751, for example, a forty-four-year-old English labourer, was committed in November 1935 and

⁴⁸ Patient 4318, General Register, Ledger 9 Folder 2.

⁴⁹ Patient 4626, General Register, Ledger 9 Folder 2.

⁵⁰ Patient 4717, General Register, Ledger 9 Folder 2.

⁵¹ Patient 5447, General Register, Ledger 9 Folder 2.

⁵² Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989), 144-154.

diagnosed with “toxic psychosis from drinking rubbing alcohol.”⁵³ He died over a year later, possibly due to his addiction. Little was known about the nature of alcoholism in this period--whether it was a mental disease, a genetic predisposition to inebriation, or personal weakness. In most hospitals, treatment was simply the complete removal of alcohol from the life of the patient through incarceration. Like SHNB, the Homewood Retreat in Guelph had recidivist alcoholics, whose families utilized the hospital as a form of respite from their disruptive behaviour.⁵⁴ The grocer from North Battleford was married with two children. Thirty-four others were married, many with children to take care of. Other patients had their relationships tested by alcohol, perhaps leading to the legal separation of patients 6423 and 7352 from their wives as their marital status indicated on the General Register.⁵⁵

Female alcoholics were far less prevalent at SHNB. According to the General Register, only two patients had the word ‘alcohol’ as part of their diagnosis: patient 5219, an American aged twenty-one-years-old, was diagnosed with psychosis due to alcohol and morphine, and patient 6785, a French urban housewife, who was diagnosed with alcoholism without psychosis.⁵⁶ These two cases make up less than one-percent (<1%) of all female patients between 1929 and 1939. An only slightly larger group of ten female patients was considered “intemperate” in the ‘habits of life’ column. Out of the eighty-eight patients of whom more individualized descriptors outside the good-fair-bad paradigm were used, fifty-four female patients were characterized by their consumption of alcohol. Forty-four of these, however, were considered “temperate.”

⁵³ Patient 6751 General Register, Ledger 10 Folder 1.

⁵⁴ Warsh, *Moments of Unreason*, 144-154.

⁵⁵ Patients 6423 and 7352, General Register, Ledger 10 Folder 1.

⁵⁶ Patient 5219, General Register, Ledger 9 Folder 2; Patient 6785, General Register, Ledger 10 Folder 1.

The use of drugs was much more popular than alcohol among female patients. Cheryl Krasnick Warsh asserts that “mood-altering drugs...became habits for women in need of emotional release, especially in a culture where saloons and alcohol were male preserves.”⁵⁷ Fifteen first-time admissions were diagnosed with drug addiction without psychosis. Only one patient, number 5219, suffered psychosis as a result of her addiction to alcohol and morphine.⁵⁸ Warsh indicates that women were more vulnerable to abusing drugs because opiates were prescribed as treatment for a variety of “female disorders.”⁵⁹ She notes that female patients received injections for pain experienced during menstruation and menopause. Other ailments, including stomach pain, depression, and insomnia, were also treated with opiates.⁶⁰ Drug laws imposed harsh punishments on those charged with drug possession, sentencing them to jail for six months to two years. As a result, obtaining drugs became more difficult as the drug trade was driven underground. Opiates could still be prescribed to users, but few doctors would chance being caught. Historian Catherine Carstairs had identified two main groups of drug users: those who started early in their lives, getting drugs from the illicit market, and those who obtained drugs from doctors.⁶¹ There were a great many female users in the second group, whose feigning of ailments elicited doctors to prescribe drugs to them, or who had access to drugs through their employment as a registered nurse.⁶²

From the General Register, some interesting trends can be found among female drug-using patients. Out of seventeen first-time admissions, only six were married; two had kids. The rest were single (two), separated (three), divorced (one), widowed (two), or left blank (three).

⁵⁷ Warsh, 163.

⁵⁸ Patient 5219, General Register, Ledger 9 Folder 2.

⁵⁹ Warsh, 163.

⁶⁰ *Ibid.*; Catherine Carstairs, *Jailed for Possession: Illegal Drug Use, Regulation and Power in Canada, 1920-1961* (Toronto: University of Toronto Press, 2006), 6.

⁶¹ Carstairs, 49.

⁶² *Ibid.*, 49, 56.

They ranged in age from twenty-one to fifty-seven, with most being in their twenties (seven). Female drug users who were patients of SHNB confirm Carstairs' findings that during the 1930s, purchasing drugs and maintaining jobs was difficult to juggle for drug users. According to Carstairs, many women reported being waitresses or housewives.⁶³ The General Register indicates of those who indicated their occupation, two were nurses, two were waitresses, two were housewives, and two had no occupation. Combined with readmissions, twenty-three cases of drug use were treated at SHNB, three of which had been transferred from Battleford Jail for psychiatric evaluations. These statistics show that most female drug users were young women in their twenties, employed, if at all, in unskilled labour, and either single or in a failing relationship. For at least four of these patients, their drug use had gotten them in trouble with the law and as a result, served time at the Battleford Jail.

Among male patients admitted for the first time, drug users comprised a group of thirty-six. Twenty-five were single, eight were married, and three were widowers. The majority were young, in their twenties (fourteen) or thirties (sixteen). Fourteen were employed in the service industry, eight of which were employed as salesmen. Another thirteen worked in blue-collar jobs, five of which were unskilled labourers. Only three were employed as physicians, those who were considered to have the greatest access to drugs. From these statistics it can be concluded that male drug users, like females, were most commonly young, single men, working in unskilled jobs or jobs with mobility and flexibility. Male and female drug-using patients, like alcoholics, were sent to the hospital to overcome their addiction through complete withdrawal. Most female patients stayed between sixteen and forty-one days, and most male patients stayed

⁶³ *Ibid.*, 60.

under two months. The type of drug was rarely listed, and the one that does appear is morphine, though historians suggest that by the early 1920s, heroin became the drug of choice.⁶⁴

According to social reformers, female drug users in the early twentieth century posed a significant threat to morality in Canada due to the fact that many earned the funds to purchase drugs through prostitution. Social reformers were concerned about prostitution, what they considered to be *the* social evil. The anonymity found in cities, coupled with increased immigration, and the “breakdown of traditional networks of...social control,” caused panic over sexually active women.⁶⁵ The definition of prostitution was expanded to include various forms of immorality, including women who occasionally had sex with their boyfriends or male dates.⁶⁶ In an attempt to curb female delinquency, specifically immorality, the Juvenile Delinquents Act of 1908 and the Ontario Female Refuges Act of 1919 were enacted to ‘protect’ girls and women from themselves. Historian Joan Sangster has noted in her research of Ontario girls charged under the Juvenile Delinquents Act that young girls deemed ‘unmanageable’ or promiscuous were subject to heightened surveillance or incarceration in a training school for an unspecified period of time.⁶⁷ Under Ontario’s Female Refuges Act, those between sixteen and thirty five, who were deemed “idle and dissolute,” were incarcerated in female refuges, similar to the English workhouse. After 1919, a sworn statement was all that was needed to arrest women.⁶⁸

⁶⁴ Robert R. Solomon and Melvyn Green, “The First Century: A History of Non-Medical Opiate Use and Control Policies in Canada, 1870-1970.” In *Crime and Deviance in Canada*, ed. Chris McCormick and Len Green (Toronto: Canadian Scholars’ Press, 2005), 356.

⁶⁵ Valverde, 103.

⁶⁶ *Ibid.*, 83.

⁶⁷ Sangster, 69-102.

⁶⁸ Joan Sangster, “Defining Sexual Promiscuity: “Race,” Gender, and Class in the Operation of Ontario’s Female Refuges Act, 1930-1960,” in ed. Chris McCormick and Len Green, *Crime and Deviance in Canada*, (Toronto: Canadian Scholars’ Press, 2005), 288.

The height of these arrests occurred during the Great Depression, the majority of which were due to sexual promiscuity, illegitimate pregnancies, and venereal disease.⁶⁹

Even though similar legislation was not enacted throughout the other provinces of Canada, it is clear that promiscuity was seen as “a female, not a male problem...[as] boys’ sexual escapades were chalked up to mere “immaturity and inadequate sex training.”⁷⁰ While the Female Refuges Act could be considered a radical Ontario-specific policy, it is useful in understanding the social paranoia surrounding female sexuality in the early twentieth-century. Historian Theresa Healy notes the increase in illegitimate pregnancies in Saskatoon, from 42.6 per thousand births in 1929 to 70.8 in 1933. Though this increase could have been because rural girls went to the city where services for unwed mothers were, it could also be that this rise could be attributed to unemployment. Unemployment made men more mobile, allowing them to abandon their pregnant girlfriends.⁷¹ In addition, due to rapid urbanization and increased mobility among young men and women, rural fathers were not able to enforce marriage as it was difficult to locate the men responsible for impregnating their daughters. Not able to qualify for relief, pregnant girls were at the mercy of charitable organizations for their survival. Because immorality was seen as a female problem, fathers were rarely hunted for even in rape cases, and if they were located, could argue their claim to fatherhood. These cases were often tainted by the victim’s sex life: if she had engaged in sexual intercourse previously, it cast doubt on any paternity claims.⁷² The way law dealt with paternity and rape cases indicates that concerns regarding female immorality and prostitution were based on social reproduction, not on female

⁶⁹ *Ibid.*, 289.

⁷⁰ Sangster, *Girl Trouble*, 34.

⁷¹ Theresa Healy, “Prayers, Pamphlets and Protest: Women and Relief in Saskatoon, 1929-1939” (MA Thesis, University of Saskatchewan, 1989), 80-83.

⁷² Campbell, 106.

abuse.⁷³ Furthermore, the ability of immoral men to evade paternity and rape convictions are further evidence of society's view that immorality was a female fault, and in order to safeguard Canadian society, women needed to be 'protected.'

To social purists and moral reformers, however, immoral women were not only seen as delinquent or criminal, but as 'defective,' 'feeble-minded', or 'psychopathic'. According to historian Jennifer Stephen, moral reformers and new professionals were:

fuelled by the success of their campaign against prostitution and venereal disease and fear of the dysgenic impact of the First World War, ...[They] widened their scope to encompass all those whose social or moral misconduct was considered evidence of their 'mental deficiency' or 'feeble-mindedness.' What had begun as a loosely defined, overused term to explain deviancy in relation to prostitution or racist assessments of the immigrant population was soon deployed to address the chief concerns of the post-war period of reconstruction.⁷⁴

The case of Violet Hypatia Bowyer, told by Constance Backhouse, reinforces the connection made between female immorality and 'feeble-mindedness.' By 1930, Bowyer had been incarcerated for two years at the Belmont Industrial Refuge after being charged under the Female Refuges Act. She served her two years, but instead of being released, Bowyer was then evaluated by two medical practitioners which led to her incarceration at the Hospital for the Insane in Cobourg. Her father initiated court proceedings to have her released, but due to her sexual history, having two illegitimate children and rumoured to be involved in prostitution and vagrancy, the appeal was denied. Medical men debated back and forth as to whether Violet was intelligent, or a "high grade moron" as the doctors from Cobourg stated. Regardless of the intelligence Violet possessed, it was her unwillingness to repent of her misdeeds and her

⁷³ Joan Sangster "Introduction to Regulation Girls and Women," in ed. Amanda Glasbeek, *Moral Regulation and Governance in Canada* (Toronto: Canadian Scholars' Press Inc., 2006), 39, 42.

⁷⁴ Jennifer Stephen, "The 'Incorrigible,' the 'Bad,' and the 'Immoral': Toronto's 'Factory Girls' and the Work of the Toronto Psychiatric Clinic," in eds. Louis A. Knafla and Susan W. S. Binnie, *Law, Society and the State: Essays in Modern Legal History*, (Toronto: University of Toronto Press, 1995), 412.

differing moral compass that made the court decide that she was a “high grade feeble-minded person, definitely lacking in moral judgement and unable to protect herself from the community.”⁷⁵

The connection between ‘feeble-mindedness’ and deviant female sexuality became a major concern for the Canadian National Committee for Mental Hygiene (CNCMH). According to historian Theresa Rupke Richardson, the path for mental hygiene was paved by Dr. Helen MacMurchy in the 1910s. MacMurchy believed that ‘feeble-mindedness’ was the cause of criminal and immoral behaviour, and that this deviant behaviour was a threat to public health.⁷⁶ Historian Jennifer Stephen suggests that the staggering number of casualties from First World War coupled with the declining birth rate among women of “preferred stock.... created fertile conditions for the production of propaganda to publicize and make tangible the threat allegedly posed by the feeble-minded.”⁷⁷ Drs. Charles K. Clarke and Clarence M. Hincks formally organized the CNCMH at the close of First World War, believing that “mental illness had to be prevented in childhood.” Highly eugenical, the committee under Clarke desired the “early identification [of defective children] and... [the] recommend[ation of] permanent institutionalization to prevent immoral behaviour and the spread of defective genes.”⁷⁸ The CNCMH under Clarke divided mental illness into three categories: mental deficiency (including ‘morons’, ‘imbeciles’, and ‘idiots’), mental diseases, and deviant conduct. Clarke counted abnormal behaviour as part of this spectrum of illness, where “individuals typed as odd,

⁷⁵ Constance Backhouse, “‘Pleasing Appearance...Only Adds to the Danger’: The 1930 Insanity Hearing of Violet Hypatia Bowyer,” *Canadian Journal of Women and the Law* 17 (2005), 9.

⁷⁶ Theresa M. Rupke Richardson, “The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada” (PhD Diss., University of British Columbia, 1987), 150, 153.

⁷⁷ Stephen, 410.

⁷⁸ Richardson, 149, 279.

disruptive or immoral could be recommended for special classes, permanently institutionalized or deported in spite of an “apparently normal intellect.”⁷⁹

Young women, like Violet Bowyer who were deemed to be ‘feeble-minded’ threatened Canadian society because they were “often attractive in appearance, but without the restraints and inhibitions that come with adult life, [which] constitute[d] a serious social danger.”⁸⁰ Though intelligence tests like the Binet-Simon were used to determine whether a person suffered from, and the level of, mental deficiency, immorality would supersede these as the prime indicator of ‘feeble-mindedness’. Psychiatrists and textbook authors, Smith Ely Jelliffe and William A. White defined in 1915 (and reiterated in their 1935 edition) the “moral imbecile” as “a condition of mental defectiveness which is shown predominantly in the absence of the highest functions, particularly the moral; capable of training to a considerable degree, but always a menace to society.”⁸¹ Stephen, in her study of the Toronto Psychiatric Clinic, found that clinic workers utilized a new category, the ‘moral defective,’ whose “inadequate social and moral intelligence made her a ‘high grade moron,’ whatever her score on the Binet-Simon scale.”⁸² Joan Sangster confirms the connection made between immorality and mental illness, as she notes that in psychiatric evaluations “sexual non-conformity was literally equated with...insanity.”⁸³ In the legal records from Bowyer’s appeal for release, Backhouse found that Violet’s score alone did not confirm her diagnosis as a ‘high grade feeble-minded person’. One of the doctors from Cobourg conceded that she did not suffer from psychosis, but felt that her mental deficiency

⁷⁹ *Ibid.*, 280.

⁸⁰ Stephen, 411.

⁸¹ Smith Ely Jelliffe and William A. White, *Diseases of the Nervous System: A Textbook of Neurology and Psychiatry*, 1st ed. (Philadelphia: Lea & Febiger, 1915), 760.; Jelliffe and White, *Diseases of the Nervous System*, 6th ed., 1116.

⁸² Stephen., 422-3

⁸³ Sangster, “Defining Sexual Promiscuity,” 290.

would prevent her past from teaching her any lessons when she returned to her former life.⁸⁴ Due to Bowyer's sexual history, lack of education and periodic vagrancy, she was returned to Cobourg indefinitely.

Out West, attitudes surrounding immorality and 'feeble-mindedness' differed little from that experienced in the east. Historian Geertje Boschma in her study of the Ponoka Hospital in Alberta found letters addressed to the hospital, inquiring about how to place "an irresponsible girl" who was pregnant with an illegitimate child.⁸⁵ Another letter asked about committing a twenty-seven-year-old woman who was pregnant with her second illegitimate child. The correspondence indicates that she was considered to be an "idiot" with violent tendencies.⁸⁶ In the North Battleford Patient Ledgers, finding women who were incarcerated for their sexual immorality is difficult, but not impossible. Patient 4991, a twenty-three-year-old single woman with two children, whose habits of life were characterized as 'not good', was committed in January 1931 and diagnosed as a 'mental defective.'⁸⁷ Patient 6633, a thirty-five-year-old rural domestic worker, was committed in July 1935. Five months later, in February 1936, her son was born and died shortly thereafter. She was diagnosed as "mental defective eight years [old]" and remained at the hospital until her parole in March 1947.⁸⁸ Patient 8384, a thirty-one-year-old single 'negro' woman was committed in December 1939 and diagnosed as 'mental deficiency without psychosis.'⁸⁹ According to Sangster, 'feeble-minded' was not the only term applied to deviant young women; women who returned to their promiscuous ways were sometimes termed

⁸⁴ Backhouse, "Pleasing Appearance... Only Adds to the Danger," 9.

⁸⁵ Boschma, 377-8.

⁸⁶ *Ibid.*

⁸⁷ Patient 4991, General Register, Ledger 9 Folder 2.

⁸⁸ Patient 6633, General Register, Ledger 10 Folder 1.

⁸⁹ Patient 8384, General Register, Ledger 10 Folder 2.

as ‘psychopaths.’⁹⁰ Patient 7996, admitted in January 1939 and sent to SHNB by order-in-council, was subsequently diagnosed as having a “psychopathic personality with pathological sexuality.” She resided at the hospital for two months before being paroled.⁹¹ According to Hilary Allen, ‘psychopath’ was a medical diagnosis “applied to certain troublesome individuals whose mental state lacked the manifest derangements of formal insanity, but whose behaviour, emotions and motivations still seemed outrageously abnormal.”⁹²

In Depression-era Canada, being a single, sexually-active woman at any age would be dangerously abnormal. The fonds of J.M. Uhrich, Minister of Public Health from July 14, 1934 to July 10, 1944 shed light on three patients at SHNB whose sexuality and misdeeds led to long-term incarceration. One, whose grandfather was petitioning her release, was patient 6748, a young Russian domestic worker with one illegitimate child. According to a letter from SHNB Superintendent J.W. MacNeill, she had arrived at the hospital shortly after giving birth to her child in November 1935.⁹³ She accused her father of incest twice, claiming that he was responsible for her pregnancy. She then changed her mind and accused another man. Changing her accusations damaged her credibility and precluded her to legal action against either man. MacNeill found her “on examination, to be a mental defective- high grade imbecile type- and her conduct has indicated that she is inclined to be incorrigible...there is no possibility of her getting along outside without a good deal of supervision.”⁹⁴ In response to this patient’s correspondence with her grandfather, where she and two other patients complained about the conditions of the hospital and of their work, MacNeill provides Minister Uhrich with details on her and her fellow

⁹⁰ Sangster, *Girl Trouble*, 139.

⁹¹ Patient 7996, General Register, Ledger 10 Folder 2.

⁹² Hilary Allen, *Justice Unbalanced: Gender, Psychiatry and Judicial Decisions* (Milton Keynes, England: Open University Press, 1987), 76.

⁹³ Letter from Dr. J.W. MacNeill to Hon. John F. Uhrich, Minister of Public Health, dated March 27, 1937.

⁹⁴ *Ibid.*

patients. One of these women identified in the correspondence was patient 7089, a twenty-seven-year-old Mennonite, who was committed in August 1936. Dr. Kiteley, the committing doctor, stated that “she [was] of Cretin appearance and [was] mentally imperfectly developed.”⁹⁵ Corroborating evidence given to him suggested that she was “a sex pervert: has lack of interest in usual livelihood: not dependable in taking care of herself.”⁹⁶ Her father complained that she was “quick tempered, stubborn, seclusive, suspicious, and not obedient.” She also personally admitted to “practis[ing] sex acts with young boys,” and had “misconducted herself with six different men.”⁹⁷ She was examined and determined to have a mental age of eight years; it was decided that she “should not be at large: in fact, she should be in the Weyburn Hospital, permanently.”⁹⁸ Instead, she was paroled in June 1938. The third woman included in the correspondence could not be found in the General Register. According to Dr. MacNeill’s letter, she was brought from the Women’s Jail in Battleford. She had previously been convicted for “maintaining a Bawdy House,” and was awaiting trial for “permitting the defilement of a girl under 18 years of age.”⁹⁹ The doctor found her to be a “mental defective- her mental age being 8 ½ years.”¹⁰⁰ These three women had been involved in deviant sexuality, whether directly engaging in it or profiting from it through prostitution. All three were deemed to be mentally defective, with varying grades and ages, and because of their errant behaviour, faced the prospect of remaining in the hospital indefinitely.

If female sexual nonconformity was equated with ‘mental defectiveness’, how was male sexuality viewed? Was it also attributed to ‘feeble-mindedness’? According to this logic, one

⁹⁵ Letter from Dr. J.W. MacNeill to Hon. John F. Uhrich, Minister of Public Health, dated May 8, 1937.

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

would expect that the numbers of females diagnosed as ‘feeble-minded’ would be higher than among men. This is not the case however. The patient ledgers of SHNB illustrate that men were diagnosed as ‘mental defective’ or ‘feeble-minded’ in equal numbers to women: nearly six percent (6%) of all men *and* women committed to SHNB were diagnosed as being ‘feeble-minded,’ ‘mentally deficient,’ or any other variant of these terms. In addition, the average age of these patients was twenty-eight for *both* men and women. While it cannot be denied that the majority of these patients were legitimately ill, looking at the ‘habits of life’ column can be helpful in understanding how these patients were viewed. Female patient descriptors range from good to bad and include ‘very simple,’ and ‘childish.’ Male patients were also defined within the good-fair-bad paradigm, but also include ‘drinks,’ ‘lazy,’ ‘poor worker,’ and ‘will not work.’ Due to the limited nature of the sources, it is impossible to conclude whether these men were incarcerated because of their deviance from the prescribed norms of temperance and work. Patient files would be more useful in answering this question. However, these cases do raise questions regarding the definition of ‘feeble-mindedness’ and deviance in Saskatchewan society, and demonstrate that it was fluid and differed among family members, society and the hospital.

From 1929 to 1939, social control or moral regulation sought to reform, protect or incarcerate those who acted contrary to social mores. Those most vulnerable included drug users, alcoholics, working-class immigrant populations, and sexually-active females. While attempting to cure drug-users and alcoholics of their deviant behaviour, these patients were kept behind locked doors until they were deemed able to return to society. Medical treatment at the hospital, regardless of diagnosis, sought to bring patients back to a level of ‘sanity’ which would allow them to integrate back into society. In this way, the hospital acted through treatment and incarceration, paroling only those who they deemed able. The Department of Immigration used

selective immigration and deportation to control Canadian population. Through these methods, only those considered to be the most likely to assimilate and better Canadian society were allowed to remain in Canada. Deportation punished those who were unemployed during the Depression era. Immigrants who were mentally ill were kept behind closed doors, never being able to achieve domicile or citizenship, or were deported. First Nations persons, who exhibited behaviour which might be considered mental illness, were denied treatment due to their poverty and the tenuous legal relationship between First Nations communities and the Federal government. Already kept outside, and often apart from white populations, they were already separate from the society Canada wanted to create. By keeping the ill or 'feeble-minded' behind closed doors, and getting rid of excess ill persons through deportation, the Saskatchewan Hospital North Battleford functioned as a political laboratory, a theatre of struggle, and a negotiated space between an ideal society, and a deviant or ill one.¹⁰¹

¹⁰¹ Chunn and Menzies, 315.

Conclusion

The struggle between survival and madness is rarely found in books dealing with the Great Depression in Saskatchewan. Most authors and historians focus on the environmental devastation on the prairies, unemployment in the cities, and the severe poverty that was experienced by most Canadian citizens. Historian Denyse Baillargeon reveals that “the Depression generated a measure of poverty and of economic, social, and psychological insecurity much greater than revealed by official statistics.”¹ Male responses to unemployment varied due to the level of fear and disorientation that came in its wake.² Eviction from one’s home is described by historian Lara Campbell as “powerful, causing chronic worry, sleepless nights and feelings of desperation.”³ Furthermore, historian Theresa Healy suggests that the grim stories of suicide, abandoned babies and murders which appeared in the Saskatoon StarPhoenix illustrate the worst of the depth and despair experienced during the Depression.⁴ While many of these scholars acknowledge that the Great Depression exacted an emotional toll on many Canadians, very few explore the connection between the Depression and mental illness. The conflict between survival and madness is an important part of Great Depression history, one that has not yet been fully investigated in Canada.

Prairie madness, considered to be a by-product of the homesteading era was still found among 1930s prairie women. Isolation, whether geographical, or due to language and cultural differences made women more vulnerable to being deemed insane. Historian Geertje Boschma,

¹ Denyse Baillargeon, “Indispensable But Not a Citizen: the Housewife in the Great Depression,” in *Nation and Society: Readings in Post-Confederation Canadian History*, Volume 2, eds. Margaret Conrad and Alvin Finkel (Toronto: Pearson Education Canada, 2008), 257.

² *Ibid.*, 64.

³ Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario’s Great Depression* (Toronto: University of Toronto Press, 2009), 122.

⁴ Theresa Healy, “Prayers, Pamphlets and Protest: Women and Relief in Saskatoon, 1929-1939” (MA Thesis, University of Saskatchewan, 1989), 105.

in her analysis of family correspondence and the Ponoka Hospital in Alberta, noted that one young woman who had worked at the hospital saw many women who had “nervous breakdowns because of the loneliness and the hardship.”⁵ Boschma asserts that “circumstances and emotional responses are clearly linked.” In some cases, women shut down emotionally to deal with the difficulty faced on the homestead. Furthermore, when distress was coupled with destitution and poverty, many were pushed over the edge of sanity.⁶ Farmers’ wives constituted thirty-five percent (35%) of the female population at the Saskatchewan Hospital North Battleford (SHNB). Sixty percent (60%) of these women were immigrants. Bachelor farmers or farm labourers also suffered due to prairie madness, perhaps because of the isolation they experienced.⁷ Historian Cecilia Danysk cited farmer Ebe Koeppen’s experience on the prairies without a wife as “slow suicide. Slow spiritual death.”⁸ Interestingly, bachelor farmers made up forty-four percent (44%) of all farmers, and twelve percent (12%) of all male patients committed to SHNB between 1929 and 1939.

Farmers were responsible for the support of their spouses and families. When farms failed, the role of provider was fundamentally challenged. Many could find sympathy for memoirist Myrtle G. Moorhouse, whose husband plummeted into alcoholism and committed suicide after successive years of decimated crops.⁹ Farmers represented thirty-four percent (34%) of all male patients committed between 1929 and 1939, and comprised the largest group

⁵ Geertje Boschma, “A Family Point of View: Negotiating Asylum Care in Alberta, 1905-1930,” *Canadian Bulletin of Medical History* 25 2 (2008), 375.

⁶ *Ibid.*, 375-6.

⁷ Cecilia Danysk, ““A Bachelor’s Paradise”: Homesteaders, Hired Hands and the Construction of Masculinity, 1880-1930,” in *Making Western Canada: Essays on European Colonization and Settlement*, eds. Catherine Cavanaugh and Jeremy Mouat (Toronto: Garamond Press, 1996), 158.

⁸ *Ibid.*, 159.

⁹ Myrtle G. Moorhouse, *Buffalo Horn Valley* (Regina: Banting, 1973), 31-32, quoted in S. Leigh Matthews, *Looking Back: Canadian Women’s Prairie Memoirs and Intersections of Culture, History and Identity* (Calgary: University of Calgary Press, 2010), 199.

of male patients. The second largest group, at twenty-seven percent (27%), were made up of farm labourers, farm hands, and other farm helpers.

Whether men or women had things tougher during the Depression is hard to conclude. Where gendered roles were concerned, masculinity's connection to breadwinning was directly challenged by high levels of unemployment, poor harvests and farm deficits. Women made due, as they always had, looking at work as something they had to do, no matter how much was on their plate. The magnitude of this herculean task surely would have increased stress upon these women. In addition, the reproductive role of women was surveilled more intensely as female sexual non-conformity led to being deemed 'feeble-minded' and to incarceration as treatment or 'protection.' As historian Mariana Valverde concluded, "females of the working class were...evaluated according to their perceived distance from the paradigmatic female working-class vice, prostitution."¹⁰ Women who had borne illegitimate children risked being labelled 'feeble-minded,' and were often prevented parole from the refuges, jails and mental hospitals used to incarcerate these women.¹¹ Birth control received more sympathy in this period, not because women begged for the opportunity to control their family size, but because it was thought that society would benefit from fewer births of those of 'poor stock.'¹² Mental hygiene, the movement that had fuelled legislated sterilization in Alberta in 1928, benefited Canada because "it justified demands for conformity against those who did not exhibit the minimal

¹⁰ Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland & Stewart, 1993), 78.

¹¹ Joan Sangster, "Incarcerating "Bad Girls": The Regulation of Sexuality Through the Female Refuges Act in Ontario, 1920-1945," in *Moral Regulation and Governance in Canada*, ed. Amanda Glasbeek (Toronto: Canadian Scholars' Press Inc., 2006), 201; Constance Backhouse, "'Pleasing Appearance...Only Adds to the Danger': The 1930 Insanity Hearing of Violet Hypatia Bowyer," *Canadian Journal of Women and the Law* 17 (2005), 12.

¹² Beth Light and Ruth Roach Pierson, eds., *No Easy Road: Women in Canada 1920s to 1960s*, (Toronto: New Hogtown Press, 1990), 85.

allegiance to Canadian institutions required for peaceful social continuity.”¹³ In Ontario, deviant girls were sent to training schools in hopes of moulding them into the “healthy, moral mothers (especially Anglo and white mothers) of the future.”¹⁴

The patient ledgers of SHNB demonstrate that diagnosed illnesses manifested themselves in near similar numbers among the male and female patient populations. For example, the most commonly diagnosed mental illness, dementia praecox or schizophrenia, was high among both male and female patient diagnoses. Tables 6.1 and 6.2 (appendix) indicate that between 1929 and 1939, thirty-one percent (31%) of female patients and thirty-eight percent (38%) of male patients were diagnosed with dementia praecox or schizophrenia.¹⁵ If a ‘female malady’ had to be found, it could be manic depression (sixteen percent of women versus eight percent of men) or neurosis or psychoneurosis (four percent of women versus one percent of men) as these were more common among female patients. Among male patients, being diagnosed as an alcoholic (four percent versus less than one percent), with post-traumatic stress disorder (less than one percent versus zero percent), senility (nine percent versus seven percent) or arteriosclerosis (nine percent versus six percent) was more common. In agreement with David Wright and the assertions made in his study of diagnosis and identification of insanity in Victorian England, these statistics challenge the argument that mental illness was feminized as both men and women were diagnosed with the same illnesses in similar numbers.¹⁶ Though there might have been a

¹³ Even in 1945, in CNCMH Director C. M. Hincks’ evaluation of Saskatchewan’s mental hospitals, he continued to petition for “selective sterilization”: Dr. Clarence M. Hincks, *Province of Saskatchewan Mental Health Survey 1945* (Saskatoon: X. L. Bindery, 1945), 3, 14, 17.; Theresa M. Rupke Richardson, “The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada” (PhD Diss., University of British Columbia, 1987), 488.

¹⁴Sangster, 194.

¹⁵ Schizophrenia, as termed by Eugene Bleuler, by in large replaced Kraepelin’s dementia praecox in early twentieth century psychiatry. This transition was made at SHNB around 1931-32.

¹⁶ David Wright, “Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England,” in Jonathan Andrews and Anne Digby, eds. *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (New York: Editions Rodopi B. V., 2004), 151.

specifically gendered way these illnesses presented themselves in men and women, without access to patient files, it is impossible to tell.¹⁷

The use of patient files would also be beneficial in looking at the equality in the representation of ‘feeble-mindedness’ in the male and female populations at SHNB. Six percent (6%) of both female and male patients were diagnosed as ‘mental defective’ or ‘feeble-minded’, or other variations of these terms. As sexual non-conformity was often linked to ‘feeble-mindedness’ in women, did gender roles influence the diagnoses of these men? Additionally, patient files would be useful in a discussion on socially redundant males. Male patients with senility-related illnesses, such as senile dementia, senile psychosis, senility or arteriosclerosis, were higher in numbers than their female counterparts. Furthermore, the second highest length of stay among male patients was two years or more. Of these, eighty percent (80%) lived out their lives as patients of SHNB. These men, considered socially redundant because of their departure from the world of work, found themselves just as vulnerable as socially redundant women. While the patient ledgers have been useful in raising these questions, answering these questions would have to come through an analysis of patient files, which would provide more detailed information on family background, personal data and how diagnoses were arrived at.

The connection between ethnically specific environmental pressures, isolation, for example, and mental illness needs to be investigated further. The cultural separation between the largely white, Anglo-Saxon population and immigrant persons and families from non-English speaking countries created a different sort of isolation. In an attempt to settle the West, immigration policy encouraged settlement of those thought best able to survive on the Canadian prairie. Women were essential to establishing a homestead, by setting up a functioning

¹⁷ *Ibid.*, 169.

household, economizing by engaging in home production, and being available to help in the fields. Female labour was the method by which children came, by whom the farm responsibility would eventually be shared. As much of the West was originally settled by bachelors, historian Dorothy Smith suggests that women were “virtually *imported* into Canada at this period to serve these functions.”¹⁸ Non-English speaking immigrant farm women had few opportunities to learn English, and as a result, had difficulty finding friendship outside their homes. White femininity had become the ideal, making difference more apparent and condemned accordingly.¹⁹ G.N. Smith et. al.’s accounting of the high rates of schizophrenia among immigrant populations reinforces the connection between stress and mental illness by focusing on ethnically specific stressors. Immigration, cultural and familial separation were pressures experienced by immigrant or recently naturalized persons and it is possible that they had the potential to manifest as symptoms of mental illness. Smith et. al. reinforce sociologist Joan Busfield’s work, who believed that biochemical processes were still important, but not the only cause. Their study illustrates that when looking at mental illness, there are important emotional and environmental factors that need to be considered beyond science and medicine. Though schizophrenia was found more prevalently among Canadian-born patients at SHNB (thirty-three percent versus twenty-four percent of foreign-born patients) and not foreign-born, their argument is interesting and needs greater attention. It is difficult to determine whether or not these ethnically based stressors played a role in committals during the 1930s at SHNB based on patient

¹⁸ Dorothy E. Smith, “Women’s Inequality and the Family,” in *Families and Work*, eds. Naomi Gerstel and Harriet Engel Gross (Philadelphia: Temple University Press, 1987), 29.

¹⁹ Sheila McManus illustrates the construction of appropriate femininity by using prairie housewife Sarah Roberts’ description of “the Dutch Woman” as a contrast. The “Dutch Woman” is castigated as “a big, raw-boned masculine woman whose general appearance would indicate that she had never had a bath...The woman never cooked a meal or washed a dish” McManus speculates that the “Dutch Woman’s” behavior might have been interpreted differently if she had acted or looked like Sarah Roberts’ and other local farmer’s wives. Sheila McManus, “Gender(ed) Tensions in the Work and Politics of Alberta Farm Women, 1905-1929,” in *Telling Tales: Essays in Western Women’s History*, eds. Catherine A. Cavanaugh and Randi Warne (Vancouver: UBC Press, 2000), 128-9.

ledgers alone, and so is without the scope of this thesis. It is clear however, that foreign-born patients demonstrated higher rates of arteriosclerosis (ten percent of foreign-born patients versus six percent of Canadian-born patients) and senility-related diseases, including senile dementia and senile psychosis, (eleven percent versus six percent) due to the lack of family connections who would have typically provided for their aging elders in their declining years. Patient files would be an asset in determining whether a connection between ethnicity and perceived or actual mental illness existed. Patient files would garner more information, detailing where the patient came from, whether they had family in Saskatchewan, under what circumstances their committal was initiated, and details on their subsequent diagnosis.

The patient ledgers of SHNB, however, have provided statistical and anecdotal evidence which has been invaluable in unearthing the spectrum of ways the hospital was used, and by so doing, have spoken to the larger issue of how mental illness was defined in Saskatchewan during the Great Depression. In addition, through the trends found by tracking admissions, discharges, occupations, length of stay, diagnoses, and even deaths, family dynamics, gender roles, and the importance of work in Saskatchewan society have been exposed through the lens of mental illness. Furthermore, they have assisted in raising important questions as to how SHNB functioned in Saskatchewan society, whether it was a maleficent institution used to house the deviant, or a benevolent hospital which treated only the willing. In an era so obsessed with forming the perfect Canadian society, by legislating 'protective' measures over female sexuality, fostering the mental hygiene movement, and curbing immigration while increasing deportation, it would follow that the mental hospital would be included in this list of social regulating methods. To assume that it solely functioned this way, however, would be erroneous. Historians David Wright, James Moran and Mat Savelli reject social control as an operating factor in their

analysis of confinement in Victorian Ontario as it assumes that the asylum functioned as a “vehicle for disciplining a particular class, gender or age group.” It is clear that SHNB did not function in such a narrow or limited way. Moral regulation, the methods by which the agency of the governed and governors was incorporated in its operation, is a better description of the way SHNB functioned in Canadian society. As Chunn and Menzies suggest, the walls of the hospital were not impermeable to the political and ideological milieu of the world outside. It was an active and an inactive shaper of society, by enforcing appropriate behaviour within the walls of the hospital, and maintaining incarceration of those deemed threatening to Canadian society, while continually receiving patients despite financial and housing constraints.

The Saskatchewan Hospital North Battleford played an active role in shaping society by insisting that gender roles be maintained within the hospital walls. Male and female populations were separated, thus ensuring little chance for sexual relations. Both men and women were expected to work; men in more physical jobs like farming, construction, and maintenance, while women sewed and assisted in housekeeping. In order to keep patients separate, men were afforded outdoor jobs while women remained indoors. Outside the hospital, many family farms utilized female labour as a replacement for labourers or through the wife’s raising of animals or vegetable gardens, but the farm at SHNB did not. By so doing, the hospital appeared to be stricter in maintaining ‘separate spheres.’

Alcoholics and drug users also came to SHNB as withdrawal was considered to be best applied in a hospital setting. Many patients returned over and over, illustrating that families utilized the hospital to provide respite care from their recidivist behaviour. It also suggests that though treatment was fairly rudimentary (complete removal of substance from the addict), it was treatment nonetheless. In addition, the hospital sought to redeem addicts from their deviant

behaviour so they could return to good Canadian society. They were kept away from family and their community until they were able to do so. Additionally, women, who were deemed 'feeble-minded' and incarcerated as a result of their sexual non-conformity, had difficulty being released from the hospital. The correspondence contained in the J.M. Uhrich fonds regarding patient 6748 and her fellow patients who were committed for their sexual deviancy, illustrates that female sexuality outside the bonds of marriage was cause for great concern. Whether for environmental or genetic reasons, these women were not considered ready for parenthood, and thus their ability to engage in intercourse was curtailed through incarceration. Though a family member was petitioning for patient 6748's release, promising supervision and support, she was not given parole and remained at SHNB until her transfer to the Weyburn Hospital in 1948. Patient 6633, a rural domestic labourer came to the hospital in July 1935 and gave birth to an illegitimate child the following February. She was thirty-five when she was committed, still within her reproductive years, and remained in hospital almost twelve years before paroled, at the age of forty-seven. Perhaps at this age, her sexuality was no longer considered to be a threat.

At the same time, however, SHNB received all patients delivered to their doors by family members and court-appointed chaperones. The hospital housed patients, who regardless of their diagnoses, were deserted by their families. SHNB also continued to take care of many patients who had no family to speak of and had nowhere else to go. It continued to do so, even when it was severely overcrowded. It is clear that while SHNB played a role in maintaining an 'ideal' Canadian society through incarcerating deviant and ill persons, it also was acted upon by family and society, having little control over its population size and limited by its operating costs and inadequate government support.

In the crucible of the Great Depression family relationships and society at large was tested. By being an active and inactive shaper of Canadian society, acting and being acted upon, SHNB cannot be defined solely as a tool of social control, or as a custodial facility. Neither conclusion can adequately encompass the variety of patient experiences had at SHNB in this period. Patient 6748 lamented to her grandfather that she and her fellow patients:

...are not sick anymore. We are just as clever as anybody who thinks he or she is clever, and that is not the reason they want to keep us here either...why don't (sic) the doctor notify the government that we are healthy and absolutely sane and fit to be released?

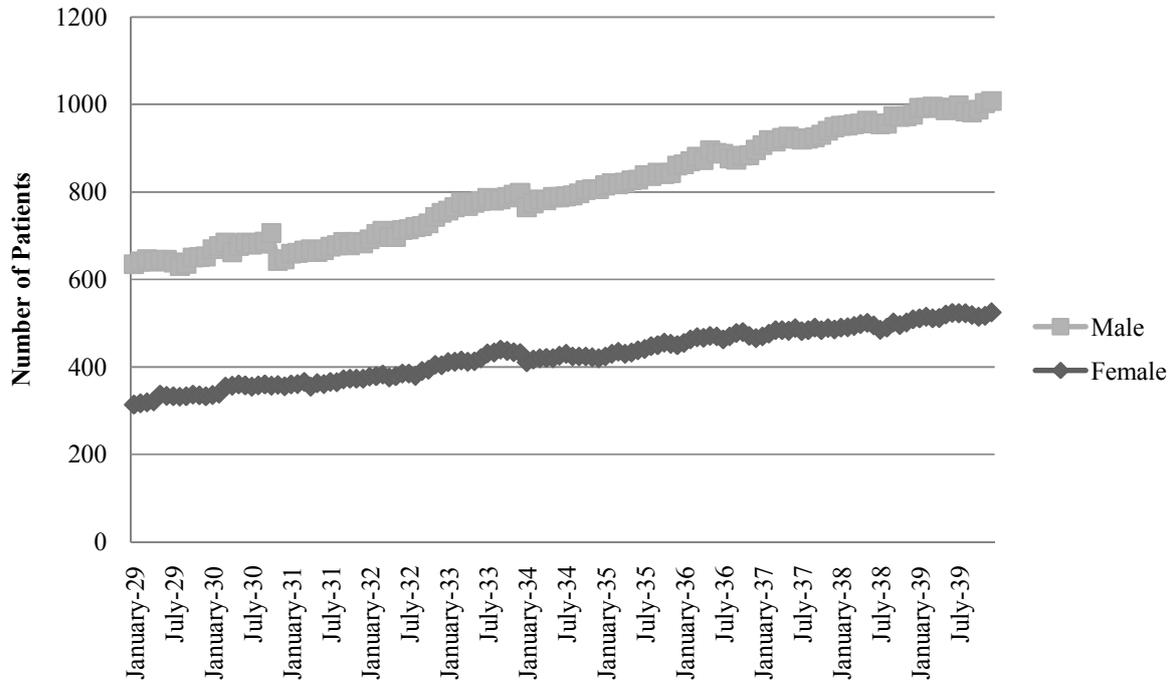
Another letter from an anonymous patient, forwarded to Minister Uhrich illustrates that other patients had quite different experiences:

I like my new home fine. It is a fine place to be...I got the best of care, the best of food while sick, and good when not sick. This is a fine place.

Both correspondences are informative as they illustrate that SHNB cannot be defined solely as a centre for control or as a custodial centre. Families were able to utilize their agency in determining where their ill relation would reside and for how long. Treatment options were based on the best method for returning ill persons to a state of normalcy, based on the definitions formed by society itself. While a significant few experienced the hand of moral regulation, through committal to a place which sought to reform and 'protect' them from themselves, the majority of experiences fall into a larger spectrum which was determined by families, society, their doctors and themselves.

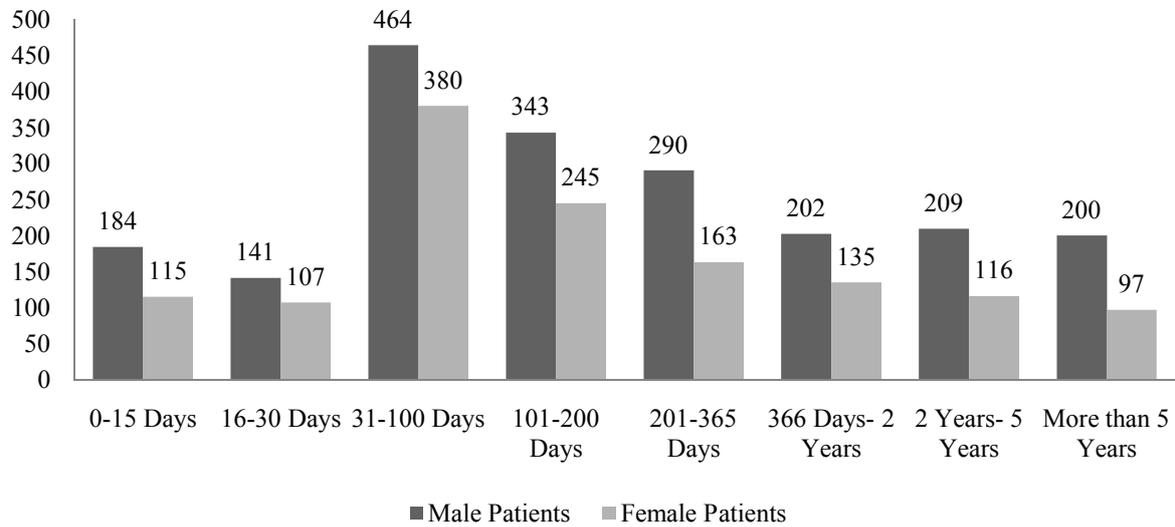
Appendix

Table 1: Patient Population Increase from 1929 to 1939, Saskatchewan Hospital North Battleford.



Source: Daily Record of the Saskatchewan Hospital for the Insane, Ledgers 3 and 4, North Battleford Patient Ledgers, Saskatchewan Archives Board.

Table 2: Length of Stay of Male and Female Patients, Saskatchewan Hospital North Battleford, 1929-1939.¹



Source: Female Index and Ward Location, Ledger 7, and General Register, Ledgers 8-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

¹These statistics were based on a patient population of 2033 male and 1358 female patients. These patients were those that had a clear admission and discharge date, and all those without clear dates (443 male and 224 females), or where one was not filled out, were not included in this set of statistics. Categories were developed by the author in order to underline the large group of short-stay patients in comparison with the smaller body of long-term or permanent-stay patients.

Table 3.1a-3.11b: Admission and Discharges of Patients by Gender by Year, Saskatchewan Hospital North Battleford, 1929-1939.²

Table 3.1a: Female Patients, 1929-30

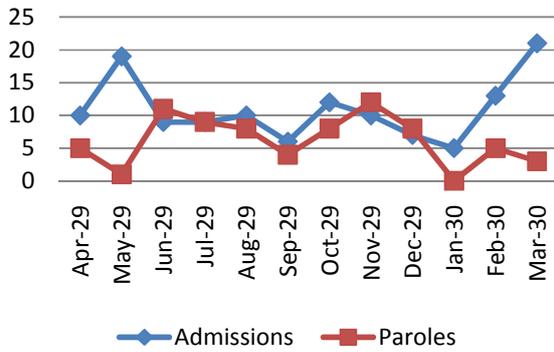


Table 3.1b: Male Patients, 1929-30

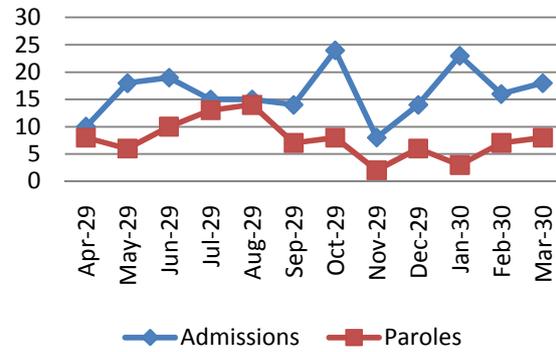


Table 3.2a: Female Patients, 1930-31

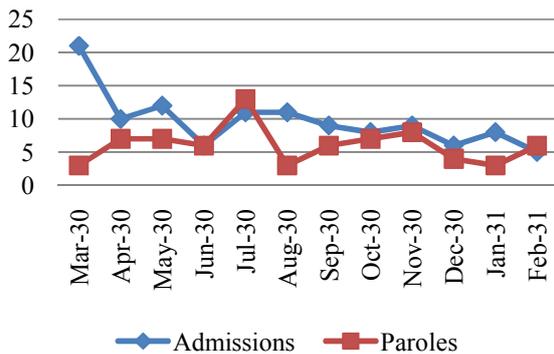


Table 3.2b: Male Patients, 1930-31

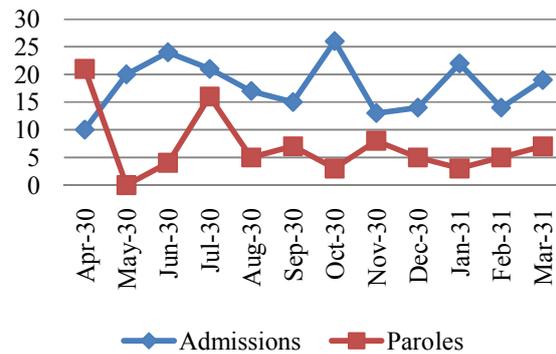


Table 3.3a: Female Patients, 1931-32

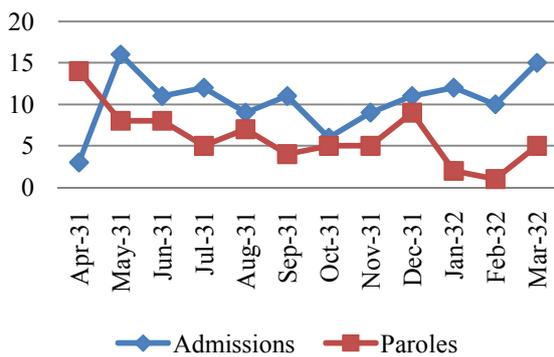
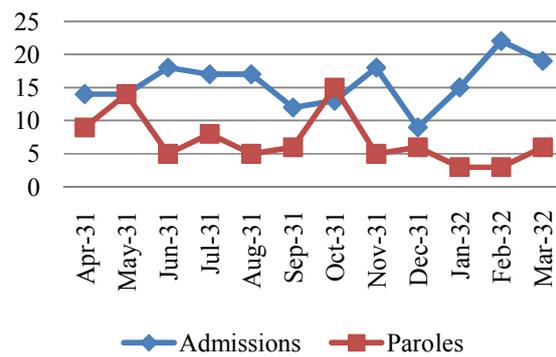


Table 3.3b: Male Patients, 1931-32



² Each graph begins in April and ends in March so trends in the latter months of the year could be highlighted.

Table 3.4a: Female Patients, 1932-33

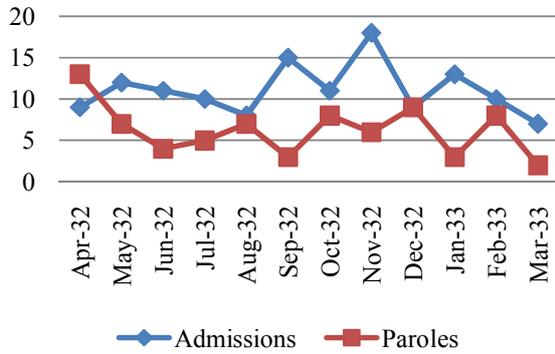


Table 3.4b: Male Patients, 1932-33

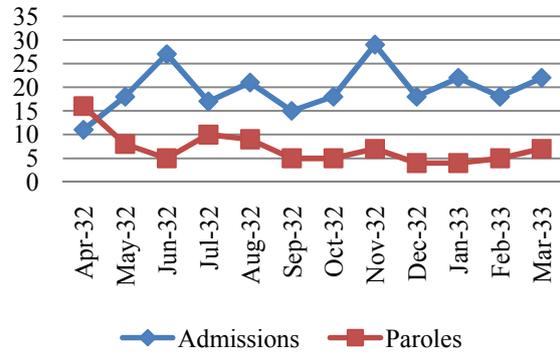


Table 3.5a: Female Patients, 1933-34

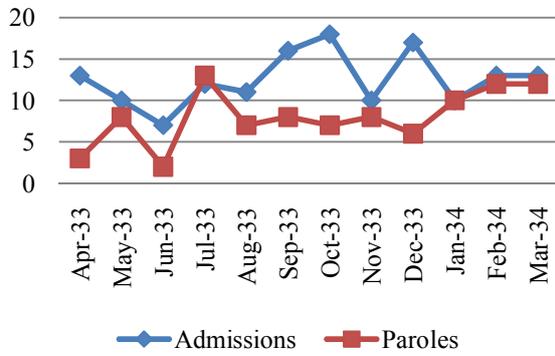


Table 3.5b: Male Patients, 1933-34

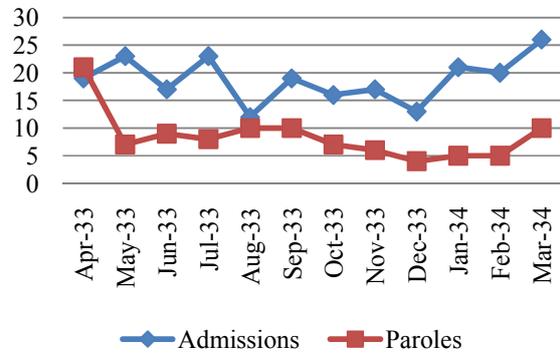


Table 3.6a: Female Patients, 1934-35

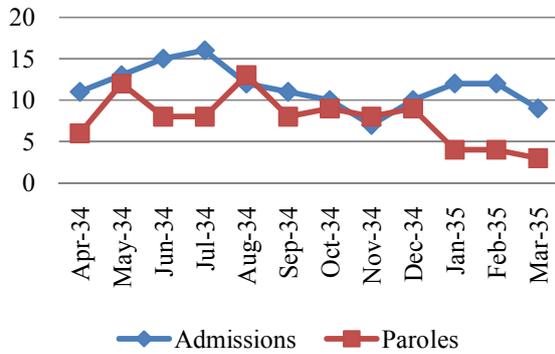


Table 3.6b: Male Patients, 1934-35

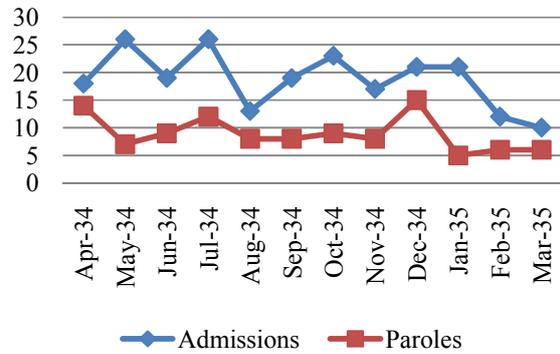


Table 3.7a: Female Patients, 1935-36

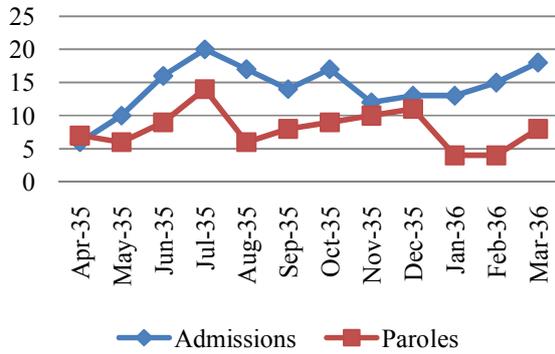


Table 3.7b: Male Patients, 1935-36

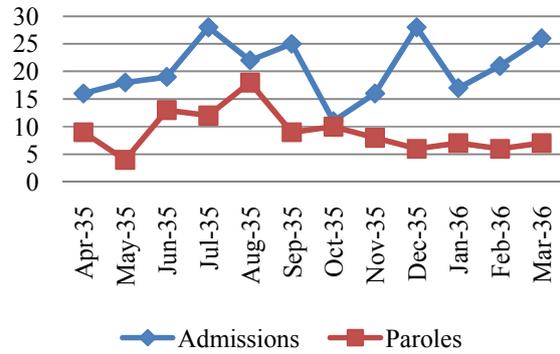


Table 3.8a: Female Patients, 1936-37

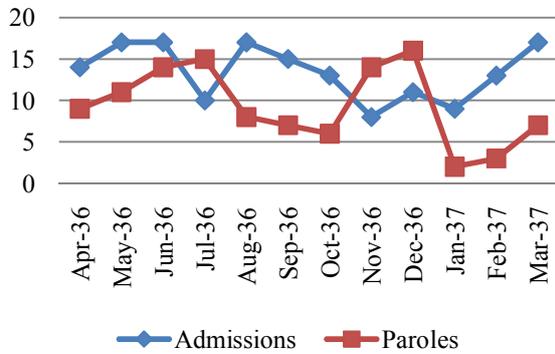


Table 3.8b: Male Patients, 1936-37

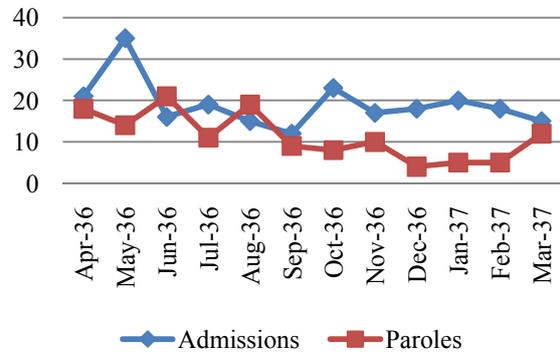


Table 3.9a: Female Patients, 1937-38

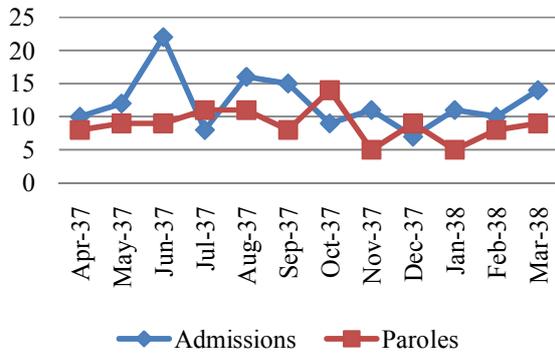


Table 3.9b: Male Patients, 1937-38

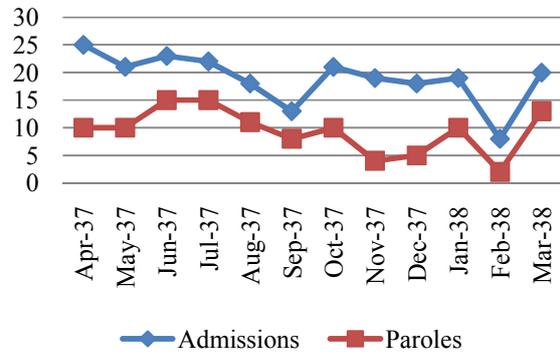


Table 3.10a: Female Patients, 1938-39

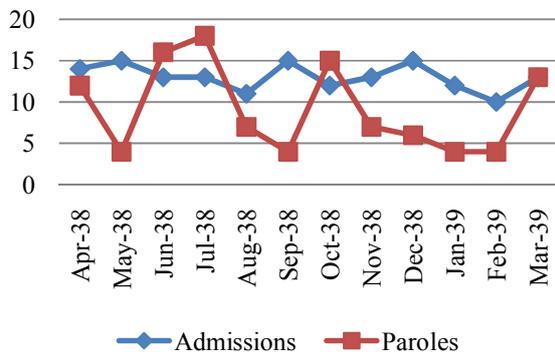


Table 3.10b: Male Patients, 1938-39

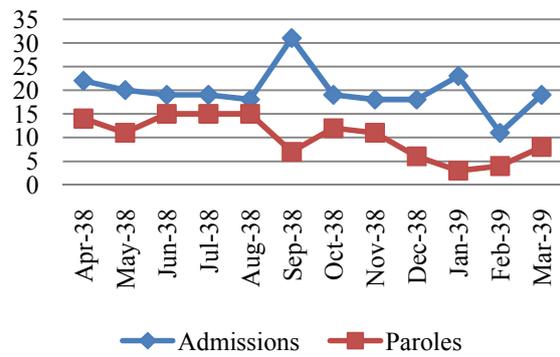


Table 3.11a: Female Patients, April-Dec. 1939

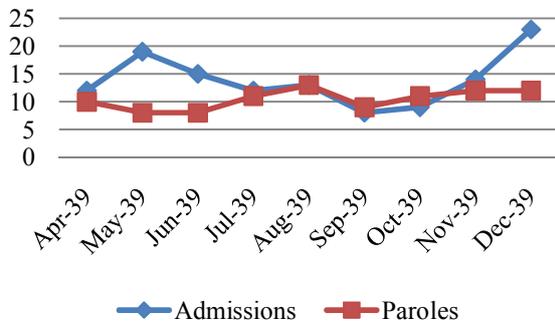
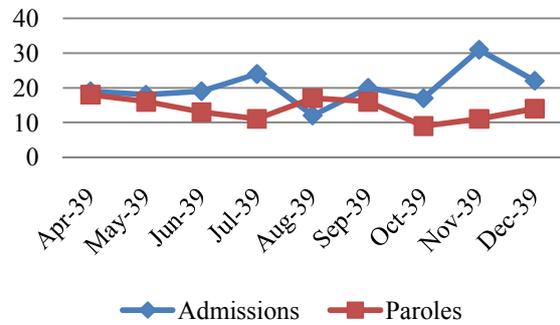


Table 3.11b: Male Patients, April- Dec. 1939



Source: Daily Record Ledgers, Ledgers 3-4, North Battleford Patient Ledgers, Saskatchewan Archives Board.

Table 4: Occupations of the Male and Female Patients of the Saskatchewan Hospital North Battleford, 1929-1939.³

Occupation	Number of Male Patients	Percentage	Number of Female Patients	Percentage
Farmer (includes farming, homesteader)	723	42.7%	6	<1%
Farm Labourer (includes farm help, farm hand)	205	10.3%	0	0.0%
Housewife	0	0.0%	707	60.1%
White Collar (professionals, doctors, nurses, dentists, lawyers, stenographers, newspaper reporters, engineers, scientists, etc.)	77	3.9%	22	1.9%
Blue Collar (urban labourer, blacksmith, tinsmith, butcher, etc.)	521	26.3%	2 (see domestic)	<1%
Service Industry (clerk, cook, dressmaker, hairdresser, waitresses, salesmen, etc.)	97	4.9%	19	1.6%
Proprietor	5	<1%	1	<1%
Teacher	8	0.4%	21	1.8%
Pensioner, retired, widow	33	1.7%	11	<1%
Domestic labourer	0	0.0%	162	13.8%
Railway Employees	28	1.4%	0	0.0%
Minor (at home, student)	12	<1%	21	1.8%
Student (over 18)	12	<1%	14	1.2%
Treaty Indian	2	<1%	2	<1%
Transient	1	<1%	0	0.0%
Unemployed (relief)	24	1.2%	4	<1%
None	99	5.0%	126	10.7%
Left blank, not known, not stated, unknown, unclear	134	6.8%	59	5.0%
Total (First-time Admissions)*	1981	100%	1177	100%

Source: General Register, Ledgers 9-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

³Occupational data was collected for first-time admissions only as the patient ledgers were seldom completed for readmitted patients. As a result, 495 male and 405 female patients were removed to calculate this set of statistics. Categories were created by the author who used the 1931 Canadian census as a guideline.

Table 5: Saskatchewan Hospital North Battleford, Farm Produce, 1929-1939.

YEAR	1929-30	1930-31	1931-32	1932-33	1933-34	1934-35	1935-36	1936-37	1937-38	1938-39	1939-40	TOTAL
PRODUCE supplied to the institution (lbs)												
Beef	7833	5335	4805	3244	13370	8996	7930	8720	7320	10675	3000	81228
Chicken	3644	3099	2507	3418	2630	5165	2872	4544	8437	7397	8694	52407
Eggs (doz)	5533	7703	8172	6101	5862	6201	5873	5299	6517	11992	14822	84075
Hens	-	795	1782	1778	2314	1291	3152	1811	2333	2604	3463	21323
Lamb	-	978	1235	1545	1477	836	997	1456	1213	1484	1891	13112
Liver	1101	770	814	929	536	642	788	677	826	503	999	8585
Milk	546585	658692	730040	734105	846776	854386	835407	744001	825785	788885	804685	8369347
Mutton	1088	682	1483	209	563	2750	807	1896	1693	1615	465	13251
Pork	55300	5335	46672	56506	62107	59152	55723	48940	60282	63165	64200	577382
Potatoes	104804	202008	209666	247200	2016	-	-	-	-	-	-	765694
Turkey	3679	3817	3551	7086	1697	3343	1828	3466	920	1918	2759	34064
Veal	105	490	-	-	-	-	-	-	-	-	-	595
GARDEN AND GROUNDS (lbs)												
Asparagus	310	365	502	351	345	47	53	-	94	445	154	2666
Beans	678	2430	2140	1079	793	1315	1562	932	1775	765	19975	33444
Bedding plants	30000	-	-	-	-	-	-	-	-	-	-	30000
Beets	1340	8510	7764	1445	44	2450	1435	100	5170		67560	95818
Cabbage	7445	5275	14477	4738	4067	13560	6570	3450	19450	6226	144952	230210
Carrots	14070	28915	880	23509	-	35000	9125	520	14380	850	167635	294884
Cauliflower	1366	940	2063	-	215	218	298	207	2250	741	16066	24364
Celery heads	200	175	300	-	131	348	66	-	1070	593	2200	5083
Citron	-	200	35	-	-	-	-	-	-	-	-	235
Corn on the cob	1445	4150	2556	-	300	-	95	710	4745	985	16688	31674
Crabapple	-	-	-	-	-	-	-	-	150	215	405	770
Cucumber long	-	52	420	379	-	29	215	-	160	-	700	1955
Green onions	-	-	3000	6725	1810	650	165	1350	350	1557	9123	24730
Green tomatoes	300	305	1195	-	-	-	-	-	-	-	-	1800
Greens	5150	-	-	-	-	2775	-	-	-	-	-	7925
Kohl rabi	-	300	-	-	-	-	-	-	-	-	1595	1895
Leeks	-	-	-	-	-	-	-	-	-	-	150	150
Lettuce heads	4000	4920	3000	210	866	501	1630	2108	2220	880	5628	25963
Mangolds	-	-	-	-	-	-	-	-	-	-	73160	73160
Marrow	200	3150	1170	-	-	225	400	-	1150	-	14005	20300
New potatoes	123017	178445	42370	12696	387	19260	16710	66270		24,000	23880	507035
Onions	6735	6725	745	10502	2035	1570	550	100	1860		9300	40122
Parsnips	4550	750	-	-	-	1200	800	-	700	-	18075	26075
Parsley	-	-	-	-	-	-	-	-	-	95	100	195
Peas	372	-	860	824	1977	911	1469	199	470	720	20225	28027
Pickle onions	-	210	605	805	-	-	115	-	-	-	-	1735

Pot plants	4000	4824	3858	-	5342	3500	3592	4483	6370	4912	4354	45235
Pumpkin	-	-	-	-	-	-	-	13	-	1256	7086	8355
Radishes	2670	925	535	1005	425	345	4905	-	1640	2885	8104	23439
Red cabbage	-	200	1245	-	200	-	-	-	-	-	-	1645
Red currants	-	-	-	-	-	-	-	-	-	40	71	111
Rhubarb	2461	3825	4402	4466	1910	1790	2240	505	1380	2545	2620	28144
Ripe tomatoes	164	234	89	540	200	291	201	950	2038	5075	14461	24243
Spinach	-	-	130	307	-	-	318	-	1384	-	2861	5000
Squash	100	400	224	33	75	-	215	-	-	-	2850	3897
Swede turnips	-	-	-	6320	-	-	-	-	-	60,000	135	66455
Swiss chard	-	4445	9585	3900	-	-	9775	11785	11505	980	7763	59738
Tender-greens	-	-	-	-	-	-	-	-	1350	1910	-	3260
Turnips	31890	54050	28658	5215	425	23230	14315	25908	37900		119777	341368

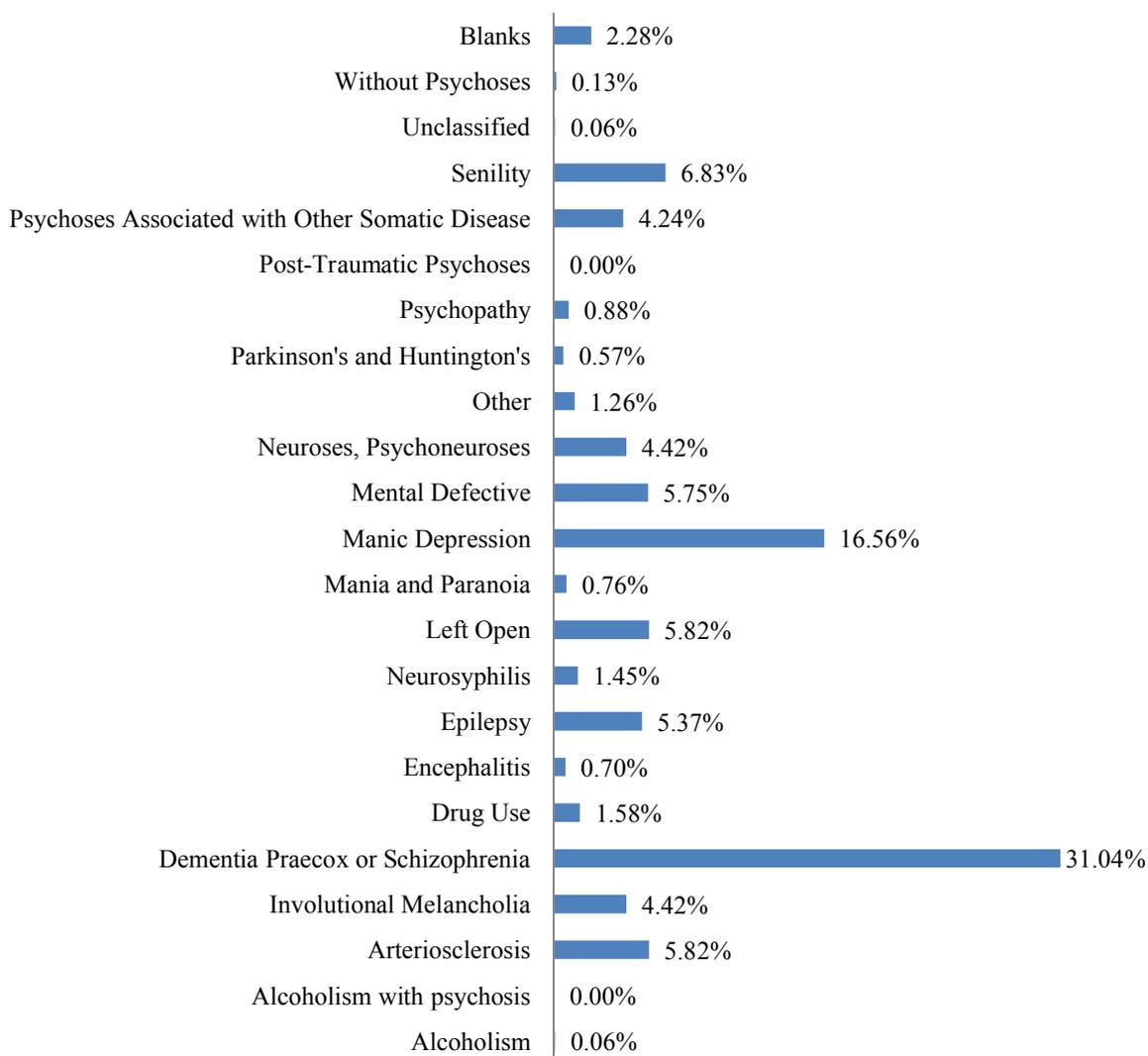
* Irrigation project began in 1938 utilizing 140 acres which had been broken in summer 1937.

** An additional 140 acres were cleared for farming in 1939.

Source: The Annual Reports of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1929-1939. (Regina, SK: J.W. Reid, King's Printer, 1929-1939).

Table 6.1 and 6.2: Mental Illnesses Diagnosed at SHNB between 1929 and 1939.⁴

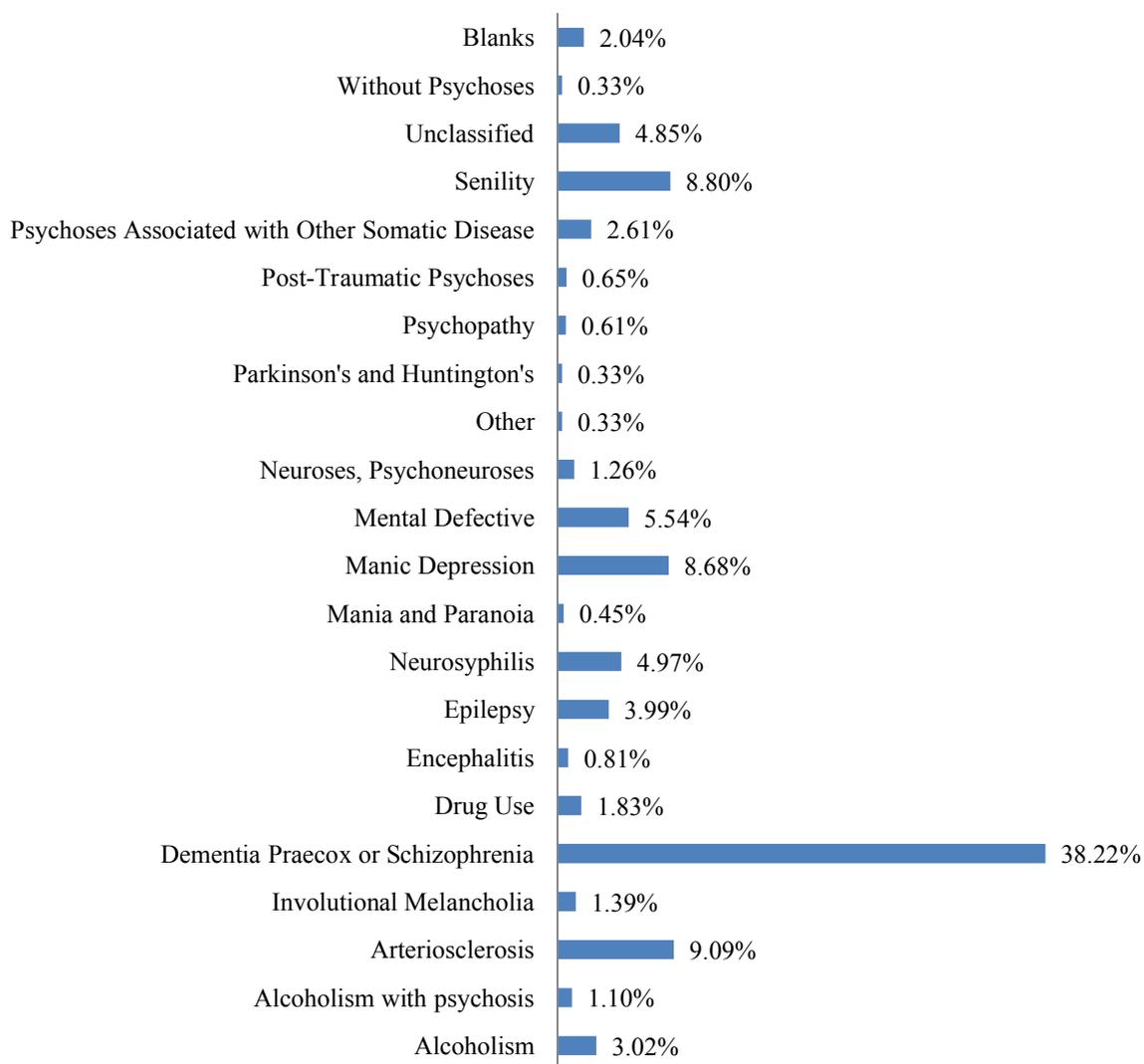
Table 6.1: Female Patients



Source: General Register, Ledgers 9-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

⁴Categories were created by the author, who used Smith Ely Jelliffe and William White's *Diseases of the Nervous System: A Textbook of Neurology and Psychiatry* (Philadelphia: Lea & Febiger, 1915) as a guideline. Diseases which manifested in less than one-percent of the patient population were grouped together, for example, 'Parkinsonism and Huntington's Chorea', 'Mania and Paranoia', and 'Other.' 'Other' includes paraphrenia, Friedrich's hereditary ataxia, disseminated sclerosis, Korsakoff's psychosis, confusion psychosis, acute infective exhaustive psychosis, degeneration, brain tumors and any diagnosis which could not be found in this textbook or in conventional literature.

Table 6.2: Male Illnesses



Source: General Register, Ledgers 9-10, North Battleford Patient Ledgers, Saskatchewan Archives Board.

Table 7: List of Most Common Diagnosed Illnesses Given to Patients of the Saskatchewan Hospital North Battleford with Simple Definitions.⁵

Alcoholism:

Alcoholic hallucinosis- an expression of chronic alcoholism, this illness manifests itself in hallucinations, delusions, and acute paranoia. It is not fatal though sometimes “merges into chronicity.”⁶

Chronic alcoholic dementia- chronic alcoholics may experience increasing enfeeblement, resulting in slovenly appearance, forgetting everyday events, and memory loss.⁷

Delirium tremens- this condition can only be manifest in those suffering from chronic alcoholic poisoning. While there is the argument that delirium tremens presents itself during withdrawal from alcohol, Jelliffe and White suggest that this is not so. Symptoms include auditory and tactile hallucinations, tremor, disorientation and anxiety. This condition lasts only a short period, around three days.⁸

Arteriosclerosis:

Cerebral arteriosclerosis- this condition occurs when the walls of the cerebral arteries begin to thicken and lose their elasticity, and have a tendency to create military aneurisms. Symptoms develop in relation to the location of the arteriosclerosis in the brain. Though various, these symptoms can include forgetting, disorientation and lack of appropriate emotional responses when situations warrant.⁹

Arteriosclerotic dementia- this condition is a product of cerebral arteriosclerosis. Symptoms can include impairment of consciousness and memory, and visual loss.¹⁰

Chorea:

Chorea- While there are many types of choreas, most are characterized by two main symptoms: spontaneous movements, and coordination disturbances.¹¹

⁵In order to understand what criteria psychiatrists of SHNB used in the 1930s, Smith Ely Jelliffe and William White's *Diseases of the Nervous System: A Textbook of Neurology and Psychiatry* (Philadelphia: Lea & Febiger, 1915) was used. Dr. Jelliffe was a significant figure in American neurology and psychiatry, and because Dr. J.W. MacNeill, superintendent of SHNB looked to eastern Canada, the United States and Europe for direction in running SHNB, this textbook was considered appropriate. Two editions were used in order to adequately encapsulate the psychiatric milieu of the period: the first edition, which was originally published in 1915, and the sixth edition which was published in 1935. Where information could not be found in Jelliffe and White, appropriate historiographical sources were utilized and are cited accordingly. It is also important to note that without knowing the names of the many doctors employed at SHNB throughout the Depression era, it is hard to determine what level of training they had and where they received it. This information would be essential in understanding how they diagnosed patients as there was no one centralized authority on mental illness. Furthermore, various universities and medical associations supported the work of many psychiatrists, and often differed in how they saw mental illness and the methodologies they utilized in treating it.

⁶ Smith Ely Jelliffe and William A. White, *Diseases of the Nervous System: A Textbook of Neurology and Psychiatry*, 1st ed. (Philadelphia: Lea & Febiger, 1915), 726-7; Jelliffe and White, *Diseases of the Nervous System*, 6th ed. (Philadelphia: Lea & Febiger, 1935), 1070-1.

⁷ 6th ed., 1072-3.

⁸ 1st ed., 722-3; 6th ed., 1067-8.

⁹ 1st ed., 752-757; 6th ed., 737, 1108-9.

¹⁰ *Ibid.*

¹¹ 1st ed., 432; 6th ed., 664.

Huntington's chorea- is a disorder which appears around age thirty to forty. Early symptoms include irritability, changes in character, and involuntary movements of muscle groups. In later years, patients experience loss of control over their movements, losing the ability to write or walk, and emotional deterioration.¹²

Dementia Praecox (Schizophrenia):

Dementia Praecox Simple- patients with this disease are characterized as a “withdraw[ing] from reality...looking within [and] occupying themselves with themselves, [and are] no longer subject to the corrective influences of the outside world...”¹³ In addition, patients with this diagnosis experience delusions, where he may identify with the universe as if he occupied the centre of it, yet at the same time pleads for assistance. Maintaining two contrasting thought patterns characterize this “split” in personality as seen by Bleuler when he termed *schizophrenia*¹⁴. At SHNB, the transition in diagnoses from dementia praecox to schizophrenia began in 1931-32.¹⁵

Catatonia- patients with this classification shut out the outside world by paying absolutely no attention to it. They may not react to any outer stimuli, neglect bodily impulses and put their bodies and faces in odd positions.¹⁶

Hebephrenia- patients with this classification show symptoms of depression, apathy, hear accusing voices, and experience a greater degree of hallucinations and delusions.¹⁷

Paranoia- these patients are more efficient at creating a “coherent and logically connected series of delusions and associated hallucinations.”¹⁸ In these cases, mental impairment is much harder to detect as they display less outward evidence of such.

Mixed- As there are not finite divisions between these classifications, patients may experience periods of each classification, alternating unexpectedly.¹⁹

Drug Abuse:

Drug Abuse- Jelliffe and White suggest that underlying the addict's use of drugs lies some form of neuropathy that needs to be addressed, or the patient will never improve. Treatment of drug use is largely comprised of rapid withdrawal of the narcotic, using other drugs to ensure the body does not go into shock or distress.²⁰

Encephalitis:

Encephalitis Lethargica- caused by lesions on the brain, this condition is characterized by lethargy, motor and behavioural disorders. Also called “sleeping sickness,” an epidemic

¹² 1st ed., 438-9; 6th ed., 668-9, 1085-6.

¹³ 1st ed., 686; 6th ed. 1021.

¹⁴ 1st ed., 682; 6th ed., 1017.

¹⁵ The transition from dementia praecox to schizophrenia was deduced by decreasing numbers of diagnoses of the former and increasing numbers of diagnoses of the latter. General Register, Ledger 9, North Battleford Patient Ledgers, Saskatchewan Archives Board.

¹⁶ Jelliffe and White, 1st ed., 694-7 ;6th ed., 1029-32.

¹⁷ 1st ed., 691-3; 6th ed., 1028-1030.

¹⁸ 1st ed., 697; 6th ed., 1034.

¹⁹ 1st ed., 699; 6th ed., 1035.

²⁰ 1st ed., 727-729; 6th ed., 1074-5.

of encephalitis lethargica began around 1917 which by in large terminated before 1940.²¹ Most afflicted with encephalitis were young; at SHNB, most patients were under 50 years of age.²² In the 1935 edition, encephalitis lethargica was added, characterized by Jelliffe and White by lethargy, delirium, mood changes, confusion and akinesia.²³

Encephalitis- this condition is caused by the swelling of the brain. Symptoms depend on what part of the brain is affected, however some of the most common symptoms include lethargy, delirium, and changes in motor function.²⁴

Epilepsy:

Classic, Genuine or Idiopathic Epilepsy- this condition is characterized by “disturbances of consciousness (“faints,” “absences,” “blanks,” amnesias) and convulsive seizures involving the voluntary and involuntary musculature.”²⁵ Considered to be solely hereditary, Jelliffe and White suggest that this group come from a “badly tainted stock.”²⁶

Traumatic epilepsy- this form of epilepsy developed from an external injury to the brain. In the Jacksonian classification, a localized lesion of the cortex has developed, causing convulsive reactions. This form is not hereditary.²⁷

Epileptic dementia- this condition comes from years of epileptic attacks, which have caused mental deterioration.²⁸

Involuntional Melancholia:

Involuntional Melancholia- this condition is characterized by significant emotional depression, apprehensive agitation leading to fears of impending danger and most often, delusions of sin. While some patients manifest extenuating stupor, many experience no impairment of consciousness, orientation, and thought.²⁹

Reactive depression- This form of depression is often linked to external events, but psychiatrists differ as to what extent. Situated solely at the emotional level, those afflicted with reactive depression mainly experience sadness. In modern psychiatry, this term is used to describe grief.³⁰

Mania, Manic Depression:

Mania- Patients with this condition experience three main symptoms, the flight of ideas (rapid and too frequent change of ideas), psychomotor hyperactivity (constant and

²¹ See Kenton Kroger, “Epidemic Encephalitis and American Neurology, 1919-1940,” *Bulletin of the History of Medicine*, 78 1 (Spring 2004) 108-147; Lazaros C. Triarhou, “The percipient observations of Constantin von Economo on encephalitis lethargic and sleep disruption and their lasting impact on contemporary sleep research,” *Brain Research Bulletin*, 69 (2006) 244-258; Joel A. Vilensky, Paul Foley, and Sid Gilman, “Children and Encephalitis Lethargica: A Historical Review,” *Pediatric Neurology* 37 2 (2007) 79-84.

²² General Register, Ledgers 9-10.

²³ Jelliffe and White, 6th ed., 723.

²⁴ 1st ed., 458-462; 6th ed., 719-728.

²⁵ 1st ed., 667; 6th ed., 988.

²⁶ 1st ed., 671; 6th ed., 996.

²⁷ 1st ed., 677; 6th ed., 991.

²⁸ 1st ed., 673; 6th ed., 998.

²⁹ 1st ed., 740-1; 6th ed., 1091.

³⁰ Conrad Swartz and Edward Shorter, *Psychotic Depression* (Cambridge; New York: Cambridge University Press, 2007), <<http://lib.mylibrary.com/login.ezproxy.library.ualberta.ca?ID=85074>> (14 June 2011), 34.

unremitting with no clear direction or goal) and emotional exaltation (action and speech reinforce their idea of their own importance).

Hypomania- symptoms of this condition include emotional exaltation, distractibility (easy change of direction in thought pattern with unclear association between ideas), and the flight of ideas. It is the mildest of the forms of mania.

Acute mania- the flight of ideas become so rapid the patient verges on being incoherent and distractibility is prominent. Pressure of activity compels patients to decline rest or food.³¹

Manic Depressive: In addition to experiencing a manic phase (of varying severity), patients with manic depression also undergo a depressive phase, characterized by difficulty of thinking, psychomotor retardation (varying degrees of slowing) and emotional depression.

Mixed- patients with this form of manic depression have symptoms which are essentially a mixture of the three main symptoms of the manic and depressive stages and occur at the same time. As such, they cannot be diagnosed as one or the other.

*Alternating*³²- the patient cycles from mania to depression with a recovery period after each.

Mental Defective :

Mental Defective- Patients with this classification are considered to be below their chronological age mentally, contribute little to society, and experience a wide range of physical and cognitive disabilities. Mental defects, or the feeble-minded are divided into three classes and assigned a mental age. Jelliffe and White include the following chart from the American Association for the Study of the Feeble-minded³³:

Mental Age	Capabilities	Class	
Under one year	Helpless	Low	} Idiot
1 year	Feeds self. Eats everything	Middle	
2 years	Eats discriminatingly	High	
3 years	No work. Plays little	Low	} Imbecile
4 years	Tries to help		
5 years	Only the simplest tasks	Middle	
6 years	Tasks of short duration. Washes dishes		
7 years	Little errands in house. Dusts	High	
8 years	Errands. Light work. Makes beds	Low	} Moron
9 years	Heavier work. Scrubs, mends, lays bricks, cares for room with simple furniture		
10 years	Good institution helpers. Routine work	Middle	
11 years	Fairly complicated work with only occasional oversight		
12 years	Uses machinery. Cares for animals. No	High	

³¹ 1st ed., 634-647; 6th ed. 944-973

³² *Ibid.*

³³ 1st ed., 759-61; 6th ed., 1116.

supervision. Cannot plan

In the 1935 edition, Jelliffe and White note the use of intelligence quotient (IQ) tests to determine mental age.³⁴ Using the above classification was common at SHNB. Chapter three provides an in-depth discussion concerning the societal fixation on the impact that mental defects or the feeble-minded had on “good Canadian stock.”

Paranoia:

Paranoia- Patients with this condition experience delusions and hallucinations (mainly hearing voices). These delusions will be well-articulated and supported by hypochondriacal physical ailments and auditory hallucinations.³⁵ In the period between Jelliffe and White’s first and sixth editions, psychiatrists continued to grapple with this diagnosis by developing sub-types, and re-classifications.³⁶

Parkinsonism:

Paralysis Agitans or Parkinson’s disease- patients with this diagnosis experience muscular rigidity and then contracture, tremor and sensory, speech and equilibrium disturbances.³⁷

Post-Traumatic Psychoses:

Traumatic psychosis- resulting from trauma, often to the head, these patients are characterized by mood and sleep disturbance, and can experience amnesia and epileptic attacks. It can take several years to manifest. In the 1935 edition, shell-shock victims were included in this classification.³⁸

Post-traumatic psychosis- named the “post-traumatic constitution,” patients diagnosed with this classification can experience irritability leading to temper outbreaks, paranoia, and hysteria-like or epilepsy-like symptoms.

Psychoneuroses and Neuroses:

Psychoneurosis- this condition is thought to derive from conflict between the conscious and the unconscious, repressed desires and compensation by wish-fulfilling fantasies.³⁹ Jelliffe and White break psychoneuroses down into several forms, some of which include:

Psychasthenia or compulsion neurosis- the patient is forced to think or do certain things against his will, knowing that it might be silly or foolish, but cannot help it. Once he gives in, he feels relief until the compulsion manifests again. Symptoms include obsessive acts, hallucinations, and phobias.⁴⁰

Hysteria- is an illness of dissociation, where the main personality allows intolerable ideas to drop off into, or be repressed in the unconscious. Hysterical

³⁴ 6th ed., 1116-7.

³⁵ 1st ed., 657-8.

³⁶ 6th ed., 976-985.

³⁷ 1st ed., 425; 6th ed. 649-655.

³⁸ 1st ed., 733-5; 6th ed., 1081-4.

³⁹ 1st ed., 596.

⁴⁰ 1st ed., 605-611; 6th ed., 922-933.

outbursts are the “manifestations of the split-off parts of the personality.”⁴¹
Symptoms include paralysis, amnesia, disturbances of emotion and delirium.⁴²

Neuroses-

Anxiety neurosis- symptoms of this neurosis, defined by Freud, include general irritability, anxious expectation (of something bad to happen to themselves or their loved ones), anxiety attacks, night terrors, vertigo, and phobias.⁴³

Neurasthenia- thought to be an auto-erotic fixation, patients with neurasthenia return back to an infantile state where they only take interest in their own body. Masturbation is thought to be a major cause and symptom. Other symptoms include fatigue, insomnia, emotional irritability and depression.⁴⁴

Psychopath:

Constitutional Psychopathic Personality- these patients do not exhibit the symptoms of a psychosis, yet their adaptation and reaction to their environment deviates from the norm. Depression or exaltation which is experienced all of the time, are common anomalies of mood among constitutional psychopaths. Some are led into crime, or immorality. This condition is considered hereditary.⁴⁵

Psychosis Associated with Other Somatic Disease:

Psychosis associated with other somatic disease- many diseases, especially those which originate in the cardiovascular and pulmonary systems have mental symptoms associated with them. Common symptoms experienced are hallucinations, depression or exaltation, and suspicions.⁴⁶

Senility:

Senile psychosis, senile dementia, senile degeneration-seen to appear after age sixty, this illness is characterized by loss of memory, insomnia and increasing disorientation.⁴⁷

Senium praecox, Presenile dementia, or Alzheimer's disease- this often rapidly progressing dementia generally occurs in patients over fifty years of age. Additionally, patients experience a great degree of disorientation, and speech difficulty.⁴⁸

Pre-senile psychosis- Jelliffe and White suggest that there are several forms of pre-senile psychosis, the majority of which are characterized by depression and very few of excitement.⁴⁹

Neurosyphilis:

General Paresis, General Paralysis of the Insane (GPI), Taboparesis, Tabes, Cerebral syphilis, Neurosyphilis are all related to an untreated syphilis infection and take up to fifteen to twenty years to manifest. Patients with any of these conditions can experience

⁴¹ 1st ed., 599; 6th ed., 914.

⁴² 1st ed., 599-602; 6th ed., 913-932.

⁴³ 1st ed., 613-618; 6th ed., 902-910.

⁴⁴ 1st ed., 621; 6th ed., 899-900.

⁴⁵ 1st ed., 777.

⁴⁶ 1st ed., 738-9; 6th ed., 1088.

⁴⁷ 1st ed., 746-7; 6th ed., 1101-2.

⁴⁸ 1st ed., 751-2; 6th ed., 1091.

⁴⁹ 1st ed., 740-746; 6th ed. 1080.

diverse symptoms including dementia, delusion, depression, megalomania, pain, inhibited motor functions and memory loss.⁵⁰

Congenital syphilis- the bacteria responsible for producing syphilis has been transmitted in-utero or through the birth canal, causing the newborn infant to become infected. Patients with congenital syphilis have diverse physical effects including malformations, and are prone to encephalitis and feeble-mindedness.⁵¹

⁵⁰ 1st ed., 535-549; 6th ed., 787-855.

⁵¹ 1st ed., 580-583; 6th ed., 862-7.

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