March 1886 – His appearance and conduct [are] indicative of idiocy. [he] refuses to speak, eat or drink. Sometimes he seems to understand what is said to him but only replies with a stupid stare. He moves about at random trying to pick up coloured stones and pieces of paper in an aimless manner.¹

July 1950 – This patient ... is an Indian male 23 years of age in good physical condition. He appears rather dull and retarded mentally. He is very slow in his speech and it is rather difficult to obtain any accurate information from him.

July 1950 – I disagree with the previous impression that he is of very low mentality. I have been observing this patient on the ward and he plays a good game of bridge and appears to shoot a good game of pool. I do not think he is mentally defective and it seems likely that he suffered an episode of complete bewilderment and depression.²
More than sixty years separate these ward notes. The first two quotations illustrate the rather uncomplimentary attitudes of some physicians regarding the First Nations patients committed to the provincial mental asylum in British Columbia. The record from 1886 is scant, a mere three paragraphs. The report states only that the patient has been sick for about two months and does not speak English. It offers neither a diagnosis nor a prognosis. The 1950 patient remained in hospital for approximately a year and a half and, at discharge, was considered to be “mentally deficient with epilepsy,” despite the opinion of the second doctor.

Colonialism and psychiatry are both normalizing discourses that seek to differentiate between populations along lines of belonging and behaviour. In British Columbia, Aboriginal patients institutionalized for mental illness contended with both of these discourses. This paper examines the committal and treatment of Aboriginal patients admitted to the provincial mental hospital system of British Columbia during the period 1872–1950. My focus is the construction of sanity and madness, and the framing of this dichotomy by colonial authorities, complicated by designations of “status,” “non-status,” and “mixed race.” Although these terms are fluid, I maintain that there was little significant change in the treatment patterns established by medical authorities in the late nineteenth century. Almost consistently, medical authorities disregarded Aboriginal patients in favour of their relatives with less “Native blood.”

This paper is based on my initial review of the Aboriginal patient case files contained in the larger collection of patient files held at the British Columbia Archives. In most instances, the admission documents clearly indicated the “race” of the patient. Further, all status Indian patients were admitted as wards of the state, and their records contain correspondence from the Department of Indian Affairs. The non-status patients were identified at admission as racially “Indian” but included indications that the patient had been enfranchised or, in a few instances, was thought to be an “American Indian.” Mixed-race patients were identified in the admission documents and patient registers by a variety of terms, including “half-breed” and “mixed.”

I start with the premise that Aboriginal psychiatric patients were subject to multiple systems of designation and surveillance. Federal Indian policy was based on the notion that Indian cultures and societies were inferior to settler society and required constant surveillance. Governmental regulation tasked a variety of bureaucrats with this surveillance, including Indian agents, who were responsible for the local control of bands; medical officials, who investigated Indigenous health; and residential school officials, police, and field matrons, who investigated the personal lives of status Indians. Although not active agents of the state, missionaries also instituted a system of surveillance designed to discourage indig-
The reports and writings of these officials contributed to the perception of Indians as distinctly other. Indeed, as Homi Bhabha argues, colonial discourse is precisely intended “to construe the colonized as a population of degenerate types on the basis of racial origin, in order to justify conquest and to establish systems of administration and instruction.”

During the period of examination, status Indians were not synonymous with those peoples identified today as First Nations. The term status Indian was a legislated designation based on perceptions of racial and cultural difference. The Indian Act of 1876 promoted assimilation through the “reorganization” of traditional land-use patterns and through the imposition of the chief-and-council system that replaced the traditional Aboriginal systems of governance. The Act determined the identity of the status Indian in relation to occupation of the land and established a system by which this occupation would be overseen through a multileveled bureaucracy. Further, this act did not consider the social and cultural distinctions between First Nations peoples but subsumed these differences with the vague wording identifying Indians as peoples with “Indian blood … who lived an Indian life style.” This excluded, among others, Indian women who married white men and Indians with a university degree. This act was amended numerous times between 1876 and 1951, but definitions of who was and who was not Indian and hence who had status did not fundamentally change.

Just as the term Indian had both a legal and cultural designation, insanity was a legal as well as a medical term. The British Columbia Act Respecting Asylums for the Insane, passed in 1873, defined a "lunatic" as "any insane person whether found so by inquisition or not." Those determined to be lunatics by this rather elastic definition were then removed from society and incarcerated in mental hospitals. Mental hospitals were thus integral components of state formation that linked notions of impropriety to psychiatric definitions of deviancy.

In many ways, nineteenth-century colonialism and early psychiatry have much in common. Both were predicated on the idea that Western society, along with the version of reality that it supported, was the most developed and represented progress as the highest achievement possible. The emerging field of medicine bolstered and was supported by colonial directives that promoted a hierarchy of race and culture. Medical investigations, such as craniometry, were used to illustrate the very physical evidence of this supposed hierarchy. Colonial and scientific authority created and privileged a definition of reality that was used as a means to promote a specific version of social order within the colonial context. Both relied upon racialized notions of “others” as representations of the “primitive mind.” Further, it seems that some forms of madness were colonial tropes for the resistance of “non-civilized” peoples.
Historiography

The literature shows that the complex relationship between colonialism and psychiatry varied between colonial settings. For example, Richard Keller’s *Colonial Madness*[^1], Lynette Jackson’s *Surfacing Up*[^2], and Jonathan Sadowsky’s *Imperial Bedlam*[^3] examine the racialized treatment of Indigenous patients within colonial mental hospitals. In his study of French North Africa, Keller reports that due to overcrowding, Indigenous Algerian inmates were removed from familiar surroundings and shipped to France for treatment. Keller notes that one physician argued that the voyage had a calming effect on Algerian mental patients.[^4] Jackson, whose work focuses on the Ingutsheni Hospital in colonial Zimbabwe, notes that Indigenous patients were housed in inadequate shelters, while white patients admitted to the hospital enjoyed a modicum of privacy and dignity.[^5] Sadowsky maintains that a large number of Indigenous people in colonial southwest Nigeria were turned away from the asylum due to lack of space.[^6]

Similarly, the response to gendered transgression of behavioural norms was not constant among colonial settings. Breaches of white masculinity concerned colonial authorities in India, while African women’s contradiction of gendered norms of colonial society branded the women as dangerous and hence fit for committal to colonial Zimbabwe’s asylum.[^7] Further, Jackson argues that it was only when the asylum succeeded in making itself a “civilized space” that white women were admitted.[^8] According to Adele Perry, colonial British Columbia followed other imperatives. Intending to build a white settler colony on the “edge of empire,” colonial authorities quickly incarcerated white women who broke with gendered, classed, and racialized notions of sanity.[^9] This literature points to the diversity of colonial responses to madness and cautions against viewing colonial discourses as overdetermining, or uniformly determining, perceptions of Indigenous people deemed insane.

There are few historical studies of the relationship between colonialism and psychiatry as related to First Nations people in Canada. In his *Revenge of the Windigo*, James Waldram outlines the development of the concept of the “Aboriginal mind” by psychiatrists, psychoanalysts, physicians, and anthropologists over the course of the twentieth century. According to Waldram, concepts of Aboriginal psychopathology influenced both social and medical authorities. His focus is on “the intellectual underpinnings of explicit and implicit models of culture that appear to be guiding research” as well as “sweeping generalizations of the Aboriginal personality.”[^10] Scholars writing about Aboriginal mental states in the early twentieth century concluded, along with Diamond Jenness, that “[t]he Indians are mentally somewhat unbalanced,” whether that was due...
to their being rooted in primitivism, prone to magical thinking, subject to environmental stress, caught in between two worlds, or experiencing the pressures of assimilation. Waldram’s study is significant because he situates the construction of the Aboriginal mind not in a self-reflective examination of Aboriginal culture by Western psychiatry but rather in the flawed Western notion of objective observation. Waldram also points to the problematic nature of a monolithic Aboriginal mind that was applied to all Aboriginal peoples and did not consider the cultural differences among Aboriginal peoples.

In their article “Turbulent Spirits,” Robert Menzies and Ted Palys examine the confluence of colonialism and psychiatry in relation to First Nations patients in British Columbia. They identify distinctive patterns of legal and medical intervention and argue that the committal and treatment of First Nations patients raise “important questions about the recursive relations of race, ethnicity, Aboriginality, and psychiatry across the province and the nation.” In particular, they note that members of Indigenous communities rarely initiated the committal of status Indian patients; rather, agents of the state were frequently responsible. Further, Menzies and Palys find that only a small number of the status Indian patients were actually treated. They indicate that 68 percent did not receive any type of treatment. Eleven percent were prescribed medicines to treat paresis, followed by six percent who were given sedatives for epilepsy. Finally, Menzies and Palys argue that, despite the pleas of family, First Nations patients were often denied discharge, as their villages were seen as sites of disease. Thus, Indian patients were isolated, often left untreated, and frequently denied discharge.

This article builds upon Menzies and Palys’ important work by comparing the symptoms, diagnoses, and treatment given to status Indian patients with those of non-status and “mixed” Aboriginal patients. This will illustrate the relationship between perceptions of indigeneity and deviance through a discussion of the handling of these patients from committal through institutionalization and treatment, and on to either death or discharge.

**Methodology**

**Understanding that Status Indian Psychiatric Patients were subject to multiple definitional practices, this paper investigates how discourses of colonialism and psychiatry converged, coalesced, and conflicted in producing both knowledge about and practices directed at psychiatric patients identified as status Indian.** Previous studies have identified approximately 276 Aboriginal people admitted to British Columbia’s psychiatric facility between 1872 and 1950. Some but not all of these were status Indians. The mix of status and non-
status Aboriginal patients provides an opportunity for comparison that may help highlight the influence of the legal definition of Indian on the treatment of status Indian patients.

Case histories present a specific set of challenges for the researcher. My research indicates that the files cannot be used as a source for the lived experience of the patient; rather, the files function as illustrations of the attitudes held by the medical authorities toward the patients. Further, I maintain that it is impossible to reconstruct the chorus of patient voices from these records, as the authorities recorded only those words and deeds, either positive or negative, that they considered relevant. Similarly, instances of patient resistance are also difficult to ascertain, even through a close reading of the files. Although escapes and suicides, the most extreme manifestations of resistance, were noted, these reflections reflect the perspectives of the medical authorities. For example, a generally well-mannered patient may be described as “wandering off,” while a more recalcitrant patient as attempting to escape from the institution. Further, psychiatric authorities did not view suicide and escape as indications of institutional failure but rather as evidence of the accuracy of the diagnosis and of the patient’s lack of insight into his or her condition. Some of the files do contain letters written by the patients; however, these are letters that were confiscated by the authorities, generally due to their negative content, and thus are not representative of the patient experience in general.

Admission was a staged procedure. Although the legal process of admission was standardized, the route to admission varied. In some cases, family or community members complained to authorities. In other cases, the police or other government officials recommended committal on the basis that the patient represented a public menace. Still other patients were admitted from state institutions such as jail or residential and industrial schools. Once the person came to the attention of the authorities, two physicians—usually general practitioners, not psychiatric specialists—examined the patient and indicated their recommendation for committal. The physicians recorded the relationship of the person who instigated the initial complaint as well as what the patient said and did during the exam and how the patient appeared physically at the time of examination. Finally, a legal official, such as a judge or stipendiary magistrate, reviewed these recommendations and gave the order for committal. In some cases, this legal official was also one of the examining physicians. Once the patient was admitted to hospital, resident doctors diagnosed the individual and prescribed a regimen of treatment. If the patient responded favourably, he or she was discharged after improvement was sustained for a reasonable period of time.

Upon admission, the doctors examined the patient to ascertain if the signs and symptoms of madness had abated or increased. Physicians also performed
a physical exam in order to ascertain the general health of the patient; for women, this often included a gynecological exam. Sometime after admission, the medical authorities interviewed the patient in a process recorded as a “verbatim.” During these sessions, the patient was asked a number of increasingly difficult questions. Generally these interviews began with inquiries as to the patient’s age and social status, and included education and occupational experience. If the patient was able to answer this type of question, the interrogation progressed to knowledge of cultural aphorisms, such as “a bird in the hand is worth two in the bush.” The medical authorities frequently portrayed Aboriginal patients as mentally deficient if they were unable to supply personal information or comment on these adages.

The centrepiece of the file is the ward notes written by the medical officials during the length of the patient’s committal. In the early years, the law required that the patient be assessed once a year. However, the files became more detailed as legislation demanded that the patients be examined more regularly. In the 1930s, social service reports were added as an important component of the case file. These reports focused on the information gathered through interviews with the patient’s family and, when possible, friends and employers. Not surprisingly, these interviews often produced contradictory evidence, which required the social worker to comment on her perception of the veracity of the witness. At every point, psychiatric patients were observed and assessed using definitions of normalcy that were culturally bound and socially produced. As wards of the state, racially and culturally defined by the Indian Act, this system placed Aboriginal patients at a disadvantage.

Discussion

At the beginning of the twentieth century, organic theories of causation informed medical decisions. By the 1930s, psychoanalysis was in ascendance, and by mid-century, medical authorities treated patients with both medicine and psychosurgery. These shifts in theory, in conjunction with the developments in technology and medication, profoundly affected the type of treatment provided to and outcome expected from the patient. In the years before radical medical intervention—such as electroconvulsive therapy (ECT), metrazol shock, and psychosurgery—was introduced, a patient was removed from the community and remained in hospital until signs and symptoms of illness ceased. Once medical intervention became the standard method prescribed, a patient was returned to the community when indications of illness were ameliorated through medication and treatment. In the first instance, the patient was considered to have regained mental balance. In the second, stability was artificially maintained as...
long as the patient adhered to a prescribed regimen. These models would have profoundly different effects on First Nations patients and their diverse communities. Those patients who lived close to centres in the lower mainland were able to maintain the medical regimen and were often compelled to do so as a requirement for discharge. Patients from outlying communities where surveillance was difficult or non-existent were often not discharged. Further, if discharged, these patients generally did not have access to the pharmacies and clinics integral to maintenance of a prescribed regimen of treatment, nor were the medical staff in smaller communities trained to deal with the continuing care of mental patients.

For example, in the early 1950s, a nurse from a small community on Vancouver Island inquired of the hospital authorities:

Dear Sir – Would you kindly give me some idea as to the condition of a recent patient of yours, an Indian from here. He wants a repeat of a large red capsule and a small white one with a cross on it. I have neither in stock here, so please send the medication, care of the hospital and instructions as to how long he is to continue same. NP There is no doctor nearer than [X], so I look after him. Many thanks for a speedy reply. I am, Yours Truly …

Patients from outlying communities often remained in hospital, despite showing improvement, as medical officials deemed their home environments to be unhealthy and not conducive to recovery and mental stability. Consider the case of Agatha, a First Nations teenager from a remote coastal community who was admitted to hospital in 1934 with depression. After a few months in the hospital with no treatment given, she was considered cured of this ailment. Despite the pleas of her parents to return her to her family and her community, she was kept in the institution, as a return to her home “could cause a return of her condition.” Agatha remained in the hospital for three more years until she died of tuberculosis. The case of Bernice, another First Nations woman admitted for depression in the mid-1940s, illustrates the tragedy that could ensue. The admission note states:

[She is quite dull and foolish Indian girl. She is uncommunicative when asked questions about herself and her behaviour in the Industrial school. She reached only the 4th grade in school and her arithmetic and general knowledge is limited. Her behaviour on the ward is quiet and co-operative to date and she follows instructions well. Thus far we have not been able to state that her illness has been more than a re-active depression in an immature and impulsive individual.]
Bernice continued to hold her improvement for a number of years and was depicted as co-operative and assisting with ward duties. Her immediate family and friends wrote numerous letters to the authorities asking for her release. However, they were always answered in the negative, with the caution that if allowed to return to her home, she may become “difficult to control.” After eight years in hospital, the ward notes show an abrupt change:

She cannot be engaged in conversation with regard to her difficulties. Patient was extremely threatening and combative towards the staff and exhibited homicidal tendencies on several occasions. There has been no previous expression of suicidal tendencies and most of her behaviour was aggressive in nature. Because of her homicidal acts, the patient was put in restraint.

However, according to the notes, within the space of fifteen minutes, Bernice got out of both a straitjacket and a restraining sheet; she wrote a short message on the wall and hung herself. The subsequent inquest relieved the authorities of charges of culpability in her death.37

The records clearly illustrate cultural ignorance of Indigenous practices on the part of the medical authorities. For example, when Aboriginal patients mentioned communication between themselves and the deceased, the authorities used this as an indication of madness.38 Edgar, a fisherman from the north coast, maintained that he had been out in a boat recently, talking with a chief and a number of his deceased friends, although the police reported he had been in the “lock up” for two days.39 Anna, described as “intemperate,” believed in ghosts and stated that a man who had been dead for four months had approached her and asked her to go with him.40 Vernon, a labourer from the interior, stated that his problems began when he was asked to drive a dead person to town. It was later confirmed that Vernon had been asked to drive a body to the mortuary and had been involved in an accident while transporting the body. Despite the confirmation of his story, Vernon remained in hospital, “dull and confused,” until he died from tuberculosis twenty-three years later.41 In contrast to the opinions of the medical authorities, ethnographers argue that communication with the dead was and still is an important component of community and identity for many First Nations.42

During the 1930s, when psychoanalysis was in ascendance, the entire life of the patient and his or her relationships became sites to examine. The disregard for First Nations culture was evident in the social service note attached to the file of Joe, a middle-aged male patient.
The Indian agent assured visitor that no information would be obtained by visiting the home, partly because of the suspicious nature of the Indian and partly the lack of English. However as the Agent is in close contact with the [X] family his records were up to date and visitor obtained information from them.43

The social service notes also illustrate the disregard for Indigenous traditions. The social service worker recorded the following information from the husband of Mary, a woman diagnosed with paranoid schizophrenia:

While patient was picking hops one of the other hop-pickers lost something and accused patient of having stolen it. Patient told them to look through her things, which they did, but did not find the missing article. One night when she was sleeping an old woman, over seventy years of age, went creeping around behind her and kicked her in the back. The next morning the patient was ill. Patient’s husband and aunt both believe that the illness is due to a spell cast on the patient and which allowed the entrance of an evil spirit. The Indian doctor and an old woman had something to do with it. If the Indian doctor at the reserve, were to be called in it is thought he could cure her by the next morning by taking off the spell. Patient’s husband is somewhat apologetic about this story of how the illness occurred. He said he knew white men thought this to be old-fashioned. However he believed it to be true.44

It is heartening to note that the traditions continued despite discouragement from the medical officials.

Perceptions, or rather misperceptions, of indigeneity held by the medical authorities influenced not only the medical course but also the social component of treatment for many Indigenous patients. Medical authorities deemed Frank, a coastal-community resident admitted in the late 1800s, to be “worse than a beast” before his death caused by tuberculosis eighteen months after admission.45 Admission notes report that Stanley, admitted from the interior in the 1890s, was “on the warpath” and noted him to be a “real Siwash in his habits.” However, Stanley remained in hospital for more than twenty-five years and was considered “generally quiet and a good worker.”46 Admitted during the 1920s, Wilma, whose father and husband were dead, did not want to be alone and talked to herself. She was noted to cause no trouble but was difficult to engage in conversation, remained apart from others, and interestingly, was “tidy for an Indian.” After ten months in hospital, she was interviewed by an interpreter, who reported that she was “not delusional, is well orientated and has a
good memory.” As soon as arrangements could be made, she was discharged as “recovered.”47 In contrast, Ida, a woman of Chinese and Aboriginal heritage, was deemed “unkempt even for an Indian.” Until her death ten years later, reports labelled her as “uncommunicative,” noting ironically that she did not speak English.48 Finally, May from the northern interior—whose case was informed by the local minister and schoolteacher, a married couple—had recently been involved with the accidental death of a friend. The minister reported that May had been “disturbing the village for a week” after the death of her close friend. The most damning evidence was that she “clings to the Indian idea of witchcraft” and had “a low intellectual capacity.” Medical authorities confirmed her mental incapacity with the observation that she “speaks only when spoken to and uses simple, concrete words.” Despite contracting tuberculosis, May was demeaned for “spitting on the floor.” May died after fifteen months in hospital.49

As mentioned previously, the only major study of British Columbia’s Aboriginal mental patients is “Turbulent Spirits” by Robert Menzies and Ted Palys. Their data is based on a review of one hundred of the First Nations patients admitted between 1879 and 1950. According to Menzies and Palys, only a handful of Aboriginal patients were treated with interventions, including ECT, metrazol shock, and psychotropic drugs.50 However, my review of a broader patient population reveals that quite a number of Aboriginal patients were given these treatments. The most important difference I have found is that most status or “full-blooded” patients lingered for years without therapy while their mixed-race cousins were treated in a timelier manner.

In my sample, fifteen Aboriginal patients were treated with ECT. Eleven of these patients were listed as “full blood.” Only three of these underwent the procedure within the first month after admission. The remaining eight waited from nearly four to seventeen years to be treated. Of the eleven patients, one was admitted in a manic state and died of exhaustion within a few days. Another was diagnosed as a “moron” and was treated after two weeks. Of the four patients listed as mixed race, all were treated within the first month after admission.

Consider the case of Elsie, who was born and raised in the Cariboo region of British Columbia. She was sentenced to Oakalla on a four-month sentence for vagrancy. While in jail, her behaviour drew the attention of the authorities and she was transferred to the hospital at Essondale. At admission, she was portrayed as mentally dull since “she cannot say the months or the days of the week and cannot read or write.” After six years, she was described as “cooperative to routine but resistive to anything outside routine.” At times she acted impulsively. After sixteen years in hospital she was treated with ECT, but with little effect. Elsie remained in hospital for another nine years, showing little change. After twenty-five years, she was given leave as “improved.”51
Joe, a trapper from the Yukon, was admitted in the late 1930s because he threatened his family and others with an axe. At admission, he was labeled as “dull, antagonistic … and delusional.” Joe was not treated and languished in hospital with “progressive mental deterioration and paranoidal delusions … and is impossible to gain in conversation.” After sixteen years he was treated with ECT, to little effect. He was given extended leave after thirty-four years, with a diagnosis of chronic schizophrenia.52

Compare the case of Milly, admitted during the same period, to those of Elsie and Joe. Milly, born and raised in the north coastal area, was given up by her Scandinavian father when her “breed” mother died. Milly feared that people were after her in order to kill her either by hanging or execution by the guillotine, and she worried that her two children had been strangled. At admission, Milly had an apathetic and despairing attitude, and her speech was slow and retarded. She was started on a course of ECT after four weeks in hospital and showed some improvement. She continued to improve and was given probation after fourteen months of hospitalization.53

The situation was similar for those who were treated with both ECT and psychotropic drugs. Consider the case of Edna, admitted from the Cariboo in the late 1930s, who feared that men were trying to kill her and her two-year-old child. As a result of her fear, she had not slept for days when she came to the attention of the authorities. At admission, she was described as “apprehensive, dull and difficult to gain in conversation and gives the impression of limited mental capacity.” The nurses noted that “if she is treated sympathetically, she will respond,” yet if she was ignored, she broke windows and caused disturbances on the ward. According to the ward notes, she remained “dull and disinterested, obviously mentally deficient, [yet] cooperative and her habits are clean.” Over the next twenty years, her behaviour vacillated between periods of cooperation and combativeness. After seventeen years of hospitalization, she was treated with ECT but did not improve. At twenty years, she was treated with Largactil and showed improvement. The psychologist reported:

Intellectually she tests in the Borderline range on the Wechsler and Porteus,54 thus she cannot be categorized as a defective. In spite of her lack of adequate social and educational background, she seems to have picked up a certain amount of knowledge and simple elementary skills. She shows relatively good planning ability and control and there were no indications of bizarre or illogical features in either her verbalization or approach.
After twenty-one years of institutionalization, she was discharged as “much improved” with a diagnosis of catatonic schizophrenia.55

Joseph, admitted in the late 1930s, was detained after causing a disturbance in a restaurant. He complained that people were persecuting him and that spies frequently followed him into restaurants. After one week in hospital, authorities described the patient as suspicious and confused, yet correctly oriented with a good memory. Due to his continuing delusions of persecution, he remained in hospital for more than twenty years without treatment. In his thirty-third year, he was treated with Largactil and other psychotropic drugs. However, Joseph remained in hospital for another seven years before he escaped.56

The case of Angela, whose parents were of mixed blood, contrasts with the experiences of Edna and Joseph. She was admitted due to episodes of anger and complaints that she heard two voices in her head that controlled her thoughts. After two weeks in hospital, she was treated with insulin shock. Two months after admission, she was free of “psychotic material” and was given discharge in full.57

My findings suggest that this difference in treatment patterns was generally, but not always, the case. Sam, admitted in the 1890s, was a fisherman from Vancouver Island with a history of “a good deal of mania.” He was detained due to “wild and threatening behaviour” that had culminated in an assault upon a stranger. Sam improved after one month in hospital, and was discharged “with no indication of psychosis” after four months in hospital.58 In contrast, Bob, admitted in the same era as Sam, was listed as “half Indian” and was a farmer from the interior of the province. He was admitted after killing a heifer with an axe and remained in hospital until his death after sixty-two years of institutionalization.59 Both patients are depicted as “slow, dull, and quiet”; the main difference is that Sam was considered to be “a good worker.”

Conclusion

Finally, let’s return to the two patients introduced through the ward notes at the opening of this paper and reconsider their situations. The first patient is defined by inaction. The notes present his silence as an integral component that frames the space between his personality and his supposed illness rather than as the reasonable action of someone who does not speak English or is culturally uncomfortable with personal discussion. His actions are portrayed as random and aimless. He is depicted as too remote and too primitive to interact with the medical authorities. Specifically, the 1886 ward note illustrates how colonial psychiatry found connections between “race and mind” as the rationale for the colonial project. Indigenous peoples, not only in British Columbia, but also
throughout the world, were diagnosed as essentially different and situated as inherently unable to cope with or understand the colonial agenda.

As well, there are a number of concerns with the diagnosis of the second patient as a mental defective with epilepsy. First, if the patient "plays a good game of Bridge," as noted in the second 1950 quotation, it seems unlikely that he was a mental defective. The diagnosis of "mental defective" was determined through the use of a number of intelligence tests, including the Porteus Maze Test. The report on the results of this test note that "his approach to the problems was fairly steady, unemotional and he was capable of profiting from his mistakes. Qualitatively he was penalized for lack of adherence to instructions (i.e. he repeatedly lifted his pencil from the paper)." Thus, the patient’s inability to properly use a pencil effectively sealed his fate. Although he was able to interact with the medical authorities, unlike the patient from 1886, this patient was still diagnosed as primitive since he was unfamiliar with an exam designed for urbanites and was considered to have a defective or diseased mental process as indicated by epilepsy. His occupation as a trapper, in the "traditional mode of an Indian," signalled his reliance upon outdated modes of subsistence, yet his ability to play bridge, a game of memory and skill was overlooked.

I do not mean to imply that ECT and psychotropic drugs were an effective means of treatment or that interventions should have been prescribed earlier for patients such as Elsie, Edna, Joseph, and Joe. As a historian, I am unqualified to comment on the efficacy of treatments. Rather, I argue that these treatment patterns indicate that the racial perceptions of the medical authorities directly influenced the treatment of the patient and of the subjectively defined prognosis of that patient. Treatment and discharge were then based in a complex discourse that marginalized the "full-blood" Aboriginal patient in relation to "less Aboriginal" patients, who were appraised to have been "improved" by the addition of "white blood."

The study of colonialism and psychiatry analyzes aspects of medical, political, and social history in order to "unsettle" or centre progressive histories of colonialism, particularly colonial medicine. Psychiatry holds a unique position as a biological, behavioural, and social science that, when in concert with colonialism, promoted race as a determinant of one’s role in civil society. Further, concepts of race, gender, and sexuality act as sites of consent and dissent in relation to biological, social, and legal issues. Thus, madness cannot be defined as a singular issue but rather as an entity viewed through and constructed by a kaleidoscope of shifting possibilities—twist one way and an image is produced, twist again and the image changes.
Notes

1 British Columbia Archives, GR 2880, box 2. As per the requirements of the British Columbia Archives, all identifiers have been removed and, when given, all names are pseudonyms. All direct quotations, unless otherwise indicated, are from the patient case files. These files are held by the British Columbia Archives in the GR 2880 collection, “British Columbia Mental Health Services, Originals, 1872–1942,” and in the 93-5683 and 93-7364 accession groups that cover patients discharged from the 1940s until the 1970s. Admission books are catalogued as GR 1754, listing patients admitted from 1872 until 1947, and GR 3019, which lists those patients admitted after 1947. Although there were four institutions in the B.C. mental hospital system, the identity number assigned to the patient remained the same throughout the course of committal. The endnote is given at the end of the discussion of the specific patient. File numbers will be disclosed to qualified researchers.

2 Accession 93-5683, box 1138.

3 Canada, Parliament, Indian Act, 1876, s.c. 1876, c. 18.

4 I have chosen 1872 as the entry point for my study, as this was the year when the asylum was established and detailed records began to be kept. Before 1872, “lunatics” were often housed in jails. The year 1950, for a number of reasons, is a logical conclusion point. An investigation spanning from the late nineteenth century until the mid-twentieth century tracks changes in psychiatric methods of treatment. These ranged from purely physical measures in the early years to psychosurgery in the 1940s. Further, until 1950 most, if not all, patients considered to need treatment were admitted to one of the hospitals in the system. After this date, patients were treated in local clinics and hospitals. The first mental hospital in British Columbia opened in 1872 on land designated as a reserve for the Lekwammen (Songhees) people in the Victoria harbour. Four Aboriginal patients were admitted to this institution. In 1878 the institution moved to New Westminster. By 1910 it was clear that this institution was overcrowded, and construction of an additional hospital began. The Aboriginal patient population grew by thirty-one admissions from 1878 to 1910. In 1913 the new hospital, located at Essondale, opened for male patients. A female ward was opened at Essondale in 1930. After the First World War, the Aboriginal patient population grew steadily with approximately fifty patients in each ten-year period. This increase in admissions occurred during the time when the Aboriginal population in British Columbia was in decline. The last hospital was added in 1919 when Colquitz, on Vancouver Island, opened to house the criminally insane. This same period, 1872–1950, marks significant decades in the implementation of Indian policy in British Columbia as reserves were laid out, Indian agents put in place, systems of medical surveillance initiated, and residential schooling made compulsory, at the same time as improved transportation and communication networks opened up all of First Nations lands to settlement and development. In these ways, government and settler observers had increasing access to observe Aboriginal communities between 1879 and 1950.
One of the major limitations of this record group is that a number of the files were “purged” during the late 1970s, rendering them incomplete. In some cases, only a few documents, such as nursing clinical files or family correspondence, were destroyed. In other cases, much of the file is missing. However, most retain the ward notes, and additional information can be obtained from the “Patient Register” books.


Stoler states, “Nationalist discourses … marked out those whose claims to property rights, citizenship, and public relief were worthy of recognition and those that were not.” Ann Laura Stoler, *Race and the Education of Desire* (Durham: Duke University Press, 1995), 8.


Richard C. Keller discusses the connection between colonial psychiatry and the inculcation of modern concepts of citizenship in “primitive” Indigenous populations. Keller builds on the work of Fanon and Memmi in his contention that Indigenous peoples were driven mad as a result of being denied full access to the status enjoyed by the colonizer. Richard C. Keller, *Colonial Madness* (Chicago: University of Chicago Press, 2007), 2, 4.


Keller, *Colonial Madness*, 42.


Sadowsky, *Imperial Bedlam*, 47.

19 Jackson, Surfacing Up, 46.

20 Perry, On the Edge of Empire, 188–90.


24 Ibid., 161.

25 Ibid., 160.

26 Ibid., 150.

27 Ibid., 153, 155. The graph on p. 155 notes that of the one hundred patients studied, six were enfranchised. Since their study examined half of the patients, it is impossible to ascertain from their published data how many of the 193 were status Indians. Dr. Geoff Smith’s comprehensive study of schizophrenia identified the remaining patients, who were described as “ethnically” Indian but were not necessarily status Indians. One hundred and thirty-seven patient files were compiled for this study. This list contains all patients identified as Aboriginal who presented with signs and symptoms of possible schizophrenia. This list does not include those patients considered to have “organic” explanations for madness. Diagnoses such as epilepsy, chorea, senile dementia, toxic psychosis, and developmental disorders are not incorporated into this list. Dr. Geoff Smith in the Department of Psychiatry at the University of British Columbia graciously supplied me with this data.

28 The difficulties associated with the use of case files are outlined in the edited volume On the Case: Explorations of Social History. In his chapter, Steven Maynard maintains that the “genealogy” of case histories indicates that they are a response to the social challenges faced during rapid urbanization and the perceived need for social regulation. He argues that since case histories incorporated statistics, social surveys, and methods of criminal identification, they were “central to the practice and professionalization of psychiatry.” Steven Maynard, “On the Case of the Case: The Emergence of the Homosexual as a Case History in Early Twentieth-Century Ontario,” in On the Case: Explorations in Social History, eds. Franca Iacovetta and Wendy Mitchison (Toronto: University of Toronto Press, 1998), 65–87, esp. 69. In his work on colonial Africa, Imperial Bedlam, Jonathan Sadowsky cautions that case files are not an “authentic source … but … polyphonous … produced as clinicians and patients, representatives of complex social worlds, work with and against each other.” Sadowsky, Imperial Bedlam, 49. Stoler stresses the double-edged nature of archival sources, as they illustrate the “rough interior ridges of governance” and act as places of “uncertainty and doubt.” Ann Laura Stoler, Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense (Princeton: Princeton University Press, 2009), 2, 4.

Erickson argues that reports of Aboriginal suicide by the authorities varied according to “commonsense ideas or ‘shared social meanings’ about the circumstances and motives that ‘typically’ culminate in suicide.” Lesley Erickson, “Constructing and Contested Truths: Aboriginal Suicide, Law, and Colonialism in the Canadian West(s), 1823–1927,” Canadian Historical Review 86, no. 4 (December 2000): 616.

The amount of time varied. In the era before drugs, patients remained in hospital for extended periods of time. The introduction of antipsychotic drugs reduced the length of committal for many patients. Largactil, the trade name for chlorpromazine hydrochloride, also known as Thorazine, was one of the earliest antipsychotic drugs widely used in the 1950s. Essentially, Largactil acted as a tranquilizer and calmed patients presenting with indications of aggression, agitation, or excitement.

The original B.C. Insane Asylums Act was passed in 1873 and amended in 1893. The Hospitals for the Insane Act replaced the original act in 1897. It was renamed the Mental Hospitals Act in 1912. This act was revised in 1940 by allowing the addition of appeal boards. In 1964 the B.C. legislature passed the Mental Health Act.

Social service reports were added to the case files in 1931. Social workers were dispatched to interview family members, employers, and acquaintances in order to gain a broader picture of the patient’s life.


Accession 93-5683, box 1126.


Accession 93-5683, box 1295.

I was reminded of the importance of this means of communication through Dr. Keith Carlson’s lecture “Beyond Aboriginal History: Engaging Historical Consciousness,” delivered 9 October 2008 at the University of British Columbia.

GR 2880, box 7.

Ibid., box 16.

Accession 93-5683, box 1346.

According to their data, three patients were given ECT, three were given ECT and psychotropic drugs, one was given metrazol, and two were given psychotropic drugs. Menzies and Palys, “Turbulent Spirits,” 160.

The Wechsler-Bellevue was an IQ test developed in 1939 that included both verbal and non-verbal, or performance, testing. The verbal and performance scores were blended to produce the IQ ratio. The Porteus Maze Test was non-verbal and required the patient to trace a route out of a maze without lifting the pencil or crossing any lines.