

**Patients, Politics and Psychiatric Classification at
Weyburn Mental Hospital: 1921-1948**



Alexander Dyck, MD
Department of Psychiatry
University of Alberta

Erika Dyck, PhD
Department of History
University of Saskatchewan

Introduction

This paper explores the evolution of psychiatry and mental disorders based on a historical overview of psychiatric institutionalization and classification, and an analysis of newly digitized admission records from the prominent mental hospital at Weyburn, Saskatchewan between 1921-1948. From its completion in 1921, Weyburn went on to amass one of the largest asylum populations in Canadian history, and at its opening was hailed as the largest asylum in the Commonwealth. For all this enthusiasm, the realities of housing thousands of mental patients, many of them indefinitely, would garner increasingly unwanted attention. Continually reinvented and recast before the public, the hospital proved to be less a marvel of medical science and progress than a pariah that masked the social problems posed by undesirable settlers and economic difficulties.

In addition to depicting this population by demographics and disease, the evolution of diagnostic classification resulting in the first *Diagnostic and Statistical Manual* (1952) is surveyed, along with a recounting of the social and political currents that led to mass institutionalization at Weyburn. Our statistical analysis covers the entire first admission ledger of 9,015 patients, with anonymized records of nativity, citizenship, education, vocation, habits of life, and family, as well as medical history, diagnoses, length of stay, and eventual disposition. Ultimately, the intersection of these narratives is revealing about the evolution of psychiatry as a medical profession, of the use of insanity – however defined – as a tool for social stratification, and of the ongoing dynamics of institutionalization today.

The Origins of Psychiatry in Saskatchewan

At the turn of the 20th century, medicine and to some extent psychiatry played increasingly prominent roles in public policy and the establishment of social order. As the settlement of North America drew westward, medical understanding and the classification of disease was shifting from regional and institutional traditions to broadly consolidated specialist groups such as the American Medico-Psychological Association. In the United States, the census bureau took an active interest in measuring the dynamics of population health with the aim of deploying medical resources to good effect. In Canada, the young Western provinces embarked on ambitious surveys of mental hygiene, starting with Manitoba in 1919, followed by Saskatchewan in 1922.¹

The Saskatchewan Hospital for the Insane at North Battleford had opened in 1914 owing largely to pressure from other provinces with already-crowded mental hospitals. Written as Weyburn's hospital was under construction, the Mental Hygiene Survey presented its observations of settlement tinged with the same morality and idealism that boosted public opinion of these new institutions. The authors were candid in their attitude toward immigration and mental illness, noting "at present, physicians trained in psychiatry are employed at Quebec and St. John and many newcomers are being rejected because of mental disability." In explanation, "it is discovered that an undue proportion of those who fail to make good citizens and who constitute a great provincial burden come from countries outside the Dominion," and "it will ever be the case that among newcomers there will be an undue proportion of the failures of other countries [...] They cannot understand that the real difficulty is to be found in themselves."²

However, the report's recommendations also suggested constructive social policies that still reverberate, including an emphasis on the early diagnosis and treatment of mental illness, special classes for handicapped children, juvenile court and detention homes, and custodial care of a "certain proportion of [the province's] insane," but adds "any scheme which to a great extent ignores the questions of prevention and early treatment falls far short of modern requirements," suggesting that cost pressures and the already-urgent need to offload cases from North Battleford was front-of-mind. With reference to the nascent medical school in Saskatoon, "educational authorities have suddenly awakened to the importance of psychiatry" and, "the strain of war brought to the surface facts long known to psychiatrists [...] and the results of early and intelligent treatment were so satisfactory that psychiatry came into its own." The report lauded plans to erect a second large asylum south-east of Regina, concluding that "psychopathic hospitals will educate the public to the fact that insanity is a disease." With respect to record keeping the report urged that "the classification of the Statistical Manual of the American Medico-Psychological Association and the National Committee is followed as closely as possible."³

The origins of the modern Mental Health Act, which defines "mental disorder," mental health "facilities," and the responsibilities of psychiatrists and

¹ See "Manitoba Survey Conducted by the Canadian National Committee for Mental Hygiene" *Canadian Journal of Mental Hygiene* 1, no. 1 (1919), and "Mental Hygiene

² *Ibid.*, 374-5.

³ *Ibid.*, 391-5.

other physicians in the involuntary assessment and treatment of patients, as well as patient rights and appeal processes began before Saskatchewan was a province. The 1879 *Act respecting the Safe-keeping of Dangerous Lunatics in the North West Territories*, clearly connected lunacy or insanity with criminal behaviour and authorized the Lieutenant Governor to send any such persons to the Stony Mountain penitentiary in Manitoba, indefinitely. A fledgling province in 1905, Saskatchewan passed *The Insanity Act*, adding that a person “insane and dangerous to be at large” could be brought before a Justice of the Peace who considered the person’s case and then sentenced them to time in either a jail or asylum. As John Elias has explained, medical evidence formed part of the case, but not necessarily the decision, which rested squarely within the legal system. The *Act* contained no provisions for voluntary admissions, and any person sent to the asylum was assumed to be incompetent. The government seized any estate or possessions to pay for the patient’s upkeep, while ‘indigent lunatics’ became wards of the state. Aboriginal patients were discouraged, unless their expenses were “guaranteed by the Superintendent General of Indian Affairs.”⁴

In 1919, *The Dangerous Lunatics Act* allowed for individuals to stay in the custody of friends or family, and made provisions for trial leaves from institutional care, referred to in the patient ledgers as “paroles.” In 1922, *The Mental Diseases Act* introduced medical certificates, allowing both doctors and magistrates to legally commit an individual to an asylum. The legal status of mental health shifted once more in the 1930s as categories of illness generated separate legal definitions: *The Mental Defectives Act* of 1930 pertained to people considered feeble-minded (morons, idiots, or imbeciles) while *The Mental Diseases Act* pertained to all other categories. Lastly, *The Mental Hygiene Act* of 1936 enabled voluntary admission. Protection was offered by limiting involuntary detention to 5 days. However, it also codified the government’s authority to deport foreign patients, and prevented voluntary admission for old age, organic disease, and mental deficiency. In 1950, *The Mental Hygiene Act* was revised to define a patient’s entitlement to care at state expense. A form of residential treatment for patients with alcohol and drug addictions evolved, with voluntary admission for these conditions allowed up to 1 year.

Following World War II, Saskatchewan attempted to reinvent the asylum as an institution of science that returned value to the public, even as depopulation and “transinstitutionalization” shifted patients into the community and other facilities. Here too, the province benefitted from international migration (now of physicians and researchers), the churn of demographic and technological change, and the rapidly accumulated wartime experience of young psychiatrists returned home. The progressively-minded provincial electorate was mobilized by public assertions of overcrowding and mistreatment in public asylums, and politicians saw opportunity in recasting Weyburn as a research center focused on rehabilitation and scientific contributions from an institution where evidence-based psychiatry would be practiced.

⁴ John Elias, “Continuity and Change in the New Mental Services Act,” paper presented at the Annual Clinical Conference of Psychiatric Services Branch, Saskatchewan Health, Regina, October 9, 1985.

Counting and Classifying Institutionalized Illnesses

One of the trends leading to this focus was the exploration of a new classification for organizing psychopathology, effectively a substitute for genuine scientific understanding of the underlying disorders. In the same decade, North American psychiatrists produced the first Diagnostic & Statistical Manual of Mental Disorders (DSM) and set in motion a practice of rigorous classification that unified different conceptualizations of mental disorder and became tightly integrated into health care systems, insurance approvals, and pharmaceutical research.

Prominent scholars have critiqued the rise of psychiatric expertise for its presumed illegitimacy as either a science or even as an ideology, but nonetheless show how judging, classifying, and ultimately attempting to organize and treat human behaviour became a preoccupation associated with modern living.⁵ Psychiatrists not only became medical entrepreneurs, but also a cultural police force at the helm of the medico-legal interface and the welfare system, with an enlarged capacity to sort people into or out of institutions.⁶

Psychiatric institutions were repositories for individuals deemed mad, deviant, disordered, defective, or disabled. With nearly a century of experience housing people in custodial institutions, pressure to rehabilitate these patients mounted as it emerged that mental illness seemed to transcend class boundaries. In particular, as soldiers once hailed as quintessential male heroes succumbed to depressive or feminized behaviour characteristic of shell shock, the desire to improve mental health care gained momentum as early as the Mental Hygiene Survey.

The language of medicine and disease also shifted: from symptoms to illnesses, from illness to disease, and from disease to treatment. These changes were reflective of new technologies, evolving theories of disease, and attempts to correlate post-mortem brain studies with observable behaviour in institutional populations.⁷ Indeed asylums, for all their faults, had created captive populations for observing, measuring and ultimately experimenting. Patient populations that had originally been siphoned into hospital wards according to gender and class were increasingly reorganized along the lines of behaviour and, gradually, disease. Symptoms were then compared and even sub-categorized, giving rise to a different set of conceptualizations regarding the nature of disorder and the potential for assessing it scientifically, then treating it clinically.⁸

Like its medical counterparts, early psychiatric nomenclature was uncoordinated and relied on the perspective of independent teaching hospitals and their clinical diaspora. Convincing disease classifications could not evolve faster than the evidence furnished by scientific discovery, which created challenges and tensions between researchers and clinicians. Within psychiatry, biomedical research tended to focus on the brain and had to confront what were often conflicting

⁵ For more discussion of these ideas, see: Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1965).

⁶ See James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth Century Ontario and Quebec* (Montreal: McGill-Queen's University Press, 2001).

⁷ Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

⁸ *Ibid.*, 46-9.

interpretations as to what drives behavior, and how best to decipher behaviour from character, culture, and the context of illness. As historian Gerald Grob has suggested, “a classification system based on external signs created formidable intellectual and scientific difficulties.”⁹

Meanwhile, treatments for “functional” mental illness evolved alongside discoveries of treatments that informed the theory of disease, not the reverse, such as the dopamine hypothesis following the discovery of neuroleptics. While several branches of medicine enjoyed a pattern of scientific discovery more true to form, in turn supporting a disease theory and opening pathways to its alleviation, psychiatrists languished with few clear avenues of discovery that provided evidence to support a theory of illness, and resultantly, few obvious options for scientific advancement. Comparing institutional patient populations according to symptoms and pathologies provided an opportunity to quantify patterns of mental illness, symptoms and disease courses. Statistical information offered a quantitative analysis that undergirded attempts to bring scientific legitimacy to this profession that routinely seemed to lag behind its clinical counterparts.

The first official attempt to collect information about mental health North America occurred in the United States with the 1880 census, which distinguished seven categories of mental illness: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1918, the American Medico-Psychological Association released the *Statistical Manual for Use of Institutions for the Insane*. Its goal was to “assist the institutions in compiling their annual statistics,” however its diagnostic value was limited to 15 pages of brief descriptions in which ‘organic’ causes vastly outweighed ‘functional’ causes of mental disturbance.¹⁰ Its emphasis was clearly on statistical formulation with the aim of facilitating statistical analysis, excluding as many biological causes of mental disturbances as possible.

The Americans were, however, also influenced by developments across the Atlantic, where attempts to parse out different behaviours into discrete disease categories had attracted considerable attention in European asylums. Notably, Emil Kraepelin combined elements of biology and heredity in what he eventually described as ‘psychosis’ in 1899, which he recognized as a feature at the heart of all psychiatric illness. Kraepelin was influential, and later even hailed as the father of modern psychiatry for advancing this concept and for drawing a line in the sand regarding what he and others recognized as the fundamental nature of mental disorder.¹¹ Yet, while almost every condition in his manual is referred to as a form of “psychosis,” Kraepelin did not further define this term.

In spite of the limitations of Kraepelin’s early classification system, the desire to categorize mental diseases captivated an eager group of psychiatrists, keen to develop a rigorous set of principles to guide their professional practice. The New York Academy of Medicine spearheaded a movement toward a nationally accepted standard nomenclature of disease in 1927, followed in 1928 by a national

⁹ Gerald Grob, *Mental Institutions in America: Social Policy to 1975* (New Brunswick: Transaction Publishers, 2009), p. xix.

¹⁰ American Medico-Psychological Association. *Statistical Manual for the Use of Institutions for the Insane*. New York: American Medico-Psychological Association, 1918.

¹¹ Shorter, *A History of Psychiatry*, p. 105-6.

conference to this effect. In 1933, they released the Standard Classified Nomenclature of Disease.

Revising the system further, the American Psychiatric Association published the first DSM in 1952, which signaled a new era of standardization in psychiatric diagnoses. The DSM was in many ways a snapshot of psychiatric thinking at the time. Like other classification systems beforehand, it offered a mix of “descriptive states, nomenclatures, and symptoms that were confounded by biological, psychoanalytic, and heuristic representations of social and intellectual currents, not to mention moral fabric, social expectations, and the pursuit of status & legitimacy by psychiatrists.”¹² Again, the manual was heavily weighted toward statistical measurement of mental illness rather than diagnostic clarity, meaning that it tended to offer summative criteria rather than speculate about how disorder might manifest individually. This result was perhaps unsurprising given that the empirical data supporting psychiatric diagnoses came from observing large patient populations in asylum settings, but its success as an acceptable diagnostic tool also indicates the willingness of psychiatrists to adopt a rather unwieldy and often cumbersome set of measurements in an effort to standardize criteria.

Of the DSM’s 119 pages (excluding appendices), just 30 pages were devoted to description. The major divisions were organic (e.g. brain tumors, arteriosclerosis, and general paresis due to syphilis) in which an anatomic/physiologic cause was evident versus functional disorders. The term “functional” persists today, referring to the surfeit of recognized illnesses that are ambiguously validated, or medically unexplained. In addition to these, psychiatrists at Weyburn appear to have addressed an impressive range of neurologic and general medical conditions. One traditional perspective of functional mental disturbances was the psychotic-neurotic continuum (literally divided at the “borderline”), and another was personality or character pathology, such as psychopathic inferiority, a type of “moral insanity” that would be akin to a personality disorder. In a nod to Kraepelin’s wayward disciple Adolf Meyer, who widely propagated psychoanalytic thought in North America as the Psychiatrist-in-Chief at Johns Hopkins University, illnesses are described as “reactions.”¹³ Unlike later editions of the DSM, clear enumerated criteria for diagnosis were not listed, and concepts of mental retardation and mental illness in children were omitted, despite their rising numbers in mental hospitals.

¹² See Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), p. 97.

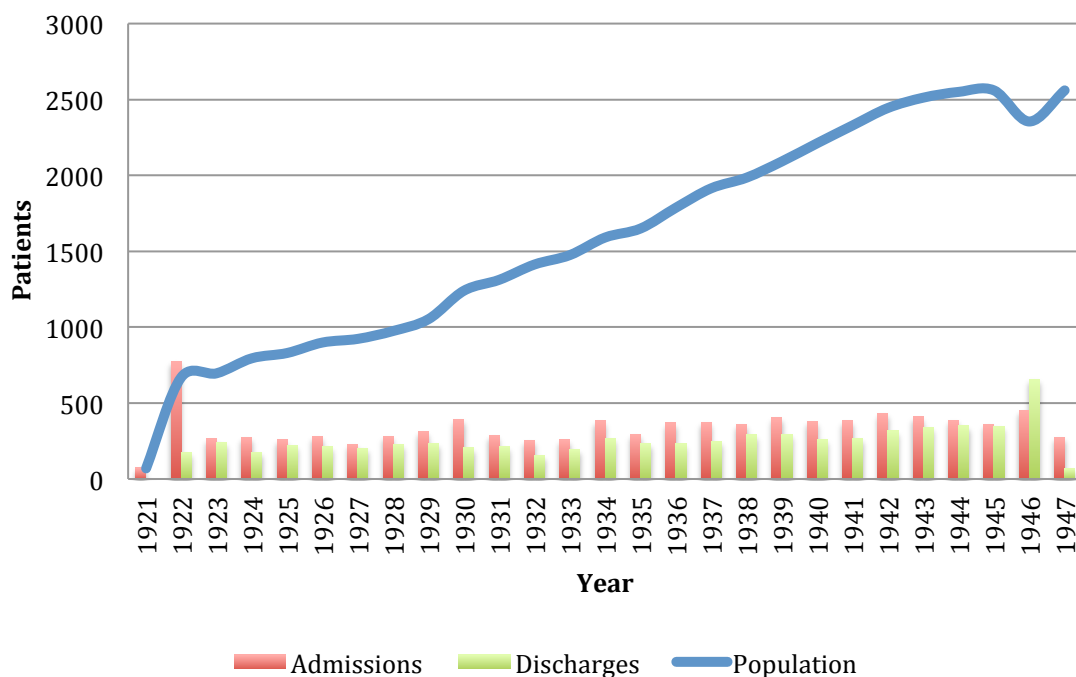
¹³ See Susan Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore, MD: Johns Hopkins University Press, 2014).

Disorder at Weyburn

As recommended by the Mental Hygiene Survey, Weyburn Mental Hospital was “seeded” upon opening with a large volume of “chronic cases” by transfer from North Battleford. Between 1921 and 1922, the first year in operation, 844 patients were admitted and 178 were discharged. By and large, these patients were categorized as sufferers of dementia praecox, Kraepelin’s original term for schizophrenia, and mental deficiency. These labels were consistent with other asylum populations, and reflect in part the crude diagnostic distinctions around psychotic disorders and those related to mental deficiency and feeble-mindedness, which were diagnosed through a combination of intelligence quotients and physical observations coupled with family histories. As other scholars have shown, feeble-mindedness often co-mingled with features of poverty, non-Anglo identity, recent immigration, and at times, criminal behaviour and/or intemperance.¹⁴

For the first two decades of admissions recorded at Weyburn, following the initial transfer in from North Battleford, the rate of growth remained relatively constant, averaging 331 admissions and 250 discharges annually, an average ratio of 1.3. These numbers indicate that the patient population grew each year, roughly in line with the institution’s annual reports. In 1946 a burst of 658 patients were discharged, mostly by transfer to a new facility designed specifically for housing mental defectives at Moose Jaw, a badly needed decompression as the population at Weyburn now numbered more than 2,500, exceeding capacity by well over 100%.

Hospital Population



¹⁴ In particular see Gerald V. O’Brien, *Framing the moron: The social construction of feeble-mindedness in the American Eugenic Era* (Manchester: Manchester University Press, 2013); and Erika Dyck, *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto: University of Toronto Press, 2013).

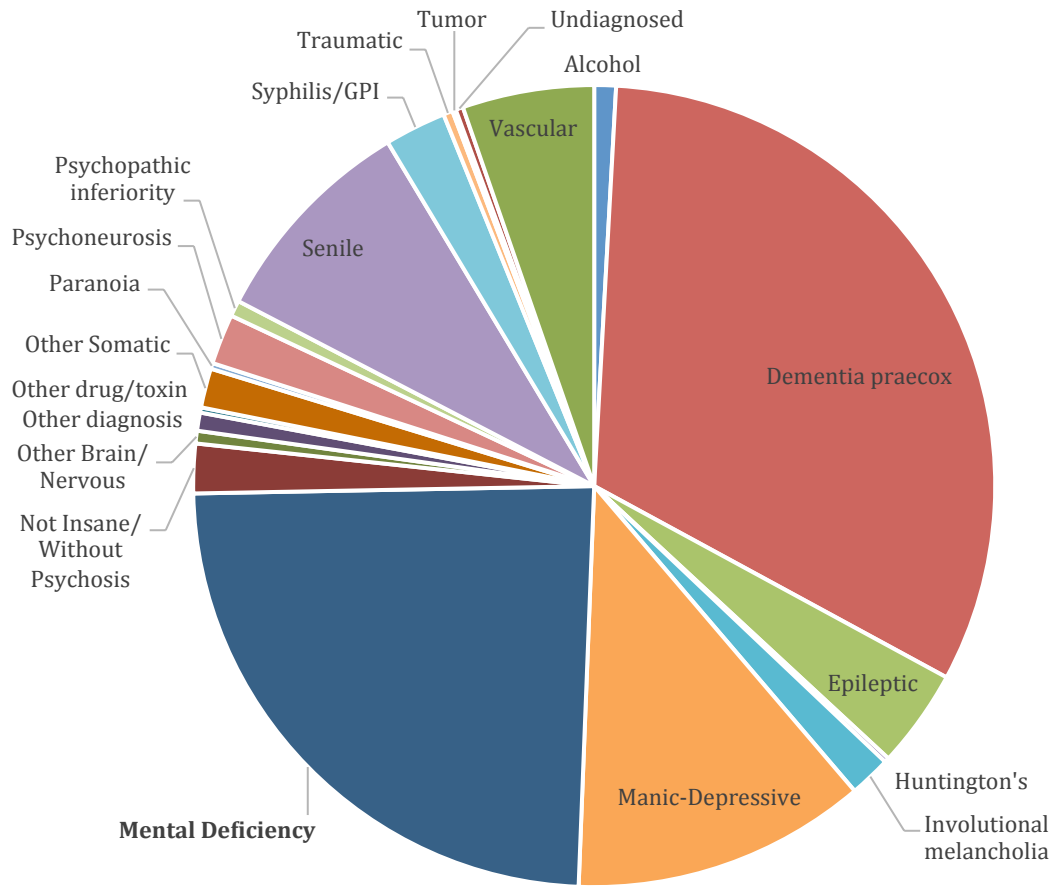
Diagnoses fell into one of eleven categories, indeed similar to the American Psychiatric Association's recommended classification system: Affective (mood), General Paresis (advanced syphilis), Huntington's chorea, Infection, Intoxication, Mental Deficiency, Personality, Psychoneurosis, Schizophrenia, Senile Dementia, Trauma, Tumor, and Vascular (stroke and/or dementia). Over time, the most marked trend is the bimodal increase in young and old patients with mental deficiency or cerebrovascular disease.

Patients ranged in age from children to people over the age of 90. The chart below illustrates the hospital's age and diagnostic distribution according to the 1918 Manual, a psychiatric classification system that was particularly crude with respect to children and adolescent patients.

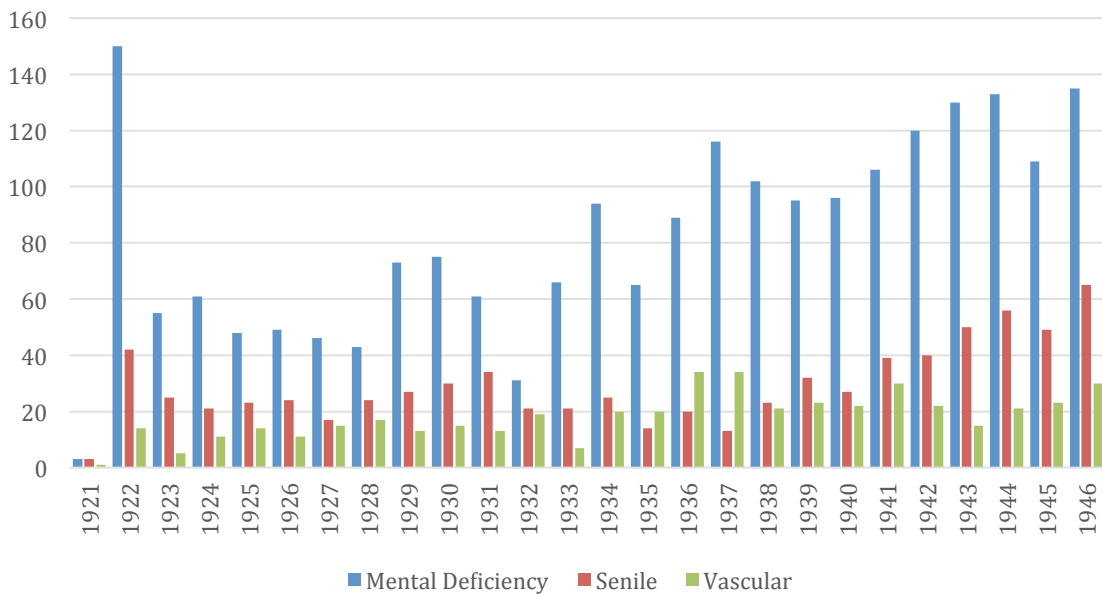
Weyburn Admissions by Age Group and Diagnosis, 1921-1948

Diagnosis	0-17	18-29	30-39	40-49	50-59	60-69	70-79	80+	Total
Alcohol		2	29	19	16	12			78
Dementia praecox	75	1016	890	571	234	46	1	3	2836
Epileptic	67	133	74	50	28	3	1	1	357
Huntington's		1	2	5	4	5			17
Involutional Melancholia	3		1	40	73	31			148
Manic-Depressive	24	242	235	294	195	63	2	2	1057
Mental Deficiency	1138	557	219	123	51	21	3		2112
Not Insane/ Without Psychosis	35	36	38	26	16	12	2	3	168
Other Brain/Nervous	3	6	3	10	6	13	2	1	44
Other diagnosis	10	10	15	8	8	9	3	1	64
Other drug/toxin	1		6	2	6		1		16
Other Somatic	6	40	29	29	23	13	2		142
Paranoia			3	8	8	2			21
Psychoneurosis	13	51	46	33	27	12			182
Psychopathic inferiority	5	29	11	8	3				56
Senile	2		4	3	74	222	303	173	781
Syphilis/GPI	1	10	47	73	61	24	2		218
Traumatic	3	6	7	11	3	1	2		33
Tumor		6	2	4		1			13
Undiagnosed	3	4	8	4	5	2			26
Vascular	2		10	37	149	169	85	18	470

Snapshot of Disease Prevalence, 1921-1948

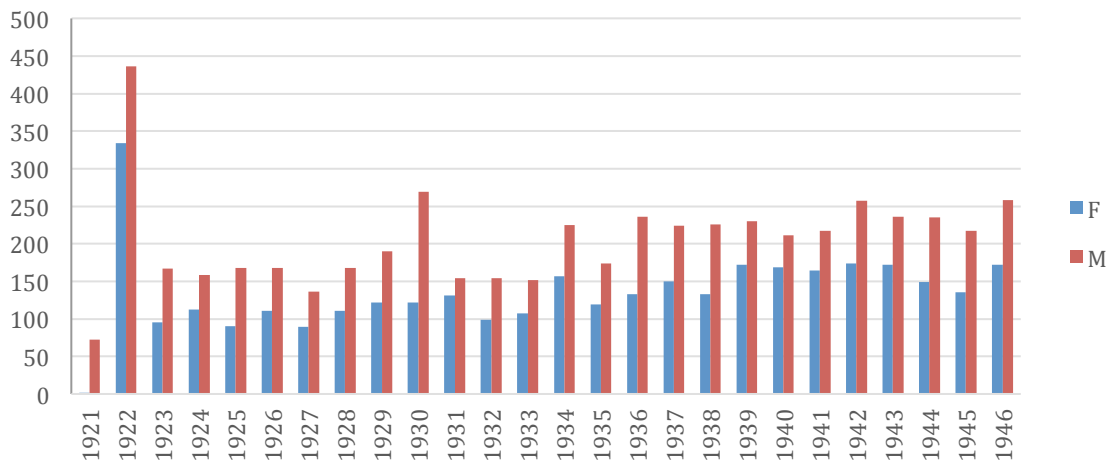


Common Admitting Diagnoses, 1921-1946

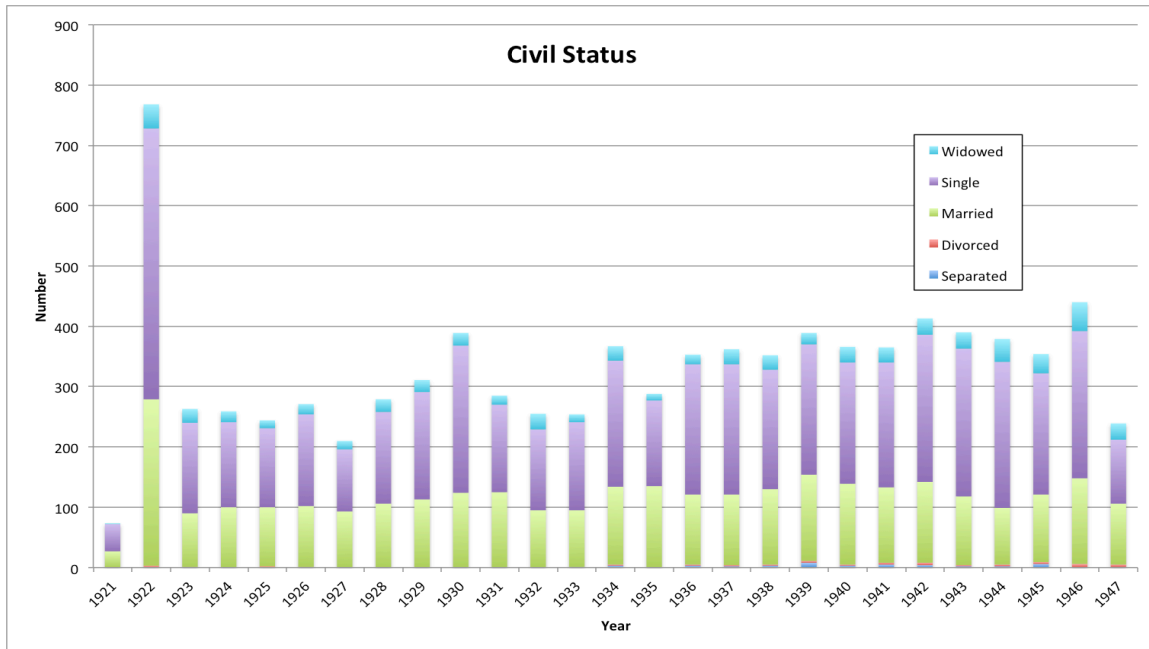


Although scholars have sometimes suggested that women were more likely to be institutionalized in psychiatric hospitals than men due to a gendering of mental illness, the situation in Weyburn was different. The gender distribution illustrates a preponderance of male admissions, which was also reflective of the larger male population in the province during this period. Male admissions outnumbered females every year, representing an average ratio of 1.52, and that figure peaked suddenly at 2.19 in 1929 coinciding with the beginning of the Great Depression.

Male Preponderance in Admissions, 1921-1946

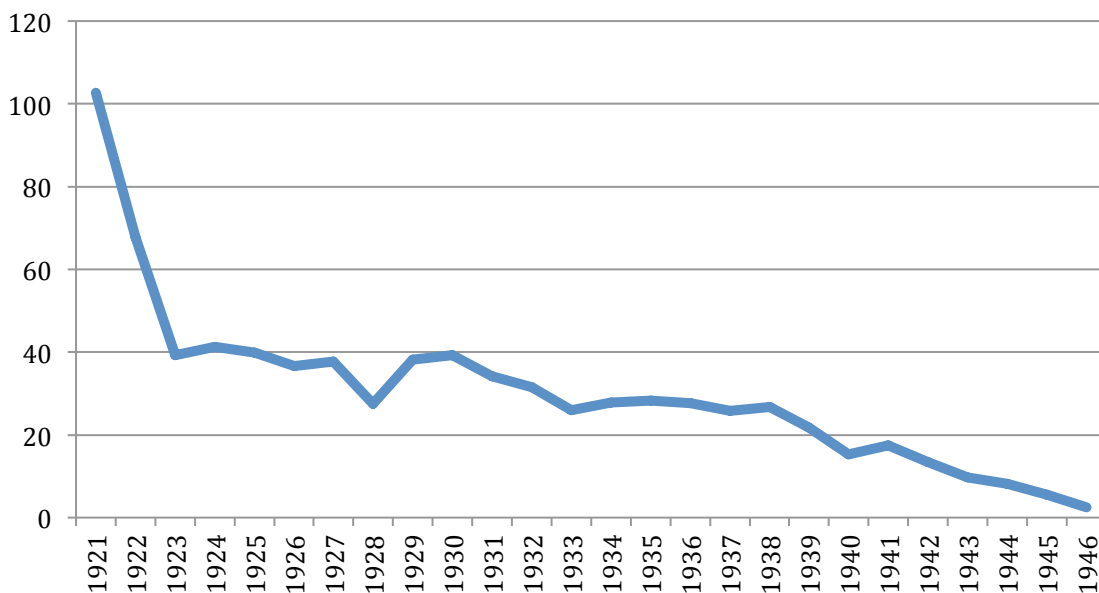


Another indicator of gender differences appears when comparing civil status, whether single, married, divorced, or widowed. There were often as many single men admitted as all other groups combined. For an extensively widespread and rural geography, these demographics suggest that mentally ill women in particular were more often and perhaps better cared-for outside the institution, or that social stigma led to denial with regard to seeking treatment, or that men were more likely to seek help for disagreeable symptoms, or further that men were more likely to exhibit behaviours that attracted the attention of police and medical authorities. There was a distinctive peak in the admissions of single men in 1930 (190), and a general increase in both single and married men over time, leading to a plateau that approximately spans the period of World War II.



Lastly, the average length of a typical admission became staggeringly short in the time under study. While deinstitutionalization was adopted in part by Tommy Douglas’s health care reforms beginning in the 1940s, the imperative arose from necessity and embarrassment, as patient mortality at Weyburn climbed to a national high in that decade. This also indicates the development of acute psychiatric services in general hospitals, and the development of outpatient psychiatric care for the reason that the medical, legal, and social roles of asylums were being seriously reconsidered. Although many psychiatric patients had occasional readmissions, separating the stabilization and maintenance phases of psychiatric treatment between the hospital and community drastically altered the public cost of mental illness.

Average Length of Admission (Months), 1921-1946



Together, these quantitative illustrations of people and their diagnostic profiles provide insights into the institutional circumstances. No doubt there was a growing and increasingly overcrowded patient load, and it was a place where despite efforts at rehabilitation, children and older adults tended to languish disconnected from their social or occupational potential. The gender imbalance also suggests that clinical criteria were not the only factors that played into diagnoses, but also that social and familial supports contributed to one's admission and length of stay.

Although the early classifications of mental illness derived from census reporting in North America through the 1800s,¹⁵ the statistical reports generated from the Weyburn admission ledgers are somewhat unreliable. Even a computerized analysis of the records is marred by inconsistencies and it is difficult to imagine how or if the results were analyzed previously. The immediately observable trend toward overpopulation in the mental health system seemed to have little bearing on policy-making, at least from the top-down.

Over time, other trends emerged throughout the province's institutionalized population: the typical patient became older, more likely Saskatchewan-born, and much more likely to suffer from mental deficiency or dementia. In fact, patients actually became less likely to suffer from a "psychotic" or "neurotic" illness. The latter of these was gradually more likely to be treated in a general hospital or in the community by the second half of the 20th century as thresholds for admission increased with improved recognition and treatment of various mental illnesses. In this way, by the 1940s, institutionalization as a treatment was already becoming much more selectively applied.

Admission criteria were fluid, involving considerable latitude on the part of magistrates, later psychiatrists and, later still, patients and their families. The criteria also evolved over time and probably differed between institutions. Although it was not specified in the admission records, opening the doors to voluntary patients beginning in 1936 led to an influx of distressed (or distressing) patients with minimal documented pathology. For instance, some cases include assessments of Krafft-Ebing status – an early classification of sexual deviance – but little else.¹⁶ In other cases, the precipitating factor was described as "Home life incompatible" or "Family discord". In 1936, Weyburn patient 4757, a 63 year-old married male farmer of Irish descent was hospitalized for 2 years due to "Financial destitution and inability to work on account of osteoarthritis", then discharged to an infirmary.

Hundreds of patients with relatively complete admission records included no diagnosis, or stated simply "without psychosis". If suicide attempts occurred prior to admission they were very seldom documented, but a large number of murders and outwardly violent acts led to admissions escorted by the RCMP. It seems that the more patients who could be admitted and sometimes treated, the more facilities like Weyburn were relied upon as a go-to for all manner of problems medical,

¹⁵ Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1985), pp. 144-166.

¹⁶ See Richard von Krafft-Ebing, Richard. *Psychopathia Sexualis* Translated by F. J. Rebman, 12th edition. (New York: Rebman Company, 1903). Sigmund Freud advocated that homosexuality was a psychological problem, signaling that there was value in its "treatment." In the DSM 5, the diagnosis of many paraphilic disorders is now derived from evidence of criminal behavior.

psychiatric, and otherwise, despite changes in terminology suggesting that admissions were becoming more rigorously based on medical diagnoses.

Judging by patient mortality and descriptions of the “Apparent or Alleged Cause”, as indicated in the ledgers, the volume of acute medical illness in these institutions was high. Many medical illnesses manifest apparent psychiatric symptoms, as was the case in dozens of patients with a Parkinsonian syndrome secondary to epidemic encephalitis in the early 1920s (“encephalitis lethargica”). On the other hand, medical illness has always been a stressor that evokes a range of responses, some which certainly appear abnormal.

Institutionalized patients in the early years were more likely to die in hospital or be transferred to another institution than to be paroled, but this trend reversed by the late 1930s. Over the years, several patients escaped. A few were killed. Many foreigners were deported. Weyburn documented a suicide by hanging every year or two. Unsurprisingly, clinical improvement was seldom reported. As stated, patients could be assessed outright as “not insane”, with no other compelling medical or psychiatric reason documented for admission. Despite admission fees to reduce demand for use as a “welfare” institution, admissions continued unchecked.

These data also help to underscore the power of mental health diagnoses as social capital. Diagnostic labels justified a reduced degree of citizenship or even rights within the hospital, as the labels could mandate a segregated existence or an institutionalized life. For example, low IQ scores contributed to diagnoses of mental deficiency, which often coincided with institutionalization along with limited or no education, employment, or in some cases, contact with the outside community or one’s family. In Weyburn, mental deficiency was the most common diagnosis outright. The length of stay that corresponded with that diagnosis was disproportionately higher than other categories, and individuals often came into the hospital at a younger age.¹⁷

Weyburn Mental Hospital, which had once been praised by locals for its innovative approach to mental health care, had, it seemed, succumbed to a more typical image of an institution that had swelled beyond its capacity and one that detained patients indefinitely. The optimism generated by new diagnostic criteria as a scientific advancement failed to address the largest cohort of patients, namely the younger individuals admitted for mental deficiency and the older patients with an assortment of dementias and undifferentiated medical disorders, all while leaving others little better off than before.

¹⁷ Robert Sommer and Humphry Osmond, “Symptoms of Institutional Care,” *Social Problems* 8(3) (1960-1), p. 254.

Analysis

Early Psychiatry Followed a Biological Tradition

The admission records from Weyburn reveal interesting findings about the medical establishment of the time: a preference for “nervous” over “psychiatric” terms, and that many “functional” mental disorders which we now consider common seemed rare, at least in hospital. On any given day these psychiatrists combined their observations of thoughts and behaviors with a diagnostic canon more similar to modern neurology or general medicine, with underlying causes of behavioral disturbance ranging from stroke to epilepsy, dementia, and a wide spectrum of infectious disease.

Yet, psychiatrists in the early 20th century were not entrusted with medico-legal functions such as the evaluation of competence and capacity for decisions about end-of-life care, nor community treatment orders where medication compliance is legally enforced, nor the assessment of fitness to stand trial or of patients with not-criminally-responsible pleas. The legal interface of modern psychiatry follows an evolution of legislation that, over decades, has paralleled institutionalization (e.g. certificates) and deinstitutionalization (e.g. treatment orders), and has gradually transferred power from the judiciary to the infirmary in service to a society that increasingly views psychiatric illness as a form of suffering worthy of compassion rather than punishment, and that mental disorders amount to much more than a risk to public safety.

The “Social Admission” Benefitted Society

Already by the mid-19th century the rise of the asylum, and along with it the rise of psychiatry as a sub-specialty of medicine, generated a new class of experts whose roles sifted individuals into categories of social worth.

A patient presenting to Weyburn Mental Hospital was subject to a brief and lightly standardized medical assessment. Diagnostic thresholds in relation to the early nomenclatures of disease were low, because it seems that the diagnosis ultimately had little meaning. There were few treatment options beyond sequestration, rehabilitation, and experimentation. Today, nearly all medical assessments somehow take social and psychological impairments into account, but these records show that the severity and functional impact of the disorder, the functional status of the individual, and the prognosis were not. The universal treatment – admission – was applied non-selectively, so there was little to be gained from a nuanced diagnosis at presentation.

There was also amazing latitude on the part of magistrates and, later on, patients and their families for admitting patients. The gendered notion of women being committed indiscriminately does not seem to apply here. Although not specified precisely in the admission records, opening the doors to voluntary patients in 1936 led to an influx of patients whose mental state was described in softer language than previously. It was by design that doctors were allowed to make admission decisions, a legacy of several precursors to the modern Mental Health Act. Psychiatrists, however, began to represent broader societal values in their admission decisions. Combined with the newly described “voluntary status,” admitting patients on “non-medical” grounds became systematized. Although there

is evidence that both psychiatrists and their patients benefited from the power dynamics of involuntary admission, the greatest beneficiary was a society preoccupied by illusions of “mental hygiene.”

Institutionalization is Still Happening

Following the closure of Weyburn’s asylum in 2006, Saskatchewan still has 488 long-term psychiatric beds by the authors’ calculation, plus over 100 acute beds between Regina and Saskatoon, and dozens more among smaller centers. This includes the Regional Psychiatric Centre in Saskatoon, a federal forensic facility, and the Saskatchewan Hospital at North Battleford, whose capacity is being expanded at the time of this writing. This does not count the large number of elderly patients in long-term nursing care, who were strongly represented at Weyburn. Moreover, the population of Saskatchewan today is hardly more than in 1931. Taking into account a considerable reduction of inpatient hospital services over the past century, as well as the “medicalization” of many earlier mental illnesses, institutionalization may be fragmented and forgotten, but is far from gone. Conversely, de-institutionalization was not a temporary epoch or an event (as it is sometimes portrayed), but part of an ongoing dynamic specific to the field of psychiatry.

Conclusions

Custodial management did work, that is, if we could accept certain compromises between medical and social care, and between patient autonomy and dependence. However, because these compromises are subordinate to mainstream values in medical ethics, institutionalization still happens but in disguise. Today, with recognition of the bio-psycho-social model, we can select from a menu of physical and social structures to complement treatment or stabilization, a wider array of dispositions than our early counterparts had in the physical structure of the asylum.

The nature of mental disorders has changed partly because different disorders are recognized (many added, others falsified), and because certain therapies have legitimized the illnesses they specifically treat, for instance mood stabilizers, anti-depressants, and anti-psychotics. Most “organic” brain diseases have now been adopted by other branches of medicine, and involve psychiatrists only peripherally, if at all.

Compared to the patients in this dataset, we now recognize as widely prevalent and relevant treatable conditions such as personality disorders and addictions, which were seldom recognized in this facility. The overall burden of psychotic illness likely reflects a lack of control over “positive” psychotic symptoms, and is hard to fathom on a scale of hundreds or thousands of patients in a single building. The distress that such populations created among staff in institutions is a plausible justification for some of the darker moments in the history of psychiatry. Psychiatrists today still face some of the same difficulties as their predecessors in Weyburn nearly 100 years ago: how best to improve patient functioning in illnesses that are characterized as “functional”?

The outpacing of psychiatry by many areas of medical science in the last 100 years has created distinct tensions. Psychiatry has at various times employed substitutes for scientific evidence in the justification of its legitimacy to inform

social policy and to allocate common resources. The evolution of these substitutions shaped the rise of institutionalization against the strains of population settlement, economic volatility, and war. Psychiatry has also made significant advances in the humane, ethical treatment of mental illness in this century, however the perspective of history helps us to understand how much ground our field has yet to cover.

Taking stock of the evolution of psychiatric diagnosis and classification positions us better in contemporary debate around the definition of medical and mental illness, as well as the use and usefulness of institutionalization – issues faced in the training and practice of psychiatrists throughout Canada, 100 years ago and today.

Bibliography

- American Medico-Psychological Association. *Statistical Manual for the Use of Institutions for the Insane*. New York: American Medico-Psychological Association, 1918.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (1st ed). Washington, DC: American Psychiatric Association, 1952.
- Dyck, Erika. *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto: University of Toronto Press, 2013).
- Elias, John. "Continuity and Change in the New Mental Services Act," paper presented at the Annual Clinical Conference of Psychiatric Services Branch, Saskatchewan Health, Regina, October 9, 1985.
- Fischer, Bernard. "A Review of American Psychiatry Through Its Diagnoses: The History and Development of the Diagnostic and Statistical Manual of Mental Disorders." *Journal of Nervous and Mental Disease* 200 (2012): 1022-1030.
- Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1965).
- Grob, Gerald. *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1985).
- Grob, Gerald. *Mental Institutions in America: Social Policy to 1975* (New Brunswick: Transaction Publishers, 2009).
- Grob, Gerald. "Origins of DSM-I: a study in appearance and reality." *American Journal of Psychiatry* 148 (April 1991).
- Lamb, Susan. *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore, MD: Johns Hopkins University Press, 2014).
- "Manitoba Survey Conducted by the Canadian National Committee for Mental Hygiene" *Canadian Journal of Mental Hygiene* 1, no. 1 (1919).
- "Mental Hygiene Survey of the Province of Saskatchewan," *Canadian Journal of Mental Hygiene* 3, no. 4 (January 1922).
- Moran, James. *Committed to the State Asylum: Insanity and Society in Nineteenth Century Ontario and Quebec* (Montreal: McGill-Queen's University Press, 2001).
- O'Brien, Gerald V. *Framing the moron: The social construction of feeble-mindedness in the American Eugenic Era* (Manchester: Manchester University Press, 2013).

Bibliography (cont.)

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

Sommer, Robert and Osmond, Humphrey. "Symptoms of Institutional Care," *Social Problems* 8(3) (1960-1), p. 254.