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“The main problem here is one of social behavior”: Intersectional Identities at the Ontario Hospital, Woodstock, 1918-1968

« Le problème principal ici est un problème de comportement social » : Identités intersectionnelles à l’hôpital Ontario, Woodstock, 1918-1968

Sarah Bergman
PhD Student, York University, Critical Disability Studies
sarahjoe@hotmail.ca

Abstract
Using the resident case files from the Ontario Hospital, Woodstock, this article looks at the experiences of white and racialized women who were incarcerated between 1918 and 1968. The Ontario Hospital, Woodstock, was one of 20 institutions operated by the province that incarcerated people deemed “feebleminded”. Woodstock’s initial purpose was to house people with epilepsy, and later, tuberculosis. This article aims to respond to the call for more intersectional approaches to disability history. Through the testimonies of doctors and nurses, I interrogate how gender, whiteness, Indigeneity, and age were perceived, constructed, and perpetuated within the walls of institutional life as seen in archival sources. The words of professionals are the only remaining sources, as patient notes and writings have not been archived. The morality and personal views of the professional staff became the basis of treatment and maintained incarceration.

Résumé
À partir des dossiers des résidentes de l'Hôpital Ontario de Woodstock, cet article examine le vécu des femmes blanches et racialisées incarcérées entre 1918 et 1968. L'Hôpital Ontario de Woodstock était l'un des 20 établissements gérés par la province qui incarcéraient les personnes considérées comme « faibles d'esprit ». L'objectif initial de Woodstock était d'accueillir des personnes atteintes d'épilepsie, puis de tuberculose. Cet article vise à répondre à la demande d'approches plus intersectionnelles de l'histoire du handicap. À travers les témoignages de médecins et d'infirmières, j'interroge la manière dont le genre, la blancheur, l'autochtonie et l'âge étaient perçus, construits et perpétués au sein de la vie institutionnelle, tels qu'ils ressortent des sources d'archives. Les paroles des professionnels sont les seules sources conservées, les notes et les écrits des patients n'ayant pas été archivés. La moralité et les opinions personnelles du personnel soignant sont devenues le fondement du traitement et ont maintenu l'incarcération.

Keywords
Disability history, institutionalization, intersectionality, archival research, Ontario

Mots-clés
Histoire du handicap, institutionnalisation, intersectionnalité, recherche archivistique, Ontario

Introduction

Power relations and the norms placed on specific identities have long been identified as key shaping forces of medicalization and psychiatrization. The construction and performativity that have continually haunted women throughout history have played a significant role in their institutionalization (Bailey & Mobley, 2019; Ladd-Taylor, 2017; Morrow, 2017). The danger of this reality is compounded when the medical system racializes these women. How medical professionals have historically theorized racialized women has led to an undermining of their lived experiences and histories that should be central in understanding these histories and contemporary oppression. An examination of the patient case files at the Ontario Hospital, Woodstock, reveals that the perceptions and experiences of white and racialized women were drastically different depending on their intersecting identities, such as age, race, and socioeconomic status.

This article is a significant contribution to the history of Canadian and, specifically, Ontario institutionalization, as it focuses on the Ontario Hospital in Woodstock, which has been severely under-researched. There is one book on this institution, written by local historian Mary Evans, who states in her preface “This book is not intended to be a scholarly work but rather a chronicle of day-by-day life in the context of the various departments that constituted the workings of a huge hospitalized medical institution” (Evans, 2000, p. 5). Woodstock is the largest city in Oxford County, located approximately 128 km southwest of Toronto, and midway between London and Kitchener. This institution opened with a focus on ‘epileptics,’ another area of Canadian disability history that has not been fully fleshed out. Far from modern schools of thought, “For most institutional professionals of this era, epilepsy was, if anything, an even more dismal diagnosis than idiocy. Indeed, with

some exceptions, epilepsy was often treated as a particularly hopeless category of feeblemindedness" (Ferguson, 2014, p. 47). This institution remained focused on epilepsy until the unit's name was changed to the "Adult Retardation" [sic] Unit in 1970. It also had a failed children's ward, which was later converted into the Chest Diseases Division, focusing on the intersection of epilepsy, feeblemindedness, and tuberculosis from the 1940s until 1971. Physically, this institution resembled the others run by the province at the time; it was situated in a small town and housed all its own facilities, aiming to minimize interaction between the city of Woodstock and the institution. The Ontario Hospital in Woodstock had four cottages, four ward-style buildings, separate residences for upper management, including the Superintendent and the Farm Manager, a bowling green, a pond, a recreation hall, a central store, and, by 1967, 400 acres for self-sustaining farming (Evans, 2000, p. 59).

In representing the lives of racialized women living within this institution, I also take on the role of the researcher, representing the sexed subaltern as problematized by Spivak (1988). In her key 1988 work "Can the subaltern speak?" Spivak introduces the concept of the subaltern, referring to those who are oppressed by colonial and postcolonial structures. The sexed subaltern is then doubly oppressed through colonialism and the patriarchy within their community. Spivak questions who can speak and be heard, as these women are often overlooked and/or ignored. In moving forward, I aim to represent the knowledge that can be gained from these case files, whilst also acknowledging that white, Western doctors wrote these files and that the women within these case files can never be fully known or understood. Disability studies has been articulately critiqued by authors like Chris Bell (2017), and in my own work, I aim to apply his call for diversification in the Canadian context. I am attempting to change how I think about who has been

institutionalized, and why. I address age, ethnicity, race, gender, and disability, interrogating how whiteness is presented, as well as how people of color (POC) are represented. Through this work, I am building on Bell's inspiration and am adding to the field of intersectionality in institutional histories.

Methodology

All notes and letters penned by patients have not been kept within the case files and archives of the Ontario Hospital, Woodstock. However, as Lykke De La Cour and Geoffrey Reaume (1998) point out in their chapter from *On the Case,* "The forms located in patient files were written primarily by medical and administrative staff. However, when approached with care and used judiciously, these documents provide important glimpses into the perceptions and viewpoints of psychiatric patients" (p. 243). Archival material can be read from two perspectives: both with the grain, to understand the meaning behind the stated professional opinions, and against the grain, to attempt to understand the experiences of the patients. This dichotomy once again highlights how power relations operated within the Hospital and continue to operate within archival practices. This work employs an against-the-grain perspective to allow for a critical analysis of the medical records. This is key to any institutional history, as patients' voices have historically been erased and undervalued (Grob, 1994; Shorter, 1997). As such, my research aims to reclaim and recenter the experiences of those who have often been pushed to the margins and erased from history, as exemplified by the disposal of material authored by patients.

In drawing from institutional archives, I am complicit in Western research practices that take unchallenged the researcher's right to knowledge. I am privileged in my allowance to read the personal medical files of such marginalized populations, which is not truly a right but has been conferred into one through colonial legacies. In

conducting this research, I submitted a Freedom of Information and Protection of Privacy Act request to obtain access to all remaining materials held by the Archives of Ontario related to the Ontario Hospital in Woodstock, spanning the period from 1918 to 1968. Upon review, my request was permitted with no redactions or provisions. I reviewed 46 boxes of archival materials, each containing a vast number of case files. I have used 28 individual case files as evidence in this work. A typical case file began with a statistical fact sheet of the patient, stating things such as their name, age, racial origin, religious denomination, economic status, alcohol habits, and family history of mental illness, mental deficiency, or epilepsy. Sometimes, a picture would be taken upon admission, and then every ten years of incarceration. Afterwards, there would be several sheets with titles such as clinical record, social record, conference report, psychological examination, or treatment record. A relatively small number of case files concluded with a discharge note. The archives are themselves a colonial institution, maintaining the records of many other colonial institutions that have caused irreparable harm. In doing this research, I aimed to give voice to patients past and shed light on a history that has been forgotten in Woodstock and beyond. It is not my intention to compound these harms through colonial practices of knowledge production, such as tragedy porn, which is the exploitation of suffering for entertainment or profit.

Within this research, I employ the concept of intersectionality, as coined by Kimberlé Crenshaw (1989). In doing so, I recognize that “marginalizations don’t add up, they multiply” (Tastrom, 2024, p. 51). To explore the specific experiences of racialized and white women, there needs to be an explicit understanding of the compilation of oppressions that have, and continue to, shape women’s experiences. The conceptual work surrounding the coining of intersectionality is built upon the

labour of Black, Indigenous, and women from the Global South, who have been continuously ignored and pushed out of spaces, specifically within women's rights spaces. Attempting to avoid the "lazy additive tendencies of uncritical intersectional theorizing" (Morrow & Erevelles, 2024, p. 485), which can lead to a lack of interrogation of disability and ableism, my work begins with the category of disablement. The primary research used is from the archives of an institution for people with epilepsy, tuberculosis, and/or "mental retardation" [sic]. The labels themselves are not important to me in understanding the human beings to whom these labels were attached. As highlighted throughout institutional histories, many institutionalized people would not be seen as disabled today. Labels are societally important as they denote who is accepted or normalized; however, I do not define my research by a specific label, only by those who have been institutionalized. Equally, medical labels do not matter to me as much as the lived experiences of the women I research. My focus is on the people, not the labels, and as such, I am providing an examination of a specific institution, not a specific diagnosis.

The scholarly work on the history of institutionalization within Canada is a constantly growing and burgeoning field. Within Ontario, there has been a significant concentration on the Huronia Regional Centre, as it was the oldest and longest running institution in Ontario (Burghardt, 2018; davis halifax et al., 2018; Jones, 1992; Park, 1990; Rossiter & Rinaldi, 2019; Viscardis, 2020; Wheatley, 2013). Geoffrey Reaume also wrote a foundational book on the Queen Street Asylum in Toronto (2000). Despite these works on other sites, Woodstock remains underrepresented. These histories of the more prominent institutions provide a basis and a framework for the histories of other institutions, which are crucial stories to be told, as microhistories are in themselves activist historical projects.

Additionally, other earlier works are critical to the foundation of Canadian disability history, such as Angus McLaren's *Our Own Master Race* (1990) and Harvey G. Simmons's *From Asylum to Welfare* (1982). McLaren's work recounts the eugenics movement across Canada from 1885 until 1945, while Simmons's focuses on the types of care experienced by people with disabilities in Ontario from 1831 until 1980. These works, however, focus on institutional constructions and provide relatively little in terms of theoretical and critical frameworks. Within disability history, there has also been a focus on the gendered aspects and impacts of institutionalization (Appignanesi, 2008; St-Amand & LeBlanc, 2012), which this article will build upon and expand upon. Woodstock is often overlooked in Canadian history due to its small size. As a result, previous historical works provide context, breadth, and understanding of the treatment of people with disabilities, allowing for the study of smaller institutions, such as the Ontario Hospital in Woodstock.

Findings

Adultist Violence

Adultist violence is the harm, discrimination, and/or oppression that young people face based on the belief that adults are inherently superior and is the result of existing within a system made by and for adults. As such, this limits the autonomy and perceived worth of young people. Crucial about the Ontario Hospital, Woodstock, is the fact that the children's ward was abandoned in favour of the Chest Diseases Division, resulting in children being incarcerated alongside adults, and as such, were subject to similar treatment. Bren LeFrançois and Vicki Coppock (2014) astutely highlight the intersections of adultism and sanism, which is the discrimination against and oppression of those who have been psychiatrized, where the incompetence denoted through both psychiatric diagnosis and age are mutually

constitutive as to maintain the social construction of these children as being incompetent and inferior (p. 166).

Institutional and adultist violence subsequently go hand in hand when youth are pathologized and incarcerated, as was the case at the Ontario Hospital, Woodstock. There were two case files examined in this research that noted young girls being sold to men for sex by their mothers. “In order to make ends meet for a family of five, the mother sent her eleven-year-old girl to her ‘friends’, two elderly men, to ‘borrow’ some money. With tears in her eyes, [the patient] admitted to have [sic] been criminally abused and seduced to perform sexual perversities to both these men for money from 25 cents up to $5.00 per visit” (Case Book #7707, B196691, 1963). The case file is less direct concerning the second patient, stating her mother “allowed a married man to live with her daughter of under 16. She has remarked, “We can always manage to get some money when we need it” (Case Book #08043, B187162, 1941). A social worker notes that the patient is “suspected of earning money by immoral sense,” but the patient denies this wholeheartedly. Examination of these notes together would seem to indicate that the mother is in control of the daughter’s sexual relationships, and not the patient herself, despite the blame repeatedly being placed on the young girl and resulting, at least in part, in her confinement. These are key examples of adultist violence, explained by Burstow and LeFrançois (2014) as “the overwhelmingly large number of children in care who have been traumatized by abuse and other forms of adultist violence, which is then reframed as these children suffering from ‘mental illness’” (p. 12). Both girls were white, which is perhaps why they were institutionalized in a hospital for sex work, instead of arrested and sent to jail. Both girls were also young, another key component of their institutionalization.

Pregnancy and Sexuality

Unfortunately, it was not uncommon for young women and girls to be placed in institutions for being sexually promiscuous or giving birth out of wedlock (McLaren, 1990, p. 125, n. 109). Placing these girls in an institution where men and women were segregated hoped to prevent the eugenic idea of “race suicide”, which believed that “undesirables” were procreating at too high a rate and therefore would result in the decline of the general stock of the population (Malacrida, 2015, pp.22-23). These women and girls were being admitted to a hospital focused on the treatment of epilepsy and tuberculosis, when this was not the primary reason for their admission. This aligns with the story of Violet Bowyer, as told by Constance Backhouse (2005). These cases highlight how socioeconomic status, sexual history, perceived mental age, and physical appearance work together to create young, sexually active, physically attractive women as the most dangerous group who need to be incarcerated.

The statistics on both voluntary and involuntary sterilizations are hard to come by. In Alberta, 2822 sterilizations were officially approved (McLaren, 1990, p. 159). According to a report by Timothy J. Christian, 64% of the individuals were women, the majority of whom were young, unemployed, and single (McLaren, 1990, pp. 159-160). Claudia Malacrida’s 2015 work reveals the purposeful acts of eugenics that occurred at the Michener Centre in Alberta. Furthermore, in McLaren’s book (1990), he notes that “prior to legislative enactments, such operations had been carried out in British Columbia; these assertions further indicate that they took place in provinces such as Ontario, where no enabling legislation ever existed” (p. 163).

As such, pregnancy was highly monitored and frequently pathologized if the woman was unmarried. One 19-year-old patient’s case file noted, “She feels no

shame regarding having a child. When asked if she thought it was alright for her to have children, she replied, “If it's alright for my mother to have children, it’s alright for me” (Case Book #7300, B179127, 1962). The doctors go on to point out that her mother is married; however, the girl claims to see no difference. This note highlights how being an unwed mother and the patient’s feelings about it resulted in this girl’s institutionalization. A 28-year-old woman was admitted to the Hospital, and the admission conference report noted that “the main problem here is one of social behavior” (Case Book #8151, B187162, 1967). She had two children out of wedlock, and after the birth of her second child, she was sterilized at the Ontario Hospital, St. Thomas. The record does not state if this was voluntary.

The note that behavior is the most concerning issue is not isolated to this one patient. In the same box of files, another patient, a 16-year-old girl, had an admission note stating “The main problem has not been her epilepsy but her behavior problem, negativism, and her refusal to either go to school or to stay at home. She has been involved with several boys but since has had a period [sic]” (Case Book #7853, B187162, 1967). Before alternative channels existed to help girls and women, they were ushered into institutions such as the Ontario Hospital, Woodstock, to keep them off the streets and stop them from having children, and other such “behavioral” issues. Although my research does not denote a specific targeting of Indigenous women within the Ontario Hospital, Woodstock, for sterilization, it is important to note the historical and ongoing eugenic practices that target Indigenous reproduction in Canada. Karen Stote (2015) writes about the genocidal act of the forced sterilization of Indigenous women and focuses on how the forced sterilization of Indigenous women in Canada was not passive, but was part of the broader genocidal policy to control and eliminate Indigenous populations by the Canadian government. A further

discussion of the treatment of Indigenous women at the Ontario Hospital in Woodstock is provided below.

These examples highlight how the norms placed on women, specifically regarding sexuality, were used to pathologize women. The solution to this was to bring the women who were exercising their sexuality into the segregated hospital setting. White middle/upper-class women specifically were assumed to be champions of morality, and any transgression was assumed to be caused by mental unwellness. The race of these women is important to note as racialized women were not held to the same standard, already assumed to be hyper-sexual and deviant (Malacrida, 2015, p. 23). This resulted in different pathologies and often different forms of incarceration, such as institutionalization versus imprisonment. Gendered assumptions, especially played out through class and race, were highly influential in being admitted and confined in institutional settings.

Further, even when women had not explicitly transgressed sexual norms, sexuality was highlighted as a central concern to the doctors. Upon admission women were forced to have a gynecological exam, where the doctor would note how many fingers the vaginal opening would admit, as well as measuring how deep the vaginal canal was by length of his finger (Case Book #00970, B186865, 1930). I could find no reason why this would be a pertinent exam, but perhaps the doctor was attempting to confirm if patients had participated in penetrative vaginal sex manually. One woman had a slight fever, was perspiring, and had swollen ankles, so the doctor performed a pelvic examination (Case Book #5241, B162558, 1961). Women's medical problems were consistently misdiagnosed as "female problems" relating to their reproductive systems. Wendy Mitchinson (2013) remarked how "it was the female reproductive system that broke down and not another system in the body,

reinforcing the sense of its fragility and susceptibility to influences" (pp. 245-6). Many female patients had their sexual history brought up again and again during their institutionalization as a symptom of their illness or a reason for them to be more closely monitored. Often, female patients were noted to require supervision as they were "caught" passing notes with male patients. However, this was seldom noted in the clinical files of male patients from the same archives. The very real concerns and issues faced by women during this period and the women's reactions were dismissed by doctors as just another symptom of mental illness. One patient, who was a mother, was noted "to be delusional, keeps talking about the necessity for her to return to take care of her children" (Case Book #4182, B179827, 1946). This remark seems quite contemptuous as it is perfectly normal to want to go back to your family and look after your children, especially when you have been forcibly removed from your home.

Despite this obsession with women's sexuality, men were often only discussed in passing, unless related to homosexuality, which was still illegal at this time in Canada. Male patients would often only have a brief mention of their sexual histories upon admission and would never have it mentioned again. This is true even when they had committed sexual crimes such as indecent assault. For one man, they even noted, "There have been repeated disturbances because of indecent exposure, but in between these, the patient has been a good worker, and at no time has he shown any evidence of psychosis" (Case Book #6957, B196512, 1960). Men's labor was privileged over their criminal behaviour, while women were expected to remain within the dominant moral narrative and were valued mainly for reproduction.

This rings authentic, even when considering issues of domestic disturbances as reasons for admittance to the Hospital. Despite the extenuating circumstances of abusive partners or spouses, the women remain the ones institutionalized, such as this example in which a female patient was known to be living, unmarried, with the father of her five children, who was also an alcoholic. After giving birth to their sixth child, the patient was sterilized. “He abused her sexually and by beating her up, hitting her on the head with whiskey bottles, etc. … Emotionally she is depressed and frequently cries and has a severe guilt complex” (Case Book #815, B187162, 1967). Because this woman was depressed and felt guilty, she was hospitalized. The notes make no mention of what happened to the man she was living with, if anything, or where her children were living whilst she was incarcerated. A woman of low socioeconomic status, whom her male partner was abusing, was pathologized and subsequently incarcerated, as her status as someone with six children born out of wedlock outweighs the violence that was inflicted upon her.

Specific to experiences within the Hospital, one young woman was weeping and when pried, claimed that a hospital staff member had raped her in the basement of a Cottage. After no sperm was found from a vaginal swab, it was decided that this patient was lying. The clinical notes detail the investigation as:

> This girl is a notorious liar, but in view of her serious accusations, the staff member accused was interviewed… This man, whose name will not be mentioned for his own protection, has had a good record of work here over a period of some twelve years, and it is my impression that the patient’s accusation is completely false” (Case Book #7655, 1961)

Due to the man's history of telling minor lies and his exemplary work ethic, the investigation comes to a halt, and it is discovered that the patient has been lying. Once again, a man’s labor is privileged over a woman’s experience. The power dynamics of a male staff member being alleged to have assaulted a female patient

significantly impact how this situation was handled, as well as the fact that most of the upper management of the Hospital were also men. The staff were able to use this allegation to stigmatize further and belittle this patient, as she was already noted to be “a notorious liar.” Despite the Hospital’s obsession with women’s sexuality, it seems that relatively little was done when the issue involves staff.

Institutional vs Societal Conduct and Norms

Furthermore, within the Hospital, women were expected to set aside their morals in favor of institutional practices. As highlighted in the previous section, outside the institution, women were highly policed for so-called promiscuity; however, upon entering the Ontario Hospital, Woodstock, they would be ridiculed for being too modest. A female patient was chastised and deemed “overly modest” for refusing to be naked in front of others and “keeps her underwear on when having a bath unless forced to take it off” (Case Book #03983, B173717, 1946). Women had an impossibly narrow box to fit inside. Furthermore, this too was reflected in the doctors’ judgment of their appearance. Under the “Mental Status” section of a 15-year-old girl’s clinical notes, a doctor commented on her “dreamy eyes” and the fact that she “looks some three years older than her chronological age of fifteen would indicate” (Case Book #6623, B191163, 1959). Another young woman was described as “tall, ungainly, and defective looking,” in her psychometric report and further along in the clinical notes, the doctor hesitated to transfer her from a ward to a cottage despite the fact “it would seem that she should get along fairly well if she were privileged but I have hesitated to make the transfer because of her personal appearance which would not add anything to the general tone of the cottage” (Case Book #1035, B170984, 1933). Women’s conduct didn’t matter if they were characterized as too attractive or too

ungainly, based solely on the judgments of the medical officials who ran the institution.

Within the institution, there was a very narrow definition of how women should conduct themselves, not only concerning sexuality and looks but also personality and feelings. This was reflected directly in the case files and the treatment of female patients, where women could not be too chatty, too quiet, too happy, or too sad; else they would be punished and/or medicated. These women could not be too mentally ill, or they would be subject to painful treatments and more medication. The less mentally ill they appeared, the more work they had to take on within the ward. If they completed their work well, they would most likely be kept within the institution to maintain it through unpaid labor. This is highlighted by the case file of a 78-year-old woman, who had been institutionalized for most of her life. The doctors noted, “She is an excellent worker on the ward. It appears that she has recovered from her mental illness, but has been institutionalized for so many years that she is quite content to remain hospitalized” (Case Book #7368, B170504, 1962). Once again, the prioritization of labor, this time combined with the age of the patient and length of institutionalization, becomes the key determining factor despite the recognition that she is no longer ill. If their work was unsatisfactory, they were deemed to be regressing and were once again subject to worse treatment. One patient began medication “To counteract patient’s euphoric mood and slap-happy attitude” (Case Book #6674, B187148, 1959). In the case file of another patient who was talking frequently even when no one was responding, the doctors stated “She was advised not to speak unless she was spoken to or unless she would have something interesting to say to those about her and she promised that she would take the advice” (Case Book #01792, B173717, 1936). The frustrations of the other patients

are understandable, but the doctors and nurses showed no understanding or patience towards this patient, who was only 16.

For the doctors overseeing the patients, the expression of sadness or fear by a patient was seen as even more cause to maintain their incarceration. Many patients expressed feelings of persecution, none of which were taken seriously, as highlighted in this clinical note: “She expresses many delusional ideas of persecution and writes to her people telling them that she is being abused by us…” (Case Book #01839, B165106, 1943). As patients became aware of what it was like to live within the institutional structure, they grew to dislike and distrust this system more and more. One doctor noted “When I first saw [the patient] her opinion of the hospital was quite indifferent as she stated, “it’s someplace different to be.” On the successive times I saw her she was more negative, stating that she wanted to leave as she didn’t like it. I feel this change is due to boredom rather than any true dislike for the hospital” (Case Book #8127, B170984, 1968). On the intake form of a woman who was being readmitted it noted, “They said that [the patient], at present, has a fear of returning here because of some unpleasant experiences when she was here before, and they wanted to reassure her that things were now different” (Case Book #3810, B165106, 1964). This highlights the societal perception that people with a history of institutionalization are not trustworthy. Even when some patients turned to their families, the families maintained their trust in the doctors and systems instead of listening to the voices of the women who were trying to exercise their autonomy. These shifting cultural definitions of mental illness, defined by doctors, are highlighted in Kira Smith’s 2021 work entitled “Ritualizing Madness.” She explores how madness has been forced onto psychiatric patients by the clinical observations that pathologize specific physical characteristics. As such, “So-called mad behaviour

can be repeated, rearranged, and restricted to fit the needs of cultural performances of madness" (Smith, 2021, p. 8). Similarly, Erving Goffman (1961) highlights that in total institutions, such as the Ontario Hospital in Woodstock, the administration and goals of the institution supersede the healing or treatment of patients, instead using patient behavior to justify the need for institutionalization. In the previous examples, regular emotions are rearranged to be pathologized as symptoms of illness requiring institutionalization.

Racialized Non-Indigenous Women

The preceding section focuses on the experiences of white women, primarily from working-class backgrounds. Racialized women are further marginalized and oppressed within dominant systems operating in colonial Western contexts. This includes Jewish women, who were deemed a race unto their own, outside whiteness. In 1939, a 26-year-old Jewish woman was admitted to the Ontario Hospital, Woodstock. At that time, Dr. Lynch was the Superintendent. Dr. Clark became the Superintendent in 1943, and in 1944, he wrote a lengthy clinical note in this patient's case file (Case Book #02276, B186865, 1944). He states,

> "It is to be greatly regretted that on admission the physician in charge at the time and the Superintendent ever agreed to cater to her religious observances as to special foods, etc. It seems too late now to discontinue these privileges as there is no doubt that she would create a terrific disturbance and would likely go on a prolonged fast, but something will have to be done shortly if her present behaviour continues."

He states in an earlier note that "There would seem to be no reason why she should be catered to more than the other patients," this despite the hospital catering to both Roman Catholic and Protestant traditions and celebrations. In 1950, they discontinued serving Kosher food to this patient, as she was not eating very much. This one case highlights the mistreatment of non-Christians at the Ontario Hospital,

Woodstock. However, it is also a reflection of larger Canadian societal attitudes towards Jewish people during the time of the Second World War.

Furthermore, the personalities of racialized women and girls were often pathologized according to their race. One young woman is noted as being a troublemaker who "quarrels a lot with other patients, apparently because of her colour. Is given to quietly making nasty remarks about others, then blaming them for calling her a n*gger…" (Case Book #4187, B190893, 1957). The doctors also remark that she has a "colour-complex" which negatively impacts her behaviour. This woman's race and gender compound to create the circumstances that the doctors blame for any racism or other problems she faces within the institution, instead of the possibility that others were targeting her. A girl, born in British Guinea to Portuguese parents, was admitted in 1967. When describing her diagnosis or reason for treatment the clinical record states "She is not psychotic but appears to be more of a behaviour disorder than anything else. Her moodiness is partly racial" (Case Book #7981, B190893, 1967). In deciding that her reason for treatment is racialized, there is the notion that all people of Portuguese descent have behavioral issues, and that this girl will never fully "improve" as her condition is part of her race.

Indigenous Women

There were a surprising number of Indigenous patients at the Ontario Hospital, Woodstock, with most being transferred on account of having contracted tuberculosis. In this section, I follow the footsteps of Kathryn McKay (2018) where she shows "how the medical authorities employed a bifocal lens composed of Western gender norms and settler-colonial perceptions of indigeneity to fashion accounts of madness and social transgression in many of the Indigenous female patients who were admitted to the provincial mental-hospital system" (p. 205).

Furthermore, several key works on Indigenous institutional histories have been published outside of Canada, including Susan Burch's *Committed: Remembering Native Kinship in and Beyond Institutions* (2021) and Carla Joinson's *Vanished in Hiawatha*. These histories need to be situated within the ongoing violence that is perpetrated by settler-colonialism across Canada. Every aspect of governmental control and regulation of Indigenous communities has been to subdue and destroy Indigenous sovereignty. The multiple tactics employed are highlighted by Hillier and Vorstermans (2024) – "using disease to disable, maim, and kill Indigenous Peoples, the violent stripping of Indigenous Peoples from their land, the apprehension of Indigenous children into state custody, and the exertion of control over reproductive and familial domains" (p. 53). They go on further to highlight the sexism that is central to colonial rule, which denotes Indigenous women as less than and bad mothers, necessitating the removal of Indigenous children into state care. This relates to another historical site of incarceration for Indigenous peoples, residential schools, which often caused/produced disability. This context is crucial to understanding the institutionalization, oppression, and discrimination faced by Indigenous people at the Ontario Hospital, Woodstock, and partially explains some of the behaviors and violence seen in the case files.

One Indigenous woman transferred from the Ontario Hospital, Port Arthur "Has stated to interpreter that she is much afraid of white people and does not know why she is here. She fears 'she may be killed.' She would stick pins in her hands "to prevent the white man from injuring or killing her" (Case Book #6950, B179827, 1960). One reason that people may self-harm is "to regain control over their body" and this woman was very much not in control of anything happening to her (CMHA B.C. Division, 2013, para. 3). Indigenous people were removed from all their

communal support and moved to a foreign, segregated institution, relying on translators to communicate. This Indigenous woman's rightful fear of the people who took her away from her family, and are keeping her there, was seen as part of her illness. Another Indigenous woman had her brother visit, who relayed that the patient felt quite well and, as such, he wanted to bring her home. The Superintendent noted, "I informed him that we would see her in Conference and decide whether or not she is ready for a trial at home. She speaks Cree, and it is doubtful if we can have anyone here to interpret for us" (Case Book #5910, B170984, 1957). Despite being unable to communicate with this woman and lacking an interpreter, the doctors still felt they had the authority to determine whether she could leave the hospital. For many of the Indigenous patients, the doctors would write that they had lower than normal intelligence due to their racial or cultural background, even when one man appeared to be a prolific Cree writer (Case Book #6978, B196512, 1960). For another Indigenous woman, the doctors, seemingly annoyed, wrote, "This old Indian lady has been making a general nuisance of herself on the ward. Unfortunately, no one is able to understand her, and she is very much annoyed about this. She is complaining all the time and we can not help her" (Case Book #7970, B187148, 1956). In this case, they "over-sedated her," resulting in her falling over and receiving bruises. Isolating Indigenous people from their communities and keeping them where no one can understand them is cruel. Furthermore, doctors conflated race and intelligence, despite plentiful evidence to the contrary. The hospital staff failed to consider the serious impact that not speaking the same language might have on their diagnoses and treatments of Indigenous people.

Many doctors, in the past and present, do not seem to understand the direct impact that colonialism has and continues to have on Indigenous peoples living

within what is now Canada (Rai, 2017, pp. 6-7). The previously outlined colonial practices enacted against Indigenous people in Canada had, and continue to have, a significant influence on the institutionalization of Indigenous people, even when there is no evidence of illness or need for care. One Indigenous girl "was found inebriated and homeless. Her mother died when she was one year old, and her father is a senile patient in hospital" (Case Book #7745, B187026, 1965). As a result, she was committed to a training school and then transitioned into the Ontario Hospital system, ultimately ending up in Woodstock. This compassionless description of how this young woman came to be "inebriated and homeless" disregards the considerable social and historical contexts that shaped her life as an Indigenous girl.

Another case is that of a 14-year-old Indigenous girl wishing to go home, who stated that "she has two sisters and has not seen her relatives for a long time; states she is tired of being with old ladies all the time and would like to have companions of her own age" (Case Book #6971, B179827, 1962). She told the social worker that if her mother did not want her back home that her sister might take care of her, but no one attempted to arrange this, as they believed she needed more time spent institutionalized as "she is not consistent and appears lazy and does not seem to care about anything" (Ibid.). Despite this girl's suggestion to the hospital of where she could go and whom she could contact, the doctors remained steady in their beliefs that this girl needed to be institutionalized. One can further wonder what the resolution would have been if this patient had been white, or male, or if the family members she asked to go home to were male. Canada's colonial mission was to erase Indigenous culture, and even further, erase Indigenous peoples altogether, and as such, maintaining incarceration was a key tenet to achieving this.

Conclusion

Gendered analyses are no longer sufficient to understand the experiences of people in institutions fully. Other socially constructed identities have a profound impact on the histories of marginalized groups, and reckoning with these intersections provides new insights into the histories of multiply marginalized individuals. Racial categories were not only important upon intake but also were reflected in the treatment and stay of those patients. Whiteness, too, must be analyzed within its own power structures, instead of being taken for granted and accepted as the norm. Age is also a significant indicator within institutional and societal contexts. During this period, young women who were entering fertility were highly surveilled and incarcerated over eugenicist fears. The elderly were also kept locked away, as they could be good workers and used to help keep the institutions running.

A more in-depth analysis of groups that bear multiple marginalizations is needed within the history of institutionalization. Although these women and girls' voices are no longer able to be heard due to the erasure of their writings, this article works to ensure that the sexed subaltern is not ignored. Using their case files adds their experiences to historical memory, rather than overlooking their lives due to the compounding effects of their race and gender. Additionally, understanding these case files through a lens of intersectionality highlights the multiple oppressions that these women and girls faced within institutional walls, as well as more generally through societal judgments. This work contributes further to the intersectional historical scholarship in the ever-expanding field of Canadian institutionalization, including smaller histories that are often overlooked but are important, nonetheless.

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