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Restraint and Patient Agency: Institutional Control at the Oregon State Hospital in the 1920s

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RESTRAINT AND PATIENT AGENCY:
INSTITUTIONAL CONTROL AT THE OREGON STATE HOSPITAL IN THE 1920S

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The Oregon State Hospital in the 1920s utilized many different forms of restraints to control their patients, strait jackets and lap belts being two of the most widely used. These restraints were one of a number of treatments physicians used to treat their patients. Medical historians examine the psychiatric body, the overarching ideas and understanding of psychiatry, from a specific time to understand motivations of physicians in the early twentieth century. This includes the use of a *therapeutic rationale*, essentially why physicians chose different therapies for their patients, the ideas behind those therapies, and what constituted therapeutic practice.[1] This rationale was influenced by the behavior of the patients and social forces placed on women at the time. Gender roles enforced by society included the loss of women's agency, specifically their physical and sexual agency. This loss of agency was reflected in the physical control which hospital staff took using restraints. Two female patient case files from the Oregon State Hospital, admitted in 1927, suggest the extent of institutional control enacted on female patients through restraint. Oregon State Hospital staff removed their patients' agency and controlled their physical bodies with restraints as a reaction to behaviors which did not conform to gender norms.

For this study of mental health institutions and treatment, patient agency is the patient's ability to either consent and assist in their treatment or resist their treatment. The removal of this agency occurs by hospital staff's reaction to their behaviors. Behaviors which do not conform to the norms of their gender regarding sexuality, outspoken opinions, and control over their own physical bodies. In order to control these behaviors, hospital staff restrained their bodies and in the case of two female patients, physically abused them.

To gain an understanding of therapies and patient experience, two female patients' Oregon State Hospital records were selected as case studies. Pseudonyms have been used for the

[1] Joel T. Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997), 35.

two patients discussed in order to comply with restriction laws and for the privacy of the patients' families.[2] Both of these patients were committed in 1927 to the Oregon State Hospital, located in Salem, Oregon. The first of these patients is Alice, committed at the age of 26, from her residence in Coquille, Oregon.[3] Alice was the parent of three children, the oldest of which she had at the age of nineteen.[4] Alice was committed for "acute mania," possibly due to an attack of "religious fervor" which started two days before her commitment.[5] Alice and her husband provided physicians with her medical and mental health history upon intake. Her commitment records state that she was feeling nervous for four years prior to her commitment.[6] Alice spent two years at the Oregon State Hospital before she died, during this time she spent several months in restraints.[7] Alice presents a case of a young mother of three whose behavior led to her being committed to the Oregon State Hospital. This case is similar to that of the other patient discussed, Helen.

Helen was admitted at the age of 40 to the Oregon State Hospital for "manic depressive insanity." [8] Unlike Alice, the duration of Helen's attack of symptoms is not given, simply stating that attacks have been happening for "some time."[9] Helen and her husband were unable to give physicians a complete medical or mental history. Helen, residing in Portland, Oregon, was also a

[2] Pseudonyms were chosen for the two female patients for two reasons: 1. To protect the privacy of the patient's and their families. The topic of mental health, mental illness, and commitment to an institution are extremely personal. My goal as a researcher does not need to infringe upon this personal privacy. 2. In accordance with the Health Insurance Portability and Accountability Act (HIPPA) medical records are restricted for 75 years following the date of a patients discharge from, or death in, an institution. The pseudonyms chosen to allow me to discuss the patients and their experiences without infringing upon personal privacy or conflicting with HIPPA laws.
[3] Insane Commitment Form, 6 August 1927, File 3958, Female Patient Medical Case Files, Oregon State Hospital, Oregon State Archives, Salem, Oregon, United States of America; hereafter File 3958.
[4] Insane Commitment Form, File 3958.
[5] Insane Commitment Form, File 3958.
[6] Insane Commitment Form, File 3958.
[7] Continued Notes, File 3958, Patient Case Files.
[8] Continued Notes, Box 55, Folder 48, Female Patient Medical Case Files, Oregon State Hospital, Oregon State Archives, Salem, Oregon, United States of America; hereafter Box 55, Folder 48.
[9] Insane Commitment Form, Box 55, Folder 48.

mother of three children; one of whom had died before Helen was committed in 1927.[10] Her occupation is listed as "housewife," and she had been married three times at the date of her commitment.[11] Helen spent over twenty years at the Oregon State Hospital before her death. During this time, she, similarly to Alice, spent days, even weeks at a time in restraints. The use of these restraints in Helen's case mirrors their use in Alice's, though over a much longer period of time. The use of restraints and other mental health therapies have been described and analyzed by both medical and social historians.

Literature Review

Medical historians examine the ideas behind the "medical body" of a period to work toward an understanding of physicians' motivations.[12] The *therapeutic rationale* of physicians is examined through the study of this body. The therapies used to treat patients evolved over time, but the ones highlighted by historians discuss the line between treatment and discipline or abuse. Therapies in mental institutions were influenced by systematic forces, including logistic, economic, and societal pressures. These societal pressures are examined by gender, sexuality, and ethnic historians.[13] Gender roles enforced by society included the loss of women's agency,

[10] Insane Commitment Form, Box 55, Folder 48.
[11] Continued Notes, Box 55, Folder 48.
[12] Braslow, *Mental Ills,* Chris Dooley, "'They Gave Their Care, but We Gave Loving Care': Defining and Defending Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital During the Great Depression," *Canadian Bulletin of Medical History* 21, no. 2 pg. 229-251; Constance Ledoux Book and David Ezell, "Freedom of Speech and Institutional Control: Patient Publications at the Central State Hospital," *The Georgia Historical Quarterly* 85, no. 1 (March 2001) pg. 106-126; Mark A. Largent, "'The Greatest Cure of the Race': Eugenic Sterilization in Oregon, 1909-1983," *Oregon Historical Quarterly* 103, no. 2 (2002) pg. 188-209; Hiroshi Maeda, "The Discovery of Hospital Patients: A Historic Epidemiology of Institutionalization in the American North, 1880-1920," Social *Science History* 40, no. 3 pg. 463-490.
[13] Susan Burch, "Disorderly Pasts: Kinship, Diagnoses, and Remembering in American-Indian U.S. Histories." *Journal of Social* History vol. 50, no. 2 (2016) pg. 362-385; John D'Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America*, 3rd ed (Chicago, IL: University of Chicago Press, 2012); William Toll, "Black Families and Migration to a Multiracial Society: Portland, Oregon, 1900-1924," *Journal of American Ethnic History* no. 17 pg. 38-70.

specifically their physical and sexual agency. Therapeutic techniques deployed by physicians of the period compounded this loss of agency. Social historians also indicate what groups were more vulnerable to institutionalization. This vulnerability came from social, economic, and ethnic status.

Joel Braslow, cultural historian of medicine, discusses the different paths which people became patients of California mental health institutions in *Mental Ills and Bodily Cures*. The monograph examines how therapeutic methods evolved through the mid-twentieth century. Braslow evaluates how physicians' practices evolved over time and the correlating effects on their patients' experiences. In his chapter on the "psychiatric body," Braslow discusses how patients were admitted to mental institutions in California in the early twentieth century. The most common involved someone filing a complaint of insanity against a person, usually someone the patient knew.[14] This would then start the process of hospitalization, where a person would become incarcerated awaiting an examination by court appointed physicians and then a trial. [15] The process described presents mental illness as a crime punishable by incarceration, though instead of a prison patients were housed in an insane asylum or hospital. The very process itself was designed to strip away individual rights, forcing them to relinquish control to the institution. Logistical pressure affected institutionalization: Braslow demonstrates the number of patients increased while the number of physicians remained steady. Admissions rose steadily while discharges stayed low.[16] This would in turn lead to physicians' treating patients based on logistical realities rather than on individual need. The vast number of patients in asylums in this

[14] Braslow, *Mental Ills*, 17.
[15] Braslow, *Mental Ills*, 17.
[16] Braslow, *Mental Ills*, 21.

period allowed a patient to lose both their identity and their individual rights as they were one of perhaps dozens of patients being treated by one physician.

Logistics also influenced how physicians treated patients. Braslow identifies different therapeutic techniques utilized by physicians including hydrotherapy and restraint. Physicians and staff members saw restraint not as therapeutic but rather a necessary evil.[17] Staff used restraints such as strait jackets, muffs, belts, and mittens.[18] This use of restraints mimics institutions of incarceration such as prisons. The devices themselves were designed to limit a patient's physical movement and agency. This was a physical extension to other limiting factors. In what seems to be a natural evolution of restraints, physicians introduced hydrotherapy, the use of which combined elements of restraint but utilized water in more "therapeutic" ways. Braslow identified two methods, the continuous bath and the wet sheet pack.[19] The sheet pack was the simpler of the two and utilized a wet sheet which was then wrapped around the patient snugly.[20] This process was strikingly similar to other restraint techniques, with the only difference being the use of a wet sheet rather than regular fabric straps or jackets. The use of hydrotherapy in insane asylums of the period was indicative of physicians' "therapeutic rationale". Hydrotherapy added a therapeutic element to restraints.

Physicians' scientific credentials were validated through the use of hydrotherapy and restraints as it gave them physical control over their patients. Braslow described similar elements with the use of clinical sterilization. Physicians at the Stockton State Hospital believed in the "medical value of sterilization", and used this perceived value as validation for sterilizing

[17] Braslow, *Mental Ills*, 35.
[18] Braslow, *Mental Ills*, 35.
[19] Braslow, *Mental Ills*, 39.
[20] Braslow, *Mental Ills*, 39.

patients.[21] The therapeutic value to the patient was both mental and physical; being especially beneficial to male patients according to Stockton physicians.[22] Braslow asserts that Stockton physicians did not sterilize female patients for eugenics but rather for what they believed were therapeutic benefits. These "benefits" included protecting female patients from the psychological and social stresses of childbirth and parenthood.[23] Braslow states that physicians sometimes considered the wishes of their patients, identifying cases where sterilization was not performed at the request of the patient even though the patient had a signed consent form.[24] This was evidence that the physician's choice to sterilize a female patient was supposed to be therapeutic. This provides the assumption that sterilizations would be performed regardless of the physician's rational, either eugenic or therapeutic. Sterilization was a different therapeutic product than hydrotherapy in that it had a permanent effect on patients, relieving them of the burden of childbirth for the rest of their lives. Patients also dealt with other medical ramifications of the procedure. Though both are therapeutic tools used to limit the agency of patients. There was also scientific validation for the use of these tools. The scientific validation for sterilization was bolstered by the eugenics movement of the early twentieth century.

In "'The Greatest Curse of the Race': Eugenic Sterilization in Oregon" the cultural historian Mark A. Largent discusses the eugenics movement in the United States in the early 1900s, specifically in Oregon, and its influences on the use of sterilizations in mental institutions.[25] The eugenics movement stemmed from the basic ideas of natural selection except the selection was artificial. It was an attempt "… to direct human evolution to create a safer,

[21] Braslow, *Mental Ills*, 59.
[22] Braslow, *Mental Ills*, 62.
[23] Braslow, *Mental Ills*, 66.
[24] Braslow, *Mental Ills*, 68.
[25] Largent, "The Greatest Curse of the Race," 188.

saner, and more productive society…" through selective sterilization.[26] This movement was especially prevalent in Oregon. The state had an active eugenics program starting in 1917 when the state passed its first eugenics law.[27] While eugenics may not have been at the forefront of therapeutic thought at the Stockton hospital identified by Braslow, it was certainly utilized by physicians in Oregon. Illnesses such as dementia or schizophrenia were linked hereditarily; people with these ailments were often labeled as problematic individuals and their goal was to eliminate them. This rationale can be layered onto those displayed by Braslow, in addition to the logistical and therapeutic reasons for sterilization. Experts in Oregon believed they could eradicate social problems by locating problematic individuals and altering them physiologically.[28] This shows how physicians and hospital staff in Oregon believed mental illness could be treated and removed from later generations. The eugenics movement supported physicians and was seen as improving the quality of the state's citizenry. The prevalence of sterilization in Oregon is highlighted by the nearly twenty-five hundred citizens who were sterilized.[29] The examples of sterilization and hydrotherapy are both therapies which remove patients' agency. There were other therapies being employed during the period which allowed for greater individual agency. Braslow and Largent stress the definitions of therapy and discipline in their examinations of therapies. Other historians analyze alternative therapies and practices which gave patients agency within the confines of hospitals.

Occupational therapy was another form of treatment used in mental health institutions in the early twentieth century. Historians Constance Ledoux Book and David Ezell examine the patient-produced and published newspaper called *The Builder* from the Central State Hospital in

[26] Largent, "The Greatest Curse of the Race," 189.
[27] Largent, "The Greatest Curse of the Race," 188.
[28] Largent, "The Greatest Curse of the Race," 206.
[29] Largent, "The Greatest Curse of the Race," 188.

Georgia starting with its inception in 1934. *The Builder* was an example of "occupational therapy," a treatment physicians began utilizing during the 1920s following the First World War.[30] "Occupational therapy" was the use of job training in the rehabilitation of patients. This first applied to veterans with disabilities. After World War I hospital staff began applying it more broadly to mental patients.[31] This therapeutic method differed from restraint, hydrotherapy, and sterilization as its focus was squarely on rehabilitation of patients and their reintegration into society. This was consistent with the creation of therapy designed for veterans rather than the mentally ill. Typing and printing were occupational skills that veterans with physical ailments could develop and utilize outside of the hospital and gives patients a societal benefit. Book and Ezell identify the economic pressure of the Great Depression as a major motivator for the expansion of inexpensive printing and publishing as occupational therapy in Georgia's state hospital.[32] Doctors used inexpensive occupational therapy to cope with less money and more patients. The experiences of patients were determined by these logistical concerns as well as the therapeutic methods of the day. The use of publishing as therapy was an example of both logistically relevant therapy as well as a popular therapeutic technique.

This practical approach to therapy was apparent in the construction of the wards of the Central State Hospital. Patients were segregated by race and gender, *The Builder* office was located in the basement of the white female ward.[33] The typing and publishing instructors were primarily women, they worked mostly with female patients. Physicians were concerned with females teaching men, which was a reinforcement of occupational gender roles. *The Builder* was a unique example of therapy as the publication was primarily published by female patients. The

[30] Book, "Freedom of Speech," 108.
[31] Book, "Freedom of Speech," 109.
[32] Book, "Freedom of Speech," 110.
[33] Book, "Freedom of Speech," 111.

publication allowed patients to communicate with each other, reaching outside of the segregated wards and interconnecting the patients. This communication extended past the confines of the hospital and allowed patients to pass information to the outside world. Ezell and Book provide an example of mental health therapy which was empowering to the patients as opposed to restricting. This empowerment of patients, specifically female patients, was one example of increased female patient agency in the mental health system of the early twentieth century. The occupational therapy provided by *The Builder* showed how patients could exercise their agency within the Georgia State Hospital. There was also increased agency in the world of female medical professionals.

Historian Chris Dooley examines another group of female professionals, nurses who worked at the Brandon Hospital for Mental Disease during the Great Depression. In "They Gave Their Care, but We Gave Loving Care" Dooley identifies the hospital administrators' practice to hire native born, middle class women for nurses.[34] The economic depression created a physically healthy and educationally valuable class of nurses for the medical profession. This educated class meant that nurses were "active" within the wards. They routinely participated in the administration of therapies including malaria and insulin injection and showed a superior patient care skill set as opposed to male physicians.[35] The nursing profession grew dramatically during this period and women found increased occupational agency and occupational identity with a "… expectation of upward occupational mobility."[36] In institutions where therapy and discipline removed the agency of patients, female nurses were able to increase their own personal monetary income and occupational movement. Dooley's focus on the nursing profession within mental

[34] Dooley, "They Gave Their Care," 236.
[35] Dooley, "They Gave Their Care," 243.
[36] Dooley, "They Gave Their Care," 246.

health institutions provides an understanding of the evolving psychiatric body of the early twentieth century.

These medical and institutional historians provide an understanding of how mental health institutions treated their patients through different therapies and techniques. To analyze the patient case files more effectively a social historian's perspective is important. Social historians allow for an understanding of the social pressures placed upon female patients. These pressures include ideals regarding sexuality, gender, and stigmas regarding race. With these perspectives social historians provide evidence of patients' agency outside of institutions. These definitions of agency influence how patients behaved within institutions and how hospital staff perceived and treated them.

In *Intimate Matters* John D'Emilio and Estelle Freedman discuss social changes during the early twentieth century. These changes included increased sexual freedom, especially for the middle-class youth for whom the routines of school and social events made up a larger part of their lives than previous generations.[37] Youths attended coed schools and engaged in social events up to four times a week on average.[38] There were more public spaces where males and females could openly engage in social activity such as "petting" parties and movie theaters.[39] This marked a movement away from the previous generation's sexual norms and allowed for greater personal freedoms. The sexual issues which preoccupied 1920s America include debate over birth control, where the future of marriage was headed, and the increased sexual freedoms of the middle-class youth.[40] These issues all provide examples of where American sexuality was headed, moving beyond marriage, to a more relaxed and public relationship. Sexual intercourse

[37] D'Emilio and Freedman, *Intimate Matters*, 240.
[38] D'Emilio and Freedman, *Intimate Matters*, 240.
[39] D'Emilio and Freedman, *Intimate Matters*, 240.
[40] D'Emilio and Freedman, *Intimate Matters*, 241.

outside of marriage was taboo. Before the privacy and freedom of movement provided by cars, youths were unable to participate in sexual relations.[41] The small towns and suburbs where middle class youth grew up were not private. The front porch or the family parlor were as private a venue as young couples could get. This combined with a restricted access to contraceptives created a hostile environment for people to express their sexuality. The debate over contraceptives became a mainstay over the next few decades.

Access to reliable and affordable birth control allowed for sexuality to diverge from reproduction. Some Americans reacted to this separation with an increased fear of promiscuity and resilience of moral order.[42] The ability to use birth control was one concrete form of sexual and physical agency for women. The medical community responded negatively to birth control showing a professional unwillingness to allow medical support to sexual agency.[43] The same scrutiny over birth control by the medical community was applied to abortions. The illegality of abortions was only reversed under the jurisdiction of the medical community. Specifically, with the use of "therapeutic abortions" which allowed physicians to perform an abortion when the pregnancy threatened the woman's life.[44] The medical and legislative community of the early twentieth century allowed for physical agency only when women's lives were at stake. The use of the term "therapeutic abortion" also indicates a motive of treatment rather than facilitating a woman's right to physical agency. It was not the choice of the woman but rather the choice of the physician to determine the woman's best interest. D'Emilio and Freedman argue that middle-class Caucasian women who could afford psychiatric care were more likely to be allowed a

[41] D'Emilio and Freedman, *Intimate Matters*, 239.
[42] D'Emilio and Freedman, *Intimate Matters*, 242.
[43] D'Emilio and Freedman, *Intimate Matters*, 244.
[44] D'Emilio and Freedman, *Intimate Matters*, 253.

"therapeutic abortion" as opposed to poorer women who visited municipal hospitals.[45] This was a perceived advantage of agency for women in psychiatric care. However, physicians and the medical community as a whole still made decisions for women about their bodies. Most ward patients who received a "therapeutic abortion" were also sterilized as a matter of policy.[46] Physicians, medical boards, and state legislatures were able to choose what lengths women were allowed to go to express their physical agency. Birth control, abortions, and sterilizations were all ways in which physicians controlled the physical bodies of female patients. D'Emilio and Freedman identify how female patients lost control of their bodies due to both their diagnoses of mental illness and their gender.

Pressures involving medical diseases were also prevalent during this time period. During the early twentieth century there was an increase in the prevalence and scientific knowledge of venereal diseases including syphilis and gonorrhea.[47] The reaction of physicians to this increasing problem was prevention rather than treatment.[48] This prevention became part of a movement toward social policing of women's sexuality. The "social hygiene movement" became an organized group of educators and social workers who advocated for "…state mandated blood testing before marriage, required reporting of cases of infection, and a comprehensive program of sex education…"[49] This movement combined the ideals of previous generations with the organizational methods of the twenties. Allowing the greater society to police the sexuality of women, even giving the government the ability to invade their bodies. Sexually transmitted diseases were clear evidence of promiscuity and D'Emilio and Freedman show how American

[45] D'Emilio and Freedman, *Intimate Matters*, 253.
[46] D'Emilio and Freedman, *Intimate Matters*, 253.
[47] D'Emilio and Freedman, *Intimate Matters*, 204.
[48] D'Emilio and Freedman, *Intimate Matters*, 204.
[49] D'Emilio and Freedman, *Intimate Matters*, 205.

society reacted to this. With an attempt to take control of women's bodies and prevent them from infecting men. In the early twentieth century gender was tied to disability. Similarly, race and social identity were tied to disability.

In "Disorderly Pasts: Diagnoses, and Remembering in American-U.S. Histories" Susan Burch, a United States historian focused on gender and race, discusses life stories from the Canton Asylum in South Dakota between 1902 and 1933 through a disability history perspective.[50] The Canton Asylum presents a unique example of the relationship between social identity and disability as it was the first federally-run psychiatric facility created specifically to house and treat American Indians.[51] The physicians, nurses, and administrators who worked with the patients were all white and the racial barrier equated race with disability. As the only non-white people present in the asylum were the Indian patients. This label came after forced relocation to the hospital, nearly 500 miles away from their original home, and the separation from their social identity.[52] The patients were isolated from their community and familial support systems. Burch describes the case of Agnes Caldwell as a way of understanding how the label of disability and race effected patients. Caldwell was a patient at Canton and was considered "feebleminded" and "oversexed."[53] Canton Asylum's Superintendent Hammer was valorized for his treatment of Caldwell while Caldwell was chastised for her consistent sexual behavior. Burch asserts that this is evidence of diagnoses of patients reinforcing stigmas about Native peoples. These stigmas also came through Native people's inability or unwillingness to conform to Western societal values. Psychiatrists were trying to enforce these values and resistance to convert was seen as a deficiency or defect as opposed to a difference of individual or cultural

[50] Burch, "Disorderly Pasts," 364.
[51] Burch, "Disorderly Pasts," 363.
[52] Burch, "Disorderly Pasts," 363.
[53] Burch, "Disorderly Pasts," 375.

values.[54] The labeling of disability by society based on cultural values equates being American Indian with being disabled. By enforcing Western societal ideals physicians are limiting their patients' agency. This agency being their ability to hold onto their native culture and operate in the Western society into which they were forced. The Canton Asylum presented a case where the entirety of the patient population was labeled with mental illness and carried the stigmas of Native peoples. Blurring the definition of mental illness from purely psychological disorder to a physical disorder. The patients in Canton lost their individual cultural freedoms and agency with the label of American Indian. A similar label is examined by other historians, and issues which arose when a racial minority group was integrated into a multiracial society.

Historian William Toll analyzes the experiences of Black families in early twentieth-century Oregon in "Black Families and Migration to a Multiracial Society: Portland, Oregon, 1900-1924." The "Great Migration" was the movement of Blacks from the rural Midwest to metropolitan cities, in this case Portland.[55] Toll indicates that Blacks in urban areas during the 1920s had relatively low birth rates. One possible explanation being Black women on the move did not risk childbirth "to avoid the emotional as well as economic consequences."[56] Black women did not experience the sexual freedom felt by middle-class Americans in the early twentieth century that D'Emilio and Freedman outlined. The economic stress of even the possibility of childrearing was too great a risk for Black women to take. Inaccessible birth control increased this stress. Toll states that blacks primarily pursued wage labor jobs in metropolitan areas and were dependent on white-owned businesses and the railroad network.[57] Blacks were service workers in the multiracial Portland. The dependency of white-owned

[54] Burch, "Disorderly Pasts," 364.
[55] Toll, "Black Families and Migration," 38.
[56] Toll, "Black Families and Migration," 59.
[57] Toll, "Black Families and Migration," 64.

businesses for employment extends their economic vulnerability; an economic vulnerability which also creates a vulnerability to being institutionalized. This was due to Black women being more likely to not have familial support. According to Toll thirty two percent of Black women were listed as single, widowed, or divorced compared to 14 percent of white women.[58] The combination of familial isolation and economic weakness meant women were more vulnerable to institutionalization. Toll focuses on the status of the black population in Portland and concludes that "…women waited for signs of stability before deciding to raise children. As marriage and home--ownership increased, so did the willingness to raise children."[59] By analyzing the demographics of the 1920s Black population in Portland, historians can identify how Black women were controlling aspects of their lives and exercising their personal agency. Choosing to start a family when they could depend on their surroundings. Other historians utilized demographics to understand mental health institutions' patients.

Social historian Hiroshi Maeda discusses the changing demographics of psychiatric patient populations in "The Discovery of Mental Hospital Patients: A Historical Epidemiology of Institutionalization in the American North, 1880–1920." Maeda identifies populations more prone to being declared insane by both economic class and race. Women of lower class and of higher age were more likely to be declared insane and institutionalized in rural and metropolitan areas and therefore more vulnerable to loss of agency.[60] The identification of gender and socio-economic class as factors of institutionalization provide additional layers to the loss of agency felt by these patients. Women were more vulnerable to institutionalization and the therapies administered therein. Maeda also indicates that the same demographic populations were

[58] Toll, "Black Families and Migration," 61.
[59] Toll, "Black Families and Migration," 61.
[60] Maeda, "The Discovery of Mental Hospital Patients," 464.

institutionalized in both rural and metropolitan areas, indicating a higher vulnerability based on aspects such as gender or race as opposed to economic class.[61] The focus on the demographics of patients allow for a broader view of institutionalized patients as opposed to historians such as Burch or Dooley who focus on a specific group. This look at the larger demographics of patients allows Maeda to discuss the nature of a mental health institution as one of two basic groups, repressive or humanitarian.[62] These two groups classify patients as either the victims of repression or the beneficiaries of humanitarian acts. Understanding this concept allows for a classification of how staff at mental institutions viewed their patients. Especially important is the demographic of patients seen as victims of repression, where the institution itself is limiting their agency.

Historians have attempted to understand the aspects which led to the institutionalization of patients. Burch and Toll describe the experiences of ethnic groups, with Burch identifying how the labels of disability were correlated with race. Through the study of demographic trends by historians such as Maeda, ethnic groups like African Americans or Native People were among those most vulnerable to institutionalization. This demographic study also indicates how the issues of gender and sexuality effected institutionalization. D'Emilio and Freedman describe the societal control placed on women's sexuality in the early twentieth century. The removal of women's physical agency in mental health institutions occurred while sexual freedoms increased in society. Therapies such as restraints, hydrotherapy, and sterilization as indicated by Braslow and Largent show how physicians were controlling women's bodies. The intent behind these therapies, or the validation of the therapies, in part distinguished them from discipline. Historians

[61] Maeda, "The Discovery of Mental Hospital Patients," 463.
[62] Maeda, "The Discovery of Mental Hospital Patients," 463.

focusing on the psychiatric body also indicate therapies which empowered patients. Book and Ezell discuss an alternative to the reductive and controlling therapies popular during the period. Historians attempt to explain mental health patients' loss of identity and agency within institutions using medical and social perspectives.

Patients' Intake

The path of a patient through a mental health institution is understood with the use of Helen and Alice's patient case files. Both women were married, with their occupation listed as "housewife," their closest legal and social representative was their husband.[63] Helen, age 40 at commitment, was representative of a slightly older generation than Alice, age 26 at commitment.[64] Both women were committed due to their behavior, specifically them being unruly, loud, or untidy. Staff noted that Alice had been affected with "religious fervor" on her day of commitment, which is said to have lasted two days before her admittance.[65] This erratic behavior was apparently surprising to the husband and family of Alice, as she had not had any similar attacks previously.[66] The Commitment Form, Patient History, and Continued Notes of Alice's file indicate that her behavior suddenly changed. Physicians do not indicate a possible reason for her behavior other than "religious fervor." Alice's extreme behavior doesn't conform to that of a more conservative housewife.

Alice's intake paperwork states upon entering the hospital she was "…talking wildly and incoherently on religious subjects" and she was "very noisy and restless."[67] This wild and unruly

[63] Insane Commitment Form, File 3958; Insane Commitment Form, Box 55, Folder 48.
[64] Insane Commitment Form, File 3958; Insane Commitment Form, Box 55, Folder 48.
[65] Insane Commitment Form, File 3958.
[66] Insane Commitment Form, File 3958.
[67] Continued Notes, File 3958.

behavior was seen as the reason for Alice's commitment. She could not control her radical behavior and physicians diagnosed her with a case of "possible acute mania…"[68] This diagnosis of acute mania, along with her seemingly uncontrollable behavior could have led physicians to believe that control was a primary goal. While Alice's behavior was erratic, staff described her as much more coherent than Helen. Helen's intake paperwork describes similar behaviors to Alice, specifically her being unruly and noisy. Helen's symptoms were more aligned with that of her diagnosis of "manic depressive insanity."[69] Staff described Helen as having long and uncontrollable bouts of melancholia and having long crying fits.[70] Helen presents a similar case of uncontrollable behavior. Both Helen and Alice were unable to modify their behavior to function within their family units. Both as being housewives and mothers they had a specific set of duties. Being present within a family unit while presenting behaviors like uncontrollable crying or incoherent religious speech did not connect. In both cases, the patients' erratic and irrepressible behaviors were contributary in their commitment to the Oregon State Hospital.

Control Through Restraint

The loss of patient agency including control over their physical bodies was evident in case files from the Oregon State Hospital. The case files of Helen and Alice present instances where hospital staff inflicted control over their physical bodies as opposed to treating their illnesses. This physical control was implemented with the use of restraints. The restraints described in these two patient files were either "full restraint" or "partial restraint."[71] Full restraint utilized large canvas belts which would hold down the patients to their beds. Partial

[68] Continued Notes, File 3958.
[69] Continued Notes, Box 55, Folder 48.
[70] Form E, Box 55, Folder 48.
[71] Correspondence with R.C. Avery, 31 December 1929, File 3958; Continued Notes 1, 1934, Box 55, Folder 48.

restraint used devices such as straitjackets and cuffs to restrain the patients' upper body and reduce their ability to interact with their surroundings.[72] Both Helen and Alice were held to their beds for months on end, for the majority of their stays at the Oregon State Hospital.

In response to the erratic behaviors these patients presented physicians, nurses, and ward staff attempted to control them. Staff described Helen and Alice as "untidy" and "noisy" throughout their stays at the hospital.[73] The use of these terms as attributes to negative behaviors indicates what physicians are looking for in terms of an *ideal* patient, a patient that was able to control their emotions and their behaviors. Along with this docility, patients were also expected to participate in the activities and goings on in the ward. Patient behaviors that were unruly, destructive, or aggressive meant that patients were unable to actively participate. Alice and Helen were two female patients that, because of their mental illness, could not conform to the standards and expectations of hospital staff. Staff reacted to this nonconforming behavior by using restraints.

The Oregon State Hospital staff utilized restraints to control patients. Alice and Helen were both kept in restraints for months on end, usually restrained to their beds.[74] Alice only spent two years in the State Hospital. Correspondence between hospital staff and Alice's relatives and the Continued Notes in her file creates a timeline of her treatment. Alice was paroled after just two months at the hospital, allowing her to return home with her husband for a short period of time.[75] Alice returned two months later. Her husband stated that she was loud and violent during her time at home.[76] After Alice's return to the Oregon State Hospital a shift occurred in her

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[72] Braslow, *Mental Ills*, 36.
[73] Correspondence with Miss M. McCall, 1940, Box 55, Folder 48; Correspondence with husband, 11 April 1928, File 3958.
[74] Correspondence, 1930, Box 55, Folder 48, Patient Case Files; Correspondence with husband, 5 March 1928, File 3958, Patient Case Files.
[75] Continued Notes, 26 October 1927, File 3958.
[76] Continued Notes, 29 December 1927, File 3958.

treatment by hospital staff. There is no mention of restraints nor a wholly negative prognosis for Alice before she returned to the Hospital. Correspondence between hospital staff and Alice's husband just after her readmittance from parole stated that "…[they] are doing the very best [they] can to assist her to gain both mentally and physically."[77] This is the last positive, or even neutral prognosis of Alice's condition by hospital staff. After this a different message was consistently repeated. While the specifics change over time the outlook for Alice was the same. Hospital staff did not see any point at which Alice might improve. Phrases such as "continuously disturbed" and "permanently impaired" describe Alice's condition.[78] Rather than focusing on what therapies or treatment might help Alice, or what the staff might do to help with her condition, the message is about mitigating Alice's loss. Her illness and mental state were impaired so heavily by her disease she would not improve. This also set the stage for Alice's restraint record.

Alice was restrained for most of her time at the Oregon State Hospital. After her readmittance there were fourteen mentions of Alice having to be restrained in correspondence between hospital staff and her family. This restraint lasted for the remainder of her time at the Oregon State Hospital and her life. The restraint utilized also resulted in physical injury and long-term health concerns for Alice. After months of restraint to her bed and "restless" behavior Alice managed to rub off skin from her elbow, which became inflamed and infected.[79] This infection would fester for months and have to be drained on several occasions. This painful and threatening health risk was created as direct result of her restraint. Alice was restrained because of her inability to control her actions. Her unruly behavior led hospital staff to restrain her to her

[77] Correspondence with husband, 7 January 1927, File 3958.
[78] Correspondence with Alice's mother, 31 January 1929, File 3958; Correspondence with Alice's daughter, 1 November 1928, File 3958.
[79] Correspondence with Mother, 6 February 1930, File 3958, Patient Case Files.

bed for long periods of time, eventually resulting in a health risk. This long-term restraint is also prevalent in Helen's case file.

Helen's symptoms presented similarly to Alice's in that she was unable to control her actions. But the mental capacity or mental presence was different between the two patients. While Alice was able to carry on a conversation when she first entered the hospital, Helen was unable to give physicians her history, nor able to describe her symptoms.[80] She was able to "reply promptly when questioned but is usually unable to complete her sentences or to make any connected statements."[81] Her mental faculties removed her from being able to connect with physicians or nurses. Staff described her mind as "permanently damaged" rather than "disturbed" as was the case with Alice.[82] Helen was restrained for similar reasons as Alice. She presented violent, loud, and unruly behaviors and could not control them. However, as opposed to Alice who did not get a specific reason for her condition, Helen did. Helen received a four plus positive in the Wasserman test, a blood test for syphilis.[83] This four plus positive result meant that she was infected with syphilis and her diagnosis was changed from manic depressive disorder to General Paresis.[84] Braslow describes the effects of General Paresis as leading "to psychosis and an agonizing death."[85] The disease evidently crippled her mental faculties and kept her from being active in her treatment.

Patient Agency While in Restraints

[80] Insane Commitment Form 5, 1927, Box 55, Folder 48, Patient Case Files.
[81] Continued Notes 1, 1927, Box 55, Folder 48, Patient Case Files.
[82] Correspondence with June Daggatt, 1943, Box 55, Folder 48, Patient Case Files; Correspondence with Mother, 18 December 1929, File 3958, Patient Case Files.
[83] Continued Notes 1, 1927, Box 55, Folder 48.
[84] Continued Notes 1, 1927, Box 55, Folder 48.
[85] Braslow, *Mental Ills*, 72.

Physicians gave declining prognoses for both Alice and Helen. Rather than support the patients or describe how treatments could help, physicians consistently stated that the two patients would not improve in the future. This negative prognosis was reflected in consistent restraint. With this negative prognosis and the consistent restraint, the physicians were enforcing control over their patients' bodies rather than treating their illness. The *therapeutic rationale* for the treatment of these patients was to mitigate their behavioral lashing out including the yelling and running described in Continued Notes. Even though staff saw restraint as having no therapeutic intent, it was the most consistent state in which these patients were kept.[86] The treatment of these patients reflected expectations of women, their behavior, and the ways in which they were controlled in the period.

Helen was stated to have been kept in partial restraint from 1932 to 1941, and when she was not restrained, she is described as "…running around the ward…" and "…sings and dances in a weird manner."[87] The description of Helen's actions go beyond her inability to control her behaviour. Descriptors such as "weird," "cackling," and "vituperative" are not present in Alice's case, yet they are in Helen's.[88] The notes of Helen's file conjure ideas of a proverbial witch rather than that of a patient. The notes themselves are othering the patient, removing them from a true humanity. Beyond this, the descriptors and recorded behaviors of Helen do not conform to the concepts of womanhood enforced by society at the time. The same enforcement of moral order described by D'Emilio and Freedman was visible with the treatment and description of Helen.[89] Helen's behaviors did not conform to the morality or traditional values which preoccupied middle class America. The descriptions of Helen's behavior differ from that of

[86] Braslow, *Mental Ills*, 44.
[87] Continued Notes 1, 1927, Box 55, Folder 48.
[88] Continued Notes 1, 1927, Box 55, Folder 48.
[89] D'Emilio and Freedman, *Intimate Matters*, 242.

Alice. “Unruly” and “untidy,” even “violent” are present in both files, but the specific odd descriptors used to characterize Helen are very different. The behavior of making unwanted or unwarranted noise is present in both case files. It is specifically labeled as coinciding with their restraint. While the main motivation for the patients’ restraint in both files was their aggressive and resistive actions, making uncontrollable noises was vilified by hospital staff.

The unruly noises created by the patients coinciding with their restraint shows a correlation between physical control by hospital staff and the unruly noises. The descriptions of “cackling” and incoherent religious speech were both outside the gendered ideals described by D’Emilio and Freedman. Both women were expressing themselves through their voices. This expression correlates with their restraint. Their restraint removed their physical agency, but they were able to exercise some agency through their voices. Whether or not their actions were conscious decisions or caused by their mental illnesses can not be determined. However, their actions, regardless of motive behind it, are ways they exercised their agency.

While both patients exercised their agency, their motivations or control over their actions differs between them. Conscious motive behind their ability to resist or be active in their treatment through their actions adds another element to their patient agency. In both cases the patients exercised their agency to resist treatment. In one case this resistance was perceived as a choice and the other a byproduct of an illness. Physicians clearly state that Helen was out of control, that she did not have the mental capacity to choose her actions or behaviors. Staff used of words like “confused in mind,” and “disoriented”.[90] Her behavior was disassociated from her mind. Helen’s actions were seen as uncontrollable because she did not have the mental capacity to control her actions. Doctors reacted to behaviors, not the delusions of the patients, when

[90] Correspondence with family member, 1934, Box 55, Folder 48.

choosing treatments.[91] It did not matter whether she had control over her actions, or the ability to perceive her surroundings. Hospital staff reacted to her behaviors with control, namely consistent restraint to her bed. They could only control her body, as her mind was unable to process or control her actions.

This is a counterpoint to Alice, who physicians felt was in full control of her actions, for at least part of her restraint. Physicians used words such as "agitated" and "disturbed" to describe Alice's mental state.[92] Rather than her being mentally unable to control her actions, Alice's doctors described her as being so disturbed that she was choosing to behave in these ways. Due to this belief and her control over her actions Alice was more fully exercising her agency. She was able to consciously resist her treatment, rather than simply reacting to her perceived surroundings. In both cases, physicians responded to these behaviors with control. Restraints were used to control patients' bodies. This control coincided with physical injuries received by Helen and Alice while under the care of hospital staff. These injuries tread the line between therapy and discipline.

Beyond Restraint

Both Helen and Alice received physical injuries as a result of hospital staff physically controlling or restraining them. One, was Alice's elbow injury, which occurred when she rubbed it raw after months of being restrained to her bed. The wound became infected and was lanced to remove puss on several occasions.[93] The infection was so persistent that it was listed as a contributary cause on Alice's Certificate of Death.[94] This wound, and infection was a direct

[91] Braslow, *Mental Ills*, 48.
[92] Correspondence with husband, 25 September 1928, File 3958.
[93] Correspondence with Mary Riddle, 6 February 1930, File 3958.
[94] Certificate of Death 1, 10 March 1930, File 3958.

result of the restraint she faced from hospital staff. Along with this elbow wound, Alice experienced another, undocumented, injury that records indicate was a direct result of conflict between her and hospital staff. In a letter sent directly to Dr. R. E. Lee Steiner, the Superintendent of the Oregon State Hospital, an anonymous hospital staff member discusses an abusive incident which occurred between Alice and the "charge," likely the charge nurse on the ward.[95] The letter urges Steiner to talk with Alice, about a particular incident, specifically, "who cut her head with her Door Keys"[96] The letter describes another physical injury that Alice received as a result of apparent control. The correspondence insinuated that the "charge" purposely cut Alice's head and that there are other possible cases of abuse or injury. In the letter the writer tells Dr. Steiner that he should speak with Alice about her treatment and that Alice could speak about her abuse.[97] The belief that Alice was mentally aware enough to speak about her abuse indicates that the writer believed Alice was not delusional. Rather, she had awareness of her surroundings and could enlist her agency through her voice if given the opportunity. The control placed upon her by the hospital staff restricted her ability to exercise this agency.

Both of these injuries show points where restraint and control of Alice moved past treatment. She exercised her agency through resistive behaviors. In reaction to these behaviors Alice was disciplined. The wound on her elbow and the scratch on her head both crossed the line of punishment. Rather than simply mitigating her impact on the ward and staff, the restraint became abuse, where Alice was physically injured as a result of her behavior. An incident resulting in a patient's physical injury is also present in Helen's case file.

[95] Anonymous letter to Dr. Steiner, File 3958.
[96] Anonymous letter to Dr. Steiner, File 3958.
[97] Anonymous letter to Dr. Steiner, File 3958.

Helen's Continued Notes section and correspondence with her family notes injuries. These records indicate that Helen received a "intracapsular fracture of the left hip." When she "voluntarily threw herself on the hard floor" on her way to the water section.[98] Records indicate this was a result of her "resistive" behavior, however there is little evidence to suggest Helen was capable of being that resistive. The resulting fracture left her with a left leg that was two inches shorter than the right and was rotated inward.[99] The water section described in the notes is the area where patients received hydrotherapy treatments. As described by Braslow, these treatments were a natural extension of the restraint which Helen was consistently experiencing.[100] This incident marks another conflict which occurred between a patient and hospital staff while they were attempting to administer a therapy. While hydrotherapy was seen as a replacement for restraint, due to Helen's resistive behavior the staff reverted back to controlling her body.[101] This altercation also resulted in a direct injury to Helen's person. Similar to Alice's elbow, her injury would affect her through the rest of her life. Both were noted on the death records of the patients. Both personal injuries highlight points where hospital staff's attempts to control their patients resulted in that patient being maimed. The injuries Helen and Alice received are both points where hospital staff's restraint of their patients moved past control. The injuries were the result of abusive behavior from the staff. Abuse which was a reaction to the resistive behaviors and expressive agency of Alice and Helen. The Oregon State Hospital's control over the patients extended past restraint and entered into patient's sexual agency.

Alice entered the Oregon State Hospital at a relatively young age of 26. The hospital continued to inflict their control over her body when they referred her to the State Board of

[98] Continued Notes 1, 1931, Box 55, Folder 48.
[99] Autopsy Record 2, 1949, Box 55, Folder 48.
[100] Braslow, *Mental Ills*, 45.
[101] Braslow, *Mental Ill*, 45.

Eugenics in 1930.[102] The board recommend a ovariotomy, a removal of the ovaries, but the procedure was not performed on Alice.[103] The removal of Alice's ovaries would have been an even stronger expression of the State Hospital's control over her. A eugenics procedure would have superseded her personal agency and ability to resist treatment. Her resistive behavior caused hospital staff to restrain her constantly. This superseding of her agency was evident in Alice's inability to decide to receive this operation or not to have it. This recommendation of Alice to the Eugenics Board is evidence of their control over her.

Considering Alice was already sterilized via "… re-section of the Fallopian tubes…" the choice to recommend her for sterilization is possible evidence of two items.[104] The first, is that hospital staff was using the Eugenics program to implement further control over Alice, that removing the ovaries would help reduce her extreme behavior. This was different than the rationale presented by Braslow. Braslow states that physicians believed sterilization removed the "psychological and social strains of childbirth and parenthood"[105] This doesn't relate to the case of Alice. She was already a mother, was already sterilized, and was not likely to ever leave the hospital. The other option was that hospital staff recommended Alice to the Board of Eugenics without consciously knowing that she was already sterilized. This option shows either the staff was unconcerned with the patient's history in terms of their future treatment or that staff was recommending such a large volume of individuals to the Eugenics Board that her case was able to slip through the cracks. Alice's possible ovariotomy would have made her one of the thirteen women sterilized at the Oregon State Hospital in 1930.[106] The recommendation for an

[102] Continued Notes 2, 14 January 1930, File 3958.
[103] Continued Notes 2, 14 January 1930, File 3958.
[104] Continued Notes 1, 17 August 1927, File 3958.
[105] Braslow, *Mental Ills*, 66.
[106] Largent, "The Greatest Curse of the Race," 204.

involuntary ovariotomy was a further extent of the control the hospital had over Alice's body. The attempt to sterilize Alice is the ultimate form of control. Physiologically changing her body in reaction to her behaviors. Behaviors which were expressions of Alice's agency. In order to curb Alice's ability to exercise her patient agency they attempted to alter her sexually and her physical body.

Conclusion

Alice and Helen entered the Oregon State Hospital in 1927. Both presented behaviors that were outside of the morally-centered female norm. These behaviors included yelling, screaming, running, dancing, laughing, and violent outbursts. Treatment of these patients was in reaction to these behaviors. Specifically, hospital staff used restraint to control the physical bodies of these patients. Full and partial restraint, hydrotherapy treatments, and sexual sterilization were techniques used to control their patients. Alice and Helen were both given negative prognoses with no hope of improvement. One from an unknown case of "acute mania" and the other of "general paresis." This negative view of their conditions meant that hospital staff simply attempted to mitigate their influence on the wards. This mitigation became the primary focus and their treatment was not designed to help their mental illnesses. Both women died in the Oregon State Hospital. They passed away after multiple months, even years restrained to their beds. This restraint straddled the line between treatment and abuse. Helen and Alice received injuries that affected them physically until their death. These injuries were a direct result of exercising their limited agency and resisting treatment. Helen's broken hip was a result of her resisting a hydrotherapy treatment. Alice's wounded elbow and scratch on her head were a result of her being restrained for her erratic behavior. This attempt to control Alice's behavior extended even

to her physiology, where hospital staff attempted to remove her ovaries. Oregon State Hospital staff chose the treatment of consistent restraint based on Helen and Alice exercising their limited patient agency.

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