"You Had To Just Kind Of Rub Her Cheek": Memories and Emotions of Mental Deficiency Nurses in Alberta, Canada, 1945 - 1975

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Introduction

Mental deficiency nursing evolved as a specialty field of nursing established in institutions for people with developmental disabilities in several countries at the beginning of the 20th century. In Canada, it became a separate area of nursing education and practice in only one province, Alberta, and it was tied to one large institution designated for developmentally disabled children located in Red Deer. This institution, initially established as a mental hospital for veterans of the World War I, was repurposed in 1923 as a provincial training school (PTS) for mentally disabled or handicapped children, then considered to be "mentally deficient." From the outset, the PTS was conceived as a medical facility, part of the provincial mental health services branch and headed by a medical superintendent. Eventually the PTS also was home to developmentally disabled adults (King et al., 1988).

Alberta was the only Canadian province that established within this institution a distinct nursing education program in so-called mental deficiency nursing, which opened in 1932. The program was modelled after similar training schools in psychiatric nursing which were established in the provincial mental hospitals around the same time, as part of a broader mental hospital reform initiative in Alberta (Boschma et al., 2005). Reform-minded psychiatrists initiated the three-year certificate program in mental deficiency nursing at the PTS, likely modelled after similar examples in Britain and Ireland. The physician couple David and Mary McCullough, appointed to direct the PTS in 1931, came from Ireland (King et al., 1988). Other Canadian provinces did not make such a distinction. In Ontario, for example, at the provincial institution in Orillia, later called Huronia Regional Centre, which was also designated for developmentally disabled people, the nursing personnel seemed to take part in the larger mental or psychiatric nurse training school structure established in mental hospitals (Simmons, 1982; Stainton, 2006).

In 1935, the first graduates received a diploma as a mental deficiency nurse (MDN). The mental health services branch of the Ministry of Health issued the diploma in mental deficiency nursing independently from the Alberta registry for registered nurses, and similar to the way the branch issued diplomas in psychiatric nursing. Despite efforts of the psychiatrists to have the nurse training programs at the mental institutions recognized by the Alberta Association for Registered Nurses (AARN), such negotiations had failed. Not only were mental institutions perceived to be of lower status than the general hospitals at which registered nurse training was established, but the largely female AARN leadership was already well established as an independent, self-regulating body by the time the mental hospitals considered the establishment of training schools in the 1930s (Boschma et al., 2005). The AARN was unwilling to open up their registry for graduates from mental institutions. In Alberta, as in other western Canadian provinces, the formation of psychiatric nursing and mental deficiency nursing was never integrated into the educational structure for registered nurses as had happened in eastern Canadian provinces decades prior (Boschma et al., 2005; Hicks, 2011; King et al., 1988; Tipliski, 2004). Whereas western Canadian provinces eventually developed their own registries for psychiatric nursing, the mental deficiency nursing program remained more locally based and uniquely tied to the PTS in Red Deer. The School of Mental Deficiency Nursing at PTS remained in existence for 40 years, until 1973, when a newly elected government initiated a broad-based reform of both the education and the health care systems, and the program was discontinued. The institution itself was renamed Michener Centre. By then, 453 MDNs had graduated from the training program (King et al., 1988).

The work and education of mental deficiency nursing students forms a unique part of nursing and Canadian history. Rather than an institutional history of the mental deficiency nursing program at the PTS, however, this article contributes a different perspective on MDNs' work and education. Drawing upon a small group interview, conducted in 2008 with three mental deficiency nurses who had been enrolled as students in the MDN training program and worked at the PTS in the decades after World War II, the main purpose of this article is to explore the history of mental deficiency nursing education in Canada through the lens of oral history.[1] The main research question guiding the analysis was how the MDNs' experiences, memories, and emotions, as conveyed in the interview, reflected larger social and cultural trends in nursing education, as well as in the institutional care of people with developmental disabilities. In the experiences of the MDNs, larger social developments can be recognized and understood within the context of the time they worked at the PTS. All three interviewees, Carla, Kathy, and Tim (pseudonyms) worked at the PTS for only a relatively short period between 1946 and 1966. Kathy and Carla obtained a diploma from the mental deficiency nursing program in 1951 and 1961, respectively. Tim worked there for a little over a year in 1950 but then left. Their memories provide a valuable glimpse into the history of mental deficiency nursing.

Background

Although no longer existing in Canada, in several other countries the specialty area of what once was called mental deficiency nursing has evolved and is currently typically referred to as learning or intellectual disability nursing. In the United Kingdom and Ireland, for example, learning or intellectual disability nursing has become a registered nursing specialty, with its own distinct registry and nursing education programs (Doody et al., 2012; Sweeney & Mitchell, 2009). The term developmental disability is also used. In the United States, nurses can obtain a certificate in developmental disability nursing, also called special needs nursing, following their registration as registered nurses or licensed practical nurses (Nehring, 2003, 2010). In New Zealand, institutions for people with a developmental disability were renamed psychopaedic hospitals in 1963, and a registry for so-called psychopaedic nurses trained in the care of children with intellectual disabilities was established. It was discontinued in the 1970s (New Zealand Hospital Design and Evaluation Unit, 1979; Prebble, 2007). In the Netherlands, a registry for developmental disability nursing was implemented in 1957. At the turn of the 21st century, this designation was transformed into a generic role of guidance counsellors, no longer specific to nursing (Hendriks & Timmerman, 2012).

We know little about the history of this branch of nursing from a first-person point of view. Sweeney (2011), Sweeney and Mitchell (2009) and Mitchell and Rafferty's (2005) work on the history of intellectual disability nursing in the United Kingdom and Ireland form some of the few exceptions. The idea of people being "mentally deficient" is now considered outdated, reflecting eugenic views of mental degeneration that are no longer acceptable. In the first half of the 20th century, however, it was a prominent view within the mental hygiene movement (Dyck, 2013). In the United Kingdom, the passage of the Mental Deficiency Act in 1913 sparked the establishment of separate institutions for people so deemed, which were branched off from mental hospitals (Mitchell & Rafferty, 2005). At the time, institutionalization was seen as progressive, contributing

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[1] Interviews with Carla, Kathy, and Tim (pseudonyms) by author, February 27, 2008.

to the prevention of mental deficiency and racial degeneration. Following World War I, the Alberta government took up the example of the British approach with an ambitious mental hygiene agenda (Dyck, 2013).

Until the 1940s the PTS remained a relatively small-scale facility for about 200 children. From 1931, the physician couple, David L. McCullough and his wife Mary led the facility, based on medical and pedagogical principles of prevention and training, and rooted in ideas of mental hygiene. While medical care and hygiene were essential in the care of severely physically and mentally handicapped children, the McCulloughs also initiated pedagogical approaches, particularly for children deemed receptive to education. Expanded activities for the residents included the initiation of summer camps, and, by the end of the decade, the purchase of an adjacent farm. The latter purportedly provided more training and work opportunities for some of the more able residents, whereas farm work also helped sustain the PTS economy (Alberta Social Services and Community Health, 1984). At that time, typically, mental institutions included a farm to provide dairy and produce. Residents who were able to worked on the farm as they did in any of the household departments, such as the kitchen and the cleaning and laundry departments (Cellard & Thifault, 2006; Reaume, 2006).

Because of the influence of the mental hygiene movement, which took firm root in Alberta in the late 1920s, the provincial government took careful note of the 1929 Canadian National Committee for Mental Hygiene's (CNCMH) report on the status of Alberta's mental health facilities, supporting improvements in the psychiatric program, in line with eugenic beliefs, including better staff training. To accommodate this goal, the MDN program was established with the dual aim to enhance capacity and recruitment of personnel (King et al., 1988; LaJeunesse, 2002). During the Depression, as well as in the decades after World War II when hospitals and institutions alike faced severe shortages of personnel, the competitive salary offered at PTS and the board and lodgings were investments in students whose primary role was to deliver nursing care and oversee the overall caretaking of the residents. Not unlike nurse training schools in other institutions, the MDN program became a resource to secure the necessary leadership within the institution, while it simultaneously served as a way to recruit staff and enhance its status. Significantly, the list of the first seven graduates from the program in the mid-1930s indicated how they immediately obtained roles as charge nurses of the wards, while one was appointed assistant matron (King et al., p. 35). One of them, Jean Cleven, noted in the commemorative history: "I joined the staff of the PTS in 1932. It was during the depression and jobs were hard to find, so I was very fortunate to find employment . . . besides room and board and uniforms, along with our salary we were given government vouchers. We worked twelve hour shifts. . . . I was charge nurse on the second floor with the [resident] girls for a time, then transferred to the third floor with the [resident] boys, where I remained until I left in 1940 to go to Edmonton [to work at the mental hospital there]" (King et al., p. 36).

These measures to enhance the education and status of personnel intertwined with the eugenic idea of prevention of so-called "feeble-mindedness." Particularly among the middle class, fears of assumed human degeneration, allegedly spreading among lower and immigrant classes, had generated support for this movement. It also received support from settlers struggling to make ends meet and for whom care of vulnerable family members was often challenging (Boschma, 2008). The majority of requests for admission, according to McCullough, pertained to "low-grade, helpless and crippled children—the type of case that, once admitted, is generally here for life" and

for whom designed infirmary wards staffed by MDNs seemed a useful measure to enhance the facility (King et al., p. 13). The indication of "low-grade" relates to a medical classification that was common up until the 1960s: classifying the mentally disabled population into certain levels or grades of "defectiveness," that is, idiots, imbeciles and morons, referring to a sliding scale of intelligence (Dyck, 2013). These notions were part of a common medical framework no longer in use that also structured the institution's organization, with units ranging from ones for largely bed-ridden, severely physically and mentally handicapped children to residential units where residents were involved in some rudimental pedagogical training or work on the PTS grounds.

Steeped in these class- and race-based fears about the alleged degeneration of the provincial population, then counting about three quarters of a million people, the province of Alberta passed a eugenic *Sexual Sterilization Act* in 1928, with the goal to prevent procreation of people regarded as "unfit" for society. A Eugenics Board was established to review cases of people deemed mentally defective, and the public health branch became involved with screening alleged cases of feeble-mindedness, within the school system, for example, and facilitating their admission to PTS. At guidance clinics, established for the purpose, public health nurses assisted with screening and "case finding" (Mansell & Hibberd, 1998; Samson, 2014). From current historical evidence, it appears the public health nurses had no interaction with MDNs (Mansell & Hibberd). They operated as two distinct fields of work, likely not only shaped by the power and status differentials between these groups, but also reflecting the relative social isolation of the mental institutions. Nursing jobs within the mental health branch did not have the same reputation and status as those of the culturally more highly regarded public health nurses, who, even among the class of registered nurses held an elite status. Furthermore, public health and prevention work and mental health work were structurally embedded in different governmental departments.

The practice of sexual sterilization remained in place until 1972. and many PTS residents were subjected to it (Grekul et al., 2009; Park & Radford, 1998). While such practice was not unique to Alberta, the scope at which sterilization was applied, the removal of informed consent from the Act in 1937, and the fact that the Act was not repealed until after the defeat of the Social Credit government in 1972 certainly were (Clarke, 2004; Dyck, 2013). Its entanglement with eugenics politics shaped the institutional context of PTS and further compromised the public perception of the institution once the perspective about institutional care changed in the 1970s.

In the post–World War II era, change was spurred on by postwar economic growth, the start of a welfare state and renewed public entitlement to the alleged fruit of scientific and technological advancement. Still, the beginning of a welfare state, which included expansion of health services and a postwar commitment to human rights, generated contradictory trends (Mullally et al., 2019). At the PTS, the post-1945 era resembled continuous institutional expansion and public belief in the merit of the institution. In fact, in the 1950s and 1960s parents were encouraged to place their developmentally disabled children in institutional care. At PTS, the arrival of a new medical director, Leonard Jan LeVann, appointed in 1949, signified this new era of scientific and medical ambitions. Strongly promoted by LeVann, it also included an ambitious program of research still steeped in eugenic ideas (Alberta Social Services and Community Health, 1984; Dyck, 2013; Pringle, 1997). PTS underwent significant expansion during the 1950–1970 period. With the additional opening of an adjacent facility for adults, called Deerhome, residents numbered over 1000 by 1958. By then, 54% of the residents at PTS were over 15 years of age (King et al., 1988, p. 17). About 10 years later, by 1970, the institutional population had doubled

once again to 2000 residents (see Table 1). In that year, the total population of Alberta was about 1.5 million. The MDN program expanded as well, with an intake of 40 students per year to meet demand. Whereas until the 1950s newly hired caretaking staff had not been required to take the nursing course, by 1954 the program had become mandatory for all staff recruited for nursing positions, which seemed in line with LeVann's ambitious agenda (King et al., 1988).

Table 1

Resident Population at Michener Centre in Red Deer, Alberta, 1940–1972

Year	Training School	Deer Home	Total
1940	216		
1952	425		
1955	698		
1956	698		
1958	758	335*	1,093
1960	756	811	1,567
1965	861	1,134	1,995
1967	977	1,228	2,205
1970	800**	1,214	2,014
1972	813	1,195	2,008

Source: Alberta Department of Health, Annual Reports, 1940, pp. 90–91; 1953, p. 157; 1956, p. 90; 1957, p. 95; 1958, p. 112; 1960, p. 131; 1965, p. 159; 1967, p. 118; 1970, p. 94; 1971–1972, p. 29.
Notes: * newly opened in 1958; ** in residence, on the books were 1,028, some of whom resided in a new pediatric unit opened at the Baker Memorial Sanatorium in Calgary in 1968.

By the time Kathy and Tim started to work at PTS, in 1946 and 1950, respectively, the context of their experience was shaped by this enormous expansion and the strong medical orientation LeVann imposed upon the institution. Moreover, the provincial mental health policy had shifted. Admission to PTS had increased because of the downsizing of mental hospitals starting in the late 1950s. The goal to move them into acute psychiatric facilities implied trans-institutionalization of people not perceived to be susceptible to cure (Boschma, 2011). Other factors, such as the advent of psychotropic medication in the early 1950s, also brought change as more disabled children began to be subjected to treatment with new medications. LeVann transformed the institution into a facility on a tight rein. He attracted new professionals such as a psychologist, a social worker, and an occupational therapist to expand screening and sense, occupational, and vocational training of selected residents (Dyck, 2013). He also introduced a regimented medical order and initiated experimental research on use of medications, as well as expansion of the eugenic program in close alliance with the Eugenic Board. In fact, his expertise in psychiatry was limited, and he largely drew on his experience in military medicine, surgery, and anesthesia in the changes he brought about (Dyck, 2013). MDN Ruth Harmon remembered the transition. She noted how the McCulloughs had a "pleasant 'good morning' for even the junior staff," on their daily morning rounds, "and didn't object to stepping around scrub pails in the halls," but after LeVann was appointed, "changes took place quickly, including no scrub pails in the halls and all wards shipshape by 10 am" (King et al., 1988, p. 52). High turn-over exacerbated the continuous shortage of health care personnel in the post–World War II era.

Although Kathy and Tim worked at PTS around 1950 while Carla did not start the program until 1957, the overall institutional context remained much the same during this period. Provincial politics changed in 1972 when the newly elected conservative government of Peter Lougheed replaced the Social Credit government, in charge since 1935. The *Sexual Sterilization Act* was repealed that same year and new leadership to the mental health branch changed the institutional context. Le Vann retired in 1974, and downsizing and upgrading of the PTS began with more attention to community care (Dyck, 2013). The institution was renamed Michener Centre. The MDN program closed a year later, in 1973.

From the late 1960s onwards, a growing liberation and human rights movement prompted a social and cultural critique on large institutions, calling for downsizing and de-institutionalization, fuelled by anti-psychiatric objection to authoritarian medical hegemony, lack of patient and parental rights of mentally disordered or disabled citizens, and continued underfunding of care. The critique shifted the collective understanding of mental institutions, including the PTS, with a public outcry over its poor conditions (Boschma, 2011; Dyck, 2011; LaJeunesse, 2002). These transformations affected not only institutionalized children and adults but also the people working in the facilities. The stories of Kathy, Carla, and Tim show how the changing view on institutions also changed the legacy of PTS and put their past work in a very different perspective. Moreover, by 1996 public controversy over the eugenic history at PTS reached a new level in Alberta, when former PTS resident Leilani M. Muir won a lawsuit against the Alberta government for her wrongful sterilization (Wahlsten, 1997). Other cases also went to trial, drawing extensive media attention to the history of PTS (McGovern, 1996; Pringle, 1997). Several MDNs had been called upon as witnesses. In other provinces, lawsuits were launched as well on behalf of former residents of institutions for people with developmental disabilities to seek an apology and compensation for humiliation, traumatization, and abuse they had experienced while institutionalized (Rossiter & Clarkson, 2013; Shaw, 2018). The interviewees' stories, shared in an interview *after* the trials, were clearly affected by these developments. Although the trials happened long after the interviewees had left PTS, they clearly had shaped their memory.

Methodology: The Lens of Oral History and Memory

Oral history provides a valuable opportunity to enhance our historical understanding of the relationship between personal experiences, memory, emotions, and collective history (Leydesdorff, 2004). In the oral history interview, the three MDNs made known and visible their subjective experiences, memories and feelings about their work at PTS. The complex history of the PTS also makes remembering complex. Interviewees remember what is important to *them*, what they want to share, not necessarily whether that is right or true (Boschma et al., 2008). Stories, once seen as too subjective to serve as historical evidence, are now valued for what we can learn about what people thought and felt, particularly *because* they offer a perspective of subjectivity and multiplicity of truth (Thompson, 2000). In oral history, the quality of the information shared is not so much related to the number of oral history interviews, Leydesdorff (2004) points out, but rather, an essential indication for the quality or explanatory power of the analysis is whether the interview is informative and enables or allows for insight in larger historical processes. By means of an analysis of memories and emotions shared in an interview, we are able to obtain a glimpse of the cultural meaning of important aspects of nursing work in the institution and with this population. Emotions matter and represent cultural and historical meaning (Burke, 2001; Harding, 2010). As such, the analysis of these stories makes visible the larger social ambivalence about care

of people with mental disability. The analysis of the group interview was part of a larger historical research project on the history of mental health care in Alberta and was augmented with published and archival documents. A commemorative history of the Alberta Mental Deficiency Nurses Association offered an additional set of short first-person commentaries and memories of MDN graduates (King et al., 1988).

Oral history is both "a framework or analytic model and a methodology" (Boschma et al., 2008, p. 81). Often it is used to draw attention to micro-history or people's experiences in their ordinary day-to-day lives. Some scholars use this model from an activist stance to counteract a dominant view by sharing developmentally disabled people's voices and perspectives typically not taken into consideration or overlooked in history (Atkinson et al., 1997; Dyck, 2013). In this article I use a narrative perspective of oral history in which the story and conversation is analyzed and interpreted for the meaning conveyed in the language and process of storytelling. In stories, people order and reorder their past mediated through experiences, memories, and interaction. The researcher examines and interprets the meaning that the experiences and memories had for the interviewees and the story they want to tell (Boschma, 2012). In both approaches, it is important to interpret the story within the context of the time and avoid presentism and not impose current values and beliefs onto the past (Connor, 2017). Malacrida (2015) for example, in a recent examination of institutional life at the PTS, describes the place as hell and nurses who worked at PTS as self-interested agents of control, offering a perspective that leaves little space to explore the story of nurses who worked at PTS within the context of its time or on their own account. Referring to the latter work as a case in point, Connor (2017) notes how presentist perspectives often serve a political agenda rather than offering a historical analysis. PTS was a complex place and circumstances difficult, whereas organizational structures were custodial and controlling, and people's interactions were circumscribed by the cultural resources available to them. Remembering, therefore, is equally complex (Prebble, 2015). Oral history provides one avenue to explore how people made sense of working at PTS then and how they remember it—holding back judgement, while trying to listen to what people have to tell (Anderson & Jack, 2006).

The interviewees' memories were shaped not only by the time they worked there but also by the increasing public controversy over institutional care and Alberta's eugenic policy later on. Their work at the time and later perceptions had left them with mixed feelings, but they also recounted some good memories and stories. Memory is not neutral. By paying attention to emotions, either recalled or transmitted in the interview, new knowledge about the meaning of disability nursing can be developed and critically appraised (Bornat, 2010). They also contribute to the history of eugenics of which mental deficiency nursing was an integral part (Samson, 2014).

At the time sterilization happened at the PTS, the MDNs were typically not informed or involved in any decision making, nor were the residents. Still, the interviewees were certainly aware the practice existed. Nurses assisted in the surgical procedure. Decades later, however, facing trials and public dispute, they suddenly found themselves confronted with a very different public response and shifting consciousness, recasting their careers as being complicit in these actions. Kathy's, Carla's, and Tim's accounts underscore these circumstances. A certain apprehension shaped the start of the interview. The analysis of their stories centres on three aspects: (1) they provide insight into MDNs initial motivation to take on a job and training as mental deficiency nurses, (2) they highlight their perceptions and emotions over their work with the

residents, remembered some 60 years later, and (3) they throw light upon the way the interviewees remembered the sterilization program.

The Nursing Program and the Appeal of Paid Employment

As was typical for most nursing students coming to work at PTS, the interviewees came from families of moderate means or were new immigrants. They applied for a job at PTS primarily for economic reasons. Kathy recalled:

> Well to go into [general hospital] medicine [for nurse training] I had to go to Calgary which was a long way then and my mother wasn't that well and plus you only got ten dollars when you went into training for [general] nursing. Then you got about twenty-eight at [PTS], [and it was] close, I could even walk [the eight miles] home which I did once in a while so I could help at home—so I decided to go there.

Having a paid job was an economic necessity for Kathy's family. She began working at PTS in the summer of 1946 as a kitchen help at age seventeen. After that summer she completed her last year of high school and then enrolled in the MDN program as a student. Sadly, her mother passed away within a few years. At that point, Kathy's income as a student nurse became even more essential to the family economy. While she was willing to quit to help out at home because of her younger brothers, her father wanted her to stay at PTS and have her pay for the room and board of one of her brothers. He had to board with a family in Red Deer to go to high school: "but my dad said well . . . I can't pay you, you're paying [for] yourself and your brother's board and room, and if you can just, help me out on your days off, and so that's the way we did it."

Beyond a small salary, the PTS also provided room and board: "I made 113 dollars a month and they paid for my room and board and uniform," Tim noted. He needed a job when he joined his family in Alberta as a recent immigrant just after the war: "I was in a bit of a situation where I needed a place to stay and so they had a residence, . . . that's what brought me to the PTS." Carla added: "And [they paid for] your food." They all agreed on the economic advantage: "That is why I went there too," Carla recalled. She started to work at PTS in 1957. In the postwar era, there was a continuous shortage of and demand for health care personnel.

Still, they remembered with caution. At the beginning of the interview, Carla showed her graduation pin somewhat hesitantly, guardedly stating how "mental deficiency nurse" was such an odd term. On the other hand, the pin symbolized her status and skill as a nurse. She recalled, when her kids much later learned she had not only worked at the PTS but also obtained a diploma as an MDN, they had been pleasantly surprised: "Mom, they had said, you are actually a nurse." Tim remembered how his short period of work had given him income and comradery:

> Well you had a lot of good friends [at PTS], it was a real good relationship amongst the staff and the guys were all in one area, . . . they would play cards, they would do everything and then there was a gym there, where you could do your sports and they had sort of a conference room where the girls and the guys [met] . . . you didn't have to worry about a thing.

Maintaining a certain status quo and not seeing improvement or recovery among the residents, however, were aspects of the work he had found difficult: "You know you're there all day long and all you're doing is maintaining and nobody is going to get better." The fact that their caring work was not tied to a culturally more highly appraised medical context of cure or recovery

and the severely handicapped status of many of the residents had shaped their experiences (Mitchell & Rafferty, 2005). Tim soon found other job opportunities and left PTS within about a year. Kathy and Carla both stayed and obtained a diploma. Despite the economic advantage of the readily available jobs, the experience had not been easy.

Memories and Emotions

Several emotions stood out in the interview: fear, compassion, pride, perturbation, and mixed feelings. First, I focus on the fear that interviewees recalled they experienced in their initial encounter with the residents: fear of the unknown. In a sense, their fear reflected the cultural othering that shaped the life of the residents. Once they got used to the circumstances and severe handicaps of the residents, the interviewees overcame their fears and developed compassion, shaping their identity as nurses. They recalled some of their interactions with the residents and took pride in the skill they had developed, but also remembered aspects they had found difficult or unfair. Despite their ambivalence, they had liked certain aspects of their nursing work with the residents. Second, I examine the interviewees' mixed feelings about the silence that was kept around the practice of sterilization and the way it affected the residents at PTS. What stood out in their perspectives and memories was the little say they had in these affairs. They insisted their work must be understood in the context of the time.

Fear and Compassion

Kathy recalled how she "started on the wards and it was a little shocking at first when you'd see some of these poor little children that were so badly deformed and you'd never seen them before." She remembered being sent over to ward six or seven: "Some of the children were so badly deformed," she explained. "I remember this one child had this hydrocephalic head and I'd never seen anything like that."[2] She had felt fearful and her first impulse probably had been to run away, because she noted: "It takes a lot, it cleared after a week or two and my mum said to stay there for another week or two and maybe get used to it . . . which you did, you know, *you got to accept it*." The acceptance had not come automatically nor easily. Kathy had to push herself, gently encouraged by her mother, taking an active stand in giving herself some time to adjust and to decide whether to stay or not. Accepting the nature of their work had been a conscious decision, pushed to awareness in their encounter with the children. Carla added that she initially had been most fearful:

> I was a real chicken, and I would stand in the dayroom and if whoever I was working with went for a break I would stand by the door and I'd have the key in the door and I thought if some of these people come close to me I'm out of here . . . it was scary, eh?

The unknown made Carla feel uneasy and fearful, a feeling that gradually faded. Once she understood what she could expect or how the children were likely to behave, "I was not scared at all," she said. She started to work at the infirmary, newly built in the late 1950s. The interviewees' emotions reflect the larger cultural process of othering that, even if unintentionally, creates a divide, expressed within distancing behaviours or differing norms. Their responses also reflect

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[2] This condition entailed enlargement of the head and brain deterioration caused by abnormal increase of fluid under the skull.

how interaction may have served to overcome such fears or to create cultural space to develop relational understanding and connection.

As Carla grew familiar with the work and the residents, her compassion also grew, as did her understanding of the wider social forces that shaped the circumstances of the residents' lives:

> I remember too, you know, there was [this] little girl, she couldn't see, she had no eyes and she hardly [could] hear, so when you fed her you had to just kind of rub her cheek and she would understand . . . but apparently her mother had had syphilis and she was abandoned but she lived till she was about fourteen, fifteen.

In this one sentence, Carla shared the way her compassion had been triggered through daily interaction but also seemed to have been challenged by larger social influences: the particular little girl was not only physically disabled but also framed or known to be an abandoned child, implying she had a mother who was unable to care for her—a very mixed gendered message—and perhaps considered a child who would not live for long. From the story, it was not clear how Carla knew the girl's life had been short-lived; she might have died while Carla worked there or perhaps many of the severely handicapped, bedridden children generally died at a young age. Carla's emotions—as conveyed in that one sentence—seem to reflect pity but also agony, if not anger, towards the child's isolation and the abandonment the institution represented. Spending time to feed the child was a core interaction nurses engaged in daily, gently patting her cheek to do so successfully. The daily interaction had created a connection that stood out in Carla's memory. Other MDNs also described how their initial encounters, although shocking at first, had instilled them with learning that had lasted a lifetime. Lloyd Bystrom, for example, vividly remembered his first moments in the job, even after 30 years. He began working at PTS in 1958. While being introduced to the male nurses in charge and to the ward, there was a "very deep voice of a very large person calling everyone within hearing distance a 'low grade.'" The comment suggests that he might have been troubled by the stigmatization implied in the act of calling a human being a "low grade." The tone and voice, it seemed, also suggested a military-like, hierarchical structure. The next 15 minutes, he recalled, he had to change into a white uniform, received a quick tour of the ward, and was educated on "how to make a bed—or 38 beds to be exact," and off to work he went. "My first 15 minutes of employment [at PTS] was probably more education to a young man straight off the farm than the average person gets in twenty years regardless of what they do," he noted (King et al., 1988, p. 67). Bystrom worked on and off at PTS for 15 years.

Pride and Perturbation

In describing some of their work with the residents, the interviewees expressed a belief in having delivered good care considering the circumstances, which they also recognized as complex and not without inconsistencies. Their work had been shaped by the medical framework and strict discipline that dominated the institution in the 1950s and 1960s. The students were expected to keep wards tidy and in order: "They had these bedspreads, Kathy recalled, that had trees on them and when you had to make the bed [the supervisory nurse] would come in . . . and all the trees had to line up." Nurses were drilled on doing this every morning. The interviewees agreed that some of these norms stemmed from nurses' past experience in the military. One of the supervisors "was an army nurse from England so, yeah, it made sense, you know," Kathy pointed out, whereas Tim remembered the rounds, further underscoring a medical order: "One of the supervisor nurses, you know, [or] the matron they would come every morning and make the rounds and they might see if

they could find any dust anywhere." Carla noted the emphasis on a good outlook: "But all the trees [on the sheets] had to be straight, had to have a good outlook." Rounds were always "a big to-do," Kathy recalled, but the strict discipline was not always linked to a check on care: "But they never checked under the blankets to see if the kids had been changed or anything," Kathy noted with a laugh. Their conversation underscored how a mixed medical and military regimen of supervision, inspection, rounds, and a clean outlook powerfully structured their work whereas the strict rules did not always seemed to make sense.

Their classes were embedded in a medical hierarchy. Most classes were taught by the doctors—either those (two) from the institution or "from downtown," Kathy and Carla recalled—the local physicians in Red Deer who helped out with the medical care at PTS but apparently also assisted with the education of the nurses (King et al., 1988, p. 18). They remembered the categorization, which determined ward organization. It was based on IQ levels Tim recalled, "idiot, imbecile and moron and they talked about high grade and low grade—in those categories." Almost apologetically Carla mentioned: "All you hear us talk about [is] morons and high grade, low grade, but that's how you spoke then." It seemed she wanted to emphasize that such language was part of the context of their work. Uniforms enforced a medical outlook, but also were a source of pride. "Oh yes," Kathy remembered, "[we all had uniforms] and were we proud of them, the first year you had the blue, eh, like the regular uniform, and the second year you got this bib with the white skirt and a white apron and . . . white cap, and the third year you would get the white uniform … then you were all in white." To them, uniforms symbolized the cultural value of their education and in a sense acknowledged their skill.

Carla remembered they were not allowed to access files and nurses had little information about the background of the residents, which she felt was not right. About her work in the ward where "high grade" girls went off to work as servants in town during the day, Carla noted: "With a little bit of help . . . [they] might have succeeded a lot more in life, but you don't know where they came from, you know." She could not relate as meaningfully to the girls as she would have liked. Her main task was to record the times the girls left and returned, for example, which in retrospect she had not found very satisfying: "You were basically babysitting." The way their work was structured, nurses did not have much chance to become familiar with the background of their charges, except "only sneakily; but other than that nobody really told you anything, hey?" Carla recalled. Even after all those years, one could still sense a certain level of frustration about such silencing.

On the other hand, they also had some good memories about their work. Conveying how they had been able to build community and connection with the children was important to them, perhaps to emphasize how they had felt their work had been worthwhile. Kathy recalled how she developed affection for the children: "Some were really lovely, you know." She remembered "one little boy, every morning he used to insist on setting the table, he was just a little fella and I let him do it . . . somebody had taught him good at home; he liked doing it and you might as well let him do it, you know." Carla recalled how one resident loved it when they sang a song with her; she sometimes also helped out because of her strength. How to go about involving this resident in such work reflected a fine line between care and control, which Carla seemed to have understood and wanted to bring across: "This resident could not leave the dayroom on her own, but the kitchen staff knew of her physical strength and sometimes asked us to come over with her," Carla recalled, so she could help with some heavy lifting, "and then we get her back in the dayroom." Probably

aware such interaction could be explained as misuse as much as it could be seen as an acknowledgement of the person's ability for which she was valued, Carla commented: "But if somebody had told me that's how you'll interact with them I would have said never, but, you know, once you got over that fear." It seemed Carla wanted to emphasize how despite the constraints of the institutional context and control, a certain level of care and sense of human connection was also present. It also seemed they saw involvement of the children in chores as a normal part of life, as was setting limits to some of their behaviours. Carla remembered that "you always had your mongoloid[3] children come [to the infirmary to help out with feeding] . . . they all had their friends . . . like they always knew who they wanted to feed." Yet staff had to carefully monitor these interactions, Carla recalled, because sometimes the kids who helped would eat the food of the kids they fed: "You always had to watch because they'd love to eat [the food] themselves." If they had done so, they knew they could not come in for a day or so: "You'd see one standing outside and you'd go 'hey, Louise, are you not coming in?' 'No, I can't today.' 'Oh, you've been eating . . . Joey's food again' . . . [and you] said, 'well, you make sure you don't eat Joey's food, then you can come.'"

They saw the connection with the children and them being involved in work as a good side of things: "Yeah, so there was a lot of interacting," Carla emphasized, while Kathy noted: "Once you learned the steps there, you know, the children and their troubles then you did [like the place better]." Interaction did generate connectedness, as much as the environment could also be challenging.

They sometimes made connections with families of the children, but not easily. In the infirmary, visitors did not come to the wards to see their children or family members. Staff in the main building would phone the wards, Carla recalled, "and say, okay, [name]'s mum is coming, which meant that we would take her out of the dayroom, put on whatever her best clothes were and you brought them to the front in the little coffee room there . . . and then the parents could visit." Furthermore, the interviewees felt that, overall, "there was very little visiting going on." In their view, that lack of visiting was not due to families living far away; sometimes families who lived nearby "never came to see their kids . . . they just abandoned them." Maintaining relations and community in the face of isolation and massive numbers of residents was difficult for all parties involved.

During the 1950s, family members did begin to organize, forming the Parent-School Association in 1954, inserting their voice and influence on the daily organization of care (King et al., 1988). Likely as part of a wider trend towards normalization, involvement in work and some more independence for some residents was one way to stimulate community integration and normalization of living circumstances (Wolfensberger, 1972). Carla remembered how the girls who were doing cleaning jobs for people downtown got some more independence in their living arrangements: "They were upstairs on [wards] seven and eight . . . , they could decorate the rooms themselves, you know, it wasn't as regimented as it was on the [other] wards."

The interviewees were cautious in their comments about institutional relationships and the structures of work. They had not found it easy to work within the strict hierarchy and perhaps keeping silent was a common strategy to cope with the more challenging aspects of the work. In

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[3] The term *mongoloid* or *mongolism* referred to what is now called Down syndrome.

the commemorative history book, one Blanche Mitchell recalled: "There were many differences of opinion as to how and why the situations were handled the way they were, but they were never often expressed to administration" (King et al., 1988, p. 71). The construction of silence around any matters controversial might have been a reflection of the hierarchical power structure and network of loyalty of which the nurses were part. Kathy was well aware that workforce relationships could be challenging. She reflected on some of the administrative politics she had encountered at PTS and the way nurses' positions and work assignments were managed:

> I found PTS was, um, kind of straight laced with the nursing staff and the fact that if friends [of those in leadership positions] came back then you didn't get promoted because a couple of times I figured I'm up for it and then one of the leader's friends came back and they would put her in there. So that's one of the reasons I left—in 1952—and went to Edmonton [to work at the Charles Camsell (Tuberculosis) Hospital], my girlfriend and I.

Leaving might have been a silent way of resisting the pressures placed upon her. As a student, Kathy had been dependent on board and some income from PTS, but once she had her MDN diploma she actually had new options. Her nursing skills were providing her with an opportunity to find employment elsewhere. As historian Kathryn McPherson has pointed out, diplomas gave registered nurses a negotiable skill based on which they could leave and explore new career options (McPherson, 1994). The same could be argued for the MDN diploma. A change of jobs gave Kathy some power to shift direction.

On the other hand, Carla also recalled the comradery among the nurses:

> I think [best was] living in residence, you know, with all the girls and we have girls from all over, you know, Saskatchewan and what have you and in, in the residence you also had a little kitchen area you could always make coffee, you had bread and jam like there was a little fridge there.

She had good memories about living in residence and the fun and friendship she had experienced with other girls, which also had been a resource in enduring the circumstances of work. Still, she also had not been unhappy to leave. She left PTS in 1961, a year after graduation: "I can still remember to this day my last day at work, okay, you know, . . . it was not something I was unhappy to leave, I was very happy that it was my last day." The work had been tough and very strictly and hierarchically organized. Moreover, much information about residents was kept hidden from the student nurses, which made it sometimes hard to understand why residents were even there. While such secrecy piqued her curiosity at some level, it also gave her mixed feelings.

Kathy, Tim, and Carla had worked at PTS in a time of rapid expansion of the institution, characterized by strong beliefs in medical progress and expanding medical opportunities. By the 1990s, however, the tide had changed and public views had become critical; the PTS received condemning publicity. Kathy told how she had felt compelled to defend the care they had provided against the negative portrayal that emerged in the media about PTS. It seemed the interviewees wanted to relate how their work must be understood in context, "how it was then," as one of them noted. They felt perturbed about some of the 1990s' portrayals of PTS, which, to them, did not fully reflect how they had tried to make sense of the practices they were exposed to at the time. It seemed they wanted some say over the way collective memory over the place was scripted in hindsight, and Kathy shared how she had sent a letter to the editor when reading a magazine article that described PTS as a "cruel world" (McGovern, 1996).

Kathy gave me a copy of her letter to the editor from 1996 that she had written in response to this account about PTS in the Alberta Report. She did not recall whether the letter was ever published, but her response was triggered when reading in the magazine that in the 1940s patients lived in "squalled dormitories, reeking with urine and feces." She wrote—almost as a witness statement in defence of the work done at the time—that "the patients [at PTS] were bathed daily and bedding changed regularly." Handicapped and bed ridden residents had been changed regularly and the place was kept clean, she pointed out: "The facilities were swept, washed and disinfected daily and more often if necessary," and "bathrooms were kept clean at all times. There was a laundry and sewing room at the premises." In the half-page letter, she described the layout of the dormitories, which she believed had "enough space, not [being] overcrowded as suggested [in the magazine in the 1990s]." She likely perceived the dormitories in comparison to hospital wards, which might have had quite similar layouts in terms of space, and hence seemed legitimate. Kathy's comment underscored that many residents, although not sick in a strict medical sense, were certainly physically vulnerable and in need of daily nursing care, which, to her, the nurses actually provided. In their account of the experiences of learning disability nurses in the United Kingdom, Mitchell and Rafferty (2005) noted a similar conflicting normative context of the need for good physical nursing for which nurses had skill of which they were proud, whereas the institutional environment in the collective memory decades later resembled very little of a hospital environment.

In her letter, Kathy further noted that PTS had a gym and a school on the premises, probably to underscore that not all residents were bedridden and were engaged in some meaningful activities. Yet, on the other hand, good nursing care seemed key, particularly on infirmary wards, considering that "many of the patients were severely crippled and had serious health problems," she wrote, which to her might have legitimized a more medically oriented environment. Kathy referred to her memory to explain the context: "I know that when I worked there, all patients received very good health care," she concluded her letter. Her note did convey that medical and hygienic concepts powerfully structured the day-to-day circumstances of living and work at PTS. While Kathy defended these norms against an allegedly rather denigrating depiction of their work in the 1990s, the interviewees' feelings about the forced sterilization practices they remembered were mixed.

Mixed Feelings and Silenced Knowledge Around Sterilization

Ambivalence over the nature of their work and the history of eugenics came through in their memories about sterilization practices. The interviewees found it difficult to discuss the matter of forced sterilization. While their anxiety was notable, they still did want to talk about it. The topic had already been touched upon at several points during the interview; they had mentioned the existence of the eugenics board for example. At the end of the interview, however, I asked explicitly about their views on sterilization, and what they might have witnessed about it at the time they worked at PTS. I will discuss three aspects: first, their memories about actual sterilization practices; second, the way silence had constrained any discussion of them; and, last, the way their views and emotions reflected larger cultural trends and responses.

Sterilization was first mentioned when we discussed how the residents' connections with the community expanded around 1960. Carla recalled "some of the seventeen year old girls going to work in town." This would have been in the late 1950s, early 1960s, when community integration was a more explicit goal. Wards had opened up, and there was more freedom for

residents to walk around on the grounds. The more able residents were also put to work and assisted with the care of the less able and dependent children. Some others obtained work as servants with families in town. Carla remembered: "Anybody who had the freedom to walk around the grounds, like your mongoloid girls, they would go and help feed the lower grades, and so they were out and there were some mongoloid boys. [And] so anybody who had access to male, female, they just sterilized them, the girls who were working downtown they had all been sterilized." It seemed the practice of sterilizing residents, particularly young women, increased in response to them having more opportunities for free interaction (Grekul et al., 2004). Kathy recalled that "when I was there [in the late 1940s and early 1950s], like I say [sterilization] was done, . . . but not very many that I ever remember, maybe one or two in the years that I was there, so I don't know, but later on when [the new director (LeVann) came], that was when . . ." Kathy did not finish her sentence. It seemed she meant that thereafter the number increased, which indeed was in alignment with LeVann's role in the expansion of the eugenics program in the 1950s and 1960s (Dyck, 2013). Both Kathy and Carla remembered how residents underwent surgery, which was performed at PTS and the nearby mental hospital in Ponoka.

Their strongest emotions around the practice, however, related to the way nurses were kept in the dark about the background of the residents and about the wider practice of the Eugenics Board. When girls were about 17 or 18, they would go before the Eugenics Board, Carla noted, but nurses would know little about the details. One day, for example, she had been unpleasantly surprised. She came back to work after a few days off to find that "all of a sudden Elaine is gone, well where did she go—and it was hush, hush, none of us, staff, were ever told where she went." Elaine lived on the ward Carla was working. Wanting to know what happened, Carla had a peek into the files during nightshift. She was night supervisor by then. She found that Elaine was the 11-year-old younger sister of 17-year-old Alice, who had indeed been assessed by the eugenic board (names are pseudonyms). But then Elaine went in front of the Board as well, to the nurses' surprise, in fact, because of her young age. The next thing Carla knew was that Elaine was gone. She recalled in the files it appeared that "[when] she went to the eugenics board they realized *this girl is normal*, she should not be here; they took her, but nobody ever informed us and because it was so secretive I think that's why it stayed with us." Carla remembered being upset about the secrecy. Only after having read the file she realized that family circumstances had triggered Elaine's admission. She apparently had been admitted for social reasons more than anything else. Such reasons for admission seemed to emphasize how institutions met a range of social needs and were used for a broader range of reasons than medical ones alone (Boschma, 2008; Moran, 2000). Carla recalled,

> The only thing that I read was, I don't know how many children were in the family, but her dad lived up north and his wife had died of tuberculosis, I believe, and he wasn't able to care for them. They were Catholic and whatever orphanage they had up north they were all filled up so the girls were eventually brought to PTS.

Learning this information had made Carla more critical about her role, the fate of the girls, and the secrecy that was maintained. Boundaries between normality and abnormality seemed arbitrary yet powerful in constructing residents' lives and the institutional context (Armstrong, 2000; Foucault, 1965). Once placed under the institutional regimen, it was hard to escape the label of being "abnormal," which may have facilitated pressure to sterilize women who in fact were not disabled (Grekul et al., 2004; Mansell & Hibberd, 1998).

Larger cultural beliefs about sterilization further structured the interviewees' memories. The older eugenic belief that degeneration could be prevented if mentally defective people would be precluded from having children was reflected in their views. They shared how it had been common but secret knowledge at PTS that several residents came from the same family in which both parents were allegedly mentally disabled, and whose children all had ended up at PTS. Discussing this case, the interviewees embraced the idea that in such situations sterilization seemed legitimate: "[These parents] had gotten married and they had these children and they couldn't look after them." But then the discussion shifted to the viewpoint of sterilization as a legitimate measure of birth control. It made sense as a measure not merely of prevention but also of protection the interviewees noted. They felt that vulnerable children at PTS should be protected against sexual abuse and, for the girls, against the risk of them getting pregnant if they were taken advantage of or engaged in sex. They did not feel comfortable discussing the details while the tape was on. I offered to shut it off for a few minutes so they could decide what they wanted to share. Then we continued, and in the discussion that followed they emphasized their view of sterilization as a legitimate means to provide girls with protection and "birth control." Unwittingly the discussion had shifted in viewpoint from debate over preventive sterilization and alleged protection against degeneration to one of contraceptive sterilization and protection against unwanted pregnancy. Their comments reflected how the public perception had changed, shaping their memory of their very real experiences at PTS. When prenatal screening and amniotic fluid testing had become more common in the late 1960s, debates over protection had changed (Dyck, 2014; Ladd-Taylor, 2014; Wright, 2011). The interviewees' work at PTS and the sterilization practices they had been part of had predated these social changes. Their sense of unsafety about discussing these experiences exposed the unequal power structures and the cultural tension tangibly present right under the surface of the talk. Like the residents, most MDNs had held little influence or say over the enactment of sterilization.

Conclusion

The public controversy over institutional care and eugenic sterilization in the late 20th century made it difficult for mental deficiency nurses' to share their perceptions and memories of their work during the 1940s and 1950s. Still, telling their stories also was an opportunity to make sense of a past that has since grown controversial. They felt compelled to emphasize how their initial struggle to accept the context of their work gradually transformed into a work attitude that they felt had been caring and compassionate, even if it was with little say over their practice. Such compassion helped them to reconcile at a personal level the larger social ambivalence about the care of people with developmental disability and the controversial context of forced sterilization for large numbers of residents at PTS during the mid-20th century. Emotions, the analysis underscores, are neither ahistorical nor uniquely individual personal experiences. An analysis of them deepens our understanding of this important segment of social, disability, and nursing history.

References

Alberta Social Services and Community Health. (1984). *Michener Centre: A history, 1923–1983* (Microlog 84-04075).

Anderson, K., & Jack, D. C. (2006). Learning to listen: Interview techniques and analysis. In R. Perks & A. Thomson (Eds.), *The oral history reader* (2nd ed., pp. 129–142). Routledge.

Armstrong, D. (2000). Social theorizing about health and illness. In G. L. Albrecht, R. Fitzpatrick, & S. C. Scrimshaw (Eds.), *Handbook of social studies in health and medicine* (pp. 24–35). Sage.

Atkinson, D., Jackson, M., & Walmsley, J. (1997). *Forgotten lives: Exploring the history of learning disability*. BILD Publications.

Boschma, G. (2008). A family point of view: Negotiating asylum care in Alberta, 1905–1930, *Canadian Bulletin of Medical History*, *25*(2), 367–389.

Boschma, G. (2011). Deinstitutionalization reconsidered: Geographic and demographic changes in mental health care in British Columbia and Alberta, 1950–1980. *Histoire Sociale/Social History, 44*(88), 223–256. https://doi.org/10.1353/his.2011.0020

Boschma, G. (2012). Community mental health nursing in Alberta, Canada: an oral history. *Nursing History Review, 20*, 103–135. https://doi.org/10.1891/1062-8061.20.103

Boschma, G., Scaia, M., Bonifacio, M., & Roberts, E. (2008). Oral history research. In S. B. Lewenson & E. Krohn-Herrmann (Eds.), *Capturing nursing history: A guide to historical methods in research* (pp. 79–98). Springer.

Boschma, G., Yonge, O., & Mychajlunow, L. (2005). Gender and professional identity in Psychiatric Nursing practice in Alberta, Canada, 1930–1975. *Nursing Inquiry, 12*(4), 243–255.

Bornat, J. (2010). Remembering and reworking emotions: the reanalysis of emotion in an interview. *Oral History*, *38*(2), 43–52. https://www.jstor.org/stable/25802189

Burke, P. (2001). Overture. The new history: Its past and its future. In P. Burke (Ed.), *New perspectives on historical writing* (2nd ed., pp. 1–24). Polity Press.

Cellard, A., & Thifault, M. C. (2006). The uses of asylums: Resistance, asylum propaganda, and institutionalization strategies in turn-of-the-century Quebec. In J. Moran & D. Wright (Eds.), *Mental health and Canadian society: Historical perspectives* (pp. 97–116). McGill-Queen's University Press.

Clarke, N. (2004). Sacred daemons: Exploring British Columbian society's perceptions of "mentally deficient" children, 1870–1930. *BC Studies*, *144*, 61–89.

Connor, J. T. H. (2017). The "human subject," "vulnerable populations," and medical history: The problem of presentism and the discourse of bioethics. *Canadian Bulletin of Medical History*, *34*(2), 496–520. https://doi.org/10.3138/cbmh.34.2.175-25022016

Doody, O., Slevin, E., & Taggert, L. (2012). Intellectual disability nursing in Ireland: Identifying its development and future. *Journal of Intellectual Disability*, *16*(1), 7–16. https://doi.org/10.1177/1744629512437091

Dyck, E. (2013). *Facing the history of eugenics: Reproduction, sterilization and the politics of choice in 20th century Alberta*. University of Toronto Press.

Dyck, E. (2011). Dismantling the asylum and charting new pathways into the community: mental health care in twentieth century Canada, *Histoire Sociale/Social History*, *44*(88), 181–196. https://doi.org/10.1353/his.2011.0016

Dyck, E. (2014). Sterilization and birth control in the shadow of eugenics: Married, middle-class women in Alberta, 1930–1960s. *Canadian Bulletin of Medical History*, *31*(1), 165–187.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason.* Pantheon.

Grekul, J., Krahn, H., & Odynak, D. (2004). Sterilizing the "feebleminded": Eugenics in Alberta, Canada, 1929–1972. *Journal of Historical Sociology, 17*(4), 358–384.

Harding, J. (2010). Talk about care: Emotions, culture and oral history. *Oral History*, *38*(2), 33–42. https://www.jstor.org/stable/25802188

Hendriks, A., & Timmerman, H. (2012). 1957: Professionalisering: Van Z-verpleging naar gespecialiseerde begeleiding [Professionalization: From developmental disability nursing to specialized guidance counselors]. Canon: website on social work history. https://www.canonsociaalwerk.eu/nl_han/details.php?cps=13&canon_id=300

Hicks, B. (2011). Gender, politics, and regionalism: Factors in the evolution of registered psychiatric nursing in Manitoba, 1920–1960. *Nursing History Review*, *19*, 103–126. https://doi.org/10.1891/1062-8061.19.103

King, J., Darrach, V., Daley, S., & Burch, I. (1988). *History of Alberta mental deficiency nurses.* History Book Committee and Adviser Graphics.

Ladd-Taylor, M. (2014). Contraception or eugenics? Sterilization and "mental retardation" in the 1970s and 1980s. *Canadian Bulletin of Medical History*, *31*(1), 189–211.

LaJeunesse, R. (2002). *Political asylums*. Muttart Foundation.

Leydesdorff, S. (2004). *De mensen en de woorden* [People and their words]. Meulenhoff.

Malacrida, C. (2015). *A special hell: Institutional life in Alberta's eugenic years*. University of Toronto Press.

Mansell, D., & Hibberd, J. (1998). "We picked the wrong one to sterilise": The role of nursing in the eugenics movement in Alberta, 1920–1940. *International History of Nursing Journal, 3*(4), 4–11.

McGovern, C. (1996). Hello cruel world. *Alberta Report*, *23*(9), 28–36.

McPherson, K. (1994). Science and technique: Nurses' work in a Canadian hospital, 1920–1939. In D. Dodd & D. Gorham (Eds.), *Caring and curing: Historical perspectives on women and healing in Canada* (pp. 71–101). University of Ottawa Press.

Mitchell, D., & Rafferty, A. M. (2005). "I don't think they ever really wanted to know anything about us": Oral history interviews with learning disability nurses. *Oral History, 33*(1), 77–87.

Moran, J. E. (2000). *Committed to the state asylum: Insanity and society in nineteenth-century Quebec and Ontario.* McGill-Queen's University Press.

Mullally, S., Boschma, G., Davies, M. J., & Phinney, A. (2019). Introduction: Arts, crafts and healing—Understanding social citizenship in BC. *BC Studies, 202*(Summer), 9–20.

Nehring, W. M. (2003). History of the roles of nurses caring for persons with mental retardation. *The Nursing Clinics of North America*, *38*, 351–372.

Nehring, W. M. (2010). Historical perspectives and emerging trends. In C. L. Betz & W. M. Nehring (Eds.), *Nursing care for individuals with intellectual and developmental disabilities: An integrated approach* (pp. 1–18). Paul H Brookes Publishing.

New Zealand Hospital Design and Evaluation Unit. (1979). *Psychopaedic services—Hospital facilities: A study of in-patient accommodation* (Report No. 7). Department of Health.

Park, D. C., & Radford, J. P. (1998). From the case files: Reconstructing a history of involuntary sterilization, *Disability & Society, 13*(3), 317–342.

Prebble, C. K. (2007). *Ordinary men and uncommon women: A history of psychiatric nursing in New Zealand public mental hospitals, 1939–1972* [Unpublished doctoral dissertation]. University of Auckland, New Zealand.

Prebble, K. (2015, June 29). *An oral historian's conundrum: How do we deal with the diversity of psychiatric mental health nurses' stories of custodial institutional care?* [Conference presentation]. Australian College of Nursing History Conference, North Sydney.

Pringle, H. (1997). Alberta barren: Alberta's Provincial Training School for Mental Defectives. *Saturday Night Magazine,* (June), 30–37, 70, 74.

Reaume, G. (2006). Patients at work: insane asylum inmates' labour in Ontario, 1841–1900. In J. Moran & D. Wright (Eds.), *Mental health and Canadian society: Historical perspectives* (pp. 69–96). McGill-Queen's University Press.

Rossiter, K., & Clarkson, A. (2013). Opening Ontario's 'saddest chapter': A social history of Huronia Regional Centre. *Canadian Journal of Disability Studies, 2*(3), 1–30. https://doi.org/10.15353/cjds.v2i3

Samson, A. (2014). Eugenics in the community: Gendered professions and eugenic sterilization in Alberta, 1928–1972. *Canadian Bulletin of Medical History, 31*(1), 143–163.

Shaw, R. (2018, April 1). BC Government to compensate pre-1974 Woodlands residents. *Vancouver Sun*. https://vancouversun.com/news/local-news/5-am-web-embargo-b-c-government-provides-compensation-to-former-woodlands-residents/

Simmons, H. G. (1982). *From asylum to welfare*. National Institute on Mental Retardation.

Stainton, T. (2006). The evolution of community living in Canada, Ontario, 1945–2005. In J. Welshman & J. Walmsley (Eds.), *Community care in perspective: Care, control and citizenship* (pp. 135–145). Palgrave Macmillan.

Sweeney, J. F. (2011). The role of the Irish division of the Royal-Medico-Psychological Association in the development of intellectual disability nursing in Ireland. *Canadian Bulletin of Medical History, 28*, 95–122.

Sweeney, J., & Mitchell, D. (2009). A challenge to nursing: A historical review of intellectual disability nursing in the UK and Ireland. *Journal of Clinical Nursing*, *18*, 2754–2763. https://doi.org/10.1111/j.1365-2702.2009.02889.x

Thompson, P. (2000). *The voice of the past: Oral history* (3rd ed.). Oxford University Press.

Tipliski, V. M. (2004). Parting at the crossroads: The emergence of education for Psychiatric Nursing in three Canadian provinces, 1909–1955. *Canadian Bulletin of Medical History, 21*(2), 253–279.

Wahlsten, D. (1997). Leilani Muir versus the Philosopher King: Eugenics on trial in Alberta. *Genetica, 99,* 185–198.

Wolfensberger, W. (1972). *Normalization: The principle of normalization in human services.* National Institute on Mental Retardation.

Wright, D. (2011). *Downs: The history of a disability*. Oxford University Press.