THE KILBURN CONNECTION: PUBLIC HEALTH NURSING EDUCATION AND THE CHILD GUIDANCE CLINICS IN BRITISH COLUMBIA 1932-1950

by

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Abstract

Mental Hygiene emphasized mental illness prevention and mental health promotion. In British Columbia, Child Guidance Clinics (CGC) were established to promote mental hygiene among children. This study draws from institutional records on the CGC from Riverview Hospital archives (1932-1950). Using nurse and social worker Josephine Kilburn as a central figure, it explores linkages between the CGCs and public health nursing education at UBC, as well as the role of nursing in the mental hygiene movement. The study highlights how nursing has been taken for granted in the mental hygiene movement, as well as how nursing and social work identities were interconnected. Josephine Kilburn found ways to use both her nursing and social work identities to advantage, working across institutional boundaries at the CGC and UBC School of Nursing. Working within established social hierarchies Kilburn’s work reveals changing priorities and approaches to mental health over the course of twenty years.
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Dedication

I dedicate this work to my brother, Daniel Edler (1991-2010).

My life is blessed and my work is inspired from having had the privilege to know you and love you. While mental illness ended your journey too soon, my journey as an educator and leader in mental health services for children and youth has just begun.
Chapter One: Introduction and Background

Public health nursing education in the early twentieth century was focussed on disease prevention through practices related to physical hygiene (e.g., hand washing and other cleaning practices aimed at preventing the spread of communicable disease). As part of their preventative focus, public health nurses at the University of British Columbia (UBC) were also taught about practices related to mental hygiene (eugenics and other practices aimed at preventing the spread of mental illness). Although mental health issues and mental hygiene did not receive the same level of attention as physical health issues and physical hygiene, both were part of the early public health movement. Key players in infectious disease prevention, mental illness prevention, and public health nursing worked in the same circles. For example, in their exploration of public health nursing at UBC in the inter-war period, Zilm and Warbinek recognized Henry Esson Young, a physician and cabinet minister in British Columbia, as a “strong and influential advocate of a degree program for public health nurses” and that he thought their education should include prevention and control of tuberculosis (TB). As a result, public health nurses at UBC learned about prevention and care of communicable diseases, “but TB was given special consideration and the students were required to do TB fieldwork.” Students in the UBC public health nursing program also learned about prevention and care of mental illness – that is, about mental hygiene. Was this because of Esson’s influence too? Given that the Riverview Hospital, a mental health facility in Coquitlim, was dubbed “Essondale” in recognition of Esson Young’s influence, it seems likely that Esson Young’s interest in

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2 Ibid., 74.
3 Ibid., 75.
mental health, public health and nursing played a role in how mental hygiene was understood, taught and enacted by nurses between 1930 and 1950.

In British Columbia, Child Guidance Clinics were established as a way to assess and promote mental hygiene among children. The mental hygiene movement searched for ways that early intervention and public health measures could be part in preventing mental illness. Public health nursing education at UBC included a mental hygiene component, and there were some linkages between public health nursing and the Child Guidance Clinics – for example, some public health nursing students spent part of their practicum time at the Child Guidance Clinics.

This study draws from available Child Guidance Clinic institutional records from the Riverview Hospital archives (1932-1950) to trace changing professional understandings of mental hygiene as documented by or about nurses. Using nurse and social worker Josephine Kilburn as a central figure, it explores linkages between the Child Guidance Clinics and public health nursing education at UBC, as well as the role of nursing in the mental hygiene movement, as revealed through Child Guidance Clinic records. The study highlights how nursing was taken for granted in the mental hygiene movement – ever present but rarely identified – as well as how nursing and social work identities were interconnected. Josephine Kilburn found ways to use both her nursing and social work identities to advantage, working across institutional boundaries at the Child Guidance Clinic and UBC School of Nursing. Working within established social hierarchies, Kilburn’s work and writing reveals changing priorities, understandings of and approaches to mental health over the course of twenty years.
This study was guided by four key questions:

1. What was the relationship between the Child Guidance Clinic and public health nursing education at UBC?

2. What was the cultural and societal context of the Child Guidance Clinics?

3. How were mental illness and disability socially constructed over a two-decade period (1932-1950) in British Columbia?

4. How were power differentials, such as gender, class, religion, or race, negotiated in the Child Guidance Clinics and public health nursing education at UBC?

The guiding questions changed over the course of this study. In historical analysis, questions are driven in part by the available historical sources – in this case, documents from the period under review housed at the Riverview Hospital archives. Through reviewing the records it became clear that Josephine Kilburn was a key link between the Child Guidance Clinic and public health nursing education at UBC from 1932-1950. As the key figure for this thesis, more details about her work, power differences that she experienced, the societal context that she lived in, and her activities in informing the public on mental illness became central to understanding the answers to the questions of this thesis.

One note about terminology used in this thesis: In the early twentieth century, the terms feeblemindedness, idiocy or mental deficiency were often applied to chronic mental illness, but also to a wide range of socially unacceptable behaviours. These terms and some others that some may consider offensive have been used in this thesis to reflect the time period of the data and to allow comparison of language from different data sources.

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The author’s intention in the use of these terms is to allow the historical characters to speak in their own voice. Currently accepted terms such as mental illness, mental health concerns, and intellectual disability have been used where the intention of the writing has been to explain or discuss a particular point where it is not necessary to be in the voice of the data.

Background

The Institutions: Essondale, BC School of Psychiatric Nursing, UBC and the Child Guidance Clinics. The “Hospital for the Mind” was opened in 1913 and became known as Essondale to honour Henry Esson Young, who had advocated for the hospital. Esson Young was a medical doctor who came to British Columbia at the turn of the century. He became a cabinet minister in the British Columbia parliament in the early twentieth century and was influential in numerous health initiatives, including public health nursing education and mental health. Essondale was considered a state of the art psychiatric hospital and included 1000 acres of farmland, as well as botanical gardens and an arboretum. For the patients, there was “not only a hospital, but a home, a school, a church, industries and occupations – features of community life that are essential to the development, restoration and maintenance of health.” Essondale reached its peak population of 4,630 patients in 1951. Essondale was renamed Riverview Hospital in 1966. After a period of deinstitutionalization from the 1970s until today, Riverview
Hospital shut its doors in the summer of 2012. The closing of Riverview Hospital marks the end of the era of mental hospitals in British Columbia.

Essondale was home to the nurses and nursing students who worked there. The school for psychiatric nursing at Essondale graduated their first students in 1932, the same year as the opening of the Child Guidance Clinic.\(^{11}\) In 1938, it took three years of training to graduate from the nursing school at Essondale.\(^ {12}\) Nurses and nursing students lived on the grounds of Essondale.\(^ {13}\) Because Essondale was not only their workplace, but their home, the nurses and nursing students had a variety of activities that were available to them, including a dancing and dramatic society and a hostess club for the returning soldiers from WWII.\(^ {14,15}\) The British Columbia School of Psychiatric Nursing moved from Riverview to BC Institute of Technology in 1972.\(^ {16}\)

There was collaboration between the nursing school at Essondale and the public health nursing students at UBC, who did orientation sessions through the Essondale training school. The first public health nursing course at UBC was fourteen weeks long and began in 1920 with twenty-six graduate nurses.\(^ {17}\) Esson Young advocated for the public health nursing program at UBC.\(^ {18}\) Public health nurses did receive education in mental hygiene in the early twentieth century at UBC. A list of classes taken by student Edna M. Upshall in public health nursing at UBC in 1929 confirms that she took a class entitled Mental Hygiene, in addition to classes such as: Preventable Disease, School

\(^{11}\) Ibid.
\(^{16}\) BC Mental Health and Addictions Services. “BC Mental Health Timeline.”
\(^{18}\) Ibid., 74.
Hygiene, Principles of Public Health Nursing, Vital Statistics and Infant Welfare, among others. What did public health nursing education have to do with the Child Guidance Clinic? In order to understand this, we will have to learn more about the key historical character that links these institutions together – Ms. Josephine Kilburn. But first, we’ll discuss the third institution in this study, the Child Guidance Clinic.

*The Child Guidance Clinic: Eugenics and Public Health in Canada.*

The theory of eugenics and race betterment permeated through multiple layers of healthcare in the early twentieth century. The term *eugenics* was coined by Francis Galton, a cousin of Charles Darwin, in 1883 to describe “the study of the agencies under social control that may improve or impair the racial qualities of future generations, either physically or mentally.” It is not hard to imagine that public health, with its premise of supporting the health of populations, was believed to be a potential avenue of racial improvement. The eugenicists believed the primary way to improve a race was to encourage the *fit* to reproduce more, and the *unfit* to reproduce less. By the early twentieth century, principles of eugenics had influence in Canada’s public health care.

Helen MacMurchy was the single most influential person in spreading the practice of eugenics to public health in Canada in the early twentieth century. As the head of the Maternal and Child Welfare Division of the Department of Health in Canada in 1923, MacMurchy was especially interested in the areas of infant mortality, maternal mortality

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21 Davies, “Mapping ‘region’ in Canadian medical history: The case of British Columbia.”

22 Ibid., 44.
and feeblemindedness.\(^{23}\) "In each case her concern was motivated more by the threat
disease posed the race than by empathy for the individual."\(^{24}\) Helen MacMurchy believed
that the poor and ignorant mothers were to blame for the death of their infants.\(^{25}\) Her
answer was to have healthy supplies of milk available and to provide education for
women, advocating for breastfeeding and condemning work outside the home.\(^{26}\) Public
health nurses in Canada followed through with MacMurchy’s recommendations. Milk
depots were established to provide safe infant formula, and health education was given to
new mothers.\(^{27}\) Public health nurses taught school girls domestic skills, imposing middle
class values on working class women.\(^{28}\) When it came to the feebleminded, “examination
and mental testing were aimed at the labelling and segregating of the handicapped [rather]
than at providing for their special needs.”\(^{29}\) MacMurchy clearly supported the superiority
of the upper and middle classes and those who were considered fit.

Programs meant to influence the infant mortality rate were often started by groups
of philanthropic women.\(^{30}\) However, principles of eugenics and the maintenance of power
differences may have influenced the motivation of these women to participate in helping
lower class and feebleminded women and preventing future concerns with their children
and the race. Mrs. M.K. Stead, a member of the National Council of Women, stated at the
annual meeting in 1901:

\(^{23}\) Ibid., 30.
\(^{24}\) Ibid., 29.
\(^{25}\) Ibid., 31.
\(^{26}\) Ibid., 32.
\(^{27}\) Bates, C., Dodd, D. & Rousseau, N. *On All Frontiers: Four Centuries of Canadian Nursing.*
(Ottawa: University of Ottawa Press, 2005).
\(^{28}\) Bates, C., Dodd, D. & Rousseau, N. *On All Frontiers: Four Centuries of Canadian Nursing.*
\(^{30}\) Bates, C., Dodd, D. & Rousseau, N. *On All Frontiers: Four Centuries of Canadian Nursing.*
Left to yourself you are not only useless, but mischievous. I have tried punishing, curing, reforming you, as the case may be: and I have failed. You are an incurable, a degenerate, a being unfit for free, social life. Henceforth I shall care for you, I will feed and clothe you, and give you a reasonably comfortable life. In return you will do the work I set for you and you will abstain from interfering with your neighbour to his detriment. One other thing you will abstain from, - you will no longer pro-create your kind; you must be the last member of your feeble and degenerate family.\(^{31}\)

Such a quote reflects some aspects of the mental hygiene movement. It was believed that if the faulty genetics could be purged, the world would be free of the mentally ill and feeble minded. Such acts as sterilization maintained power differences between classes, the able and the unable.

Eugenics and MacMurchy’s ideals influenced public health care across Canada, including one of British Columbia’s prominent leaders, Henry Esson Young. Young was a supporter of public health nursing education at UBC.\(^{32}\) Young consulted often with public health nurse leader, Edna Muriel Upshall, whose letters to Young are included in the data for this project. He served the province as the Minister of Education and then as Secretary of the Provincial Board of Health. Young was an influential person in the development of many health services in BC, including public health, school health, and psychiatric services. Young, influenced, in part, by eugenicist Helen MacMurchy, began special classes for the *retarded* in the Vancouver school system in 1910.\(^{33}\) The school inspection act, which allowed for a physical exam for every school child in the province

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\(^{32}\) Zilm & Warbinek, “Early tuberculosis nursing in British Columbia.”

once a year, was passed in 1911 under the guidance of Young.\textsuperscript{34} Young had influence both in public health as well as the mental hygiene movement in BC, which included the Child Guidance Clinic.

\textit{Eugenics, Mental Hygiene and the Child Guidance Clinics}.

Mental hygiene was a movement in the early twentieth century to address the treatment of the mentally ill. It started with Clifford Whittingham Beers’ book, \textit{A Mind that Found Itself}, written in 1908.\textsuperscript{35} This biography centered on Beers’ experience of mental illness and highlighted his views that mental illness treatment should be based on principles of non-restraint.\textsuperscript{36} He began the National Committee for Mental Hygiene in the United States in 1909.\textsuperscript{37} The Canadian National Committee of Mental Hygiene began to audit asylums across the country in 1918, seeking to improve the conditions that were marked by overcrowding and a high staff turnover.\textsuperscript{38} Improvements to asylums meant that mental health practices would be based on scientific therapies, medical research and training schools for nurses.\textsuperscript{39}

Mental Hygiene Clinics, later called Guidance Clinics, began in the United States, and spread to England and to Canada.\textsuperscript{40} The focus of these clinics was on the screening of developmental or behavioural problems in children.\textsuperscript{41} The first Child Guidance Clinic in BC opened in Vancouver in 1932. The Guidance Clinics were staffed by psychiatrists, nurses, and psychologists.

\begin{itemize}
\item \textsuperscript{34} Zilm & Warbinek, “Early tuberculosis nursing in British Columbia.”
\item \textsuperscript{36} Ibid.
\item \textsuperscript{37} Ibid.
\item \textsuperscript{38} Boschma, G. “Gender and professional identity in psychiatric nursing practice in Alberta, Canada, 1930-75.” \textit{Nursing Inquiry} 12, no. 4 (2005): 243-255.
\item \textsuperscript{39} Dooley, C. “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.” \textit{Canadian Bulletin of Medical History} 21, no. 2 (2004): 229-251.
\item \textsuperscript{40} Jones, K. \textit{Taming the troublesome child: American families, child guidance, and the limits of psychiatric authority.} (Cambridge: Harvard University Press, 1999).
\item \textsuperscript{41} Boschma, G. “Community mental health nursing in Alberta, Canada: An oral history.”
\end{itemize}
psychologists and social workers. Nurses in British Columbia likely had similar training in mental hygiene as their counterparts in Manitoba. In Manitoba, “pupil nurses also worked outside the hospital to perform outreach work such as administering intelligence tests at mental hygiene clinics in the schools.” Child Guidance work was intended to prevent future mental health concerns.

There were two elements in mental hygiene: scientific and humanitarian. These two elements were sometimes contradictory: desiring an efficient and ordered society at the same time as being concerned with rights and the alleviation of suffering. While the humanitarian element worked to improve the conditions of the mental hospital, eugenics was considered to be part of the scientific element. The Mental Hygiene movement supported the eugenicist ideals of the superiority of the Caucasian race, the upper classes and the able. The Canadian Journal of Mental Hygiene clearly advocated for eugenics and warned about the societal danger of mental defectives. The eugenic part of mental hygiene moved to the background as other scientific perspectives took hold, such as the psychoanalytic perspectives of Freud.

Public Health Nursing Education and Mental Hygiene.

Zilm and Warbinek write about the education of public health nurses at UBC in TB care. The first public health program at UBC was a certificate course lasting

42 Boschma, G. “Community mental health nursing in Alberta, Canada: An oral history.”
43 Dooley, C.. “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,” 244.
47 Zilm & Warbinek, “Early tuberculosis nursing in British Columbia.”
fourteen weeks which started in 1920.\textsuperscript{48} Mary Ardconie MacKenzie was the head of the program at that time.\textsuperscript{49} Much of the focus was on preventing infectious diseases, such as TB and malaria.\textsuperscript{50} What else were they learning in the early twentieth century? Weir, in a survey of nursing education, recommended: "More emphasis in the training of all nurses, but especially of public health nurses, should be devoted to Mental Hygiene and Sociology (Rural and Urban).\textsuperscript{51} These courses, which should be as functional and applied as possible, should receive special attention in the year of post-graduate training, or in the last two years of the four or five-year university course."\textsuperscript{52} UBC’s public health nursing program already had a mental hygiene course in 1929. Was this learning influenced by eugenics? This thesis will seek to further explore mental hygiene as part of nursing education in public health.

\textit{Summary}

Exploring the past helps to understand the context of mental health nursing today. Understanding the past also gives us hope for change in the future. In what ways can we find parallels between the past and the present? What directions do we wish to take from where we are today? How does understanding the past help guide our dreams for nursing practice in the future? All of these questions are evoked from work in nursing history, and will be discussed later in this thesis.

\textsuperscript{48} Ibid.
\textsuperscript{49} Ibid.
\textsuperscript{50} Ibid.
\textsuperscript{51} Weir, G.M. \textit{Survey of Nursing Education in Canada}. (Toronto: University of Toronto Press, 1932): 141.
\textsuperscript{52} Weir. \textit{Survey of Nursing Education in Canada}, 141.
Chapter Two: Literature Review

The literature review aims to place this work in the context of what is known in historical literature, particularly in nursing historical scholarship. To this aim, the literature that was gathered will be explored by theme. Women’s work and a gendered perspective of power and privilege are relevant to this thesis and will be explored through literature in this chapter. Literature on public health nursing and nursing education is relevant to this thesis. The social construction of mental illness is important to this work and is one of the main research questions, so exploring the literature on this topic will be included in this chapter. Finally, an exploration of literature on eugenics as well as the Child Guidance Clinics will be discussed.

Search and Retrieval Strategies for Literature Review

The articles for this literature review were obtained in a variety of ways. Some articles were suggested by professors, obtained in class, or suggested by the archival staff at Riverview Historical Society. Other articles were found through literature searching in data bases. Searches were conducted to allow for the highest number of retrieved articles. For example, in a CINAHL search, headings were used to search for all of the related words in the search and compared with searches without using the CINHAL headings. The method that produced the most results was used in the final combined search using and / or Boolean terms to link the concepts together. A detailed chart of the searches that were performed can be found in the appendices. While all of the literature searches were meant to retrieve articles about mental health, nursing, children or youth, and history, the articles that were found relate to a number of different topics that are relevant to this
thesis. This chapter outlines the literature that is relevant to this thesis and organizes them by topic.

Gender and Women’s Work

Writing from a gendered perspective is not just thinking about women, or adding female historical figures into the writing of history, but making them visible and interrogating power and privilege. Two articles touch on gender as more than just the power differences between men and women. Johnson wrote that history needs to have a Martin Luther-style wake-up call when it comes to gendered perspective in history. Included in her article is a list of eleven theses fashioned after Luther that are meant to rouse history to gender perspectives. Roman discusses how mental health patients were colonized by medicine. Colonialism was one way where power differences led to racial, gender, class and ablest oppression. Through the social construction of the fit and unfit, our country underwent a medicalized colonization of “lands, peoples, bodies, and minds.” These articles expose the importance of exploring power differences in history.

One theme that runs through this thesis is the parallels that can be drawn between nursing and social work, and the concerns of power that run through women’s work. Struthers explores the profession of social work as women’s work, which may allow some parallels to be drawn to nursing. Struthers asks the question: “Why, in the crucial years between 1918 and the early 1950s, when social work first evolved as a paid career, did women, although numerically dominant within the profession, fail to capture its key

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53 Johnson, S.L. “Nail this to your door: A disputation on the power, efficacy, and indulgent delusion of western scholarship that neglects the challenge of gender and women's history.” Pacific Historical Review 79, no. 4 (2010): 605-617.

54 Ibid.

A large number of social workers in the inter-war era were single women who had lost their husbands in the war. "The result was a paradox. Although composed primarily of career-oriented single women, social work as a profession, in the years following World War I, could not view the role of women in Canadian society outside of the constricting framework of motherhood."

Social work reinforced the woman’s role in the home, not in the workforce. Like nursing, social workers were expected to have mother-like abilities to do their work, such as self-sacrifice. Men in social work were meant to have gendered male work, such as administration. Women were believed to be unable to do the administrative work because of their gendered role as nurturers. Such power differences within social work, as women’s work, allow a comparison with nursing.

A number of articles described women’s work, either more generally, or more with a nursing focus than the Struthers article described above. Kirkwood discusses the dilemma of being a good woman but with aggressive male qualities like leadership. Kirkwood also discusses the way that equal rights feminists distanced themselves from the traditional female professions, like nursing. Nurses could not rise above their gendered role.

Stuart explored how the lines between doctors and public health nurses were blurry when the doctors were not available. Nurses were not allowed to do diagnosis or treatment, only carry out instructions of the doctors. However, when doctors were not available, or did not have the time to provide education for families, nurses filled in what

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57 Ibid.
was needed by the families with whom they worked.\textsuperscript{59} Nursing work is steeped with the power differences between genders and professions, especially between nursing and the medical profession.

The development of gender specific character traits was important in the development of women’s work. Whitehead compares two journals that gave advice for working women in the 1920s and 1930s in Australia.\textsuperscript{60} The two practical guidance journals on women’s work focussed on the importance of character, “to construct specific individual and occupational identities for middle-class women workers.” Nursing seemed to fit with the character of a woman, including patience, sympathy and practical intelligence. Discourse on careers was not gender neutral. This discourse is important to understand the role of gender and women’s work.

The discourse on nursing education was also steeped in the social construction of gender. Baumgart and Kirkwood discuss public health nursing education starting as a university degree program in the 1930s.\textsuperscript{61} Weir had to write an entire chapter in his survey of nursing education to address women’s intelligence, as the social construction of gender was that women were not capable of intellectual pursuits. Nurses had to go against the grain of the social construction of their gender to participate in university education in the early twentieth century.\textsuperscript{62}

\textsuperscript{60} Whitehead, K. “Career advice for women and the shaping of identities.” \textit{Labour History} 92 (2007): 57-74.
\textsuperscript{62} Ibid.
Public Health Nursing

A few of the articles and books that were reviewed for this thesis had information that was relevant to understanding the history of public health nursing in Canada. The literature focused on public health nursing being a preferred area of nursing because of the autonomy and the wages that public health nurses received. Public health nursing was moving from a focus on infectious disease to a more generalist practice by 1950. Public health nursing was guided by the gospel of hygiene.\(^{63}\) While mental hygiene is not mentioned by these articles, it seems as though it would make sense that public health nurses being so steeped in hygiene practices for the prevention of infectious diseases would also relate well to the idea of mental hygiene to prevent mental health concerns.

Minimum requirements for nurses to become public health nurses were introduced in the 1940s. Lyle Creelman, Director of Public Health Nursing for Metropolitan Health Services, advocated for minimum requirements for employment as a public health nurse, which included education.\(^{64}\) She surveyed public health services in BC. Creelman reported, in the 1943 edition of *The Canadian Nurse*, that 50% of new nurse employees did not have adequate public health qualifications.\(^{65}\)

These suggested minimum requirements included study in mental hygiene. An article entitled, *Minimum Requirements for Employment in the Field of Public Health Nursing* in *The Canadian Nurse* stated that public health nursing education should include prevention in psychiatry, as well as medicine, surgery, communicable diseases, and other


clinical areas. In public health nursing education, “A study should be made of preventative medicine (lectures and laboratory), public health nursing, teaching procedure, social work, nutrition, oral hygiene, mental hygiene, and psychology.” Mental hygiene was a part of the suggested minimum requirements for work as a public health nurse.

Public health nursing was a preferred area of nursing. Bates, Dodd and Rousseau, in their work on the history of public health in Canada, wrote that public health nurses, “were counted amongst the profession’s elite,” enjoying greater financial stability and higher salaries than other nurses. McPherson wrote that public health nursing was “the model of all that nursing could and should be.” Public health nurses had more autonomy and professional responsibility than nurses in the hospital. McPherson quoted Ethel Johns, “You are not tied to routine duties like your sisters in the hospitals, you are not harassed with 1001 petty interruptions; you have time to think and read and plan, and above all, you have the opportunity to break new ground; you don't have to patch up other people's mistakes and blunders, you will only have to patch up your own; think of that and be happy.”

Public health nurses had the opportunity to travel, and, according to the Weir Report, they were better paid and experienced more job satisfaction. Public health nursing work changed from a focus on infectious disease to become involved in a variety of services to the public. By 1920, three main areas of specialization developed in public

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67 Ibid., 587.
health: TB control, child hygiene programs, and school inspection programs. TB nurses showed families how to care for loved ones and to prevent the spread of disease. School health nursing included the medical inspection of children in schools and teaching girls domestic skills. Child welfare or child hygiene nursing focussed on infant mortality, health education to new mothers, milk depot programs, and ensuring families had basic supplies for newborns. McPherson states that public health nurses were some of the first groups of “social welfare workers.” Between 1920 and 1950, public health nursing moved to a generalist practice, including venereal disease control, immunization, inspection of preschool children, prenatal classes, home nursing instruction, and prevention of chronic diseases. McPherson wrote that public health nursing relied on evangelical symbolism. The gospel of health and the age of light, soap and water were to serve the public good.

Weir conducted a survey of Nursing Education in Canada in 1932, as requested by the Canadian Nurses’ Association and the Canadian Medical Association. Along with many recommendations he made was, "More emphasis in the training of all nurses, but especially of public health nurses, should be devoted to Mental Hygiene and Sociology (Rural and Urban). These courses, which should be as functional and applied as possible, should receive special attention in the year of post-graduate training, or in the last two years of the four or five-year university course.” This recommendation is particularly relevant to the link between public health nursing and the mental hygiene work at the Child Guidance Clinic.

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71 Ibid.
73 Weir, G.M. *Survey of Nursing Education in Canada*. (Toronto: University of Toronto Press, 1932): 141.
Eugenics

In addition to the articles used to complete the Background section of Chapter One, several more articles were found in the literature review that relate to eugenics. Sterilization and immigration restriction were two important parts of eugenics in Canada.

Dowbiggin wrote about the influence of a Canadian psychiatrist named Clarke who advocated for immigration restrictions, which was part of eugenic principles recommended by Helen MacMurchy. In 1905, Toronto was in a public health crises with the amount of vice, disease, and criminality in districts populated by immigrants. Public health officials believed that indiscriminate immigration led to a rise in mental retardation. Clarke became involved in immigration because of his frustration with psychiatry's unimpressive cure rate. "In other words, eugenics provided a plausible rationalization for the frustrations psychiatrists felt in their professional lives, as well as an excuse to desert the asylum and contribute their self-professed expertise about insanity to the struggle to improve public mental health."74

Grekul wrote about the Sterilization Act in Alberta.75 While Alberta and British Columbia both had sterilization legislation and had about the same population size, Alberta sterilized about ten times more people. The Sterilization Act was brought in by the United Farmers of Alberta (UFA) party in 1928, and remained under the governments of William Aberhart and Ernest Manning until 1972. Marginalized groups, such as women, youth, Aboriginals, and Eastern Europeans were over-represented among those who were sterilized. The Alberta eugenics board passed 99% of the cases brought before

“It never said 'no.'” The popularity of eugenics beliefs in the latter part of the nineteenth century can be traced, in large part, to the faith and hope invested by politicians and social elites in a vision of progress and in the power of science to achieve this vision. Underneath such progressive goals lay solidly-entrenched patterns of structured social inequality and equally pervasive racist and sexist attitudes and beliefs.”

Child Guidance Clinics

The Child Guidance Clinics were started in Boston, MA. William Healy worked in the Judge Baker Foundation in Boston, which was a clinic that was started for the treatment of delinquents, but eventually served children and families from all walks of life. The Child Guidance Clinics made mental hygiene more popular by transforming their work from the delinquent youth to the ordinary young person from any social class. Healy believed that many children with behavioural concerns were actually of normal intelligence and could be treated with psychological interventions. The troublesome behaviour of children, from delinquent behaviour to those more ordinary children who violated moral values, caused adults to look for expert advice. The Child Guidance Clinics were based on a psychodynamic interpretation of the behavioural problems of children, and recommended a team of psychiatric, psychological and social work professions trained to work together to treat problem children. The Child Guidance Clinics spread from the major cities in the United States to Canada and

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77 Ibid., 359.
79 Ibid., 15.
80 Ibid.
81 Ibid.
82 Ibid., 6.
England. Clarence Hincks started the Canadian National Committee for Mental Hygiene in 1918.\(^{83}\)

While the Child Guidance Clinic began to make sense of the behaviour of the child, it also began to focus on the interactions in the family. By 1940, child guidance was synonymous with mother-blaming.\(^{84}\) Social workers worked with the mothers, and the psychiatrists worked with the children.\(^{85}\) This way of understanding mental illness in children has echoes of the eugenic ideas of MacMurchy believing that the mothers were to blame for the deaths of the children.

**Social Construction of Mentally Ill and Mentally Deficient**

The social construction of the mentally ill has shifted over time. A social construction is the idea held by a group of people about a particular phenomenon. This idea has been built by the social group and not by the qualities of the thing itself. A social construction is built by innumerable decisions and interactions of people perceiving a social reality. A social construction, as it is built by a social process, shifts over time and is of interest in historical analysis. The availability of treatment for mental health concerns and deinstitutionalization are some of the influences that have changed the social construction of mental illness. As new treatments emerged, the social understanding of mental illness also shifted and changed. The following articles give some insight into the social construction of mental illness and mental deficiency.

The process of deinstitutionalization came alongside a change in the social construction of mental illness. Finnane explored the opening and the closing of the mental

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\(^{83}\) Richardson, T.R. *The century of the child: The mental hygiene movement and social policy in the United States and Canada.*

\(^{84}\) Ibid., 8.

\(^{85}\) Ibid., 9.
hospital in Australia. By 1990, patients had become consumers of healthcare. Stigma and lack of resources were concerns with having the mentally ill living in the community, rather than the mental hospital.\(^8^6\) Boschma also wrote about deinstitutionalization and the development of community mental health nursing as a reconstruction of institutional places.\(^8^7\) Deinstitutionalization was happening all around the western world at the same time. After WWII, professions such as psychology, psychotherapy and social work were developing in the mental health field. After medications became available in the 1950s, over the next decade there was a move from mental hospitals to general hospital psychiatric units. Nurses had to develop independent and therapeutically-based professional identity as patients moved to the community.

Power inequities were apparent in Weaver’s work. Weaver used data from coroner’s inquests from suicides in Queensland, Australia from 1890-1950 to understand more about the treatment for mental health disorders.\(^8^8\) More affluent people received private psychiatry, while less affluent people were treated in an asylum. Seventy percent of married women who ended their lives were treated outside of asylums. People with severe mental illness, who later committed suicide, were more likely to have been treated in an asylum. Those with less severe illness were given more treatment options, such as psychotherapy. Other treatments changed the ideas around mental illness, including LSD research in Saskatchewan.

Dyck wrote about the use of LSD in the development of biochemical theories of schizophrenia. Nearly all antidepressants and antipsychotics were developed from the


\(^{8^7}\) Boschma. “Community mental health nursing in Alberta, Canada: An oral history.” 128.

pharmacological research that took place in the 1950s. Drugs like chlorpromazine helped to empty mental hospitals throughout North America and Europe. Osmond and Hoffer, researchers in Saskatoon, used LSD to understand schizophrenia. They used LSD to successfully treat alcoholism in 1953. Control trails were just starting in the 1950s, and Osmond and Hoffer failed to use this type of research in their work with LSD. The media in the mid-sixties demonized LSD use and by 1968, LSD research in North America had become criminalized.

Mills and Dyck describe the role of psychologists in Saskatchewan-based mental health research in the 1950s. While Hoffer and Osmond were doing their research on LSD, psychologists Cumming and Cumming were looking at the psychological experiences of patients in the community and warned against deinstitutionalization. Among the psychologists who researched mental hospital patients, Sommer invented the term *personal space*. He found that patients were the culture carriers of the institutions and he found that the arrangement of spaces allowed for patients to interact with each other more. Sommer worked to socially reorganize the mental institution at Weyburn, Saskatchewan. Other psychologists changed the way that the mental hospital operated, including Ayllon who developed token economies and behaviour modification and Weckowicz who researched the perceptual and cognitive worlds of schizophrenia. This psychological research ushered in a new therapeutic paradigm of mental health care, and changed the social construction of mental illness.

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Coleborne reviewed a number of different histories of psychiatry. Coleborne states that social history of medicine has been concerned with the people’s history of health. “People at the margins of good health, or at risk of poor health, have attracted historians' attention for a number of reasons: their stories balance out older histories of the healers in medicine; their histories are important in political terms and allow political engagement with the themes of medicine and the state; and the very documenting of their experiences is perhaps quintessential 'social history.'” Coleborne also talks about familial responsibility in a world where mental illness is managed in the community. The suffering of aboriginal people in the mental institutions, even to the point of being sick and dying, is a topic of colonialism in this article.

Clarke wrote specifically about the social construction of the mentally deficient. Clarke states that the mentally deficient were, "seen as socially and economically incompetent deviants who, if not properly controlled, threatened the economic, social, physical, and moral well-being of their families and communities, the mentally deficient were linked by large tracts of Western society not only with chronic dependency, poverty, vagrancy, prostitution, crime, and a myriad of other forms of 'immoral' and 'antisocial' behaviors but also with the biological degeneration of the human race." Eugenics spread like wild-fire across Canada. Mental hygienists, as part of their emphasis on science,
had placed themselves and their values at the centre of the child welfare movement.\textsuperscript{98} British Columbia passed the Sexual Sterilization Act in 1933. Mental hygienists also recommended removing mentally deficient children from schools and placing them in special classes, which focussed on employment skills.\textsuperscript{99} They believed that if the mentally deficient mixed with normal children, they would negatively affect the normal children.

The family perspective was an important part of the social construction of mental illness. Boschma’s article from 2008 explored the meaning of mental illness and institutional care from a family perspective.\textsuperscript{100} Boschma states that the terms feeblemindedness and mental illness or insanity were used to describe a range of socially unacceptable behaviour. Sterilization of the mentally deficient may have met family needs in settler communities that were struggling to raise their developmentally challenged children in difficult circumstances. Families negotiated admission to the mental hospital. Socio-economic problems were often a reason for admission. Women were often the caretakers of the mentally unwell.\textsuperscript{101} Family interactions could be an important part of the development of understanding about mental illness.

\textit{Summary}

The literature search on mental health, nursing, children and youth, and history gives context to this thesis work. The influence of power differences, gender and considering women’s work is relevant to nursing history. Public health nursing education will be explored in this thesis, so the information on the history of public health nursing is important to place this thesis in perspective. Eugenics and the social construction of

\begin{itemize}
\item \textsuperscript{98} Ibid., 68.
\item \textsuperscript{99} Ibid., 71.
\item \textsuperscript{101} Ibid.
\end{itemize}
mental illness and intellectual disability have been explored in the data for this thesis, so a
greater understanding of these concepts has been explicated here. Finally, a better
understanding of the mental hygiene movement and the Child Guidance Clinics is
important to this work.
Chapter Three: Research Design, Methodology, and Procedures

In comparison with the approaches to inquiry typically used in nursing research (informed primarily by science), historical approaches (informed primarily by humanities) are not as concrete or clearly defined. Historical inquiry involves reading, thinking, writing and rewriting while trying to represent the data accurately. One nurse historian describes her approach to historical research this way: “I get curious about a problem and start reading up on it. What I read causes me to redefine the problem. Redefining the problem causes me to shift the direction of what I’m reading. That in turn further reshapes the problem, which further redirects the reading. I go back and forth like this until it feels right, then I write it up and send it off to a publisher.” Historical work is an iterative process, without firm methods and procedures. However, for the purpose of having a systematic and appraisable work, the methods section will be laid out in detail.

Historical inquiry begins with a set of questions or a broad area to be explored. I started my work with an interest in my own clinical area – child and youth mental health. I am a nurse with experience working in mental health services for children and youth in British Columbia, and currently hold a position as a nurse educator in this same field. In addition, members of my family have struggled with both mental illness and intellectual disability. I am aware of the services that are available for children and youth in mental health today in British Columbia and these experiences influenced my choice of topic and lent direction to the type of questions with which I approached the data.

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Historical data can be documents, photos or artifacts related to the topic under study.\textsuperscript{104} Importantly, data must be both rich (providing enough evidence to piece together a story and argument) and accessible. For this thesis I relied heavily on archives from the Riverview Hospital in New Westminster, B.C, described more fully below. In addition to historical documents from the Riverview Historical Society, I also used the published annual reports of the BC Government, submitted to the BC Legislative Assembly from the period under review (1932-1950), as well as material on the public health nursing program at UBC, housed in the UBC History of Nursing Archives.

After the data had been collected, research questions, review of literature, as well as an analysis and integration of findings into current knowledge were completed.\textsuperscript{105} This is the same process as other types of nursing research. Pijl-Zieber, Grypma and Barton state that, “nurse-historians bring both an experiential and theoretical lens to data analysis.”\textsuperscript{106} The research topic and questions came from my own experience as a nurse working in child and adolescent mental health. The research questions for this thesis were:

1. What was the relationship between the Child Guidance Clinic and public health nursing education at UBC?
2. What was the cultural and societal context of the Child Guidance Clinics?
3. How were mental illness and disability socially constructed in the 1930s and 1940s in British Columbia?

\textsuperscript{104} Pijl-Zieber, E., Grypma, S. and Barton, S. “Nursing education: Rearranging deck chairs on the Titanic, or cruising into our golden years? A Retrospective.” \textit{Western & North-Western Region, Canadian Association of Schools of Nursing} (forthcoming).


\textsuperscript{106} Pijl-Zieber, E., Grypma, S. and Barton, S. (2013).“Nursing education: Rearranging deck chairs on the Titanic, or cruising into our golden years? A Retrospective.”
4. How were power differentials, such as gender, class, religion, or race, negotiated in the Child Guidance Clinics and public health nursing education at UBC?

Archival Sources Used

*BC History of Nursing Archives.* All of the data from the BC History of Nursing Archives was from the Edna Muriel Upshall fonds. These included some of her school reports and other documents related to her public health nursing education at UBC, from which she graduated in 1929. A few notes from an audio tape of Edna Muriel Upshall and two other public health nurses talking about their experiences in the 1930s have also been used.

The Edna Muriel Upshall documents are of a personal nature. The main document that was used from Edna Muriel Upshall was one of her term papers on the feebleminded while she was a student at UBC. The class paper would have been written using directly the information and knowledge that Upshall learned in class. Because it is from her class, it is a good representation of what students would have learned. Other documents, such as one about the history of public health nursing in Nanaimo, would have been retrospective and would not provide a clear snapshot of what was believed about a complex topic, like mental illness or mental deficiency, at a particular time.

*Annual Reports of the Medical Superintendent and Child Guidance Clinic.*

The bulk of the data of this thesis came from the Annual Reports of the Mental Hospitals of the Province of British Columbia. This data was located at Riverview Hospital Historical Society Archives. The Annual Report of the Mental Hospitals of the Province of British Columbia began to document the mental health services in BC for the Legislative Assembly. The Child Guidance Clinic reports, along with the Social Service reports have been photographed from 1933, the first year they appear, to 1960, a few
years after the last Child Guidance Clinic Report. To help give the context of other changes happening in mental health practice, The Medical Superintendent’s report for the same years was also included. To help limit the context of this thesis, only the documents from the beginning of the clinic in 1932 to 1950 have been analyzed. All of the data from the annual reports of the Child Guidance Clinic, and the annual reports of the Medical Superintendent of Mental Hospitals was written for the purpose of the Legislative Assembly in Victoria to review the various mental health services in BC. These reports would have been written and reviewed carefully before they were published. Government officials would have reviewed them carefully so they reflected the accepted point of view of the time. These documents are the key to fulfilling the objectives presented above.

*Miscellaneous reports from Byrne, Director of the Child Guidance Clinic.* As a cover letter states, in 1992, Judge B. Patricia Byrne sent a package of letters, papers, and speeches written by Crease, one of the prominent psychiatrists at Riverview Hospital, to her father. Photographs were taken of each of these documents, with a total of 160 pages. This file was provided by the Riverview Hospital Historical Society. Most of these documents date from about 1950. These documents were crucial in understanding how the social construction of mental illness had evolved from 1932 to 1950.

Many of the miscellaneous reports from Byrne in the late 1940s and early 1950s were documents that were used for professional training or for community education either in person at Parent Teacher Association (PTA) meetings or over the radio. These reports are highly reliable because of their professional nature. They were intended for a wider audience than personal items or documents would have been.
Data Analysis

Historical research is “not inherently rule- or procedure-based.” Historians can prefer ambiguity in variables and causation, rather than firm and irrevocable truths. The basic method of historical analysis is reading, writing, and representation. One reads to learn, to discover what is and what is not, and to understand the variables. It is an inherent goal of historical analysis to understand evidence in the context of its time. Writing and rewriting is the method of processing and analyzing the data. Representation is to present the data in a way that would be accessible for not only nurses, but patients and the public.

In all cases the data collected was copied using a digital camera. How have these digitized copies been read, analyzed, written, and represented? I started my work by organizing and coding the data. I organized the data into folders by type (annual reports, miscellaneous reports, and books), and then in each folder by year. I began my work by reading the data and transcribing parts of the data that fit with my research questions into a spreadsheet, along with citation information, such as the year, author, etc. I then started systematically organizing the data into codes. I then organized these codes into categories that fit the research questions. The categories were: Prevention, Education, Changing Meanings of Mental Illness, and Chronology. The Prevention category was about the actual work of the clinic. The Education category was about the education of public health nurses and other professionals as it related to the data. Changing Meanings of Mental Illness was meant to encapsulate many of the findings about the social

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construction of mental illness. The final category, Chronology was anything that was interesting in the data that would help provide context to the overall findings. These were the first steps in organizing the data.

I then needed to represent my findings in writing. I found this to be an iterative process between writing and reading the data. I would read the data that was coded with the same code, and then create a written description of what the data was about. When the context of the data in the spreadsheet was unclear, I would re-read the original documents to help understand and be able to represent my findings in writing. My writing began as a simple description of the data. As I described the data, I asked questions, such as, “What does this mean for nursing?” These questions that arose have guided my analysis and discussion.

To describe this process step-by-step:

1) Read source
2) Record quotes, ideas, questions, and relevance in a spreadsheet document
3) Organize spreadsheet into codes and then categories that relate to the research questions.
4) From the organization of themes, describe the data in writing
5) From the description and organization of data, analyze and interpret the findings.

Ethical Considerations

An ethics review was not necessary for this thesis work. All of the data that was used was available in the public domain. My data does not include anything that is of a personal nature. Most of the data is simply government-issued reports on mental health services around the province. When the data was about patients, it was presented in an aggregate format, which would not allow the singling out of any individual patient. This
is fitting with the Trinity Western University Research Ethics Board statement available online which is, “An ethics review is not required when research data are derived from a) a public data base where aggregated data which cannot be associated with any one individual or group of individuals is obtained, b) observations of behaviour within a public gathering which cannot be associated with any specific individual, organization or self-identified group of individuals, and/or c) information already in the public domain (e.g. autobiographies, diaries or public archives).”

Genuiness and Trustworthiness

The nature of truth in historical writing is contested. While there is no objective truth in history; the purpose of doing historical work is to make an accurate and true sense of the past. Multiple truths allow for a more complex understanding than one-dimensional truths. I have represented a few different truths about my subject, Josephine Kilburn and about her context and mental hygiene work. A historian should aim to be truthful to the data. This means being careful about your own values and interpretations. I am a nurse with experience working with children and youth that have mental health concerns. I bring my own interpretations and assumptions into this work. My questions and curiosity have shaped this work, and my understanding has shaped this analysis and writing.

Having genuine data is also very important in the trustworthiness of historical analysis. It is likely that the data that was used for this work was genuine, as all of it was located in an archive. Most of the data that was used were documents prepared for the

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Legislative Assembly of BC and thus have been cared for and bound into books. The genuineness of the data also lends to a truthful telling of history.

One of the ways that trustworthiness can be seen in historical analysis is through the use of footnotes and by using more than one source. Quotations and footnotes of this work reflect its connection to the voice of the key participants, including Kilburn, Byrne, and Upshall. The use of more than one source helps to round out perspectives that may have been too narrow with only one source. A literature search is used to place this work into the context of other historical works. While the transferability of this work will be explored further in the discussion, this work does raise questions of the invisibility of nursing in today’s practice in the care of children and youth with mental health concerns. It also speaks to the power of leadership and educator roles in health care. It was not my intention to paint a completely rosy picture of Kilburn, so I included some information that showed that while she was ahead of her time, there is still evidence of her preference for intellectually normal children, as well as possible race and class discrimination on her part. This provides for more authentic writing and explains Kilburn in the context of her time, rather than merely casting a completely positive picture of her.

Limitations

There are a number of limitations to this study. Historical inquiry is limited by the data that is available. It would have been interesting and valuable to have more data about public health nursing education at UBC between 1932 and 1950. This would have given more perspective on what was taught at UBC in public health and created a more clear connection between what the Child Guidance Clinic was doing in the same time period.

This study is circumscribed by the type of data that was available. Only the Edna Muriel Upshall data was personal. The rest of the data was from professional documents.
Official documents about the clinics were very helpful in understanding the types of clients seen at the clinic, the work that was done, and the professionals that worked in the clinic. It did not help me to understand personal stories. Although some elements of Kilburn’s story can be discovered by reading her reports of her work, it would have been very interesting, and led this study down a slightly different path, if some personal documents had been available.

Summary

It has been an adventure to explore this data and use historical method in this work. It has been my privilege to have access to the data that has made this project possible. This data includes documents related to Edna Muriel Upshall’s education at UBC in public health nursing, letters from Byrne related to his work as director of the clinic, and Kilburn’s reports on the Child Guidance Clinic. This data has been analyzed through coding and represented through writing, revealing Kilburn’s connection to UBC public health nursing as well as the Child Guidance Clinic as a leader and educator. She experienced the Great Depression and WWII, embodied the invisibility of nursing and took part in the public discussion on mental illness. I aimed for an analysis that produced a meaningful and engaging work that has something to say to nursing practice today.
Chapter Four: The Kilburn Connection

Josephine Kilburn was an influential leader in the care of mental illness in children and youth in the 1930s and 1940s. Kilburn was connected to both the Child Guidance Clinic and UBC School of Nursing because of her roles as a leader and educator. While Kilburn was simultaneously discreet and powerful in her roles, the nurses working in the Child Guidance Clinics were rarely acknowledged and nearly invisible. Kilburn, originally a nurse and then a social worker, eventually dropped the title Registered Nurse (RN) furthering the invisibility of nursing in the Child Guidance Clinics. Power differences between Kilburn and Byrne highlight the influence of gender and profession in the late 1940s. While exploring Kilburn’s roles, as well as searching for nursing in the data, the theme of nursing became so inconspicuous it was almost invisible.

Kilburn: Leader and Educator

Kilburn was a key leader of the Child Guidance Clinics between 1932 and 1950. She was one of the primary staff who helped to organize the first Child Guidance Clinic in British Columbia.\textsuperscript{114} In the early years of the Child Guidance Clinics, Kilburn had the dual role as the clinic social worker and psychiatric social worker for Essondale. She began her career as a nurse, although this fact was rarely referenced in the material reviewed. As the Child Guidance Clinic work in Vancouver was only one day a week in 1932, Kilburn continued working at Essondale as well as at the clinic. The Child Guidance Clinic had close links with Essondale, the two places shared staff for the first years of the clinic. Kilburn became the Supervisor of Psychiatric Social Workers in 1939 and continued in a leadership position to 1950 and beyond.\textsuperscript{115} Because of her leadership

\textsuperscript{115} Kilburn, Josephine F. “Child Guidance Clinic.” (1939). X17.
role, she was responsible for writing the annual report for the Social Service Department, which included the Child Guidance Clinic Report. As the Child Guidance Clinics across the province and the Social Work Department at Essondale grew, Kilburn took more leadership of both services. By 1944, Josephine Kilburn became the Provincial Supervisor of Psychiatric Social Work. Most of the detailed information about the Child Guidance Clinic in the data for this thesis was written by Kilburn.

Chronologically, Kilburn was first a nurse, and then a social worker. There is no data on her training or nursing experience. Kilburn’s professional history as a nurse may have led to her long term commitment not only to Social Work education, but also public health nursing education at the University of British Columbia. There seems to be blurred lines between the professions of social work and nursing as she was an educator for both professions. While Kilburn was clearly committed to the education of professionals, her background in nursing may have been a motivating force in staying connected to nursing in particular. Regardless of Kilburn’s motivations to remain connected to the education of nurses, her ideas about her work at the Child Guidance Clinic, rooted in mental hygiene, guided what she taught students.

*Kilburn’s Connection with UBC*

Kilburn was an educator at UBC. The students Kilburn taught included social work and public health nursing. She lectured and arranged practical field work at the Child Guidance Clinic for both sets of students. Kilburn stressed the social implication of

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the psychiatric illnesses in her lectures. Kilburn ensured there was at least a sentence or two in her annual report about the education of students. Sometimes these sections are entire paragraphs. Educating students seems to have been one of her passions.

The public health nursing students had the opportunity to gain practical experience at the Child Guidance Clinic. They came for “study and observation of the techniques employed.” Other notes about the students’ experiences at the clinics state that they had “periods of orientation.” These statements give indication that some of the students spent time at the clinic. There is little information on the number of students that came to the Child Guidance Clinic. For a glimpse into the number of students that the Child Guidance Clinic saw, in 1947, twenty-three public health nursing students came for observation. The public health nurses also had Kilburn as a class lecturer.

It is likely that Kilburn was more than merely a guest lecturer in the public health nursing courses at UBC. Kilburn gave a “series of lectures…In the past University session a request for ten additional lectures was complied with.” While this statement is made generally about Kilburn’s involvement in both the social work and public health nursing programs, this would still mean a significant number of lectures were done by Kilburn. If ten lectures were added to Kilburn’s previous series of lectures, it would mean a significant portion of the classroom teaching of a course would have been taught by Kilburn. This level of influence in these university programs would have an impact on the

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121 Ibid., S26.
students with whom Kilburn was connected. Kilburn’s perspectives on mental illness would invariably make an impression on the students’ perceptions as well.

Kilburn loved teaching and working with students. She made this statement, “This is a most satisfying piece of work, as we later meet these workers in different localities throughout the Province and they are able through this practical experience to further the cause of mental hygiene.” 123 Not only was teaching enjoyable for Kilburn, she also saw the value of the education that she provided in shaping the careers of the professionals she taught. She stated, “We are sorry in that there is not more time to devote to the enlightenment of these young people.” 124 Josephine Kilburn clearly valued teaching.

**Kilburn’s Connection with the Child Guidance Clinic**

The Vancouver Child Guidance Clinic opened in Vancouver on July 15, 1932. 125 The first Child Guidance Clinic was not located on the Essondale grounds, or even in Coquitlam. Esson, Young, and Whittaker, the Provincial Architect, had a house remodelled at 455 West 13th Avenue, Vancouver to suit the needs of the Child Guidance Clinic (see picture). 126,127 While no explanation was given for why the clinic was located in a house, the location did allow the service to become integrated in the community.

The Child Guidance Clinic was meant to prevent children from developing mental illness later on in life. Crease, the Medical Superintendent of the Mental Hospitals of British Columbia, wrote in 1933 that between eight and nine thousand patients were “marching into the mental institutions in this country each year.” 128 The goal of the Child

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129 Picture of the Child Guidance Clinic. Riverview Historical Society, no. 906, CHILD
Guidance Clinic was to “study the personality of the problem child, remedy the deviations from the normal, and endeavour to prevent the child from breaking into the psychotic field, thus ultimately relieving the State of the responsibility of his care later on in life.”

Josephine Kilburn’s writing from the same year confirms this purpose and states, “The whole idea of the clinic is that of prevention…”

The clinics clearly filled a need, which is shown by steady growth in demand and the spread of the clinic services across the province of British Columbia. Services were offered through stationary facilities and a travelling team. While the clinic in Vancouver originally operated one day a week in 1932, by 1939, it was operating full-time. In 1935, appointments in Vancouver had to be booked many months in advance, indicating that it could have been opened full-time earlier. Victoria opened a stationary clinic in 1934. A full-time travelling clinic was Kilburn’s suggestion in 1944 to meet the needs of a number of different communities. The traveling team had regular visits in Nanaimo, Courtenay, New Westminster, and Chilliwack. The traveling clinics relied on partnerships with community professionals, such as public health nurses, to follow through with recommendations for the children that were assessed by the clinic. It is unclear if communities that had regular clinics eventually had their own staff, or continued to rely on the traveling team. This expansion across the province shows the public demand for the clinic’s services.


130 Ibid.
The Child Guidance Clinic’s aim was to prevent mental health disorders from occurring in at-risk children through interdisciplinary assessment and treatment. The clinic’s focus on children with intellectual disabilities waned as the focus shifted to children of average intelligence with emotional and social concerns. The clinic’s assessment included a “complete physical, psychometric, psychiatric, and clinical examination.” These parts of the assessment were conducted by the various interdisciplinary professionals who were involved with the clinic. The staff included not only social workers, but also psychiatrists, psychologists, and nurses. By 1946, both Vancouver and Victoria had permanent full-time psychiatric social workers. The psychologists performed numerous psychological tests to aid in the diagnosis of a variety of concerns explored by the clinic, from reading and writing concerns, to IQ and temperament. They collaborated with the Vancouver School Board to gain access to data that was gathered while patients were in school. The Child Guidance Clinic made recommendations for school adjustments and relied on the school nurse to ensure home co-operation of the recommendations given. To emphasize the value of interdisciplinary teams in mental health work, Kilburn stated, “If the Psychiatric Social Worker were not a participating part of the clinical team, they alone could not enjoy the promising beginning and the additional progress that is in sight.”

The treatment of mental health concerns in children by the clinic developed later on. The early services of the Child Guidance Clinics were more aimed toward the

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diagnosis than the treatment of mental health concerns in children. This focus on assessment and diagnosis rather than treatment became an issue for referring agencies by 1937, when a meeting was held to discuss this concern. At this meeting it was decided that the Child Guidance Clinic should be a treatment centre rather than solely a diagnostic one. This resulted in more families making return visits to the clinic.  

By 1950, social workers at the Child Guidance Clinic had case-loads, which suggests that they had the capacity to follow and provide treatment and recommendations to the children and families that came to the clinic.

**Nurses: The Invisible Professionals**

J. F. Kilburn’s professional designation in the annual reports reflects the relationship between the social work and nursing professions. She was originally a nurse. She would have had training or other experience in social work that helped her qualify as the social service worker in 1932, although this is not mentioned in the data. As the data begins with the start of the clinic, Kilburn’s previous career experience may have been mentioned in an earlier report. It would be interesting to know what nursing experience she had before assuming the role as psychiatric social worker. The RN designation is given as part of her title in the reports only in the years 1934, 1939, and 1940. The inconsistency of her use of the title RN and the fact that she did not use it after 1940 in her reports raises questions about why she no longer identified with the profession or wanted to be seen as a nurse. While nursing was an established avenue of work in the 1930s, the field of social work was just emerging. It is possible that as social work was becoming its own defined professional body, that Kilburn felt it less

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145 Struthers, “‘Lord give us men’: Women and social work in English Canada, 1918 to 1953.”
important or meaningful to identify herself as a nurse. Dropping the RN title may also have made sense as Kilburn’s role changed from Social Service Worker to Supervisor of Psychiatric Social Workers and eventually to Provincial Supervisor of Psychiatric Social Work. In dropping the title RN, Kilburn embodied the reality of how invisible nurses were in the Child Guidance Clinic.

Nurses worked at the clinic, but were overlooked, or considered part of the clerical help. It is interesting to note that, while there is evidence that nurses did work at the Child Guidance Clinics, they were most often not mentioned as part of the team. In one draft of a document entitled “Provincial Child Guidance Clinics,” most likely written by Byrne, one finds that the original Child Guidance Clinic team consisted of Crease and Josephine Kilburn, along with “nursing and clerical help from the Provincial Mental Hospital,” confirming that the clinic had nursing staff in the early years.\footnote{146} This particular line was actually removed from the final version of this document that was prepared to read on the radio in 1950. In another description of the Child Guidance Clinic teams that were being formed in 1946, Byrne lists the staff as follows: “…one psychiatrist with special training in child psychiatry, two clinical psychologists, four psychiatric social workers, including a case-work supervisor, and necessary clerical help.”\footnote{147} Did clerical help also include nursing?

However, the clinic did notice when there was a lack of nursing staff. Kilburn does mention that in 1943 there was no clinic nurse to assist the psychiatrist in the physical examinations, because of the war-time shortage of nurses. The Social Workers took on the role of the nurses for a time. Kilburn notes “While they were not as great a

help to the Psychiatrist, they, in turn, learned a great deal of medical information which
was of value to them in their case-work both for clinic and hospital cases.”¹⁴⁸ Even
though the profession of nursing was barely mentioned in the reports, nurses were
present. While it may be possible that the traveling clinics were held in public health
clinics, and may have been supported by public health nurses, the statement from Byrne
about “nursing and clerical help from the Provincial Mental Hospital,” being part of the
Child Guidance Clinics lends itself to the idea that psychiatric nurses helped, at least at
the local Vancouver Clinic.¹⁴⁹

Kilburn’s work in the education of public health nurses was eventually reflected in
the staff at the Child Guidance Clinic. The original nurses in the Child Guidance Clinic in
Vancouver were from the Provincial Mental Hospital, as confirmed by Byrne above.
Likely due to a variety of factors, including Kilburn’s focus on the education of public
health nurses, the Child Guidance Clinic eventually hired public health nurses. Two
public health nurses became a part of the regular Child Guidance Clinic team in
Vancouver, and one public health nurse was part of the Travelling Child Guidance Team
by 1950. By 1950, nurses had a more established and more visible role in the work of the
clinic.

Tensions between the New Medical Director and Kilburn

Ultan P. Byrne became Director of the Child Guidance Clinic in 1946. There was
tangible tension between Byrne and Kilburn. Byrne’s position as Director of the Child
Guidance Clinics as a man and a doctor emphasized the power differences between men

Riverview Historical Society, Child Guidance Clinic folder.
and women, social work and medicine. Both social work and nursing were considered women’s work, so the power differences outlined here are relevant to nursing.

Byrne’s position as a man and doctor gave him leverage as a leader. In the 1940s, medicine was primarily a male profession. In 1933, Byrne was the head of the laboratory at Essondale.\(^{150}\) As the data for this thesis starts in 1933, I have no record of Byrne’s work experience before the laboratory. While he had apparently been successful in his work in the laboratory, this type of work is not the same as mental hygiene experience. Byrne’s service in World War II may have allowed him more exposure to mental health and prevention.\(^{151}\) After Byrne became the director of the clinic, he attended the University in Toronto to study industrial mental hygiene.\(^{152}\) Another advantage of Byrne’s position was the ability to create international prestige for the clinic. In the year 1949, visitors from England, Australia, Finland and Hong Kong inspected the clinic.\(^{153}\) This type of international prestige was only obtained after the Child Guidance Clinic was led by a doctor. Byrne’s position as a doctor and a man allowed him to have more widespread influence than Kilburn.

By the time Byrne became director, Kilburn had almost 20 years of experience with the Child Guidance Clinics. Byrne, however, also came with a different understanding of treatment in mental health than Kilburn. This will be explored further in the next chapter. The tension between Kilburn and Byrne is apparent in the annual reports of the Child Guidance Clinics. Kilburn continued to write her own report about the Child Guidance Clinic, even though Byrne also wrote a report on the same topic. This transition

seems to be awkward in the data. Even the titles of Kilburn’s reports seem abnormally lengthy after Byrne became Director of the Child Guidance Clinic. Kilburn had to use long sentences as titles such as “Report of Social Worker’s Participation in the Child Guidance Clinic Services.” The simple report title “Child Guidance Clinic” was now taken by Byrne. To further the case that there was tension between Kilburn and Byrne, there are some discrepancies that become apparent in Kilburn’s reports after Byrne became the director. In 1947, Kilburn notes, “The orientation of social workers and public health nurses has been established and has been a function rather than a sideline with the social workers.” This statement shows how important the education of these professionals was to Kilburn and her staff. However, her statement in 1949 about the education of social workers and public health nurses seems out of line with other similar statements that Kilburn made throughout her experience teaching students. She wrote in 1949, “In this last year we have had more students for orientation from one-day to two-week periods…. We are conducting the clinic for the treatment of children primarily, and not a teaching clinic. The latter is incidental but also most important.” It seems as though Byrne may have not agreed with Kilburn’s desire to make the Child Guidance Clinic an essential part of the social work and public health nursing students’ education. It seems that this difference of opinion between Kilburn and Byrne may have been the reason for Kilburn stating that the teaching of students was “incidental,” when everything that Kilburn had written before supports that she believed that the teaching of students was a fundamental part of her work.

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It is noteworthy that the personal tension was palpable through these official reports for the Legislative Assembly of British Columbia. It is possible that Kilburn was reacting to a profound sense of the power difference between herself and Byrne. As a social worker and nurse, did she have the choice to continue in leadership of the Child Guidance Clinic? Her expertise had no chance of helping her hold her position as leader once the decision was made to have a director from the field of medicine. This power difference raises questions about the power differences between professions and genders. Was it because Byrne was a man and a doctor that he could become the director, even while Kilburn was still in her position?

Summary

Josephine Kilburn was the connection between public health nursing education and the Child Guidance Clinic. Kilburn herself embodied the invisibility of the nursing profession in the subtle act of dropping the title RN. Nursing work at the clinic was not often recognized as part of the clinic’s work until public health nurses were hired as part of the team in the late 1940s. The involvement of public health nurses likely had everything to do with Kilburn’s passion for teaching. Power differences were reflected in Kilburn’s relationship with Byrne in the 1940s.
Chapter Five: Kilburn and Changing Perspectives on Mental Illness

Nurses are uniquely situated to be an influence in the social construction of illness. Nursing work includes caring for the ill and through this interaction, nurses create meaning. Nurses develop personal meanings about illness, suffering, despair, as well as hope, love, and care. Nurses carry these meanings to their social network of friends and family members. In the case of nursing leaders, these social constructions could be passed to a broad audience including nursing students and the general public. Their meanings have credibility because of their contact with the sick. Because of their proximity to patients (and therefore authority related to knowledge about patients), nurses have the power to correct false assumptions about illness or to perpetuate stigmas.

Josephine Kilburn’s perspectives on mental illness reflected the changing and sometimes contradictory perspectives in mental hygiene. Mental hygiene was based on scientific and humanitarian views on mental illness, and eventually introduced psychological constructs. This chapter will explore some of the changes and challenges of the incongruous perspectives present in mental hygiene practice. Kilburn contributed to the popularization of mental hygiene through community contact. Kilburn’s direct experience with children and families at the Child Guidance Clinic gave her unique insight into the meaning of mental illness.

To gain perspective on Kilburn’s ideas about mental illness, this chapter will compare Kilburn’s views with two others: Edna Muriel Upshall and Byrne. Upshall was a student of the public health nursing program at UBC. She graduated in 1929. One of her term papers in 1929 was on the mentally deficient and represents the wider held views of many health professionals of her day. This paper lends some contrast with Kilburn’s
perspectives in the early 1930s. Byrne, as explored in the previous chapter, became Director of the Child Guidance Clinic in 1947. His perspective on mental illness shows the developing treatment in child mental health. However, in order to set the stage of this comparison, one must understand the societal context in British Columbia between 1932 and 1950.

The Social Context of the Great Depression and WWII

To begin this chapter, it is important to understand the broader social context of the time period that Josephine Kilburn lived and worked in. The time span of the data collected on the Child Guidance Clinic goes from the beginning of the Great Depression through the end of WWII. The Great Depression made its impact on children and families in British Columbia. As families suffering from poverty doubled up in homes, Kilburn wrote that, "the housing situation has, we feel, greatly added to the problem of the poorly adjusted child," including the lack of belonging, security, and discipline.\footnote{Kilburn, Josephine F. “Child Guidance Clinic.” (1945): BB22.} World War II also influenced the mental health of children. "There have been quite a number of cases studied where the fathers have been away in the armed forces and the family difficulties have been precipitated by his absence."\footnote{Kilburn, Josephine F. “Child Guidance Clinic.” (1944): GG23.} WWII also resulted in many parents of feebleminded children being unable to care for their children in the family home, which resulted in “unhealthful and often delinquent forms of self-expression.”\footnote{Kilburn, Josephine F. “Social Service Report.” (1941): N18.} The post-WWII era was one of greater financial security and economic growth. "The business executive, the family physician, the lawyer, judge, or parent run against problems which baffle them and they subsequently call on us for expert help.”\footnote{Kilburn, Josephine F. “Child Guidance Clinic.” (1942): Y20.} These cases were
particularly demanding to the Child Guidance Clinic team because, “they have already been dealt with by intelligent people and still have not improved.”\textsuperscript{160} The Child Guidance Clinic in the time period being studied had seen a number of significant societal changes. Another change that occurred was that the public became more aware of mental illness.

As the public became more informed about mental health concerns and their treatment, public concerns about the ethics of mental health treatment came to the foreground. The media helped to shape public perception of mental illness as well as criticize the mental health systems that were in place. Mental hygiene was a topic in newspapers and magazines in 1937.\textsuperscript{161} While some of the information available in the media may have been educational, the media was also challenging the norms of mental health practice. Crease noted that psychiatry had come to be a real medical specialty in 1946, despite the way that mental health practice was written about in the media. He wrote, “The great impetus rendered to this study has been caused in no small measure by the open criticism given to it by the public write-ups of mental hospitals in the press and the stories told over the radio.”\textsuperscript{162} The media opened up the discussion about mental illness to the general public.

In 1941, Crease wrote about the public concerns around the Mental Hospitals Act. These concerns, in part, may have been raised through the media’s challenging of mental health practices. A new sensitivity to the rights of the individual suffering from mental illness was taking place. The words \textit{lunatic} and \textit{hospital for the insane} would no longer be used. Another change to the act was that patients who were held in the mental hospital for three months received the right to ask for a re-examination by two qualified

\textsuperscript{160} Kilburn, Josephine F. “Child Guidance Clinic.” (1942): Y20.


The Medical Superintendent was also able to request a re-examination of a patient. These changes reflected a powerful movement of change in the public perception of mental illness toward patient rights and away from conformist ideals.

The year 1950 was the end of an era and the beginning of a new chapter of mental health care. Crease retired as the medical superintendent of Essondale in 1950. The first medications for mental health became available in the 1950s. Crease wrote that, "There has been a gradual change taking place in psychiatry. At last it is coming into its rightful place in medicine." All of these changes set the stage for the following comparison between Upshall, Kilburn, and Byrne.

_Eugenics: The Way to Heaven on Earth_

Edna Muriel Upshall graduated in 1929 from the UBC School of Nursing in public health. Upshall’s perspectives on the mentally deficient in 1929 were specifically shaped by her nursing education and are representative of the wider social perception of feeblemindedness at the time. One of Upshall’s assignments in her schooling was a paper entitled, _The Mentally Deficient: A Community Problem_. This paper outlined the recommendations for the mentally deficient in the late 1920s from the eugenicist point of view.

To highlight Upshall’s views on public health and the feebleminded, a document in the Upshall fonds entitled, _Public Health_ gives insight into how eugenics could lead to a heaven on earth:

> Public health consists of the sanitation of towns and cities, including that of dairies, restaurants, epidemics, and a service so that the individual of the

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community may have further opportunity to learn and practice the principles of healthy living. Again, this movement is one to better the health of the community to such a degree that the span of life is lengthened and that the world will gain much happiness as a result of less sickness. Somewhat this same idea is carried out in Edwin R. Embree’s new book ‘Prospecting for Heaven.’ In it is being discussed how it would be possible to have a heaven on earth --and the first consideration is the wiping out of disease and the prevention of mental illness and also the prevention of birth of the mentally deficient [emphasis added].”

The eugenic version of heaven on earth was the prevention of illness and preservation of the health of the population through “sterilization, colonization, training, and permanent supervision” of the mentally deficient. Upshall clearly wrote about the concept of the master race or Great Society to which the mentally defective needed to “adjust himself.” These preventative measures were believed to help ensure that the mentally deficient were not a burden on society. After all, as Upshall stated, “the motto of Public Health is ‘Prevention is better than Cure’ and incidentally is cheaper.”

Upshall wrote in her school paper that sterilization, colonization, training, and permanent supervision were meant to limit the feebleminded burden on society and maximize their usefulness. Sterilization would ensure that the genetics, which were believed to be the primary cause of feeblemindedness, would slowly be wiped out of the

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Great Society. Training would ensure that the feebleminded would be of the greatest possible use in their community. Training started with feebleminded children in special classrooms. They would learn to “read simple articles and do enough arithmetic to allow them to take care of their simplest financial affairs.” It was through training that the feebleminded were believed to have the opportunity to become “law abiding helpful and happy citizens.” Supervision would make sure they were, like children, taken care of forever, "for what are these children of any age but babies mentally.” Colonization would allow for permanent supervision, as well as ensure that the feebleminded were segregated from society and not influenced to participate in criminal behaviour. Colonization would “safeguard the interests of society against the special peculiarities of the feebleminded.” Colonization would protect the feebleminded person from the “evil suggestions and perniciousness of certain sections of society …” There would be “someone to guide him to prevent him degenerating and swelling the population of our asylum, prisons and work houses.” Heaven on earth was believed to be a place where the mentally deficient were no longer a visible part of the community.

*Kilburn’s Perspectives*

Upshall’s perspectives are more strongly linked to the eugenicist view compared to Kilburn’s more moderate views. One must take into consideration that Upshall was a nursing student with possibly little experience with feebleminded children or adults. Her views as written in her paper were solely formed by her education experiences and

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represent the social construction among many contemporary health professionals. Kilburn’s perspectives were formed by her direct experiences with children and their families and represent her clinical expertise. It is interesting to note that Kilburn would begin to teach at UBC shortly after Upshall’s graduation.

Kilburn’s perspectives on the etiology and treatment of mental illness and intelligence reflect her expertise, and a shift in practice from Upshall’s time. While Upshall used the word ‘feebleminded’ to describe a range of socially unacceptable behaviour, Kilburn used a completely different vocabulary. Even before 1935, Kilburn used words like delinquency, mental disease, mental hygiene, behaviour, low mentality, reading disabilities, and personality to describe the concerns to which the Child Guidance Clinic attended. Kilburn’s perspective on mental hygiene of children included a range of potential causes of concerns, not just heredity. In the first year of the Child Guidance Clinic, Kilburn saw that there were a number of internal factors that could lead to mental hygiene concerns, such as hypersensitiveness, personality changes following illnesses, as well as fear and timidity.\footnote{177 Kilburn, Josephine F. “Report on the Child Guidance Clinic.” (1933): L15.} While Kilburn endorsed other parts of mental hygiene, she also shows a moderate connection to eugenic practices. Kilburn recommended that mental defectives should have stabilization in institutions and that families could learn to care for their loved ones by copying institutional care.\footnote{178 Kilburn, Josephine F. “Social Service Report.” (1944): GG21.} This perspective, while still supporting institutionalization, is a more moderate view than Upshall’s perspective who recommended permanent institutionalization. Kilburn also supported training the feebleminded and felt that there was a “lack of adequate training of the feebleminded, and
also of those children who have special abilities in only a few subjects."\(^{179}\) While she supported training and institutionalization for the feebleminded, Kilburn’s perspectives were based on her experience that, “a child of limited mental capacity can make an adequate adjustment and not become a community problem."\(^{180}\) Kilburn’s moderate perspectives on the causes and treatment of mental health concerns came from her experiences working with children at the Child Guidance Clinic.

Kilburn valued the importance of families in her work. Kilburn had a family-oriented view of her work with children because of her perspectives as a social worker and to some degree, a nurse, as well as following with the perspectives from the mental hygiene movement. She changed from merely involving the family in the discussion to making sure that the family situation was being examined for its impact on the child. She mentioned in 1935 that the clinic was interpreting the child’s behaviour to the parents.\(^{181}\) By 1944, Kilburn stated that, “you can not treat an individual only, but the environment in which he lives must also receive attention; so that we have examined whole families as a means of adjusting the total situation."\(^{182}\) Kilburn’s perspective was that families were an important part of the child’s behaviour and would require partnerships with the Child Guidance Clinics.

Kilburn was sensitive to power differences with the families with whom she worked. Kilburn aimed to partner with families supporting children who were at risk of mental illness. While the medical model upheld the expert opinion and authority of the doctor, she recommended to “involve the other members of the family with the idea of

eradicating or abating the causes more on a studied and partnership basis than the imposition of authority. “183 This perspective may have been shaped by the wider mental hygiene movement, and also Kilburn’s own experiences with children and families. These partnerships she developed through her sensitivity to power differences resulted in patients and families losing the “false shame of attending a child guidance clinic.”184 Consequently, they would then start advising other friends to seek advice from the clinic.185 She was able to truly partner with the families that she worked with because of her awareness of power differences.

Josephine Kilburn educated the general public to popularize mental hygiene perspectives on mental illness, like many other Child Guidance Clinics in Canada and the United States.186 “Populizers transformed the troublesome child from the poor immigrant delinquent youth of the social reformers to the ordinary annoying youngster who challenged the authority of parents from any social caste but particularly those families who could claim to belong to a broad middle class.187 Such popularization would influence the social construction of mental illness of the time. While Kilburn writes in 1934 that existing social and medical agencies have co-operated with the Child Guidance Clinic, she states that regular people were not yet “mental-hygiene minded.” She found that the laity was becoming interested in the causes and prevention of social behaviour.188 Members from the general public were actually coming to the clinic to find out what it

186 Jones, Taming the troublesome child: American families, child guidance, and the limits of psychiatric authority, 15.
187 Ibid., 15.
was about in 1933.\textsuperscript{189} For parents and teachers who were interested in the parent-child relationship, talks were arranged in 1935 for the Parent Teachers’ Association and other groups.\textsuperscript{190} As time went on, the Child Guidance Clinic was not just receiving referrals from social agencies, but also from “private physicians, magistrates, and key members of social agencies.”\textsuperscript{191} This suggests that there was a broadening understanding of mental health concerns that included the middle class.\textsuperscript{192} “The community as a whole has become more conscious of mental health and its implications.”\textsuperscript{193} By the 1940s, Kilburn wrote that there was a feeling that the Child Guidance Clinic had a definite place in the communities that it served.\textsuperscript{194}

Although Kilburn was for the most part humanitarian in her thoughts on mental illness, she did make statements that indicated class and race discrimination as well as a preference for working with children of average intelligence. This reflects some of the contradiction between the scientific and the humanitarian parts of the broader mental hygiene movement.\textsuperscript{195} Eugenic thoughts about race, as they were supported by Darwin, Galton, and other scientists, were believed to be the scientific basis of the mental hygiene movement. In a list of problems seen by the clinic, Kilburn listed “lack of early training in the home, due to the inability of the parents to guide their offspring, either due to their mentality, instability, or immorality.”\textsuperscript{196} This statement could be interpreted as Kilburn’s preference for middle class values. She also wrote in one report concerns about mixed

\begin{footnotesize}
\begin{enumerate}
\item Kilburn, Josephine F. “Child Guidance Clinic.” (1934): Q16.
\item Jones, Taming the troublesome child: American families, child guidance, and the limits of psychiatric authority, 15.
\item Kilburn, Josephine F. “Child Guidance Clinic.” (1936): V16.
\item Richardson, T.R. The century of the child: The mental hygiene movement and social policy in the United States and Canada.
\end{enumerate}
\end{footnotesize}
race children being at risk for mental health concerns.\textsuperscript{197} The Child Guidance Clinic did begin to focus more and more on the behavioural concerns of children of average intelligence.\textsuperscript{198} As the child’s cognitive ability could not change, it could not be “treated as the real problem.”\textsuperscript{199} “Obviously, there is nothing to be expected in the way of success if we require a child with an 8-year-old mind to achieve that which requires the intelligence of a 10-year-old child.”\textsuperscript{200} These statements were fitting with the popularization of mental hygiene. While these types of statements were infrequent in the data, they do paint a more rounded picture of Kilburn in her historical context, and show some of the contradictory nature of the mental hygiene movement.

Kilburn’s viewpoint on mental illness was shaped by her direct experiences with children, adolescents and families. Overall, her perspectives showed some of the same understanding about eugenics as Upshall. Kilburn’s understanding of etiology and intelligence was practical. She was sensitive to power differences between medical professionals and families, as well as the stigma of mental illness. Kilburn was actively involved in shifting the public perception on mental illness.

\textit{Byrne: Into a New Era}

Byrne became director of the Child Guidance Clinic in 1947. Byrne held many of the same perspectives on mental illness that Kilburn had. Byrne continued Kilburn’s work to popularize mental illness through engaging the community. He had a psycho-biological understanding of mental illness which was in keeping with some of Kilburn’s perspective.

\textsuperscript{198} Kilburn, Josephine F. “Child Guidance Clinic.” (1940): T19.
\textsuperscript{200} Ibid., X16.
Byrne’s practice was in line with contemporary changes to systematize the diagnoses of mental health concerns, which was a change from Kilburn’s approach.

Under the new leadership of Byrne, clear categories and diagnoses are presented in tables in the Child Guidance Clinic reports in 1949. While the clinic had psychiatrist input earlier from Crease and likely other Essondale doctors, Kilburn had been the primary leader of the clinic. Kilburn, as a nurse and social worker, would not have had a clear objective to make diagnoses systematic. Byrne’s professional medical perspective helped to shape the development of diagnostic categories when he became director of the clinic. Systematic ways of thinking about mental illness were just emerging in the late 1940s, and Byrne’s leadership of the clinic saw it through those changes. Byrne’s leadership, along with changing social constructions of mental illness helped to shape the new organization of mental health disorders in children and youth.

Byrne used media to carry on with the work Kilburn started in discussing mental hygiene with the general public. In 1947, Byrne arranged for the staff to prepare radio talks, hold panel discussions, and meet with groups to educate the general public about Child Guidance.201 Documents from Riverview Historical Society reveal the content of some of the talks and meetings. There were a variety of topics from marriage and parenting to normal sexual development. The Family in the Home was read on the radio in 1947 and The Child at Home and at School was part of a PTA meeting that same year. A document entitled Provincial Child Guidance Clinics, had handwriting on it stating that it was “embodied in radio talk at Penticton March 19, 1954.”202 These talks seem to have been practical parenting advice, as well as guidance for teachers. The media was used as

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an ally to the cause of the Child Guidance Clinic as Byrne carried on Kilburn’s work of
discussing mental illness with the general public. The information presented in these
documents show a bio-psychosocial model of mental illness that was shifting the social
construction of mental illness in British Columbia.

Byrne had a holistic understanding of mental illness that was consistent with
Kilburn’s understanding. During Byrne’s time as director of the Child Guidance Clinic,
new ideas emerged about mental illness being biological as well as having emotional,
social, intellectual, and spiritual dimensions. This perspective is fundamentally different
than the eugenic perspective which was based on heredity. This perspective has many
similarities with Kilburn’s perspective from the early 1930s. "Finally, I would leave with
you the importance of considering the individual as a whole, an entity, a functioning
psycho-biological unit. The individual does not act as a series of separate structural units
or functions, but as Kessler terms it - a psychophysical entity. The mind and body cannot
be divorced and must meet each problem in an integrated way."

The psycho-biological unit included the social, emotional, intellectual, and
spiritual dimensions. Byrne believed that the social dimension, including the family, had
implications for the child’s well-being. Byrne states that, “Thus the family of the child go
to school with him and accompany him when he undergoes the transition through
adolescence. The only way he can meet life is in accordance with what he has learned
from his family.” While the social development of a child was important, there were
“ordinary normal children in ordinary homes, who have problems within themselves, and

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in their personal relationships, that deserve our time and attention, when our objective is
the greatest possible mental health, for the greatest possible number of people.” 205
Emotional health had to do with the psychological needs of affection, belonging,
independence, creative achievement, recognition, and personal worth, things that could
only be internal. 206 Emotional health had to do with internal qualities that would help a
person effectively meet the various challenges of life. Byrne understood intelligence to be
one part of the overall functioning of the child, rather than a predictor of certain success
or failure. The idea that mental deficiency would mean certain moral ruin, or that a high
intelligence would guarantee a successful life was changing. "Even in the adult a high IQ
is by no means a safeguard against superstitions, fraudulence or instability." 207 Byrne
stated that “a degree of mental retardation alone should not be made responsible for a
personality difficulty." 208 Instead, intelligence should be considered alongside the child’s
background, physical status, and their social context. 209 The spiritual dimension was only
briefly mentioned in one of the documents in the collection of Byrne’s reports and
lectures. Byrne wrote about how the personality was developed in a healthy way when the
person “accepts himself, assets and liabilities; learns to live with others in social way and
makes progress in making and keeping friends; gradually develops compromise with life

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205 “Provincial Child Guidance Clinics.” (n.d.) This document seems to be a draft version of the
one read on the radio. Riverview Historical Society, Child Guidance Clinic folder.
Child Guidance folder.
1950” Most likely written by Byrne. Riverview Historical Society, Child Guidance Clinic folder.
1950” Most likely written by Byrne. Riverview Historical Society, Child Guidance Clinic folder.
1950” Most likely written by Byrne. Riverview Historical Society, Child Guidance Clinic folder.
and finds philosophy or religion that gives meaning and purpose to life...”

Byrne shared a psycho-biological perspective of mental health.

Kilburn showed evidence that she also thought that there were psycho-biological dimensions to mental health, although she did not have as concise of language to describe this understanding. She stated that the Child Guidance Clinic’s examination included “social, physical, psychological, and psychiatric” components. A variety of concerns were examined by the Child Guidance Clinic, including heredity, scholastic progress, emotional nature, and “the experiences which evoke the reactions that shape his character.”

Regarding the social dimension, "Child Guidance problems very often concern the whole family and not merely the individual and his environment." While Kilburn did not have as advanced language about the dimensions of mental health compared to Byrne around 1950, there was evidence that she shared a psycho-biological understanding of mental health and illness.

Summary

Josephine Kilburn had a holistic perspective in her understanding of mental illness. Compared to Upshall’s perspectives, Kilburn seems moderate in her views on the feebleminded. She had more advanced views on the etiology and treatment of mental health disorders because of her professional experiences with children and families. Kilburn was able to partner with families, especially because of her sensitivity to power differences. She actively worked to popularize mental hygiene. Kilburn did show some indications that she had class and race biases, as well as a preference for working with

children with average intelligence. Byrne continued Kilburn’s work in popularizing mental hygiene and the work of the Child Guidance Clinic. He also worked to systematically organize the mental health diagnoses used at the Child Guidance Clinic. Kilburn and Byrne shared a multi-dimensional view of mental health.
Chapter Six: Discussion, Conclusion and Recommendations

Discussion and Recommendations

Kilburn was an inspirational educator and leader. She exemplifies the invisibility of nursing, and how nursing duties were taken for granted. She was impacted by power differences, and was uniquely situated to understand mental illness. Studying Kilburn’s life eighty years later has been inspirational to me. I have learned so much about my own practice from studying hers. Kilburn experienced power differences between herself and the psychiatrist, as well as with the children and families with whom she worked. These power differences were a reflection of the traditional family roles of the man, woman, and child. While the power imbalance with the psychiatrist was a challenge, her awareness of power differences with families allowed her to put aside the imposition of authority to partner with her patients. Health professionals are uniquely situated to shape the social construction of mental illness because of their experiences with patients. They should continue to leverage this knowledge to influence our society’s ideas about mental illness.

Kilburn was an example of the invisibility of nursing. She allowed her title of RN to fade into the background like the nurses who worked at the Child Guidance Clinic. It is difficult not to notice the similarity in today’s context: Nurses in today’s mental health services for children and youth in British Columbia continue to fade into the background. I believe that they are actually at risk of extinction.

Kilburn’s role in two women’s work professions may have influenced her experience of power differences. Josephine Kilburn’s career as a social worker and a nurse shows relatedness and differences between these two women’s work professions. Social work was a profession that had parallels with motherhood and traditional female
roles, much like nursing. Women’s work professions were particularly influenced by power differences between men and women and were modeled after traditional family structure and motherhood roles. Kilburn was likely never married, as the convention was that married women would leave the work force. Even as a single, career-oriented woman, her work did not leave the framework of motherhood. Kilburn showed a reflection of these power differences in her relationships with Byrne and with her patients. The power difference with Byrne was a challenge, as he was in authority over Kilburn, much like the traditional husband role in the family. The power difference with the patient resulted in Kilburn’s caring and partnering, much like the role between mother and child. The paradigm of women’s work and motherhood was very apparent in the power differences experienced by Kilburn.

Kilburn’s work was influential in her time and has had an influence on my practice. I identify with the challenges of making education of students a priority. This is especially important as many professionals view education of students as something that gets in the way of patient care, or as a mere favour to the universities. I hope that the lessons learned from this work can be applied to other nurses in their roles as educators and leaders in mental health services for children and youth and the broader mental health care community. During my thesis work, I have been hired as Clinical Nurse Educator for Child, Youth and Young Adult Mental Health. My role as an educator and leader in mental health services for children and youth has some parallels with Kilburn. Studying her career has influenced the way that I think about power differences in my work, the voice of nurses and the understanding that nurses have because of their work directly with

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214 Struthers, “‘Lord give us men’: Women and social work in English Canada, 1918 to 1953.”
patients. I can see how important it is for nurses to be part of the conversation about stigma and mental health services for children and youth.

Just as the nurses at the Child Guidance Clinic became invisible, the same concerns stand today in Child and Youth Mental Health in British Columbia. I worked as a nurse in one of these teams in the Lower Mainland. To my knowledge, there are less than 10 nurses in total across the Lower Mainland teams in Child and Youth Mental Health. With my move back to acute care and a colleagues’ move to another province, I assume this number is now even less. These numbers lead me to believe that nursing in the mental health care of children and youth outside of the hospital is near extinction. I believe that nurses continue to have difficulty articulating the important role they play in a mental health team for children and youth. I believe that nurses have a unique perspective on mental illness and are an important part of the mental health team. Nurses understand severe mental illnesses such as schizophrenia and bipolar disorder as illnesses that need medical treatment, as well as psychosocial care. They can provide medical treatment and monitoring, such as taking vital signs and administering injectable medications that falls outside of the scope of their colleagues’ practice. Nurses understand medications, their side effects, and doses. Nurses understand the integration between acute care and community settings and how to leverage these setting for the advantage of their clients. Nurses understand the importance and the use of the Mental Health Act to ensure the care of their patients. I believe that interdisciplinary teams that include nurses are the best way to care for children and youth who have mental health concerns. If there is no voice for nurses in our current community care settings, care for our clients will suffer, if it has not already.
The paradigms have shifted for nursing. The way that nurses partner with patients has been influenced by the consumerist movement, which has changed the power that patients have in the relationship. Patients also have a different understanding and value of the work and knowledge of nurses. However, very vulnerable patients can be negatively influenced by the power differences between professionals and the patient. The power difference between genders is different than in the past, especially with more male nurses and female psychiatrists. Power differences are more likely seen in a nuanced way than overt ways between professions, genders, and between health care professionals and patients. Nurses should continue to explore the way that they are influenced in their work by power differences.

Nurses are uniquely positioned to understand the concerns of the populations for which they care. Nurses working in mental health care should work to shift stigma around mental illness. Josephine Kilburn had a depth of understanding about mental illness and intellectual disability because she worked directly with the children and families at the Child Guidance Clinic. She also actively worked to engage the professionals and the public in the discussion around mental health, both through connecting with the community and being involved in professional education. Kilburn stated in 1944, "Psychiatry should not be for the use of the few working in this particular field but should be an implement for use in allied fields and for the individual." She believed that knowledge in psychiatry should be used not just in mental health work, but also across different professions, as well as for individuals in the community. Kilburn was engaged in the professional education of public health nurses and social workers at UBC. Through

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these efforts to engage the community and nursing education, Kilburn influenced the public’s concepts about mental illness.

Nurses today have the opportunity to be engaged in the public conversation occurring online around mental illness. Nurses have unique knowledge to share because of their experiences working with children who suffer from mental illness. Mental Health Services, including nurses, should be engaged in social media and the internet because the general public often gathers information about anxiety, depression and psychosis from these sources. Some of the websites that break down stigma the most powerfully offer personal stories of mental illness. There are also many apps that can assist patients in their mental health treatment, from ones that help patients track their moods, practice mindfulness, and prompt patients to use their Dialectical Behaviour Therapy skills. While technology is breaking down stigma and aiding mental health treatment, it can also impact mental health in negative ways. Social relationships are changing because of technology, which may have a negative impact to those that are vulnerable to mental health concerns. Unfortunately, the internet can allow people to have access to information that is not helpful for their mental health, such as methods to commit suicide, or pro-eating disorder sites. As the internet is our culture’s social and public forum, it is very important that nurses are involved in the social construction of mental illness online.

Conclusion

In conclusion, I would like to answer the questions explored in this thesis. The first question was that of the relationship between the Child Guidance Clinic and public health nursing education at UBC. One single person can link whole organizations and ideas together. Kilburn was one person who linked public health nursing education and the child guidance clinic together. One organizational chart in 1950 shows that public
health nurses were hired by the clinic, which is potentially reflective of Kilburn’s work in mental hygiene training of public health nurses. The education that she was involved in at UBC played a key role in the scope of nurses’ work. Secondly, the Great Depression and WWII were the social context. WWII atrocities, although never mentioned in the data, likely were an influencing factor on shifting social constructions of mental deficiency and mental illness away from the eugenic practices of sterilization, education, segregation, and colonization. The third question was about the social construction of mental illness. Mental illness was in some ways stigmatized in the general public. Kilburn worked to popularize concepts from mental hygiene as many mental hygienists did. Power differences were present between professions, genders, and between nurses and patients. Kilburn used her understanding of power differences to partner with her patients. Finally, Kilburn exemplified the invisibility of nursing. Just as she dropped the title RN from her name, so the nurses at the Child Guidance Clinic were hardly recognized for the work that they did. Nurses today need to give voice to their work so that they can continue to be an influence in the care of children and youth with mental health concerns.

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216 Provincial Mental Health Services – Child Guidance Clinic and Mental Health Centre. (Dec 9, 1950).
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Weir, G.M. *Survey of Nursing Education in Canada*. Toronto: University of Toronto Press, 1932.


### Appendix A – Search and Retrieval Strategies for Literature Review

#### April 6, 2012 JSTOR search

**Goal is to retrieve historical method articles relevant to thesis**

<table>
<thead>
<tr>
<th>Search Query</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 searched ‘history’ (All are searched with full-text selected)</td>
<td>2422992</td>
</tr>
<tr>
<td>#2 searched ‘nurs*’</td>
<td>129396</td>
</tr>
<tr>
<td>#3 nurs* AND history</td>
<td>52166</td>
</tr>
<tr>
<td>#4 historical methods</td>
<td>394605</td>
</tr>
<tr>
<td>#5 historical methods AND nurs*</td>
<td>9996</td>
</tr>
<tr>
<td>#6 historical methods AND nurs*(from 2007)</td>
<td>567</td>
</tr>
<tr>
<td>#7 Applied inclusion/exclusion criteria From title:</td>
<td>23</td>
</tr>
<tr>
<td>• Obviously from ecology, biology, sociology, law or politics (without reference to nursing, health, social</td>
<td></td>
</tr>
</tbody>
</table>
- Accessible
- No evidence that the study may be a nursing history article

From Abstract:
- No mention of history or not a historical study
- No mention of nursing, women, social determinants of health, health issues or health policy
- Historical study outside of approximate time range (such as ancient history) or outside western world (such as Turkey)

#8 Further exclusion criteria:
- No mention of mental health, public health, gender or children

<table>
<thead>
<tr>
<th>Results: 8</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31, 2012 Cinahl Search</td>
<td>Articles Relevant to history in mental health of children and public health</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>#1 searched mental health in the cinahl headings – clicked on every single word related to mental health</td>
<td>Results: 59347</td>
</tr>
</tbody>
</table>
| Just ‘mental health’ | Results: 61253  
(more results just searching ‘mental health’) |
| #2 Searched history in the cinahl headings and included every related field in the heading menu, except for those related to dentistry and dental hygiene. | Results: 143678 |
| Just ‘History’ | Results: 83573  
(more results using all of the different terms) |
<table>
<thead>
<tr>
<th>#3 Searched ‘Child’ in the cinhal headings. Included all related terms, but excluded specific illness and parental concerns</th>
<th>Results: 245737</th>
</tr>
</thead>
</table>
| Just search ‘child’ | Results: 230899
(More results using all of the different terms) |
<p>| #4 Searched using just mental health, the expanded version of history and child | Result: 867 |
| #5 Realized that I also needed something to do with Adolescence. Searched Adolescence. Including all of the subheadings under adolescence except for the specific diseases | Yield: 171870 |
| Just ‘Adolescence’ | Result: 171024 |</p>
<table>
<thead>
<tr>
<th>#6 searched the expanded versions of the child and youth searches. Combined using OR.</th>
<th>Result: 338860</th>
</tr>
</thead>
<tbody>
<tr>
<td>#7 (Child OR Youth) AND mental health AND history (expanded versions of child, youth, and history used)</td>
<td>Result: 1243</td>
</tr>
<tr>
<td>#8 Made it so it was only full text articles (just because of time – this was not meant to be a knowledge synthesis)</td>
<td>Results: 465</td>
</tr>
<tr>
<td>#9 Seems like all of these articles would be highly interesting to read. Wondering if it would be helpful to narrow it a bit to nursing care.</td>
<td>Results: 58</td>
</tr>
<tr>
<td>Nurses AND (all the rest above)</td>
<td></td>
</tr>
<tr>
<td>#10 Inclusion/Exclusion Criteria</td>
<td>Result: 1</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Excluded: if specifically states it is from a non-western country</td>
<td></td>
</tr>
<tr>
<td>if content is not readily understandable from the title</td>
<td></td>
</tr>
<tr>
<td>if about an illness, not mental health</td>
<td></td>
</tr>
<tr>
<td>if about dementia</td>
<td></td>
</tr>
<tr>
<td>Separated between Present-focused and historical inquiry. Only one paper presented anything to do with historical data</td>
<td></td>
</tr>
</tbody>
</table>