camh Centre for Addiction and Mental Health

Mental Health at Earlier Toronto Margins –

An Historical Perspective

Psychiatry
UNIVERSITY OF TORONTO

Institute of Medical Science
UNIVERSITY OF TORONTO

Mental healthcare in this region has strived to advance through allied partnerships and scientific evidence, while faced with overcoming stigma and misunderstanding

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History's Value for Clinical Care and Scientific Research

- **Expanding our awareness for revealing errors**
- **Detecting distortions in knowledge as applied to patient care**
- **Helping avoid mistakes in public policy, *e.g.*, early 20th century's extreme eugenics**

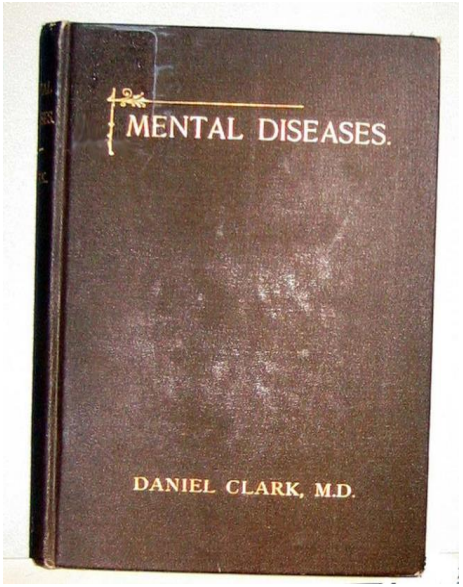
- **Offering a perspective for insights on possible trends**
- **Concluding: History seldom provides direct answers - rather, a context within which to seek them.**

- Musto DF (1978), *Am J Psychiatry* 135 (July), Supplement, 22-6

History's Benefits for Health Professional Learning

Learning the history of health care is said to:

- **contextualize medical practice;**
- **reveal the provisional and fallible nature of medical knowledge;**
- **foster a cautiousness and humility in the medical thinker;**
- **complement the teaching of bioethics through illustrative real-life examples;**
- **instill humanity in medicine's white-coated experts;**
- **improve the skills of medical history-taking and constructing;**
- **improve the skills of critical appraisal and interpretation of evidence;**
- **promote scholarship, and contribute positively to professional identity-formation."**



Fuller, J. and Olszewski, M.M. (2013). "Medical History in Canadian Undergraduate Medical Education, 1939 – 2012," *Canadian Bulletin of Medical History, 30:2, 200.*

Historical mainstream advances edged forward from custodial asylums and isolated experimentation to "Moral [humane] Treatment" a.k.a. "Moral Therapy"

The Enlightenment (age of reason) – end of 17th Century through the 18th C.

- Political revolutions leading to new values
- the rise of the individual within society
- Decline of the church as the centre of thought
- Rise of science as the new epistemology
- For mental illness care: Pinel (France), Tuke (UK), and Thomas Kirkbride (USA) influenced gradual emergence in Canada

Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury.
Pinel removing the chains from patients
at the Paris Asylum for insane women.

Mid-19th Century launch of Toronto's Asylum Era

Upper Canada's Temporary Asylum (far left) operated independently and as a stop-gap, while the first permanent mental health facility was constructed - opening in 1850. It was designed to be state-of-the-art for **"the care, *not* the incarceration, of the insane."**

"The presence of an institution for the cure of mental diseases, as an adjunct to… the general hospital, will present to the student advantages of an importance that he should not be deprived. … A school for medical instruction, of which the projected lunatic asylum should form a part, will afford results of an immensely valuable nature… to this favoured province."

– College of Physicians and Surgeons of Upper Canada – 1840.

Drugs in psychiatry: 2nd part of 19th century

Morphine (apomorphine) + hyoscine (scopolamine) subcutaneously (Wood 1855):control of excitement, agitation and aggression.

Potassium bromide (Lockock 1857): relieving restlessness, anxiety and tension.

Chloral hydrate (Liebreich 1869): calming and inducing sleep.

Paraldehyde (Cervello 1882): calming and inducing sleep.

Effects on psychiatry:

Day and night-time sedation: replacement of physical restraint by pharmacological means.

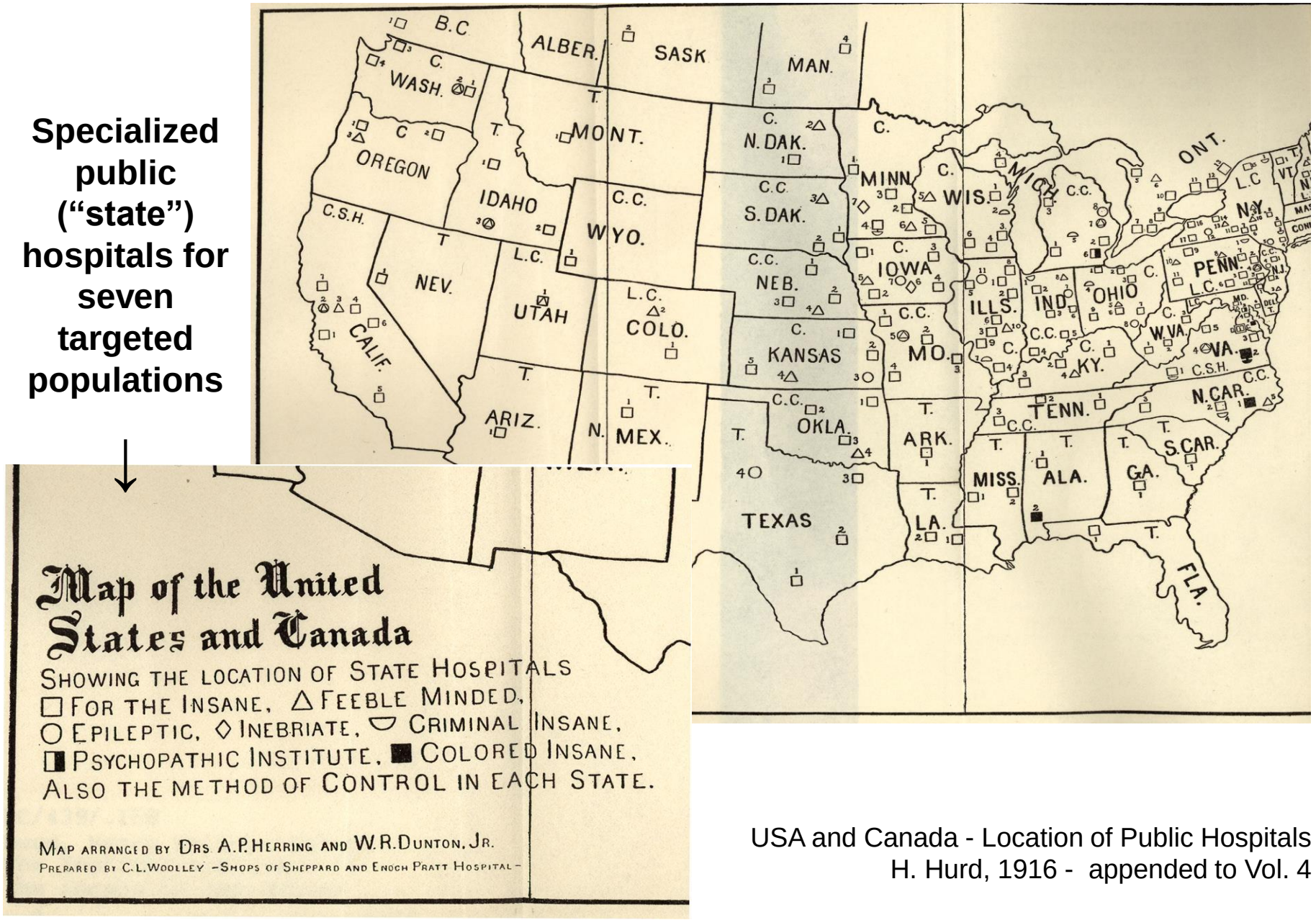
Control of behaviour: collection of information and the study of patients throughout their illness.

Information collected: psychopathology and psychiatric nosology provide a foundation for psychiatry.

SOURCE: Ban, TA, 2018 - Psychiatry and the Pharmceutical Industry - excerpt, 4-5

By the early 1900s, North American MH hospitals had proliferated – 10 in Ontario

Specialized public ("state") hospitals for seven targeted populations



USA and Canada - Location of Public Hospitals
H. Hurd, 1916 - appended to Vol. 4

Ontario's Other Marginalized Populations in Care Settings: Specialized Public Asylums and Residential Facilities – 1914 example

- 43 Hospices and Houses of Refuge
- 33 Orphan Asylums/ Orphanages
- 30 County Houses of Refuge
- Houses of Industry, Providence, Convalescent Homes; Toronto Hospital for Incurables

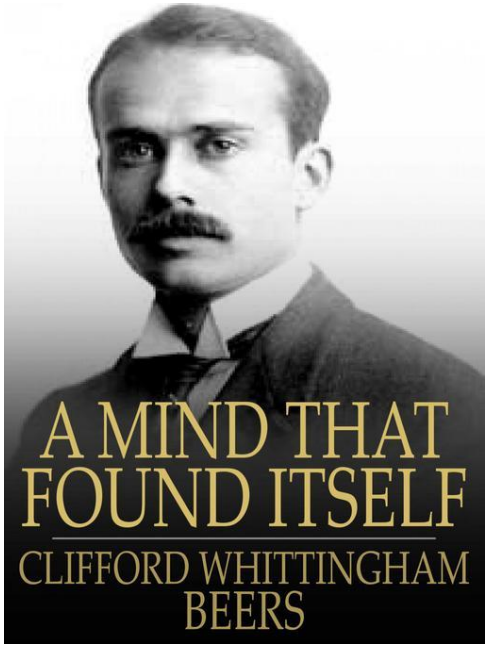
In her Annual Report for 1914, Ontario's "Inspector of Feeble Minded" Dr. Helen MacMurchy, reported in part:

"There are now 33 orphanages in Ontario, and in every one of these, except in the case of one or two who refuse to admit any feeble-minded child, from five to 20 percent of the inmates are feeble-minded. The Social Service Commission of Toronto reports 60 mentally-defective children in the Toronto Orphanages alone. In the industrial schools the proportion is far greater."

Marjorie Keyes, RN of the Feeble Mindedness ("F.M.") Clinic at TGH

MENTAL HYGIENE MOVEMENT

- Increased concern for physical & mental public health and prevention
- Community and politically-based rather than in universities & hospitals – but certain key overlaps
- 1908, USA - Clifford Beers' *A Mind that Found Itself* (upper-right)
- Promoting the idea that mental illness could be prevented
- 1912 - American National Committee for Mental Hygiene (ANCMH)
- 1918 - Canadian National Committee for Mental Hygiene (CNCMH)
- 1951 – Hincks retired; renamed & refocused as the Canadian Mental Health Association (CMHA)




Maclean's Magazine, February 15, 1946

Sterilize

THE UNFIT

By CLARENCE M. HINCKS, M.D.

General Director, The National Committee for Mental Hygiene (Canada)

SUBNORMALITY and mental unfitness seem to be on the increase in Canada. There is evidence that the number of these among 10% of our population vary in mental health from predicted mental disability to a state that might be called marginal disability.

What's more, we can expect the percentage to mount unless we act soon to improve the mental quality of our stock. For the mentally unfit are apparently breeding faster than the fit, and will continue to do so until we prevent those with undesirable hereditary traits from passing their disabilities on to their children.

While stronger mental health and welfare programs are necessary for the prevention and treatment of mental disorders, these measures alone will only partially stem the rising tide of mental disabilities. Common sense and scientific judgment dictate a combined attack on mental health problems aimed at both the environmental and hereditary factors involved. And this means, among other things, selective eugenical sterilization.

Selective sterilization has the backing of psychiatrists and other technical personnel. But no genuine program can be made until the general public sees eye to eye with the scientist and is ready to grant approval.

Sterilization does not involve the removal of organs and it produces no physical changes in the body. It does not in any degree unsex the individual, except in making parenthood impossible. Those who have been operated upon report no change in their marital relations.

Whom Should Be Sterilized?

STERILIZATION should be restricted to individuals who have disabilities of a hereditary nature wherein a predisposition to mental ill health may be passed on to succeeding generations. Such disabilities include mental deficiency or stunted mental development; certain psychoses or so-called insanity; certain forms of epilepsy; and certain pronounced cases of neuroses.

Mental defectives are individuals who always retain the minds of children. They constitute two per cent of our total population. Regardless of how well they are trained they cannot get along without supervision and guidance. In the absence of supervision they contribute, out of all proportion to their numbers, to such social problems as delinquency, dependency, illegitimacy and the spread of venereal and other diseases. If they marry and have children it is a foregone conclusion that a proportion of their progeny will be born with inherent mental defects and that the remainder of their children might just as well be mentally defective because they will be warped by unsuspecting and unintelligent upbringing. In other words, mental defectives are a menace to themselves and others.

Psychotic (insane) individuals differ from mental defectives. It has been well said by Dr. A. F. Tredgold of England that while mental defectives never possessed an adequate mental bank account, psychotics once had a mental bank account but subsequently lost it, or at least part of it. One and one half per cent of the Canadian adult population is afflicted with psychoses, and half of this percentage requires hospitalization.

One form of psychosis, dementia precox, is responsible for more chronic invalidism than tuberculosis or cancer, and requires more hospital beds for its treatment than any other form of human illness. Approximately one quarter of all hospital beds in mental institutions are occupied by victims of dementia precox, carried out in the opinion of authorities by precox patients forces even the most cautious to admit that this disease occurs in certain families at a rate that can be explained only on a hereditary basis.

Another prevalent form of mental illness is manic-depressive psychosis, wherein the factor of inheritance is most important. One third of the offspring of a manic-depressive parent will show the same disorder (whereas in the average population, the frequency is only 4 in 1,000). Another one sixth of the children will show milder mood disorders. If both parents have manic-depressive illness, two thirds of the children will be manic depressive and the remainder will show milder disturbances.

There are other forms of psychosis that owe their origin in considerable degree to inheritance, and it is a well established clinical datum among psychiatrists that psychotic individuals should not have children even after apparent recovery.

Convulsive disorders or epilepsy are as prevalent as diabetes. One in 200 of the population is afflicted. Where epilepsy is not caused by brain injury, it has been found that when one parent is affected the condition is transmitted to 10% of the offspring. Aside from the hereditary factor, parenthood is unwise for epileptics because the added burden of bringing children into the world may invite more frequent seizures.

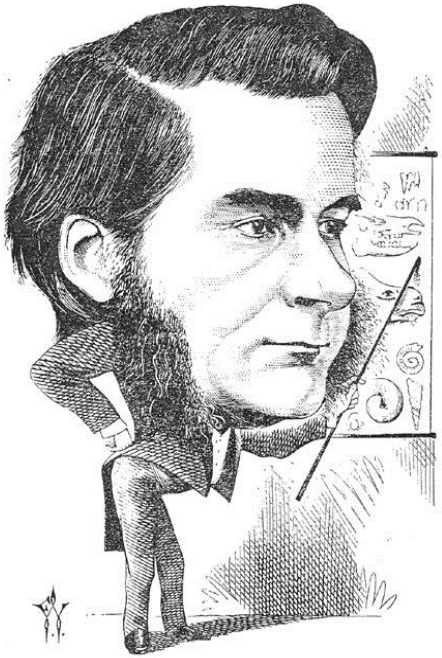
Neurotic individuals suffer from such symptoms as anxiety, hysterical reactions, depressions, extreme fatigue, feelings of inadequacy and so on. One third of all medical practice is devoted to the treatment of neurotics. Although there is considerable second evidence to indicate that people with a pronounced nervous make-up may transmit to their offspring a mental and physical constitution with a low threshold of resistance to neuroticism. Although this field is admittedly more controversial, it is probable that for individuals with very intense, prolonged and disabling neuroses, parenthood is undesirable because of the danger of creating an

Continued on page 39

Our society is menaced by race deterioration, says this authority. His remedy: Prevent the mentally unfit from having children

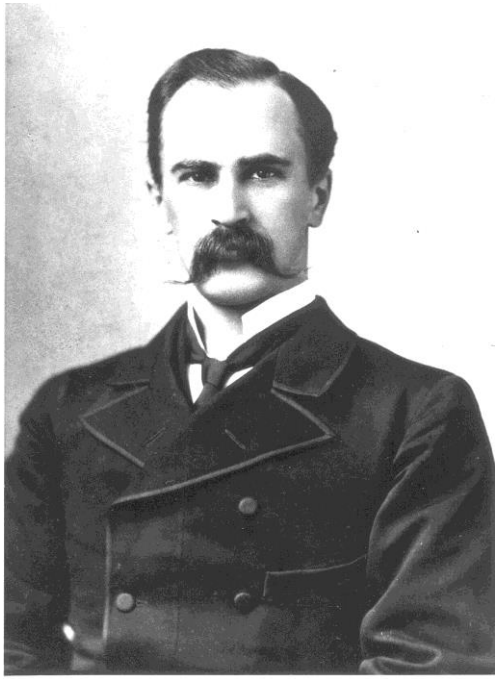
- **1946 article by C.M. Hincks in Macleans, "Canada's national magazine" (right)**

From the 1860s, Charles Darwin's academic associates & followers revolutionized biological and medical education together with clinical science teaching and research



Thomas Henry Huxley - School of Mines (now Imperial College), London, U.K.

Henry Newell Martin - U.K. and Johns Hopkins U.



Sir William Osler – McGill, U. of Penn., Johns Hopkins and Oxford

1880s to 1920s – Biomedical Psychiatry added a novel treatment facility model

Henry Phipps Psychiatric Clinic
Johns Hopkins Hospital
opened 1913

Boston Psych. Hospital, 1917

Toronto Psych. Hospital (TPH), 1925 - 1966

Multi-disciplinary

Professional and student nursing (illustrated: women's infirmary unit)

In 1885 at the Kingston Asylum, Superintendent C.K. Clarke established Canada's first professional nursing school in a psychiatric facility. Returning to Toronto in 1905, he did the same at Queen Street. That led to additional Registered Nursing schools, centrally integrated and teamed with the general hospitals, at the province's other psychiatric hospitals. Clarke also began integrating the emerging allied health disciplines.

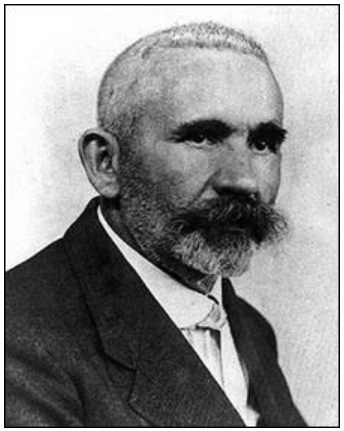
Psychology/ Psychometry

Social services

Occupational therapy

Industrial therapy

1880s to 1920s – Emerging and Competing MH Treatment Paradigms



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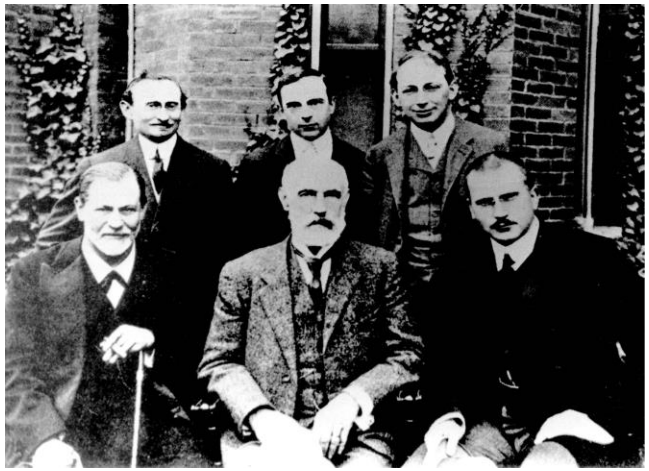


Profs. Emil Kraepelin of Munich (left), Nissl, Alzheimer and others for biological somatic psychiatry vs. Sigmund Freud and his followers for psychoanalysis.

vs.

In Ontario, alienists coalesced from 1907 around Prof. C.K. Clarke (left) of U. of T. Medicine's new Department of Psychiatry.

Neurologist rival Campbell Meyers (right) remained within Internal Medicine, operating a TGH "Nervous Ward" (1906 to 1911) and a private Toronto "Neurological Hospital" (1894 to 1927).

Survey on Psychiatry's Most Impactful Post – WW2 Changes (Micale, 2014)

A. Informal Survey of *ca.* 200 Mental Healthcare Providers – 2011-14

1. The 'psychopharmacology revolution' of the 1950s.
2. Deinstitutionalization, or the movement of massive numbers of psychiatric patients out of state asylums into community health care facilities.
3. The 'decline and fall' of psychoanalysis.
4. Shifts in the practice of psychotherapy from psychiatrists to non-medical professionals, especially clinical psychologists and clinical social workers.
5. The rise of a vast scientific research programme, including massive institutional and financial resources, for studying the neurochemistry and neurobiology of mental illness.
6. The introduction and widespread adoption since the 1980s of a new generation of anti-anxiety and anti-depressant compounds, especially the so-called SSRIs such as Prozac (fluoxetine).
7. A steady increase in the influence of the pharmacology industry throughout the psychiatric profession (e.g. 'big pharma').
8. The growth in influence of the *Diagnostic and Statistical Manual of Mental Disorders*.
9. The multiplication of 'new' diagnoses.
10. The de-pathologizing of homosexuality.

Micale, Mark S., "The Ten Most important Changes in Psychiatry since WW2," *History of Psychiatry*, 25:4 (Dec. 2014), 485-491.

Addendum: which Major Post-WW2 Impacts should we consider adding to those already acknowledged, or re-order in priority?

Which ones will aid most in advancing mental health & wellness?

1. **Combating Stigma** – steadily erode the prejudice and discrimination against MI to raise confidence & self-respect, and improve pathways to care.

2. **Neuroscience, including genetics and DNA research, non-invasive brain therapies, PET scanning** with an array of present and prospective benefits:– diagnostic; early intervention; associating disorders with specific brain sectors or lesions; individually-tailoring therapies and/or medication dosages.

3. **The emergence of the new psychotherapies** (CBT, IP, DBT, etc.) and their demonstrated efficacy when employed in conjunction with **neuroscience and other biological psychiatry**, as recommended by the MHCC (2012, 61).

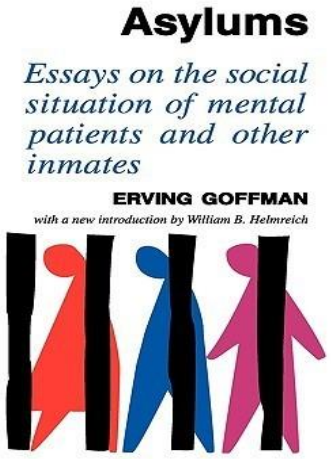
4. The acceptance into psychiatry of certain severe ailment clusters formerly isolated or even disparaged as psychiatric issues, notably **addictions** (commencing with alcoholism → opioids, etc.) and **eating disorders**.

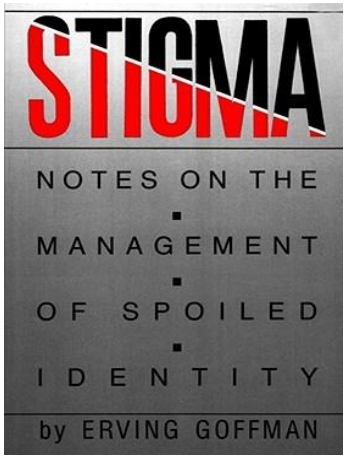
When was Stigma identified as an issue for Psychiatry?

- **1855** – At the annual meeting of the A.P.A. (as now known), Dr. Joseph Workman, the Toronto Asylum Superintendent, did *not* use the term, stigma, yet referenced the **counter-stigmatic impact** of mental illness associated with a highly-prominent, respected sufferer, (the late) King George III. This drew "the attention of the world, and especially the medical profession, to the subject of insanity and its treatment. … Although it was unfortunate… that the Monarch was so severely afflicted, it was probably, in its results, fortunate for humanity."

- **1893** – At that year's A.P.A. annual meeting: "A paper was presented by Dr. Fisher of Boston… in which he recommended that the title *asylum* and the word *insane* in the hospital [name] be removed so that the **stigma** which is thus placed on institutions for the insane be done away with."

- **1961 and 1963 –** Erving Goffman, an acclaimed, University of Toronto alumnus (BA 1945, PhD Chicago), published his highly impactful participant-observation studies that have helped close the asylum era and place **stigma** into general awareness.





Stigma Defined

• Original literal meaning: a physical, visible mark as an indicator of an ailment, disability or other undesirable bodily feature.

• Metaphorically: a negative personal trait or identity indicator associated with infamy, disgrace, opprobrium or social unacceptability.

• Only the original, literal definition was found in two sampled early-20th-century medical dictionaries (1918 and 1928).

• **Psychiatric stigma:** negative feelings & attitudes leading to behaviour expressed against others having cognitive, psychological or organic impairment of their mind/ brain.

• **Attitudes …** an emotional mindset embodying aspects of aspersion, disdain, prejudice, disgust, alienation.

• **Behaviour …** expressed action against individuals or populations targeted by those attitudes via overt subjection to degrees of discrimination.

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Conceptual Model: The Stigma – Compassion Continuum

An array of emotional attitudes toward others that may be experienced subjectively or perceived objectively

← **Identified as Negative** — **Identified as Positive** →

Stigma — **Affectively and Culturally Neutral** — **Compassion** (**)

←----------→

Related Attitudes/ Emotions (along the same continuum)

Prejudice	Suspicion	Openness	Warm regard	Empathy (**)
Abhorrence	Mistrust	Curiosity	Concern	Understanding
Disgust	Apprehension		Pity	Acceptance
Hatred/ despising	Antipathy			Caring
Psycho-/Socio-pathy cluster	Intolerance			Sympathy
Deeply negative connotations (*)				

Related Behaviour – Responses/ Actions (along the same continuum)

Discrimination	Casting aspersions	Indifference	Inquiry	Understanding
Avoidance/ shunning	Resentment	Obtuseness	Expressed concern	Acceptance
Humiliation	Disregard		Other caring & ameliorative responses	
Vehement disrespect	Rivalry		"Beneficent action" (Nussbaum, 2001, ch. 8)	
Verbal/ emotional abuse	Stereotyping			

(*) Wright, D. (2011), 148.

(**) "Compassion involves feeling moved by, and wanting to alleviate suffering. Empathy is the ability to follow feelings and thoughts in oneself and others with kindness and warmth."

Structural Stigma has recently been identified and targeted

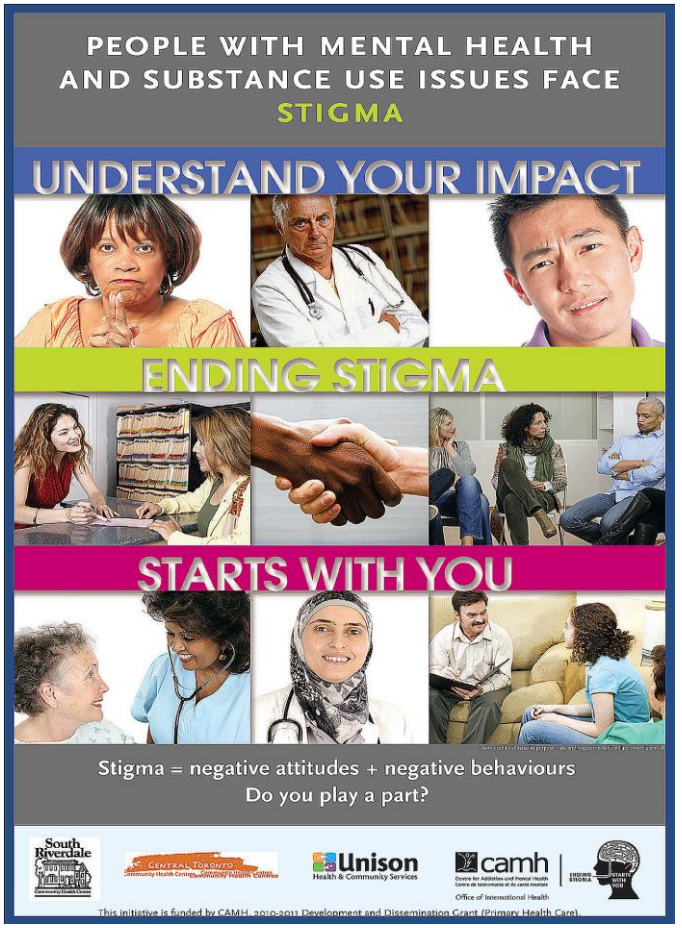
- leadership from the U.N. Declaration of Persons with Disabilities and the Mental Health Commission of Canada (MHCC)

- Moving away from blaming the victim to blaming the accumulated organizational practices that enable or fail to alleviate social inequity

Promote Social Inclusion

Social exclusion of mental health patients manifests in unemployment, lack of social networks, diminished social roles, and lack of economic and social participation. Because poverty, disability, and lack of social networks are in a mutually reinforcing relationship with discrimination and mental illness,[59] it is an ethical and pragmatic imperative to actively promote social inclusion in this population.[60–62] A deep cultural shift is needed to achieve social inclusion of patients with mental illness: both significant educational efforts for

- Abbey, Susan *et al.*, 2011, Stigma and Discrimination, C.P.A. Position Paper – *Cdn. J. Psychiatry , v.*56-10



- Poster excerpt - CAMH Transformative Global Health and partners

> As health care providers, we must continue to challenge our own attitudes and co-create strategies with our patients to address stigma.
>
> DR. IVAN SILVER, VICE-PRESIDENT OF EDUCATION

CAMH online course reducing stigma around the world

We know that people with mental illness and addiction often face stigma in society, but many people would be surprised to learn that they face it in health care environments as well. This year, CAMH and the **Mental Health Commission of Canada** launched a free online course called **Understanding Stigma**, designed to help health care professionals develop strategies to change attitudes and behaviours, leading to improved patient-provider interactions and better care for people with mental illness, including addiction.

The online course is hosted on CAMH's website, making it easily accessible to health care providers and frontline clinicians across Canada. In just the first month, over 1,000 participants signed up from at least 20 countries in North America, Europe, Asia, and the Middle East.

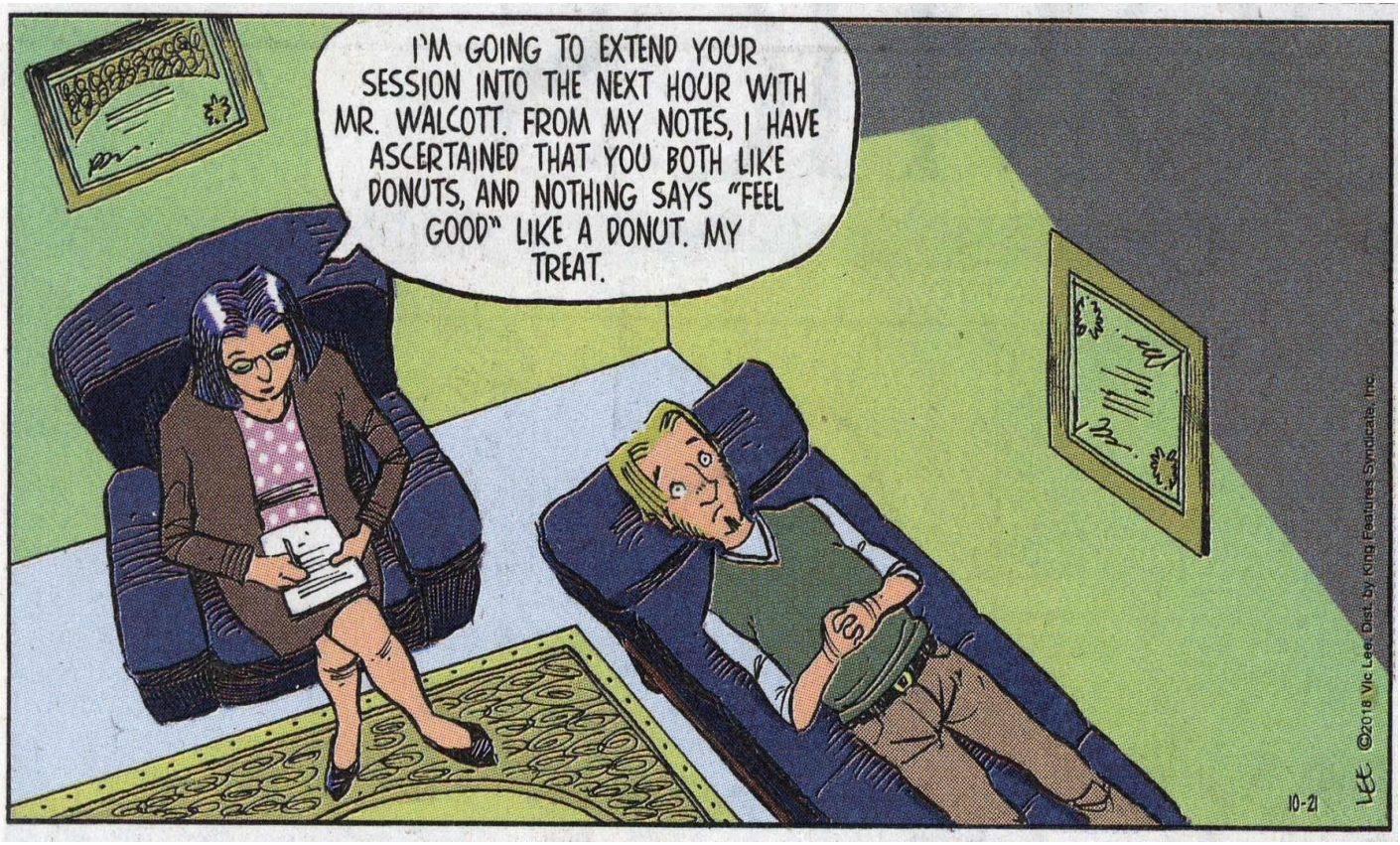
"CAMH is committed to improving the quality of care and driving mental health advocacy through education. We are delighted to partner with the Mental Health Commission of Canada to reduce the stigma of mental illness," says **Dr. Ivan Silver**, CAMH's Vice-President of Education. "As health care providers, we must continue to challenge our own attitudes and co-create strategies with our patients to address stigma."

Mental Health is Health

CAMH and CAMH Foundation Annual Report, 2017 – 2018, p.12

Inward from the professional margins

Occupational stereotyping of front-line MH/MI workers may be gradually moderating



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PARDON MY PLANET *BY VIC LEE*

Is the field's depiction in generally light-hearted humour winding down? Although many issues remain on our collective agenda, including advocacy for widely addressing imbalances in the social determinants of mental health, and combatting recurrences of stigma, there is scope for optimism.