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MINOR TRANQUILIZING DRUGS AND
THE MEDICALIZATION OF EVERYDAY LIFE
IN ENGLISH-SPEAKING CANADA, 1945-1962

by

Leona Crabb, B.A., M.R.E., M.A.

A thesis submitted to the Faculty of Graduate Studies
in partial fulfilment of the requirements for the
degree of Doctor of Philosophy

Department of History
Carleton University
Ottawa, Ontario
July 1997

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Graduate Studies acceptance of the thesis

"Minor Tranquilizing Drugs and the Medicalization of
Everyday Life in English-Speaking Canada, 1945-1962"

submitted by

Leona S. Crabb, B.A., M.R.E., M.A.,

in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

Chair, Department of History

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ABSTRACT

In 1955, meprobamate became the first minor tranquilizing drug to appear on the pharmaceutical market in both Canada and the United States. It was promoted as a safe and effective means of alleviating mild to moderate anxiety, tension, and mental stress, and was originally intended for use in clinical practice to treat conditions of a medical nature. But, almost overnight, the consumption of meprobamate became quite fashionable, especially in the show business community and among the middle class. Demand for the drug increased, sales figures grew, and the conditions for which it was used expanded to include minor worries and everyday upsets. Significantly, women were twice as likely as men to receive a prescription for this new product.

This thesis explores the meprobamate phenomenon as a case study in the process of medicalization. It asks two main questions: What does the introduction and widespread use of minor tranquilizing drugs in English-speaking Canada during the 1950s reveal about the medicalization of life in general and the medicalization of gender in particular? In what way can this investigation shed new light on the historical interpretation of Canada in the postwar period?

Drawing on a wide range of written material, this

thesis argues that any postwar analysis of the medicalization process needs to take into consideration the role of pharmaceutical companies. After the war, the drug industry grew dramatically and assumed more and more responsibility for informing and educating both doctors and the general public about the latest in drug therapy. It also argues that the fifties decade in Canada was a time of great paradox in that it was characterized by the desire for progress through medicine and medical science, and the desire for stability through the strict adherence to narrowly-defined gender roles. Meprobamate and other minor tranquilizing drugs promoted by pharmaceutical companies appealed to both the desire for progress and change and the search for stability and status quo. Together, these factors helped contribute to the medicalization of everyday life in general and the medicalization of gender in particular in English-speaking Canada after World War II.

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INTRODUCTION

A number of newly-developed drugs became available to the North American public in the mid 1950s. These drugs were known collectively as anti-anxiety agents or "minor" tranquilizers and they were intended to alleviate mild to moderate anxiety, tension, and mental stress. From a medical standpoint, tranquilizing drugs were a practical and effective means of treating the many anxious and tense individuals who came to their doctors in search of relief. But, almost overnight, the use of these drugs became

The term "minor" tranquilizer was used to distinguish these anti-anxiety agents from the "major" tranquilizers or anti-psychotic drugs. This distinction became more formalized by about 1957. Prior to that time, anti-anxiety agents and anti-psychotic drugs were often lumped together under the broader term "tranquilizer" in spite of the fact that they were chemically distinct drugs that were most often used to relieve very different symptoms. For example, minor tranquilizers were more effective in the treatment of neuroses, anxiety, and anxiety-related illnesses such as psychosomatic disorders and found their greatest use among the general population. By contrast, major tranquilizers, which first appeared on the pharmaceutical market in 1953, were particularly effective in the treatment of psychoses such as schizophrenia and found their greatest use in institutional settings. For an early discussion of the emerging distinction between major and minor tranquilizing drugs, see D.R. Kennedy, "Tranquilizers -- Part I," Canadian Pharmaceutical Journal 90,8 (August 1957), 61-2.

The word "tranquilizer" can also be written as "tranquillizer" but, in the interest of consistency, the term will be spelled with only one "l" throughout this work.

something of a mass cultural phenomenon.

Meprobamate was the first and best known of the anti-anxiety agents to come onto the pharmaceutical market during the 1950s. It was introduced into popular use in Canada and the United States in April 1955 by Wallace Laboratories of New Brunswick, New Jersey under the brand name Miltown (Illustration 1). A few months later, Wallace made an arrangement with Wyeth Laboratories of New York which gave Wyeth permission to distribute meprobamate in Canada and the United States under the brand name Equanil. According to

All drugs were given at least three names: a chemical name, a nonproprietary/proper name, and a proprietary/brand name. The chemical name described the chemical composition of the drug. The chemical name for meprobamate was 2-methyl-2-n-propyl-1,3-propanediol dicarbamate. The nonproprietary/proper name was used by all producers of the drug as a means of identification. It was also the name by which the drug was known in the scientific literature. The nonproprietary/proper name was usually derived by combining syllables from the chemical name. The nonproprietary or proper name for meprobamate was meprobamate. The proprietary/brand name distinguished a particular firm's preparation of a given drug from those of other firms. The proprietary or brand name given meprobamate by Wallace Laboratories was Miltown. Wyeth Laboratories chose to market the same drug under the proprietary/brand name Equanil. Drugs tended to first become known in professional and lay circles by their proprietary/brand names because pharmaceutical companies promoted them this way in the knowledge that their firm would be assured a greater portion of any increased sales of the drug. For more information on the naming of drugs, see Grant L. Kalbfleisch, "Pharmaceutical Nomenclature," Canadian Pharmaceutical Journal 86,1 (January 1, 1953), 12-6; Lloyd C. Miller, "Doctors, Drugs, and Names," Journal of the American Medical Association 177,1 (July 8, 1961), 27-33.

ILLUSTRATION 1: Miltown bottles and tablets manufactured by Wallace Laboratories. Source: Oscar Schisgall, Carter-Wallace, Inc.: One Hundred Years (1880-1980) (np: Carter-Wallace, Inc., 1980), 33.

Wallace and Wyeth, the therapeutic advantage of meprobamate was that, unlike the barbiturates, it acted selectively on the central nervous system and therefore quieted patients emotionally without leaving them feeling drowsy and mentally clouded. Moreover, they argued, early clinical studies had shown that meprobamate effectively reduced anxiety and tension without resulting in any serious addictive or toxic side effects.

The excitement over meprobamate spread rapidly among medical professionals and through the general population. Use of the drug, apparently among the middle class in particular, increased dramatically.³ Within one year of its introduction, more than one billion tablets of meprobamate

³ It is generally assumed by commentators that minor tranquilizing drugs were most popular among members of the middle class. See John Brooks, The Great Leap: The Past Twenty-Five Years in America (New York: Harper and Row, 1966), 141; Douglas Miller and Marion Nowak, The Fifties: The Way We Really Were (New York: Doubleday, 1977), 138; J. Ronald Oakley, God's Country: America in the Fifties (New York: Dembner Books, 1986), 313. While these authors do not substantiate their claim for a relationship between minor tranquilizer use and a middle class lifestyle, there appears to be little compelling evidence to suggest otherwise. Therefore this thesis is concerned about attitudes toward and use of minor tranquilizing drugs among what was probably a primarily middle class group. Clearly, however, this assumption requires further research.

The term "general population" also needs to be clarified. In this thesis, it is used to refer to the consumers of mass market magazines, newspapers, films, and advertising in which minor tranquilizing drugs were noted or promoted. Since there is no way of knowing exactly who these consumers were, a general term had to be employed here.

had been sold in the United States alone.⁴ Moreover, wholesale drug companies and druggists in Canada reported that the increase in minor tranquilizer sales did not result in a reduction in barbiturate sales but represented an additional use of nervous-system depressants.⁵ At the same time, the number of ailments involving anxiety and tension for which meprobamate was said to provide symptomatic relief expanded to include conditions such as allergies, asthma, hypertension, peptic ulcer, petit mal epilepsy, and typhoid fever.⁶ Meprobamate was also recommended for use to alleviate common anxieties and routine tensions of a non-medical nature like those associated with uncomfortable personal situations such as getting married, working in a

⁴ Ralph W. Gerard, "Drugs for the Soul: The Rise of Psychopharmacology," Science 125,3240 (February 1, 1957), 201.

⁵ The Canadian information was made available to Dr. R. Gordon Bell, Medical Director of the Bell Clinic, a centre near Toronto for the treatment of alcoholics and drug addicts. Bell revealed this information in R. Gordon Bell, "A Noted Doctor Talks About Alcohol and Tranquilizers," Maclean's, February 15, 1958, 38. Similarly, growing sales of minor tranquilizing drugs in the United States did not coincide with a reduction in sales of barbiturates and other sedative drugs. See Francis Bello, "The Tranquilizer Question," Fortune, May 1957, 166.

⁶ A more extensive list of the conditions for which meprobamate was recommended is included in D.R. Kennedy, "Tranquilizers -- Part II," Canadian Pharmaceutical Journal 90,10 (October 1957), 44-5; David J. Greenblatt and Richard I. Shader, "Meprobamate: A Study of Irrational Drug Use," American Journal of Psychiatry 127,10 (April 1971), 34,36.

noisy place, and homesickness in children." The growing demand for and apparent indiscriminate use of these drugs for the relief of everyday anxiety and tension motivated one American psychiatrist to complain that anti-anxiety agents were being prescribed for "everything from falling arches to falling dandruff."² A significant but rarely recognized characteristic about the widespread consumption of meprobamate and other minor tranquilizing drugs during the 1950s was the fact that there was a striking gender imbalance in the distribution of these drugs that resulted in middle-class women, especially housewives and menopausal women, receiving anti-anxiety agents at least twice as often as men in spite of the fact that there was no empirical evidence to support the argument that women were more anxious than men.³

Despite the initial enthusiasm which greeted the introduction of meprobamate in 1955, over the next ten years

² T.F. Rose, "The Use and Abuse of the Tranquilizers," Canadian Medical Association Journal 78,2 (January 15, 1958), 148; Greenblatt and Shader, "Meprobamate," 34.

³ Thomas Whiteside, "Onward and Upward with the Arts: Getting There First With Tranquility," New Yorker, May 3, 1958, 117.

³ The first study to document the distribution of minor tranquilizing drugs by gender was undertaken by Sam Shapiro and Seymour H. Baron, "Prescriptions for Psychotropic Drugs in a Noninstitutional Population," Public Health Reports 76,6 (June 1961), 481-8.

the popularity of meprobamate went through the "well-documented cycle of panacea, poison, pedestrian remedy" that characterizes most new therapeutic treatment methods.¹¹ In 1956, meprobamate was the most widely prescribed drug in the United States.¹² One year later, tranquilizer sales peaked in North America and meprobamate sales began to level off.¹³ In the early 1960s, meprobamate was gradually overshadowed and eventually eclipsed as the premier minor tranquilizing drug following the introduction by Roche Laboratories of chlordiazepoxide (Librium) in 1960 and diazepam (Valium) in 1962 (Illustration 2). Finally, in April 1965, meprobamate was dropped by the U.S. Pharmacopoeia from its list of "drugs of choice" because of doubts about its therapeutic value.¹⁴

¹¹ Victor G. Laties and Bernard Weiss, "A Critical Review of the Efficacy of Meprobamate (Miltown, Equanil) in the Treatment of Anxiety," Journal of Chronic Diseases 7,6 (June 1958), 517. For a more thorough examination of the therapeutic life cycle, see Garfield Tourney, "A History of Therapeutic Fashions in Psychiatry, 1800-1966," American Journal of Psychiatry 124,6 (December 1967), 784-96.

¹² Milton Moskowitz, "Wonder Profits in Wonder Drugs," Nation, April 27, 1957, 357.

¹³ "Sputniks, Recessions Fail To Up Tranquilizer Demands," Financial Post, February 8, 1958, 9; William I. Latourette, "Less Tranquility," Barron's, March 31, 1958, 13; "Tranquilizer Trend\$," Canadian Medical Association Journal 83,25 (December 17, 1960), 1328.

¹⁴ "Letdown for Miltown," Time, April 30, 1965, 47; Brooks, The Great Leap, 141; Morton Mintz, By Prescription Only, 2d ed., rev. and enl. (Boston: Houghton Mifflin,

ILLUSTRATION 2: Share of minor tranquilizer market by drug, 1960-1980. Source: Mickey C. Smith, Small Comfort: A History of the Minor Tranquilizers (New York: Praeger, 1985), 35.

A few Canadian historians have noted the drug craze in passing. For example, in her account of the rapid rate of development in the Atlantic provinces during the 1950s, Margaret Conrad speculated on how "for some people, the appearance of tranquilizer drugs in 1956 perhaps helped to relieve tensions in the fast-paced age."¹⁴ Making a link between technological innovation and the rising expectations of Canadians between 1957 and 1967, Jack Granatstein and others suggested that "medical science held out the promise of revolutionizing human behaviour, beginning with tranquilizers and birth-control pills."¹⁵ And, in a more indirect fashion, Roger Graham highlighted the popularity of tranquilizing drugs during the 1950s by noting that Leslie Frost, premier of Ontario from 1949 to 1961, was nicknamed "The Great Tranquilizer" because of his "gift for obscuring the defects of a tired, corrupt, and inefficient administration."¹⁶ Apart from these examples, most of the

1967), 196.

¹⁴ Margaret Conrad, "The 1950s: The Decade of Development," in E.R. Forbes and D.A. Muise, eds., The Atlantic Provinces in Confederation (Toronto: University of Toronto Press, 1993), 383.

¹⁵ Jack L. Granatstein et al., Nation: Canada Since Confederation, 3d ed. (Toronto: McGraw-Hill Ryerson, 1990), 456-7.

¹⁶ Roger Graham, Old Man Ontario: Leslie M. Frost (Toronto: University of Toronto Press, 1990), 306.

brief historical references to minor tranquilizer use during the 1950s appear in books and articles which have examined the phenomenon only in its American context.¹⁷ None of these works has investigated the introduction and widespread distribution of minor tranquilizers as a possible case study in the process of medicalization. Only a few historians have mentioned that women were more likely than men to have taken these drugs.¹⁸ And, there has been little attempt to look at how the problem of minor tranquilizer use during the fifties contributes to an understanding of the decade as a whole.

It is my intention in this thesis to help fill these

¹⁷ Stephen J. Whitfield, "The 1950s: The Era of No Hard Feelings," South Atlantic Quarterly 74,3 (Summer 1975), 295; Miller and Nowak, The Fifties, 138; Eugenia Kaledin, Mothers and More: American Women in the 1950s (Boston: Twayne, 1984), 181; William Henry Chafe, The Unfinished Journey: America Since World War II (New York: Oxford University Press, 1986), 126; John Patrick Diggins, The Proud Decades: America in War and in Peace, 1941-1960 (New York: Norton, 1988), 187; Elaine Tyler May, Homeward Bound: American Families in the Cold War Era (New York: Basic Books, 1988), 215. An exception to the general rule, Mickey Smith explored the history of minor tranquilizing drugs in the United States in some detail but he did not really situate their introduction and popularity during the 1950s within a wider historical context. See Mickey C. Smith, Small Comfort: A History of the Minor Tranquilizers (New York: Praeger, 1985).

¹⁸ Barbara Ehrenreich and Deirdre English, For Her Own Good: 150 Years of the Experts' Advice to Women (Garden City, N.Y.: Anchor Books, 1978), 255; Oakley, God's Country, 313; Rochelle Gatlin, American Women Since 1945 (Jackson: University Press of Mississippi, 1987), 63.

gaps in the historical literature by exploring two main questions: What does the introduction and widespread use of minor tranquilizing drugs in English-speaking Canada during the 1950s reveal about the medicalization of life in general and the medicalization of gender in particular? In what way can this investigation shed new light on the historical interpretation of Canada in the postwar period?

American sociologist Irving Zola first coined the term "medicalization" in 1968.¹³ Strongly influenced by social control theory, Zola defined medicalization as "a process whereby more and more of everyday life has come under medical domination, influence, and supervision."¹⁴ Zola began to write and speak publicly about medicalization in the early 1970s but it was Ivan Illich, co-founder and

¹³ Irving Kenneth Zola, "The Political 'Coming-Out' of I.K.Z.," in Irving Kenneth Zola, Socio-Medical Inquiries: Recollections, Reflections, and Reconsiderations (Philadelphia: Temple University Press, 1983), 243.

¹⁴ Irving Kenneth Zola, "Individual Choice and Health Policy: A Sociopolitical Scenario for the 1980s," in Irving Kenneth Zola, Socio-Medical Inquiries: Recollections, Reflections, and Reconsiderations (Philadelphia: Temple University Press, 1983), 295. For a more complete statement of Zola's thesis of medicalization, see Irving Kenneth Zola, "Medicine as an Institution of Social Control," Sociological Review 20,4 (November 1972), 487-504; Irving Kenneth Zola, "In the Name of Health and Illness: On Some Socio-Political Consequences of Medical Influence," Social Science and Medicine 9,2 (February 1975), 83-7; Zola, "Individual Choice and Health Policy," 285-96.

lecturer at the Centre for Intercultural Documentation in Cuernavaca, Mexico, who popularized the term with the publication in 1975 of his book Medical Nemesis. Illich argued that the health care systems in developed countries like Canada and the United States medicalized so much of everyday life that they had actually become disease-causing or iatrogenic in nature. According to Illich, the medical establishment was a threat to the physical and emotional well-being of patients because it inflicted more clinical damage than it helped, diverted attention away from political and social problems which contributed to ill health, and rendered patients unable to manage their own health care. Illich concluded that a political program which limited professional medicine was needed in order to allow patients to assume their rightful responsibility for the health of the nation.²²

The concept of medicalization as a form of social control was attractive to a number of groups, including feminists, who were critical of the biomedical model of medicine. Feminists were particularly angered by the medicalization of those aspects of women's lives such as contraception, abortion, and childbirth which were central to the experiences of most women and in which medical

²² Ivan Illich, Medical Nemesis: The Expropriation of Health (London: Calder and Boyars, 1975).

intervention was most intrusive.²² Feminist historians tended to argue that the increased medicalization of women's lives reflected the extent to which the male-dominated medical profession and even women themselves were influenced by the culture-bound assumption that women were by nature physically and emotionally more fragile than men and therefore in greater need of medical intervention. Moreover, they contended, this intervention only served to undermine women's autonomy and trust in their understanding of their own life experiences while it reinforced their victimhood and dependence on oppressive patriarchal institutions.²³

If medicalization as a form of social control theory had its adherents, it also had its detractors. One of the best-known and most vocal critics of medicalization was French historian and theorist Michel Foucault. Among other things, critics of the social control model argued that it

²² For a summary of some of the ways in which the lives of Canadian women have been medicalized, see Wendy Mitchinson, "The Medical Treatment of Women," in Sandra Burt, Lorraine Code, and Lindsay Dorney, eds., Changing Patterns: Women in Canada, 2d ed. (Toronto: McClelland and Stewart, 1993), 402-10.

²³ For example, see Carroll Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth-Century America," Social Research 39,4 (Winter 1972), 652-78; Ann Douglas Wood, "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America," Journal of Interdisciplinary History 4,1 (Summer 1973), 25-52; Ehrenreich and English, For Her Own Good.

provided an overly simplistic explanation for historical change. They asserted that historical change was a multifaceted process and not merely the product of one group of people imposing its will on another group of people. Critics also argued that the medical profession was not a monolith nor were its members necessarily autonomous, authoritarian, and all-powerful. Instead, critics of social control suggested that the medical profession was pluralistic in that doctors regularly disagreed among themselves, were motivated to act by a variety of factors, and had varying degrees of success in securing patient compliance. As far as patients were concerned, social control critics challenged the assumption that all patients were passive victims of a dominating and self-serving medical profession. They pointed out that patients, like doctors, were a diverse group. Moreover, critics contended that whenever possible patients attempted to take greater control of their own health care. This meant choosing from a number of options open to them when they were ill including doing nothing, resorting to self-treatment, consulting alternative healers, or seeing a medical doctor. The latter option in itself was also a complex choice as critics noted that patients who decided to seek the advice of a doctor did so for a variety of reasons and brought with them certain expectations which may or may not have

coincided with the expectations of the attending physician.²⁴

As the weaknesses of social control theory became more apparent, the interpretation of the medicalization process became more complex. The work of American historian Judith Walzer Leavitt is a case in point. In her 1986 monograph Brought to Bed, Leavitt examined the way in which the childbirth experience had changed in the United States between 1750 and 1950. She noted that in 1750 childbirth was a woman-centred home event and male physicians were just beginning to be invited to attend normal labours and deliveries. By 1950, childbirth had become a predominantly hospital-centred medical event presided over and directed by health care professionals. In order to explain these changes, Leavitt analyzed the experiences of upper- and middle-class birthing women and especially the role they played in the medicalization process. Her findings suggested that birthing women were not passive victims in the face of an increasingly powerful medical profession but the most active agents in bringing about changes in childbirth practices and procedures prior to childbirth moving to the hospital during the first third of the

²⁴ For a summary and critique of the social control model, see Tom Brown, "Foucault Plus Twenty: On Writing the History of Canadian Psychiatry in the 1980s," Canadian Bulletin of Medical History 2,1 (Summer 1980), 27-39.

twentieth century. She asserted that while birthing women and their doctors did not always agree with each other, they did share a growing faith in the power and possibility of medical science, a desire to make the birthing experience safer for women, and a commitment to negotiating the labour and delivery process. Leavitt concluded that

Changes throughout childbirth history were the result of long-term negotiations between upper- and middle-class birthing women and their physicians. Both believed they had something to gain by changing childbirth procedures at each historical juncture. Neither group could determine all parts of childbirth practices at any given time, but until the middle of the twentieth century both groups had enough power to negotiate their interests as they saw them.²⁵

Therefore, although childbirth was medicalized and birthing women were more dependent on the medical knowledge and expertise of doctors by 1950, Leavitt emphasized the extent to which women had actively participated in bringing about these changes even though they could not have foreseen that the move to the hospital in the hopes of a safer delivery would eventually result in a reduction in their ability to control the environment of their labour.

The process of medicalization as discussed in the literature is ultimately a debate about the relationship

²⁵ Judith Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (New York: Oxford University Press, 1986), 207. See also Judith Walzer Leavitt, "Birthing and Anesthesia: The Debate over Twilight Sleep," Signs 6,1 (Autumn 1980), 147-64.

between social control and human agency in history. Using the introduction and widespread use of minor tranquilizing drugs in Canada during the 1950s as a case study, this thesis will address this debate by asking: To what extent was the popularity and widespread use of these drugs, especially among middle-class women, the result of the aggressive advertising campaigns launched by pharmaceutical companies aimed directly at practicing physicians and indirectly at the general public? To what extent was it the result of indiscriminate and gender-biased prescribing practices on the part of members of the male-dominated medical profession? And, to what extent was it the result of the demand by anxious patients, especially anxious female patients, for the latest in drug therapy?

Over the last twenty years or so, Canadian historians have painted an increasingly complex picture of Canada after 1945. Donald Creighton was one of the first historians to assess Canada in the postwar period in his 1976 book The Forked Road. Articulating many of the same sentiments as those expressed one decade earlier by George Grant in Lament for a Nation, Creighton viewed postwar Canada as a country in decline. Creighton argued that in 1939 Canada faced a forked road to the future: one road led towards a new concept of Commonwealth complete with British institutions

and the monarchy while the other road led towards the liberal bureaucratic welfare state and closer ties with the United States. In Creighton's opinion, Canada made the wrong choice when it opted for the American rather than the Empire road. The result was a bitter and pessimistic historical account of Canada in the postwar period with a particular emphasis on political and federal events and a strong anti-Liberal and anti-American bias.⁴⁶

In 1981, historians Robert Bothwell and John English and economist Ian Drummond published what amounted to a detailed refutation of The Forked Road and Lament for a Nation entitled Canada Since 1945. The authors established their more generous position from the outset by stating that

Canadian history is a success story -- an account of coping with troubles and triumphing over adversities. Although the years since 1945 have contained their shares of disappointments, they have been more successful than most.⁴⁷

In contrast to Creighton and Grant, Bothwell, Drummond, and

⁴⁶ Donald Creighton, The Forked Road: Canada 1939-1957 (Toronto: McClelland and Stewart, 1976). See also George Grant, Lament for a Nation: The Defeat of Canadian Nationalism (Toronto: McClelland and Stewart, 1965).

⁴⁷ Robert Bothwell, Ian Drummond, and John English, Canada Since 1945: Power, Politics, and Provincialism (Toronto: University of Toronto Press, 1981), 3. In 1989, a revised version of this work appeared though the main argument remained unchanged. See Robert Bothwell, Ian Drummond, and John English, Canada Since 1945: Power, Politics, and Provincialism, rev. ed. (Toronto: University of Toronto Press, 1989)

English admitted a preference for the more centralized but outward-looking Canada of the 1940s and 1950s.²⁸ In fact, the authors depicted the Mackenzie King and especially the Louis St. Laurent years -- when a powerful federal government guided the economy, sponsored the building of the welfare state, and maintained a high international standing -- as something of a golden age in Canadian history.

In contrast to this favourable assessment of liberal democracy in the postwar period, political scientist Reg Whitaker and journalist Gary Marcuse recently argued in Cold War Canada that between 1945 and 1957 the federal government was responsible for creating a national "insecurity" state. Whitaker and Marcuse described themselves as leftists with "progressive political and social commitments" who especially deplored postwar decisions and actions that could be called anti-Communist and pro-American.²⁹ They suggested that the perceived domestic and international threat of communism after World War II led the state to reinforce a new conservative consensus in Canada and subordinate its own goals to the agenda of the United States. According to Whitaker and Marcuse, this resulted in a postwar atmosphere

²⁸ Ibid., 4.

²⁹ Reg Whitaker and Gary Marcuse, Cold War Canada: The Making of a National Insecurity State, 1945-1957 (Toronto: University of Toronto Press, 1994), x.

characterized by an all-or-nothing mentality which systematically bolstered the forces of wealth and power while it silenced individuals with less conservative interests who dared to question the social relevance of cold war capitalism and class inequality.

The historiographical debate over the relative merits of a postwar period dominated by a federal government that emphasized central planning, social security, and foreign affairs was joined by a debate which focussed more on the actual life experiences of ordinary Canadian citizens during the 1950s. Historians of women in particular have been interested in exploring, in an increasingly complex manner, the images and realities of women in Canada after World War II. In Canada, as in the United States, the assessment of women in the 1950s has been strongly influenced by the writing of Betty Friedan.³⁰ Friedan was the first to analyze systematically women's experience of the decade in her 1963 book The Feminine Mystique. She argued that American women, especially white, middle-class, suburban women, were deeply dissatisfied with their lives because

³⁰ Florence Bird et al., "Report of the Royal Commission on the Status of Women in Canada," Royal Commission on the Status of Women in Canada (Ottawa: Information Canada, 1970), 2; Joanne Meyerowitz, "Beyond the Feminine Mystique: A Reassessment of Postwar Mass Culture, 1946-1958," Journal of American History 79,4 (March 1993), 1456.

there was a major discrepancy between the reality of their experience as women and the domestic ideal to which they were attempting to conform.³¹ This domestic ideal, or "feminine mystique," held that women could find personal fulfilment in life only through a devotion to their role as wives, mothers, and homemakers. Friedan asserted that postwar journalists, educators, advertisers, and social scientists had created and perpetuated the feminine mystique to the exclusion of all other images. As a result, women adhered to the mystique for lack of a better choice.³² This decision, however, left women unhappy because it denied them the opportunity to find personal identity and fulfilment through individual achievement. In response, many of them took tranquilizers "like cough drops" in order to escape their wretched domestic existence.³³

Friedan's interpretation of women's place in the 1950s was refined and reinforced by some of the new feminist scholarship. Some early feminist historians in Canada were strongly influenced by social control theory and argued that fifties women were victims not by choice but as a result of oppressive social and economic structures. Like Friedan,

³¹ Betty Friedan, The Feminine Mystique (New York: Norton, 1963), 9.

³² Ibid., 67, 93, 172-3.

³³ Ibid., 20, 31.

these historians emphasized the prevalence of the feminine mystique. Unlike Friedan, they tended to focus their research on women in the paid labour force, especially during World War II and the immediate postwar period. In 1986, Ruth Roach Pierson published a monograph entitled "They're Still Women After All". Pierson challenged Friedan's assertion that women had won equal status with men during the war but had lost it again after 1945 thanks in large part to the efforts of a postwar mass culture which systematically promoted the feminine mystique. According to Pierson, women had never achieved equality with men in the first place because the massive federal government recruitment of women into the paid labour force during the war was intended only as a temporary measure in the interest of the Canadian war effort rather than a recognition of women's right to work. Therefore, Pierson argued, the widespread acceptance of the feminine mystique after World War II was not the result of a concerted effort on the part of postwar writers but an indication of the extent to which social attitudes toward women and employment outside the home had not been greatly altered by the war experience.³⁴ The work of Pierson was complemented by studies of the

³⁴ Ruth Roach Pierson, "They're Still Women After All": The Second World War and Canadian Womanhood (Toronto: McClelland and Stewart, 1986), esp. 22.

immediate postwar period which emphasized the discriminatory practices of the war industry as it attempted to move women out of the labour force and into the home.³⁵ Added to this were studies which explored the various ways in which the Canadian government, national magazines, and films encouraged women to give up their jobs at the end of the war in order to devote themselves full-time to their role as mothers, wives, and homemakers.³⁶ In short, some early feminist historians tended to portray fifties women in Canada as passive victims in a society which strongly pressured them to conform to a narrowly-defined domestic ideal.

With time, a new interest in how women's lived experiences differed from the prescribed norm encouraged

³⁵ Ruth Pierson, "'Home Aide': A Solution to Women's Unemployment After the Second World War," Atlantis 2,2, Part II (Spring 1977), 85-97. For a less critical view of the same subject, see Gail Cuthbert Brandt, "'Pigeon-Holed and Forgotten': The Work of the Subcommittee on the Post-War Problems of Women, 1943," Histoire Sociale/Social History 15,29 (May 1982), 239-59.

³⁶ Yvonne Mathews-Klein, "How They Saw Us: Images of Women in National Film Board Films of the 1940s and 1950s," Atlantis 4,2 (Spring 1979), 20-33; M. Susan Bland, "Henrietta the Homemaker and 'Rosie the Riveter': Images of Women in Advertising in Maclean's Magazine, 1939-50," Atlantis 8,2 (Spring 1983), 61-86; Paul Rutherford, "Researching Television History: Prime-Time Canada, 1952-1967," Archivaria 20 (Summer 1985), 79-93; Don Morrow, "Sweetheart Sport: Barbara Ann Scott and the Post World War II Image of the Female Athlete in Canada," Canadian Journal of History of Sport 18,1 (May 1987), 36-54.

other feminist historians to view fifties women less as "passive victims" than as "active agents." With this shift, these historians also placed less emphasis on what women did not do during the 1950s and more emphasis on what women were able to accomplish in spite of structural inequality and domination. As a result, these feminist historians began to demonstrate that not only was the postwar image of Canadian women more varied and complex than Friedan had indicated, but that the activities and realities of women in the fifties were more varied and complex than Friedan's focus on middle-class suburban housewives would suggest. For example, some historians emphasized the fact that some women remained or became politically active in the 1950s through their involvement in organizations such as labour unions and peace groups. Barbara Roberts investigated the activities and ideas of women involved in women-only peace groups in Canada. Roberts discovered that, despite the tendency for the government to regard dissent from mainstream opinion on peace issues as constituting a danger to public safety and national security in the age of the Cold War, a small number of women continued their work for peace during the 1950s. The Women's International League for Peace and Freedom, the oldest women's peace organization in Canada, was one group which persevered in spite of a relatively small membership. In the latter half of the 1950s, the growing public concern

over the dangers of the nuclear arms race and the fear of the effects of radioactive fallout on children motivated more and more women to become involved in nuclear and peace issues. This increased activity culminated in the founding of Voice of Women in 1960 which ushered in a new era of women's peace activism in Canada.³⁷

³⁷ Barbara Roberts, "Women's Peace Activism in Canada," in Linda Kealey and Joan Sangster, eds. Beyond the Vote: Canadian Women and Politics (Toronto: University of Toronto Press, 1989), 292-6. During the 1950s, a number of articles about women and politics appeared in the popular press. For example, see Ellen Fairclough, "Women in Politics Haven't Much Sense," Chatelaine, September 1950, 18; David MacDonald, "The Most Powerful Woman's Lobby in Canada," Chatelaine, June 1957, 14. For some historical accounts of women's political activities during the 1950s, see Eileen Sufrin, The Eaton Drive: The Campaign to Organize Canada's Largest Department Store, 1948 to 1952 (Toronto: Fitzhenry and Whiteside, 1982); Candace Loewen, "Mike Hears Voices: Voice of Women and Lester Pearson, 1960-1963," Atlantis 12,1 (Spring 1987), 24-30; Ann Porter, "Women and Income Security in the Post-War Period: The Case of Unemployment Insurance, 1945-1962," Labour/Le Travail 31 (Spring 1993), 111-44. Other studies which explored postwar diversity in Canada include Shirley Tillotson, "Human Rights Law as Prism: Women's Organizations, Unions, and Ontario's Female Employees Fair Remuneration Act, 1951," Canadian Historical Review 72,4 (December 1991), 532-57; Veronica Strong-Boag, "Canada's Wage-Earning Wives and the Construction of the Middle Class, 1945-60," Journal of Canadian Studies 29,3 (Fall 1994), 5-25; Mariana Valverde, "Building Anti-Delinquent Communities: Morality, Gender, and Generation in the City," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 19-45; Joy Parr, "Shopping for a Good Stove: A Parable About Gender, Design, and the Market," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 75-97; Joan Sangster, "Doing Two Jobs: The Wage-Earning Mother, 1945-70," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 98-134; Franca Iacovetta, "Remaking Their Lives: Women Immigrants,

In addition to challenging the stereotypical image and reality of fifties women in Canada, some historians of the postwar period have entered into a debate concerning the nature of the relationship between the 1950s and 1960s. On the one hand, historians like Veronica Strong-Boag have emphasized the fundamental differences between the two decades whereby the radical sixties represented a rebellion against the more conservative fifties. For example, she asserted that, out of their particular frustrations and accomplishments, many suburban women from the 1940s and 1950s developed an awareness and sense of self-confidence that made them identify with the liberal, essentialist feminism of the 1960s.³⁸ Strong-Boag also argued that the feminist demands made in the 1960s by the "daughters of the suburbs" were based in part on an examination and rejection of the domestic ideal embraced by their parents after World War II.³⁹ On the other hand, Doug Owsram suggested that

Survivors, and Refugees," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 135-67; Alison Prentice et al., Canadian Women: A History, 2d ed. (Toronto: Harcourt Brace, 1996), 336-438.

³⁸ Veronica Strong-Boag, "'Their Side of the Story': Women's Voices from Ontario Suburbs, 1945-60," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 46-74.

³⁹ Veronica Strong-Boag, "Home Dreams: Women and the Suburban Experiment in Canada, 1945-60," Canadian Historical Review 72,4 (December 1991), 504. For some American

there were many things which indicated a great deal of continuity between the 1950s and 1960s. In his book Born at the Right Time, Owram traced the experiences of the so-called baby-boom generation -- those Canadians born between 1947 and the mid 1950s⁴⁰ -- from the end of World War II to the late 1960s. Based on his analysis, Owram contended that there were a number of factors which linked the fifties and the sixties including the youthful nature of the population, the extent to which these young people possessed a sense of being special, the sharp distinction between youth and adult society, the belief in the potential for unlimited personal and social improvement, and the economic growth and rise in living standards.⁴¹

In effect, postwar Canada, depending on the historian and the subject under discussion, was either the best of times, the worst of times, or a time somewhere in between these two extremes. Using the introduction and widespread

examples of this emphasis on change, see Thomas Meehan, "Must We Be Nostalgic About The Fifties?" Horizon 14,1 (Winter 1972), 4-17; Marty Jezer, The Dark Ages: Life in the United States, 1945-1960 (Boston: South End Press, 1982); Kaledin, Mothers and More; David Halberstam, The Fifties (New York: Villard Books, 1993).

⁴⁰ Doug Owram, Born at the Right Time: A History of the Baby-Boom Generation (Toronto: University of Toronto Press, 1996), 4.

⁴¹ For a concise summary of his argument, see *Ibid.*, 308-15.

use of minor tranquilizing drugs in English-speaking Canada during the 1950s as a case study in the medicalization of Canadian life in general and the medicalization of gender in particular, this thesis will contribute to the historical interpretation of Canada and the postwar period by asking: To what extent did the popularity and widespread use of these drugs, especially among middle-class women, suggest that postwar Canada was confident in itself and eager to take advantage of the latest therapeutic innovations medical science had to offer? To what extent did it suggest that postwar Canada was an insecure and anxious country in search of a quick fix? And, to what extent did it suggest that postwar Canada was a decidedly different experience for middle-class women than it was for middle-class men?

While minor tranquilizing drugs and the medicalization of English-speaking Canadian life will be the focal points of my study, this thesis is ultimately an exercise in cultural history in that it analyzes these issues squarely within the larger context of postwar Canadian politics, economics, science, psychiatry, medicine, and society.⁴² As such, the starting point of this study is 1945. Perhaps for

⁴² On the importance of culture in understanding women and medicine, see Wendy Mitchinson, The Nature of Their Bodies: Women and Their Doctors in Victorian Canada (Toronto: University of Toronto Press, 1991), 7-9.

less obvious reasons, this study ends in 1962. This year was chosen as an end point because it coincided with the announcement of the birth of seriously deformed babies to some women who had taken the sedative drug thalidomide in Canada and around the world.⁴³ Among other things, this news marked a turning point in the ability of medical professionals and the public to trust in the power and potential of medical science to develop a pill to cure almost every ill. While medical and lay expectations of scientific medicine remained high in the aftermath of the thalidomide tragedy, there was no longer a general willingness to accept without question the ability of doctors, drugs, and medical science to make a lasting contribution to the improvement of individual and social well-being.⁴⁴

⁴³ The sedative drug thalidomide was first marketed in Canada in 1961 as a safe and effective anti-nausea agent for pregnant women. The drug was distributed in Canada by William S. Merrell Company under the brand name Kevadon. Thalidomide was later traced to serious congenital defects in babies born to women who had taken the drug in the first trimester of pregnancy. See Henning Sjöström and Robert Nilsson, Thalidomide and the Power of the Drug Companies (Middlesex: Penguin, 1972).

⁴⁴ This questioning of authority was a characteristic in general of the protest movements which gained momentum in the 1960s and included the civil rights movement and the women's liberation movement. For examples of the impact of the thalidomide tragedy on professional and public attitudes toward medical science, see June Callwood, "The Unfolding Tragedy of Drug-Deformed Babies," Maclean's, May 19, 1962, 13; Helen B. Taussig, "The Thalidomide Syndrome,"

The subject of minor tranquilizing drugs and the medicalization of everyday life in English-speaking postwar Canada is divided into four chapters. Chapter One discusses Canada in the immediate postwar period and provides a backdrop for the postwar interest in women, neurosis, anxiety, and social stability. In particular, it examines the authority of the psychiatric profession, the prevalence of psychoanalytic and psychodynamic theories, and the basic organization of Canadian society.

Chapter Two sets the professional and public stage for the introduction of minor tranquilizing drugs by outlining the medical and social impact of the advent of new drug therapies including antibacterials such as sulfanilamide and penicillin and the antipsychotic drug chlorpromazine.

Chapter Three looks at the introduction and popularization of minor tranquilizing drugs after 1955 with a special emphasis on the first and best-known anti-anxiety agent, meprobamate.

Chapter Four deals specifically with women and minor

Scientific American 207,2 (August 1962), 29-35; "The Chronology of Thalidomide," Canadian Doctor 28,9 (September 1962), 42-6; Sidney Katz, "Overmedication -- Part 1: Your Health and the Almighty Pill," Maclean's, December 1, 1962, 17; Sidney Katz, "Overmedication -- Part 2: The Criminal Record of the Miracle Drugs," Maclean's, January 5, 1963, 14; Sidney Katz, "Overmedication -- Conclusion: Some Straightforward Proposals to Make Drugs More Trustworthy," Maclean's, January 26, 1963, 20.

tranquilizer use during the 1950s. It explores in more detail the image and reality of middle-class women's lives, scientific and popular notions about the nature of men and women, and the way in which gender was employed in pharmaceutical advertisements for anti-anxiety agents.

Finally, the conclusion brings together the main threads of my argument and provides a concise statement of my research findings with respect to anti-anxiety drugs and the medicalization of everyday life in English-speaking Canada during the 1950s.

While this work examines minor tranquilizing drugs and medicalization in English-speaking Canada during the 1950s, it draws on both Canadian and American source material. Thus the issue of sources is intertwined with the issue of the significance of the international border. This thesis considers the information published in Canadian journals but recognizes that Canadian doctors read American medical journals and kept abreast of the happenings within their field in the United States. For example, when Kenneth Clute undertook a study of general practice in the provinces of Ontario and Nova Scotia in the late 1950s, he found that the three medical journals read most frequently by family doctors included the Canadian Medical Association Journal, Medical Clinics of North America, and Postgraduate Medicine,

the latter two of which were American publications.⁴⁵ Canadian psychiatrists were also interested in and knowledgeable about clinical and professional developments taking place in the United States. This was partly due to the fact that many of them had received their specialist training in the United States, partly because they regularly read and published in American journals,⁴⁶ and partly because Canadian psychiatrists had belonged to the American Psychiatric Association prior to the establishment in 1951 of the Canadian Psychiatric Association. Even after the Canadian organization was set up, some Canadian psychiatrists continued to belong to and participate in the American association.⁴⁷ Therefore, the use of American medical journals in a dissertation about Canada is relevant because these journals contained information of importance to Canadian doctors including the results of clinical

⁴⁵ Kenneth F. Clute, The General Practitioner: A Study of Medical Education and Practice in Ontario and Nova Scotia (Toronto: University of Toronto Press, 1963), 449-50.

⁴⁶ Daniel Blain and John D. Griffin, "Canadian Psychiatrists in Publications of A.P.A., 1948-1958: Source Material," Canadian Psychiatric Association Journal 20,7 (November 1975), 543-7.

⁴⁷ George H. Stevenson, "Report on the Formation of the Canadian Psychiatric Association," Canadian Medical Association Journal 65,6 (December 1951), 592-4; Charles A. Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," Psychiatric Journal of the University of Ottawa 4,1 (March 1979), 36.

studies on minor tranquilizing drugs like meprobamate and because these journals give some sense of the attitudes within the profession toward these new drugs through the publication of editorials, letters to the editor, special articles, conference proceedings, and news of particular interest to the profession.

The above examples serve to justify the critical inclusion of American medical sources in a work on Canadian history but this thesis recognizes that medicine practised in Canada was distinct from that practised south of the border in terms of both the response of Canadian medical professionals to specifically Canadian issues and the medical delivery system itself. For example, attempts were made to establish the Canadian Psychiatric Association partly because many Canadian psychiatrists wanted a completely autonomous Canadian organization to represent and speak for them in discussions with the federal and provincial governments.⁴⁶ With respect to minor tranquilizing drugs, Canada differed from the United States in that meprobamate could be purchased over the drugstore counter without a prescription in some Canadian provinces. It was only after much effort that members of the Canadian

⁴⁶ Roberts, "Thirty-Five Years of Psychiatry in Canada," 36; Isabel Dickson, "The Canadian Psychiatric Association, 1951-1958," Canadian Journal of Psychiatry 25, 1 (February 1980), 86.

Medical Association managed in 1959 to get the Canadian government to place all minor tranquilizing drugs on a prescription basis.⁴⁹ Therefore, this thesis will draw on information contained in both Canadian and American medical journals but not lose sight of the medical issues and events which were particular to the Canadian context.

Statistics on the manufacture and distribution of minor tranquilizing drugs give a good indication of the popularity of these drugs both as a group and on an individual basis. Unfortunately, I have not been able to find any numbers which pertain specifically to the manufacture and distribution of minor tranquilizing drugs in Canada during the 1950s. Sales figures reported by Wallace and Wyeth Laboratories tended to reflect overall meprobamate sales with no breakdown according to country of sale.⁵⁰ Moreover, my attempts to contact these companies directly for information on the Canadian scene in the late 1950s were

⁴⁹ "Additions to Prescription Drugs," Canadian Medical Association Journal 81,7 (October 1, 1959), 599. The different regulations surrounding the distribution of meprobamate and other minor tranquilizing drugs in Canada and the United States are discussed in more detail in Chapter Three.

⁵⁰ For example, see Oscar Schisgall, Carter-Wallace, Inc.: One Hundred Years (1880-1980) (np: Carter-Wallace, Inc., 1980).

turned down without explanation.⁵¹ By all accounts, however, meprobamate and other minor tranquilizing drugs were popular in Canada with both doctors and members of the general public. At the time, as far as the use of statistics pertaining to Canada was concerned, American numbers were regularly cited on the assumption that they were relevant to the Canadian situation.⁵² Often a disclaimer was added stating that the figures for Canada were certainly high but probably not quite as high as those for the United States. For example, Dr. T.F. Rose, an internal medicine specialist from Victoria, B.C., warned delegates to the 90th annual meeting of the Canadian Medical Association in June 1957 that something had to be done to reduce the indiscriminate use of tranquilizing drugs in Canada. In order to heighten the immediacy of the situation, Rose quoted American statistics with a Canadian disclaimer:

⁵¹ Shamim Jamal-Rajan, North York, Ont., to Leona Crabb, Ottawa, typed letter signed, July 15, 1994. Jamal-Rajan is the Manager of Drug Information and Surveillance at Wyeth-Ayerst Canada, Inc.; Carol G. Emerling, Madison, N.J., to Leona Crabb, Ottawa, typed letter signed, July 19, 1994. Emerling is the Corporate Secretary at American Home Products Corporation. Carter-Wallace sent a company-produced history of its first one hundred years and statistics pertaining to the previous ten years but the package did not include a covering letter.

⁵² For example, see "Tranquilizers on the Wane?" Canada's Mental Health 8,9 (November 1960), 17-8.

In the United States last year [1956] an estimated 50 million prescriptions were written for the tranquilizers. At any one time 5% of the population was under medication with them. In the first nine months of that year, one manufacturer of a popular tranquilizer [meprobamate] sold 30 billion tablets. In New York 10% of all prescriptions written were for tranquilizers. In Canada the position, if not as fantastic, must be at least comparable [emphasis in original].⁵³

While Rose's use of statistics was less than scientific, he was not the only physician at the meeting who was concerned about the widespread use of minor tranquilizing drugs in Canada. This meeting of the Canadian Medical Association also marked the beginning of a two-year campaign by a group of concerned Canadian doctors to pressure the federal government into placing meprobamate and all other minor tranquilizing drugs on a prescription basis throughout the country. These doctors argued that changes to the Food and Drugs Act were necessary because of the indiscriminate use of anti-anxiety agents in Canada and the potential for their abuse.⁵⁴ Given the lack of minor tranquilizing drug statistics pertaining specifically to Canada in the 1950s, I will use American figures only as an indication of the popularity of minor tranquilizing drugs in general during

⁵³ Rose, "The Use and Abuse of the Tranquilizers," 146. See also "Sputniks, Recessions Fail To Up Tranquilizer Demands," 9.

⁵⁴ K.J.R. Wightman, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 77,5 (September 1, 1957), 417-8.

this period and assume that if the issue of tranquilizer consumption was such a serious concern in some Canadian quarters that the drugs were probably relatively widely used in Canada, even if not to the same extent as in the United States.

If statistics pertaining specifically to the manufacture and distribution of minor tranquilizing drugs in Canada during the 1950s are difficult to come by, statistics about anti-anxiety agents and Canadian women are impossible to find. They do not exist. The first study to look at gender and minor tranquilizer use in Canada drew on information from 1965 and 1966. It found that women were at least twice as likely as men to receive a prescription for minor tranquilizing agents.⁵⁵ At the same time, the few American studies from the 1950s which looked at gender and minor tranquilizer distribution concluded that women received prescriptions for minor tranquilizing drugs twice as often as men. The first American study which confirmed this gender differential analyzed material from 1959.⁵⁶ If there is no direct evidence available which makes a link between gender and tranquilizer prescription rates in Canada

⁵⁵ Ruth Cooperstock and Mary Sims, "Mood-Modifying Drugs Prescribed in a Canadian City: Hidden Problems," American Journal of Public Health 61,5 (May 1971), 1007-16.

⁵⁶ Shapiro and Baron, "Prescriptions for Psychotropic Drugs in a Noninstitutional Population," 481-8.

during the 1950s, indirect evidence can be used to support such a claim. For example, statistics from the fifties demonstrate that Canadian women were twice as likely as men to be diagnosed as anxious, neurotic, or emotionally unstable. Statistics from the fifties also demonstrate that Canadian doctors were more likely to prescribe tranquilizing drugs to patients who they felt were anxious, neurotic, or emotionally unstable. Together, these statistics suggest that fifties women in Canada were more likely than men to receive a prescription from their doctors for minor tranquilizing drugs. Therefore, for the purposes of this thesis, it will be assumed that in Canada, as in the United States, there was a distinct gender differential in the distribution of minor tranquilizing drugs during the 1950s.⁵⁷

Popular sources such as magazine articles can be useful to chart public response to the introduction of minor tranquilizing drugs. Obviously, these sources must be read critically, acknowledging that they were written for a particular purpose, by a particular author, at a particular time, and in a particular place. Nevertheless, when taken together, they can provide an interesting glimpse into the excitement and concern which followed the appearance of

⁵⁷ For a more detailed description of this evidence, see Chapter Four.

meprobamate and other minor tranquilizing drugs in 1955.

Because of source availability, only English-language material produced in Canada are drawn upon. American sources that can be demonstrated to have been available to Canadians are also considered. Writer Melinda McCracken was a teenager in Winnipeg during the 1950s and she remembered the attraction at that time of all things American.

"Everything American was so desirable," she wrote, "America appeared to be the source of all good things, things that were magical and ingenious and fun."⁵⁸ The most popular American magazines in Canada during the 1950s were Life, the Saturday Evening Post, and Time Canada, while popular American television shows included Ed Sullivan, Father Knows Best, and Walt Disney.⁵⁹ American magazines and television were also two media through which Canadians learned about minor tranquilizing drugs. This point was acknowledged by Canadian journalist Dorothy Sangster in an article she wrote for Chatelaine magazine about these drugs. In fact, Sangster was concerned that it would be difficult to prevent

⁵⁸ Melinda McCracken, Memories Are Made Of This (Toronto: James Lorimer, 1975), 60. See also J.M. Bumsted, "Canada and American Culture in the 1950s," in J.M. Bumsted, ed., Interpreting Canada's Past, Volume II, After Confederation (Toronto: Oxford University Press, 1986), 399.

⁵⁹ Paul Rutherford, When Television Was Young: Primetime Canada, 1952-1967 (Toronto: University of Toronto Press, 1990), 11-2; Owram, Born at the Right Time, 90-1.

Canadian women from indiscriminately taking minor tranquilizing drugs "considering the barrage of favourable propaganda that is being aimed at this country from the United States."⁶⁰ Dr. Ern McKercher at the Westminster Veteran's Hospital in London, Ontario was also aware of and unfavourably impressed by the influence of American popular culture on the Canadian public. He complained that patients were going to their doctors and asking for "some of Bob Hope's jolly pills" after seeing the American comedian use a number of Miltown jokes in one of his televised comedy specials.⁶¹ Therefore, in addition to material produced in English-speaking Canada, this thesis will examine aspects of American popular culture because many Canadians had access to and were sometimes influenced by this information even if the information did not originate specifically from within the Canadian context.

Although the subject of minor tranquilizing drugs seemed to be a regular topic of public discussion in the 1950s, it was difficult to find detailed first person

⁶⁰ Dorothy Sangster, "Should You Take A Happy Pill?" Chatelaine, April 1957, 21. See also Rose, "The Use and Abuse of the Tranquilizers," 147; Heinz E. Lehmann, "Tranquilizers and Other Psychotropic Drugs in Clinical Practice," Canadian Medical Association Journal 79,9 (November 1, 1958), 702.

⁶¹ Alexander Ernest McKercher, "Tranquilizing Drugs in Psychiatry," Medical Services Journal: Canada 16,7 (July-August 1960), 635; Whiteside, "Onward and Upward," 111.

accounts by Canadians or Americans of their experiences with these drugs. Selected accounts exist by women who drank alcohol, consumed stimulants/appetite suppressants like dextro-amphetamine sulfate (Dexedrine), or inadvertently took thalidomide, but in terms of minor tranquilizing drugs, the record is virtually silent.⁶² Unfortunately, attempts to obtain interviews with Canadian men and women who remembered the introduction and popularization of minor tranquilizing drugs during the 1950s were not successful. Nevertheless, it is still possible to offer some insights into anti-anxiety agents and the medicalization of everyday life in general and the medicalization of gender in particular during the 1950s. Such speculation is based on the critical use of available source materials in the context of a careful reconstruction of the period. While this sort of process is always methodologically risky, it may help to open up possible future areas of research on the subject of minor tranquilizing drugs and the medicalization of life in English-speaking Canada during the 1950s.

⁶² For example, see Adele White, "The Loneliest Woman Alive," Chatelaine, October 1950, 14; Kay Macpherson, When In Doubt, Do Both: The Times of My Life (Toronto: University of Toronto Press, 1994), 77; Brett Harvey, The Fifties: A Women's Oral History (New York: HarperCollins, 1993; HarperPerennial, 1994), 125; Joan Anne Niblock, "Arms for Alex," Chatelaine, March 1968, 16.

CHAPTER ONE

Psychiatry, Mental Health, and Canadian Society

In August 1948, an International Congress on Mental Health was held in London, England. The Congress was organized by the International Committee for Mental Hygiene in order "to help to infuse a scientific spirit into the movements of reform and reconstruction under way in many countries." The Congress was comprised of three Conferences, the largest and most important of which was the International Conference on Mental Hygiene. In keeping with the liberal internationalist vision which dominated professional and public opinion immediately following World War II, the theme of this conference was "Mental Health and World Citizenship." The five-day event attracted approximately 2500 psychiatrists and social scientists from

John Carl Flugel, ed., "Proceedings of the International Conference on Mental Hygiene," International Congress on Mental Health, London 1948 (New York: Columbia University Press, 1948), 286. The first Congress was held in Washington in 1930 and the second one was held in Paris in 1937. John D. Griffin, In Search of Sanity: A Chronicle of the Canadian Mental Health Association, 1918-1988 (London, Ont.: Third Eye, 1989), 146.

Flugel, ed., "Proceedings," iii.

60 non-communist countries.' On the first day of the conference, delegates were handed an official Statement relating to the topics under discussion. The Statement had been compiled and agreed upon by an International Preparatory Commission which had met in Roffey Park, Sussex for two weeks prior to the Conference. The Statement represented an attempt by the Commission to consolidate into one document the essence of the three or four hundred theme-related Preparatory Reports that had been submitted to the Conference over the previous year by multi-disciplinary groups representing mental health professionals from around the world.⁴ Much to the delight of organizers, the Statement was received enthusiastically by Conference delegates.

The "Roffey Park Manifesto," as the Statement came to be known, made three general assertions: First, it argued that mental health was the basis for permanent world peace and social well-being because the ultimate goal of mental health was to enable world citizens to better live together in a world community.⁵ Second, the Statement asserted that the leadership and work of psychiatrists and social

⁴ Griffin, In Search of Sanity, 146-7.

⁵ Flugel, ed., "Proceedings," iii; Griffin, In Search of Sanity, 147.

⁶ Flugel, ed., "Proceedings," 299, 304.

scientists was essential to the establishment of worldwide mental health.² And, third, the Statement concluded that healthy emotional development was best facilitated by re-teaching people how to establish and maintain healthy interpersonal relationships, the expansion of preventive mental health services to include all public agencies interested in the welfare and education of people in the community, the prevention of mental disorders through prompt intervention, especially in the early stages of development, and, as a last resort, the treatment of mental illness.

Delegates to the Conference on Mental Hygiene had been shaken by the scale of the destruction unleashed during World War II and were afraid of the possibility of a third global conflict in the near future. As outlined in the International Preparatory Commission Statement, delegates were confident that mental health was the key to ensuring permanent world peace. They were also optimistic that the intervention of psychiatrists and social scientists at the individual and community level would greatly contribute to society's overall mental well-being. Their optimism in the

² Ibid., 298,301.

³ Ibid., 291,293,306,307. For another example of the emphasis on the relationship between emotional maturity, citizenship, and social stability, see George S. Stevenson, "Mental Health -- A Look Ahead," Mental Hygiene 32,3 (July 1948), 353-63.

ability of mental health professionals to effect change in people rested on the recent research of psychiatrists and other social scientists which had demonstrated the latent goodwill of the individual, the modifiability of human behaviour, and the extent to which human beings were the product of their early environment. In this context, delegates believed that early psychiatric intervention would remove obstacles to personal and social development and thereby help release human potentialities, individually and collectively, for the common good. At the same time, Conference delegates had a sense of urgency about their mission because the war, and especially the actions of Adolf Hitler in Germany, had demonstrated all too clearly that the malleability of the human personality could also be exploited in the service of mass death and suffering. Therefore, delegates strongly recommended that psychiatrists and other health practitioners help governments around the world develop community-based intervention programs aimed at promoting mental health among people of all ages but focussing particularly on the emotional needs of children.

The ideas raised by the International Preparatory Commission were not unique to the postwar period however much they emerged out of the experience of World War II. In fact, by 1948 psychiatrists in Canada had been attempting to increase their involvement in the lives of ordinary

Canadians for at least three decades. For example, following World War I, psychiatrists and government officials in Canada also made a link between the stability of a nation and the mental health of its citizens, argued for increased involvement of psychiatrists at the community level, and expressed a strong belief in the principles of prevention, education, child welfare, early intervention, and community-based programs. A major difference between the two postwar periods, however, was that after World War II psychiatric ideas became more popularized and permeated Canadian society more thoroughly. This chapter will argue that there were a number of reasons for this popularization of psychiatric ideas after 1945 including the emergence of psychiatry as a specialty within medicine, the significant contributions made by psychiatrists during the war, the ability of psychiatrists to promote themselves and their world view, the willingness of governments to take increased responsibility for the health and welfare of all Canadians, the strength of nation-wide public education campaigns, the general publicity and availability of information pertaining to psychiatry and mental health issues, and the greater acceptance by the general public of psychiatric explanations for human motivation.

World War I contributed to the professionalization of

Canadian psychiatry and marked the beginning of a greater emphasis within the profession on the psychological and social basis of mental illness.⁷ In 1915 and 1916 Canadian military authorities requested the help of psychiatrists and neurologists to deal with the growing number of soldiers suffering from symptoms of shell shock or, as it later came to be known, war neurosis. Those who took up the challenge soon found themselves in disagreement with each other over the cause and treatment of the illness. On the one hand there were the somaticists who were influenced by the mid-nineteenth century work of psychiatrists like Wilhelm Griesinger of Germany. The somaticists believed that mental and nervous diseases were really physical diseases of the brain for which there was no known treatment. On the other hand there were the psychogenicists who were influenced by the late nineteenth century work of Sigmund Freud in Vienna and Pierre Janet in Paris. The psychogenicists argued that mental and nervous diseases were of psychological origin and responded to treatment methods like psychotherapy.⁸ At the

⁷ Much of the following information about Canadian psychiatry and shell shock during World War I was taken from Tom Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War," in Charles G. Roland, ed., Health, Disease, and Medicine: Essays in Canadian History (Toronto: The Hannah Institute for the History of Medicine, 1984), 308-32.

⁸ For a more thorough discussion of these different theories and therapies, see Brown, "Shell Shock," 309-11; George Rosen, Madness in Society: Chapters in the Historical Sociology of Mental Illness (Chicago: University

beginning of the war, the belief in the physical basis of mental illness dominated the psychiatric profession. The somatic theory also seemed to be vindicated by the initial evidence which suggested that shell shock symptoms were manifestations of the physical changes in the brain which resulted from the sheer force generated by the explosion of shells on the battlefield. By the end of 1916, however, some of the limitations of the organic approach to mental phenomenon became apparent when it was observed that many of the individuals who presented with symptoms of shell shock had never come under heavy fire or even been to the front lines. This new information suggested that these soldiers were either cowards attempting to feign illness in order to avoid combat duty or victims of a real illness of psychogenic origin.¹⁰

In an attempt to rehabilitate shell-shocked soldiers and return them to the front, psychiatrists effectively employed a number of treatment methods. Psychiatrists who believed that shell-shocked soldiers were cowards or malingerers in need of more discipline placed their patients in isolation rooms or applied electric shocks to their bodies. Other psychiatrists relied more on the power of

of Chicago Press, 1968), 279-83.

¹⁰ Brown, "Shell Shock," 311-2.

reason and used psychotherapeutic techniques like hypnosis with their patients. By the end of the war, divisions over the underlying cause of mental illness persisted.

Nevertheless, thanks to its contribution to the treatment of shell-shock victims, the psychiatric profession emerged from the conflict with more status and prestige than it had had upon its entry into the war effort in 1915. Now for the first time politicians and the general public recognized and appreciated the work performed by members of the psychiatric profession.³³ Equally significant, World War I marked the beginning in what became a trend in psychiatry towards the acceptance of psychodynamic or psychoanalytic principles with their emphasis on the importance of psychogenetic theories and therapies in explaining and treating mental and nervous illness.³⁴

³³ Ibid., 322-3; John C. Burnham, "The New Psychology: From Narcissism to Social Control," in John Braeman, Robert H. Bremner, and David Brody, eds., Change and Continuity in Twentieth-Century America: The 1920s (Columbus: Ohio State University Press, 1968), 362.

³⁴ James Stuart Tyhurst et al., More for the Mind: A Study of Psychiatric Services in Canada (Toronto: Canadian Mental Health Association, 1963), 2; Rosen, Madness in Society, 282. Psychiatrists did not agree among themselves as to the similarities and differences between psychodynamic and psychoanalytic psychotherapies. Generally speaking, however, both approaches assumed that mental and nervous illnesses were of psychogenic origin and responded best to verbal discourse. In terms of differences, psychodynamic psychotherapy tended to be supportive in nature and concerned primarily with quickly reducing symptoms while psychoanalytic psychotherapy was more expressive in nature

After World War I, some psychiatrists began to work in the community where they focussed much of their energy on the promotion of mental health and the prevention of mental illness, especially among children. This move was a major departure for psychiatrists who up until the war had worked almost exclusively in insane asylums where their job was to provide custodial care to the chronically ill. Part of the rationale for the move into the community came from the experience of World War I and the support it generated within psychiatry for the work of people like Sigmund Freud who challenged the traditional model of disease.¹³ Contrary to accepted wisdom, Freud argued that health and disease were not mutually exclusive concepts whereby health was present when disease was absent. Instead, Freud argued that mental health and mental illness represented opposite ends along a continuum. The idea of a continuum from normal to abnormal behaviour emphasized the importance of the patient's life history and early environment and therefore

and concerned primarily with character change. See L. Rangell, "Similarities and Differences Between Psychoanalysis and Psychotherapy," Journal of the American Psychoanalytic Association 2 (1954), 734-44; E. Bibring, "Psychoanalysis and Dynamic Psychotherapies," Journal of the American Psychoanalytical Association 2 (1954), 745-70.

¹³ Brown, "Shell Shock," 323; Dennis Guest, The Emergence of Social Security in Canada, 2d ed., rev. (Vancouver: University of British Columbia Press, 1985), 69; Rosen, Madness in Society, 283.

eliminated any notion of a clear distinction between mental health and mental illness. The continuum idea also suggested that it was possible to prevent minor neuroses from becoming serious psychoses through early psychiatric intervention.¹⁴ The fact that approximately nine thousand apparently normal and mentally fit young men were diagnosed as shell-shocked during the war seemed to indicate to psychiatrists that everyone had a breaking point and that perhaps mental disabilities were much more prevalent in Canadian society than asylum numbers had suggested.¹⁵ Moreover, it also seemed to point towards a greater need for psychiatrists to be involved in the community where they could intervene with individuals experiencing intense environmental stress of a psychological, social, or physical nature. It was hoped that such intervention would help prevent latent neuroses from developing into full-blown psychoses and thereby contribute more directly to the

¹⁴ Gerald N. Grob, "The Forging of Mental Health Policy in America: World War II to New Frontier," Journal of the History of Medicine and Allied Sciences 42,4 (October 1987), 412-3.

¹⁵ The estimate of nine thousand shell-shock victims was taken from J.P.S. Cathcart, "The Neuro-Psychiatric Branch of the Department of Soldiers' Civil Re-Establishment," Ontario Journal of Neuro-Psychiatry 8 (1928), 44. Tyhurst et al., More for the Mind, 2; Brown, "Shell Shock," 323.

overall mental health of the nation.¹⁰

The move of psychiatrists into the community was also facilitated by the growth of the mental hygiene movement in North America after 1900. Mental hygienists viewed disease as a product of environmental, hereditary, and individual deficiencies and were committed to creating a society which maximized health and minimized disease.¹¹ Coinciding with the rise of the eugenics movement and the popularity of hereditarian theories, however, mental hygienists tended to trace mental illness and other social problems to hereditary rather than environmental factors. Therefore, the mental hygiene movement in Canada during the early part of the century focussed its attention mainly on the problem of feeble-mindedness. The movement was particularly interested in segregating the mentally retarded in institutions in order to prevent them from reproducing.¹² The high number

¹⁰ Charles K. Clarke and Clarence B. Farrar, "One Thousand Psychiatric Cases from the Canadian Army," Canadian Journal of Mental Hygiene 1 (1919-20), 313; Clarence M. Hincks, "Recent Progress of the Mental Hygiene Movement in Canada," Canadian Medical Association Journal 11,11 (November 1921), 823; F.H. Mackay, "Some Aspects of the Psychoneuroses," Canadian Medical Association Journal 13,7 (July 1923), 495; Brown, "Shell Shock," 323.

¹¹ Gerald N. Grob, "American Psychiatry: An Ambivalent Specialty," Prospects 12 (1987), 163.

¹² Angus McLaren, Our Own Master Race: Eugenics in Canada, 1885-1945 (Toronto: McClelland and Stewart, 1990), 40-1. For a discussion of some of the early activities of the mental hygiene movement in Canada, see Griffin, In

of shell-shock casualties during World War I highlighted the problem of mental illness and motivated Dr. Clarence Hincks to found the Canadian National Committee for Mental Hygiene in 1918.¹⁸ The National Committee was concerned about the institutional care and treatment of the mentally ill but its main goal was to prevent the actual onset of mental illness or, if necessary, treat the illness in its early stages.¹⁹ With Hincks as its driving force, the National Committee

Search of Sanity, 2-4.

¹⁸ Hincks was a medical doctor whose interest in mental health stemmed in part from his own experience with severe depression. In 1917, Hincks met American Clifford Beers who had founded the National Committee for Mental Hygiene in New York in 1909. Beers became interested in mental health issues after he had suffered an episode of mental illness and was institutionalized. Upon his release, he wrote about his experience in A Mind That Found Itself which was published in 1908. Beers helped Hincks organize the Canadian National Committee for Mental Hygiene in 1918 and the two men worked together in subsequent years to promote mental health and mental health issues in both Canada and the United States. For more information about Hincks, Beers, and the founding of the Canadian National Committee for Mental Hygiene, see Clifford Whittingham Beers, A Mind That Found Itself: An Autobiography, 7th ed. (Garden City, N.Y.: Doubleday, 1948); "The Canadian National Committee for Mental Hygiene," Canadian Journal of Medicine and Surgery 43,6 (June 1918), 163-5; "The Canadian National Committee for Mental Hygiene," Canadian Medical Association Journal 8,6 (June 1918), 551-4; John D. Griffin, "The Amazing Careers of Hincks and Beers," Canadian Journal of Psychiatry 27,8 (December 1982), 668-71; Charles G. Roland, Clarence Hincks: Mental Health Crusader (Toronto: Dundurn Press, 1990); Griffin, In Search of Sanity, 6-16.

¹⁹ Clarence M. Hincks, "The Scope and Aims of the Mental Hygiene Movement in Canada," Canadian Journal of Mental Hygiene 1 (1919-20), 20-9.

initiated a number of community-related projects involving mental hygiene research, education, and service. Some of these projects included surveys of provincial mental hospitals with recommendations on ways to provide better and more adequate facilities for institutionalized patients, mental hygiene research designed to gain a better understanding of child behaviour and development, professional and public education in mental hygiene and psychiatry, training of mental hygiene leaders including public health nurses and social workers, the establishment of mental hygiene clinics for the early detection and prevention of mental illness in children, and the provision of psychological and psychiatric guidance services to parents, teachers, and students in the school setting. Together, these projects provided psychiatrists with an opportunity to broaden the scope of their professional involvement in Canadian society. By 1939, however, the majority of psychiatrists still worked in mental hospitals with the chronically ill. Nevertheless, the combined impact of World War I, Freudian theories, and the mental hygiene movement had allowed the profession to secure itself a foothold in the community as an important force for the

∴ The work of the Canadian National Committee for Mental Hygiene in the interwar period is discussed in more detail by Griffin, In Search of Sanity, 17-99.

promotion of mental health and the prevention and early detection and treatment of mental illness.

As their functions and responsibilities broadened, psychiatrists also began to focus more on the profession itself and ways in which they could preserve their authority and enhance their status in the mental health field. This led psychiatrists to place a growing emphasis on certification, education, and professional autonomy as well as attempt to identify the profession more closely with the larger field of scientific medicine. In 1929, the Royal College of Physicians and Surgeons of Canada was founded. It was responsible for formally identifying, through written and oral examination, those physicians who were qualified to practice as medical and surgical specialists. During the 1930s, psychiatry and several other specialties sought a similar recognition of proficiency in their respective areas of expertise. In response, the Royal College introduced a certification program in 1942 which set out formal training and examination requirements for a number of different specialties including psychiatry. The first certification examinations were held four years later. This meant that Canadian doctors who wanted to specialize in psychiatry after 1946 did not have to go to the United States or overseas but could receive their specialty training in

Canada.⁴²

Clarence Hincks was in favour of certification because he said it put psychiatry on a level similar to that of internal medicine and surgery.⁴³ Robert Jones, professor of psychiatry at Dalhousie University in Halifax, was also interested in associating psychiatry more closely with other fields of medicine. In 1949, Jones recommended to the Royal College that psychiatric postgraduate education no longer be the responsibility of individual hospitals or institutions but come under the auspices of the psychiatric department of the medical faculty of a university whose job it would be to ensure that future psychiatrists gained a more unified and integrated training experience with access to any one of a number of hospitals and institutions associated with the university. Jones argued that one of the advantages of a university-based program in psychiatry was that its training standards could be readily compared with those of other medical fields. Not stated was the fact that these modifications would also give academic and community-oriented psychiatrists greater control over specialist

⁴² For a brief description of the events surrounding the certification program, see David A.E. Shephard, The Royal College of Physicians and Surgeons of Canada, 1960-1980: The Pursuit of Unity (Ottawa: The Royal College of Physicians and Surgeons of Canada, 1985), 15-9.

⁴³ Griffin, In Search of Sanity, 74.

training. The recommendations were accepted by the Royal College in 1950 and extended to cover other specialties as well. As a result, after 1950 universities began to take more and more responsibility for postgraduate psychiatric education.⁴

In addition to pushing for certification and a more secure foothold in medical schools, psychiatrists sought greater professional autonomy through the founding of a national association of Canadian psychiatrists and a professional psychiatric journal. Since the mid-nineteenth century, Canadian psychiatrists had been members in what became in 1921 the American Psychiatric Association. In 1945, a section of psychiatry was established in the Canadian Medical Association in order to address some of the issues of specific interest to Canadian psychiatrists and to allow psychiatrists to forge closer relations with people from other fields of medicine. Soon, however, some psychiatrists began to feel limited by their association with the Canadian Medical Association because it did not give them direct authority or power to negotiate, for example, with the federal and provincial governments regarding the development of psychiatric and mental health services. Instead, psychiatrists had to go through the

⁴ Shephard, The Royal College of Physicians and Surgeons of Canada, 184-9.

Council of the Canadian Medical Association which some felt did not have the time necessary to negotiate properly on their behalf. As a result, an organization drive began and in 1951 the Canadian Psychiatric Association came into existence as the first autonomous national association of Canadian psychiatrists. One year later the first issue of the Bulletin of the Canadian Psychiatric Association appeared which gave the Association a vehicle for voicing its concerns. In 1956, the Bulletin became the Canadian Psychiatric Association Journal.

World War II had a major impact on psychiatric thinking and practice. In particular, the war experience seemed to confirm the lessons of World War I in that it reinforced the principles of psychodynamic and psychoanalytic psychiatry with their emphasis on the importance of life experiences and the role played by socioenvironmental factors in the etiology of mental disorders.

George H. Stevenson, "Report on the Formation of the Canadian Psychiatric Association," Canadian Medical Association Journal 65,6 (December 1951), 592-4; Isabel Dickson, "The Canadian Psychiatric Association, 1951-1958," Canadian Journal of Psychiatry 25,1 (February 1980), 86-7.

John Carmichael, "Army's New Attitude Toward the Misfit," Saturday Night, April 29, 1944, 20; John C. Burnham, "The Influence of Psychoanalysis Upon American Culture," in Jacques M. Quen and Eric T. Carlson, eds., American Psychoanalysis: Origins and Development (New York: Brunner/Mazel, 1978), 57; Grob, "The Forging of Mental

In Canada, psychiatry became more important to the war effort as the conflict progressed. When war broke out in 1939, only a few psychiatrists were available for employment in the Canadian Armed Services.¹ At the time, most psychiatrists worked in mental hospitals where it was their job to treat and care for the chronically mentally ill. A combination of things, including the limited action seen by Canadian troops overseas at the beginning of the war, the time needed to mobilize war-related production at home, and the general lack of concern regarding psychiatric problems demonstrated by the Canadian Army, Navy, and Air Force, meant that there was little initial demand for psychiatric services in the military.² By the summer of 1941, however, the situation was more urgent as a growing number of soldiers began to suffer from debilitating mental and nervous conditions brought on or accentuated by the war.³

Health Policy in America," 415.

¹ John D. Griffin, D. Griffith McKerracher, and F. Sam Lawson, "Psychiatry in the Canadian Army," American Journal of Psychiatry 100,1 (July 1943), 137-41.

² Griffin, In Search of Sanity, 101-2.

³ The first published study of mental health casualties in the Canadian Army during World War II was William Baillie, "A Summary of 200 Neurological and Psychiatric Admissions from the Canadian Army Service Forces," American Journal of Psychiatry 97,4 (January 1941), 753-79. See also W.D. Ross, "Mental Hygiene and Reconstruction," Public Affairs 6,4 (Summer 1943), 199; Griffin, In Search of Sanity, 105.

Because there were not enough trained psychiatrists available to meet this rising demand, the military put a number of general practitioners through an intensive seven-month psychiatric training program and pressed them into war service as military psychiatrists.⁴⁰ Their task was twofold: to screen all potential new recruits for psychological disorders and appropriate job placement and to manage incidents of mental breakdown among military personnel.⁴¹ During the summer of 1941, the Canadian Army set up a Personnel Selection Directorate in order to coordinate the appropriate selection and placement of military personnel. The Directorate established a program in which all recruits were required to complete a written psychological test, written health questionnaire, physical examination, and personal interview. The program was organized in such a way that if at any point in the process a recruit was suspected of having low intelligence or suffering from a mental or nervous disorder he was immediately referred to a psychiatrist for a more thorough

⁴⁰ Griffin, McKerracher, and Lawson, "Psychiatry in the Canadian Army," 140; Ross, "Mental Hygiene and Reconstruction," 199; Charles A. Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," Psychiatric Journal of the University of Ottawa 4,1 (March 1979), 35; Grob, "The Forging of Mental Health Policy in America," 413.

⁴¹ J.B. Collip, "Science and War," Canadian Medical Association Journal 49,3 (September 1943), 209; Tyhurst et al., More for the Mind, 5.

assessment to determine if he should be rejected for military service because of psychiatric disability.⁴ The process itself assumed that it was possible to predict, based on an assessment of personality and life history, whether or not an individual was predisposed to emotional disturbances. However, the Canadian screening program, like the one in the United States, was criticized from both within and without psychiatry on a number of accounts. For example, some opponents argued that the techniques used to screen candidates were not able to predict future performance with any degree of reliability. Canadian military medical personnel involved in the selection process disagreed. Director of Personnel Services William Line and Consultant Psychiatrist John Griffin asserted that the standard psychological test used by the Army, the so-called "Revised Examination M" or "M" test, was able to accurately predict how well new recruits would perform in their army training and placement. The reliability of the test was confirmed, they argued, by the results of a complete statistical analysis of the relationship between the scores

⁴ For a more detailed discussion of the selection process, see William Line and John D. Griffin, "Personnel Selection in the Army," Canadian Medical Association Journal 48,5 (May 1943), 394-9; D. Griffith McKerracher, "Psychiatric Problems in the Army," Canadian Medical Association Journal 48,5 (May 1943), 399-404; Griffin, McKerracher, and Lawson, "Psychiatry in the Canadian Army," 137-41.

and subsequent success rates of more than two hundred thousand men who had taken the test to May 1943.³³

The problem of selecting appropriate military personnel soon gave way to the problem of what to do when individuals already in the Armed Forces began to show signs of emotional disturbance. In contrast to World War I, military psychiatrists during World War II were less likely to assume that soldiers with psychiatric disabilities were cowards or malingerers who needed stronger discipline.³⁴ As mental and nervous disorders came to be regarded less and less as a matter of inherited strength or weakness, Canadian psychiatrist Charles Roberts remembered that the Air Force became less inclined to use the term "lack of moral fibre," and the Army gradually gave up using the phrase "unlikely to make a useful soldier" when referring to mental casualties.³⁵ Instead, he notes, psychiatrists began to

³³ Line and Griffin, "Personnel Selection in the Army," 395. See also Griffin, McKerracher, and Lawson, "Psychiatry in the Canadian Army," 139. For examples of the belief in the general predictive reliability of screening techniques, see Line and Griffin, "Personnel Selection in the Army," 398; McKerracher, "Psychiatric Problems in the Army," 399. For criticisms of the American screening program, see Grob, "The Forging of Mental Health Policy in America," 413-4.

³⁴ McKerracher, "Psychiatric Problems in the Army," 400.

³⁵ Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," 35. See also Tyhurst et al., More for the Mind, 11.

place a greater emphasis on the role of the individual's environment. Psychiatrists observed that even the most healthy soldiers had a breaking point when exposed to a stressful situation, such as combat, for any length of time. They also observed that prolonged exposure to environmental stress could manifest itself either as a mental illness such as psychoneurosis or as a physical illness such as a peptic ulcer.³ Upon closer examination of life histories it was discovered that the majority of military personnel who displayed psychoneurotic or psychosomatic symptoms during World War II had already had underlying emotional problems upon enlistment which were then brought to the surface by the stresses of wartime dislocation.⁴ It was further discovered that many of these individuals had come from broken homes characterized by things such as the loss of a parent through separation or divorce, serious quarrelling,

³ Ross, "Mental Hygiene and Reconstruction," 202; H. Dyson Carter, "Treating Our Minds Tomorrow," National Home Monthly, December 1944, 11,25; Roy E. Grinker, "Psychiatric Objectives of Our Time," Canadian Medical Association Journal 56,2 (February 1947), 157; Nora Gold, "Mental Health in Canada: 1947-1959," Canadian Social Work Review 5 (Summer 1988), 209.

⁴ H.H. Hyland and J.C. Richardson, "Psychoneuroses in the Canadian Army Overseas," Canadian Medical Association Journal 47,5 (November 1942), 432; John D. Griffin et al., "Psychoneurotics Discharged from the Canadian Army," Canadian Medical Association Journal 52,4 (April 1945), 332.

or alcoholism.³³ These observations suggested that social and environmental factors played a more important role than heredity in the etiology of mental maladjustment, a shift in emphasis that was also facilitated by a strong reaction against Hitler's decision to kill and not just sterilize Germany's insane and feeble-minded.³⁴ These observations also reinforced in the minds of psychiatrists the Freudian belief that unhealthy adults were the products of unhealthy early home environments created by emotionally immature and conflicted parents who were unable or unwilling to maintain their biologically-determined roles within the family unit. Therefore, psychiatrists reasoned that not only did environmental factors such as combat fatigue, horror, and danger precipitate the emotional and/or physical breakdown of soldiers with weak personality structures but that socioenvironmental factors such as poor parenting and an inadequate home life were responsible for faulty personality formation in the first place.⁴ The idea that environmental

³³ A.F. Menzies, "Post War Problems," Canadian Medical Association Journal 45,5 (November 1941), 399; Ross, "Mental Hygiene and Reconstruction," 200.

³⁴ For a more detailed analysis of World War II and the decline of the eugenics movement, see McLaren, Our Own Master Race, 147-50.

⁴ Menzies, "Post War Problems," 399; Ross, "Mental Hygiene and Reconstruction," 200; Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," 35; Grob, "The Forging of Mental Health Policy in America," 414.

stress was a contributing factor in the onset of mental disorders made military psychiatrists more optimistic than ever that their interventions could alter psychological outcomes. As a result, some argued that more psychiatrists should get out of the mental hospital and into the community to educate and work with community leaders in order to prevent children from becoming socially maladjusted adults with poor parenting skills.⁴³

During the war, military psychiatrists dealt with mental casualties in a number of ways. They discharged some of them. Soldiers with psychiatric conditions made up one third of all medical discharges from the Canadian Army during the war while still others who suffered from less severe disturbances were discharged on administrative grounds because the Army could not find suitable employment for them within the Service.⁴⁴ Sometimes psychiatrists recommended ways in which the military could reduce the risks associated with environmental stress. For example, they suggested that soldiers be assigned to fixed tours of duty instead of spending long periods of time in combat.⁴⁵

⁴³ Ross, "Mental Hygiene and Reconstruction," 200; Grob, "The Forging of Mental Health Policy in America," 415.

⁴⁴ Griffin et al., "Psychoneurotics Discharged from the Canadian Army," 330, 331.

⁴⁵ Grob, "The Forging of Mental Health Policy in America," 415.

And, finally, military psychiatrists successfully employed a number of therapeutic techniques in order to treat mental casualties and return them to active duty.⁴³ One popular treatment method was "brief psychotherapy," a simplified "talk therapy" that borrowed concepts from psychoanalysis but took only a fraction of the time to complete.⁴⁴ Psychiatrists also used hypnosis and narcosynthesis⁴⁵ to help patients bring to consciousness and work through deeply repressed experiences and fears.⁴⁶ In the end, psychiatrists who attempted to deal with the relatively high rate of emotional disturbance among military personnel reached what they considered an important if not original conclusion: early diagnosis and prompt treatment was the key to preventing the development of more serious mental illnesses and the need for hospitalization.⁴⁷

⁴³ Carter, "Treating Our Minds Tomorrow," 11,25; Grinker, "Psychiatric Objectives of Our Time," 157.

⁴⁴ Gordon George, "Mental-Health Problem in America," America, May 1, 1954, 132.

⁴⁵ Narcosynthesis, or narcoanalysis, is a form of psychotherapy that uses the slow intravenous administration of barbiturates like sodium amytal in order to release suppressed or repressed thoughts and feelings.

⁴⁶ Carter, "Treating Our Minds Tomorrow," 26; Helen H. Stacey, "What Can Be Done For Mental Casualties?" Saturday Night, May 5, 1945, 16; Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," 35.

⁴⁷ Ross, "Mental Hygiene and Reconstruction," 200; Carter, "Treating Our Minds Tomorrow," 28; George, "The

After World War II, psychiatric ideas became more popularized as knowledge about psychiatry and psychiatric principles became more widespread. This popularization is explained in part by the fact that former military psychiatrists who assumed leadership roles in postwar society used their positions to heavily promote the value of psychodynamic and psychoanalytic psychiatry. They even went so far as to promise that they and other mental health specialists could make the world a better place in which to live by helping remove barriers to unlimited personal growth and social progress.^{4*} These postwar psychiatrists reinforced the idea that life experiences and socioenvironmental factors played an important role in the etiology of mental adjustment and mental illness.^{5*}

Mental-Health Problem in America," 132.

^{4*} Burnham, "The Influence of Psychoanalysis," 60-1; Grob, "The Forging of Mental Health Policy in America," 415,428; Gerald N. Grob, "Mad, Homeless, and Unwanted: A History of the Care of the Chronic Mentally Ill in America," Psychiatric Clinics of North America 17,3 (September 1994), 555-6.

^{5*} While the balance tipped in favour of the psychodynamic model during the postwar period, the traditional somatic or medical model continued to find support among a wide variety of mental health professionals. Debate was often fierce as can be seen by the differences of opinion which arose among some members of the American Joint Commission on Mental Illness and Health during the 1950s. The debate over concepts of mental health and mental illness involving Marie Jahoda, a social psychologist, and Walter Barton, a psychiatrist, is documented in Marie Jahoda, Current Concepts of Positive Mental Health (New York: Basic

Assuming that there was a smooth continuum from health to disease, they also argued that it was important to prevent the onset of serious mental illness through early intervention and prompt treatment at the community level. Perhaps not surprisingly, these postwar psychiatrists felt that they were particularly well-qualified to play a primary role in ensuring the mental well-being of a postwar world. The task they set before themselves, however, implied a very different role for psychiatry than the one it had enjoyed up until that point.²¹ They envisioned a profession in which psychiatrists would practise mainly in the community and not in the mental hospital. Once in the community, psychiatrists would focus primarily on the prevention and early detection and treatment of neuroses, especially among children, and not on the long-term care and treatment of adult psychoses. And, in order to promote prevention, psychiatrists would work mainly to effect social and environmental changes that would supposedly maximize the mental and physical health of all citizens and not concentrate on preventing the reproduction of individuals with hereditary defects.²²

Books, 1958).

²¹ Grob, "American Psychiatry," 166-9.

²² For example, see Clarence M. Hincks, "The Future of Canadian Psychiatry," Canadian Medical Association Journal

Canadian Brock Chisholm is an example of one military psychiatrist who rose to prominence after the war and strongly advocated a broader role for psychiatrists and psychiatry in postwar society. In October 1945, Dr. Chisholm delivered two lectures as part of the prestigious William Alanson White Memorial Lectures Series. The general theme of his lectures was "The Reestablishment of Peacetime Society." The first lecture, entitled "The Responsibility of Psychiatry," was given on October 23 in Washington, D.C. while the second lecture, entitled "The Responsibility of Psychiatrists," was delivered on October 29 in New York City.¹⁴ In these lectures, Chisholm built on the lessons learned by psychiatrists during the war in what amounted to a dramatic reformulation of the psychiatric mission.¹⁵ In effect, Chisholm argued that permanent world peace depended upon psychiatry replacing religion as the dominant comprehensive world view. According to the psychiatric view

57,2 (August 1947), 161-5.

¹⁴ G. Brock Chisholm, "The Reestablishment of Peacetime Society: The Responsibility of Psychiatry," Psychiatry 9,1 (February 1946), 3-11; G. Brock Chisholm, "The Reestablishment of Peacetime Society: The Responsibility of Psychiatrists," Psychiatry 9,1 (February 1946), 12-20.

¹⁵ For a critical analysis of Chisholm's lectures and the place of psychiatry in the postwar period, see Christopher Lasch, Haven in a Heartless World: The Family Besieged (New York: Basic Books, 1977), 97-100.

of the world, social problems were rooted in psychiatric problems and therefore required the intervention of psychiatrists and other social scientists whose job it was to prevent mental illness and promote mental health through the amelioration of socioenvironmental conditions. In particular, Chisholm argued that psychiatrists must shift their professional focus from an exclusive emphasis on the treatment of immature adults to a greater emphasis on the prevention of children from developing into immature adults in the first place."

Chisholm believed that the only real hope for permanent world peace lay in the establishment in every country of the world a large number of mature and reasonable people who would take responsibility for the more tangible issues of security and economic well-being." The problem, as Chisholm saw it, was that the vast majority of people in the world had not developed into emotionally healthy adults." Chisholm located the root of our failure to mature successfully in popular religion-based childrearing methods which taught children moralities and rights and wrongs."

¹⁴ Chisholm, "The Responsibility of Psychiatry," 9.

¹⁵ Ibid., 6.

¹⁶ Ibid., 7.

¹⁷ Ibid., 8.

The solution, Chisholm argued, was to reject these unhealthy authoritarian methods and, in their place, substitute childrearing practices which would instill in children the ability to think, and thereby to act rationally, in the face of an increasingly precarious world situation.¹⁸ According to Chisholm, "freedom from moralities means freedom to observe, to think and behave sensibly, to the advantage of the person and of the group, free from outmoded types of loyalties and from the magic fears of our ancestors."¹⁹

Because the central component to the reestablishment of peacetime society was the reestablishment of the mature, integrated personality, Chisholm argued that it should be psychiatrists who took primary responsibility for the education of children.²⁰ In particular, he envisioned psychiatrists, along with other social scientists, as advisors who dispensed information on how to raise mature children to people in the community like teachers, parents, and church groups who were more intimately involved in the socialization process.²¹ In short, Chisholm believed that the most important postwar activity was the raising of

¹⁸ Ibid., 7-9; "The Responsibility of Psychiatrists," 18.

¹⁹ "The Responsibility of Psychiatry," 9.

²⁰ Ibid., 9.

²¹ Ibid., 9.

healthy children¹¹ and that it was the primary responsibility of psychiatrists to become "specialists in living"¹² who did whatever was necessary to ensure that children were brought up to be mature adults, independent, flexible, and tolerant, capable of maintaining a mature and stable world order which would reduce the possibility of future global conflicts.¹³

Chisholm later took his psychiatric world view into the international arena through his involvement in the United Nations' World Health Organization (WHO). In 1946 Chisholm became the Executive Secretary of the Interim Commission set up to bring the WHO into existence. In 1948 he became the WHO's first Director General. As Director General, Chisholm was responsible for framing the WHO's constitution. Many of the ideas Chisholm discussed in his 1945 William Alanson White lectures eventually emerged as basic principles of the WHO constitution.¹⁴ Significantly, the first constitutional principle reflected the postwar influence of psychodynamic psychiatry in that it championed a broad definition of

¹¹ Ibid., 10.

¹² Chisholm, "The Responsibility of Psychiatrists," 20.

¹³ Ibid., 17.

¹⁴ Sheila Joy Pollock, "Social Policy for Mental Health in Ontario, 1930-1967," D.S.W. thesis, University of Toronto, 1974, 175-8.

health which rejected the medical model of disease in favour of an emphasis on the importance of socioenvironmental factors. According to this principle, "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."¹⁷

In spite of the prominence of Brock Chisholm and the World Health Organization, not all psychiatrists wanted to have increased authority over and greater involvement in both private and public matters after the war. This difference in opinion was part of a larger postwar debate which caused a serious split among some members of the American Psychiatric Association over the future direction of the organization. On one side were psychiatrists like Chisholm who supported the principles of psychodynamic psychiatry and wanted psychiatry to become more involved in the amelioration of political and social problems. On the other side were psychiatrists who placed more emphasis on the organic aspects of mental disease and were committed to work in the mental hospitals.¹⁸ In the context of this

¹⁷ The constitution of the WHO is reprinted in full by T.C. Routley, "The World Health Organization," Canadian Medical Association Journal 55,4 (October 1946), 385.

¹⁸ The struggle within the American Psychiatric Association is discussed in more detail by Gerald N. Grob, "Psychiatry and Social Activism: The Politics of a Specialty in Postwar America," Bulletin of the History of Medicine 60,4 (Winter 1986), 477-501.

debate, some psychiatrists challenged psychiatrists like Chisholm by arguing that the actual need for community-based mental health professionals was unclear because it was impossible to determine the number of neurotics at any given time. American psychiatrist Henry Davidson pointed out that while there were a number of theoretically sound methods available for determining the incidence of psychoneurosis in the community, none of these methods had ever been employed on any significant scale. Therefore, he concluded that people who quoted incidence figures for neurosis had no reliable basis for their claims.¹¹

Other psychiatrists agreed with mental health professionals like Chisholm who argued that there was a clear need for psychiatrists but they were disturbed by the expansion of psychiatry into new domains and what they saw as the increasing medicalization of society. American psychiatrist Leslie Farber complained that psychiatrists had turned what was otherwise human into something medical to the extent that they were now authorities in the areas of morality, philosophy, and religion.¹² American

¹¹ Henry A. Davidson, "The Numbers Game in Neuroses," New Republic, November 14, 1955, 22.

¹² Leslie H. Farber, "Martin Buber and Psychiatry," Psychiatry 19,2 (May 1956), 119. See also J. Donald L. Howson, "Psychiatry Assumes a Role of the Church," Saturday Night, August 24, 1946, 14.

psychiatrists Lessie Fleming and Desmond Curran were particularly concerned about the implications of the broad and all-inclusive definition of health adopted by the World Health Organization. Fleming observed that to define health as "a state of complete physical, mental, and social well-being" opened the way for health professionals to become involved in virtually any social institution including the home, church, or school.¹¹ Curran felt that psychiatric claims had gone too far and that the WHO definition of health only added to the problem of increased medicalization. According to Curran, the WHO definition blurred the line between mental health and mental illness so much that almost any socially undesirable behaviour could be interpreted as a sign of emotional instability in need of psychiatric treatment. For Curran, the danger of such a fluid definition of health was that it became very difficult to prove or disprove a diagnosis of mental illness.¹²

Psychiatrists who argued that the scope of psychiatry was in danger of becoming too broad were joined by critics who argued that the ability of psychiatrists to prevent and cure mental illnesses was greatly overestimated. Writing in

¹¹ Lessie T. Fleming, review of Mental Health Planning for Social Action, by George S. Stevenson, Marriage and Family Living 19,2 (May 1957), 210.

¹² Desmond Curran, "'Psychiatry Ltd.'," Canadian Medical Association Journal 68,1 (January 1953), 63.

Saturday Night magazine in 1954, social critic and author J.B. Priestley pinned the blame for this overestimation on self-serving psychiatrists who had intentionally fostered unrealistic expectations and made unsubstantiated claims in order to legitimize their professional status and gain public support for their policy initiatives.⁷³ Other critics focussed their attention on the latest theories about mental health and mental illness which they said had not led to any advancements in understanding the cause, progression, and cure of mental illnesses. For example, American psychiatrist Francis Braceland asserted that the relationship between socioenvironmental factors and mental disorders was not as certain as once thought because studies of Hutterite communities across North America demonstrated that a relatively simple and uncomplicated lifestyle did not eliminate the presence of mental disorders.⁷⁴ Critics of the therapeutic claims of psychiatrists were also bolstered by the fact that there was no clinical evidence to support the popular belief that neuroses could be prevented from

⁷³ J.B. Priestley, "The Insane Specialists and the Individual," Saturday Night, August 28, 1954, 7-8; Eric J. Cassell, "The Changing Concept of the Ideal Physician," Daedalus 115,2 (Spring 1986), 196; Grob, "Mad, Homeless, and Unwanted," 555.

⁷⁴ Francis J. Braceland, review of Culture and Mental Disorders, by Joseph W. Eaton and Robert J. Weil, America, September 10, 1955, 567.

developing into psychoses through prompt intervention and early treatment."⁵ And, finally, studies failed to prove that the presence of community-based psychiatric facilities would prevent the hospitalization of a large number of mentally ill patients. For example, a 1958 study in California showed that the vast majority of patients who had been hospitalized in a state institution were, upon release, unsuitable for treatment in community clinics and eventually needed to be readmitted to hospital.⁶

In spite of this opposition to developments from within the profession, the principles of psychodynamic and psychoanalytic psychiatry had considerable influence on the postwar approach to mental health. In Canada, this shift in psychiatric theory and practice was reinforced by the willingness of the government to play a greater role in ensuring the health and social welfare of all Canadians. This was a period of strengthened federal power in which the primary role of the federal government in health and welfare was to provide the provinces with political, financial, and technical support in order to carry out federal

⁵ Grob, "The Forging of Mental Health Policy in America," 439-40. Of course, it is difficult to imagine the form an experiment would have to take in order to demonstrate the value of preventive measures.

⁶ Harold Sampson et al., "Feasibility of Community Clinic Treatment for State Mental Hospital Patients," A.M.A. Archives of Neurology and Psychiatry 80 (July 1958), 77.

initiatives.¹⁰⁰ Like the changes in psychiatry, the expansion of the welfare state was fuelled in part by World War II. Influenced by the economic principles of John Maynard Keynes and hoping to avoid social, economic, and labour problems similar to those which followed the end of World War I, the wartime Liberal government of Prime Minister Mackenzie King had promised to introduce a comprehensive system of social security, including plans for a national health insurance scheme, in order to ease the transition from a wartime to a peacetime economy. King had enacted the Unemployment Insurance Act of 1940 and the Family Allowances Act of 1944 but the promise of a comprehensive social security system was stalled at the 1945 Conference on Reconstruction because the federal government and the provinces could not agree on financial details. As a result, the social security system in Canada after the war developed in more of a piecemeal than a comprehensive fashion.¹⁰¹

Nevertheless, one example of the greater willingness of the federal government to take on more and more

¹⁰⁰ Robert Bothwell, Ian Drummond, and John English, Canada Since 1945: Power, Politics, and Provincialism, rev. ed. (Toronto: University of Toronto Press, 1989), 55-8.

¹⁰¹ Guest, The Emergence of Social Security in Canada, 104-44; Griffin, In Search of Sanity, 126; Annalee Götz, "Family Matters: The Canadian Family and the State in the Postwar Period," Left History 1,2 (Fall 1993), 11-3.

responsibility for ensuring the health and welfare of all Canadians was its introduction in 1948 of a new National Health Grant Program. Generally speaking, the purpose of the health grant system was to extend federal financial assistance to provincial governments in order to help strengthen very diverse public health services. In particular, the program committed the federal government to provide provincial governments with at least \$30 million per year in grants. With this money the provinces were expected to conduct surveys of health personnel and facilities so as to help ensure long-range and balanced planning of public health services and health insurance, to combat a wide variety of diseases and disabilities, and to build hospitals and rural health facilities.⁷⁹ The grants amounted to about \$2.40 per person per year.⁸⁰ Assuming that federal monies were fully utilized and that provincial governments matched federal grants as required, the implementation of the National Health Program promised to increase total expenditures on health and hospital care in Canada from \$86.5 million to at least \$132.5 million annually.⁸¹

Government concern for the mental health of Canadians

⁷⁹ Joseph Willard, "The Canadian Health Grant Program," Canadian Welfare 24,5 (October 15, 1948), 2.

⁸⁰ Ibid., 3.

⁸¹ Ibid., 2.

was reflected in the relatively generous amounts of money made available to the provinces under the National Health Program in the areas of mental health and hospital construction.⁷³ The Mental Health Grant promised \$4 million to the provinces in 1948 with an additional \$1 million every two years to a maximum of \$7 million per year starting in 1954.⁷⁴ Illustration 3 compares Canada and the United States in terms of federal per capita appropriations for comparable grants to provincial and state governments. It indicates that the initial amount earmarked for mental health in Canada in 1948 was thirty-two cents per person which represented almost fourteen percent of the total appropriations.⁷⁵ Only the areas of general public health and hospital construction received a larger proportion of grant money at fifteen percent and forty-five percent respectively. Money from the Mental Health Grant was primarily intended to help provincial governments train additional mental health personnel, develop preventive

⁷³ The National Health Grant Program and its provisions for mental health care are discussed in more detail by Pollock, "Social Policy for Mental Health," 182-204.

⁷⁴ Willard, "The Canadian Health Grant Program," 4.

⁷⁵ The total figure of \$2.32 per capita quoted in Illustration 3 excluded the money directed toward professional training (five cents per capita) and health surveys (four cents per capita) for a total initial expenditure in Canada of \$2.40 per capita. Ibid., 4.

HEALTH GRANTS

A COMPARISON OF U.S.A. AND CANADIAN
GRANTS TO STATES AND PROVINCES
AMOUNTS APPROPRIATED PER CAPITA*

ILLUSTRATION 3: Comparison of Canadian and American health grants to provinces and states, 1948-1949. Source: Joseph Willard, "The Canadian Health Grant Program," Canadian Welfare 24,5 (October 15, 1948), 5.

services such as mental health clinics, and increase the number of beds designated for Canadians suffering from mental illness."⁵ The Hospital Construction Grant, on the other hand, earmarked \$13 million annually for hospital construction on the condition that the provinces matched the federal contribution."⁶ In terms of building new provincial mental hospitals, the federal grants offered assistance to provincial governments at a rate of \$1,500 per bed."⁷

Contrary to initial intentions, the actual implementation of the federal Mental Health and Hospital Construction Grants reinforced economic inequalities between the provinces and led to the uneven distribution of mental health resources across the country. The wealthiest provinces, Ontario and Quebec, benefitted most from these grant programs in part because they were the most densely populated provinces, they already had the most well-equipped and sophisticated hospitals and universities, and they had the financial resources to match federal hospital construction grants."⁸ Nevertheless, federal priorities, as outlined in the Mental Health and Hospital Construction

⁵⁵ Ibid., 6.

⁵⁶ Ibid., 34.

⁵⁷ Ibid., 34.

⁵⁸ Tyhurst et al., More for the Mind, 14; Gold, "Mental Health in Canada: 1947-1959," 214-5.

Grant programs, further supported the shifts in psychiatric theory and practice which emerged out of World War II in that they emphasized, among other things, the need for more mental health personnel, the value of community-based prevention and treatment facilities, and the importance of effecting socioenvironmental changes in order to maximize the mental health of hospitalized patients. For example, the number of qualified mental health workers increased dramatically between 1949 and 1959. Administrative staff increased by two hundred percent, the number of psychiatrists, psychologists, and psychiatric social workers increased by three to four hundred percent, and the psychiatric nursing staff increased by fifty percent.⁸⁰ The Mental Health Grant was also responsible in whole or in part for the increase in the number of community mental health clinics from 17 in 1948 to 77 in 1953 to almost 150 in 1960.⁸¹ This money also helped promote community mental health care through the development of psychiatric treatment

⁸⁰ Tyhurst et al., More for the Mind, 14. See also Paul Martin, "The Canadian Pattern of Health Progress," Canadian Medical Association Journal 69,2 (August 1953), 172.

⁸¹ Martin, "The Canadian Pattern of Health Progress," 172; J. Waldo Monteith, "Canada's Mental Health Program," Canada's Mental Health 8,4 (April 1960), 4. See also, Gold, "Mental Health in Canada: 1947-1959," 214.

services in general hospitals and out-patient clinics.²¹ Finally, the Hospital Construction Grant helped make available an additional 18,000 beds in Canadian mental hospitals between 1949 and 1959.²² Some of these beds were in new or renovated hospitals designed to treat patients in accordance with the medical model of disease but many could also be found in smaller regional hospitals and renovated older hospitals designed to create for patients a more humane and personal environment or "therapeutic community."²³ This attention to the therapeutic importance of the environment meant that these mental hospitals made special efforts to do things like increase the staff-patient ratios, improve the food, brighten up the decor with new lamps and curtains, and encourage the implementation of architectural designs that were believed to be more conducive to mental well-being.

Psychiatric ideas also became more popularized in the postwar period in part because a great deal of information which emphasized the importance of sound

²¹ Tyhurst et al., More for the Mind, 14.

²² Ibid., 14.

²³ "The Therapeutic Community," Canada's Mental Health 7,9 (November 1959), 1-3. See also Gold, "Mental Health in Canada: 1947-1959," 214-5.

mental health was made available to the general public after the war and the majority of this material was permeated by the principles of psychodynamic and psychoanalytic psychiatry.⁴ For example, much of this information assumed that there was a continuum from health to disease and that it was possible to prevent the onset of serious mental illness through early diagnosis and prompt intervention at the community level. It also placed a lot of emphasis on the important role played by socioenvironmental factors in the etiology of mental illness and the need, especially in the case of children, for the creation of socioenvironmental conditions which were conducive to mental and emotional well-being. Overall, the information was hopeful and suggested that psychiatrists and other mental health professionals could make the world a better place by helping remove obstacles to the possibility of unlimited personal and social improvement.

In Canada, a good proportion of the mental health information and education which was directed at the public after the war was sponsored by the Division of Mental Health of the federal Department of National Health and Welfare,

⁴ Robert O. Jones, "The Place of the Psychiatrist in the Community Medical Services," Canadian Medical Association Journal 68,1 (January 1953), 3; Anthony Horder, "The Tranquilizer Problem," Science Digest 52,2 (August 1962), 78; Tyhurst et al., More for the Mind, 11; Gold, "Mental Health in Canada: 1947-1959," 212.

the National Film Board of Canada, and the National Committee for Mental Hygiene (Canada) which in 1950 changed its name again to the Canadian Mental Health Association. The goal of these educational efforts was essentially twofold: to increase public awareness about mental health, mental health/psychiatric services, and healthier ways of relating to one another, and to better inform parents about how best to raise a happy and mentally healthy child."

Public education events took many forms. For example, in 1950 the Canadian Broadcasting Corporation produced "In Search of Ourselves," a series of weekly radio plays depicting some of the more common mental health problems in children and adults. These dramatic sketches were discussed with the use of previously-distributed pamphlets by groups of concerned citizens organized by Home and School Associations across the country." Documentary films were also popular educational tools. The Division of Mental

" Margaret Ecker Francis and Robert Francis, "Mental Health of Canada's Future Citizens," Saturday Night, August 14, 1948, 22-3; Ron Kenyon, "The Child Who Is Mentally Ill," Saturday Night, June 19, 1951, 30-1; Albert Ellis, "How To Live With A Neurotic," Maclean's, October 26, 1957, 30.

" Griffin, In Search of Sanity, 168. For a more detailed discussion of this experiment in mental health education, see Francis Hugh Cameron, "An Analysis of Discussions of a Radio Series Promoting Mental Health [CBC's In Search of Ourselves]," M.S.W. thesis, McGill University, 1951.

Health made "Mother and Child" and "Know Your Child" which emphasized the need to prepare the home environment psychologically for the arrival of a new baby.⁶⁷ The National Film Board, under the direction of the Division of Mental Health, made films such as "Feeling of Rejection,"⁶⁸ "Breakdown,"⁶⁹ and "Stigma"⁷⁰ as part of the "Mental Mechanisms" series intended to promote discussion and better understanding of mental health problems. Psychiatrists gave public lectures in order to raise community awareness about the prevention and treatment of mental illness.⁷¹ Amateur actors performed plays with mental health themes published by the Canadian Mental Health Association before lay audiences and then took part in the discussion period that followed.⁷² The Division of Mental Health and the Canadian Mental Health Association distributed literature, pamphlets, and study guides on a wide range of mental health topics to

⁶⁷ Francis and Francis, "Mental Health of Canada's Future Citizens," 23.

⁶⁸ Miriam Chapin, "Mental Illness Need Not Be A Calamity," Saturday Night, April 17, 1948, 36; Francis and Francis, "Mental Health of Canada's Future Citizens," 23.

⁶⁹ "Breakdown," Saturday Night, June 12, 1951, 11.

⁷⁰ "Stigma," Canada's Mental Health 6,6 (June 1958), 17.

⁷¹ Jones, "The Place of the Psychiatrist in the Community Medical Services," 4.

⁷² Griffin, In Search of Sanity, 168.

interested individuals, groups, and organizations across Canada.¹³³ And, in 1951, the Canadian Mental Health Association designated the first week in May as Mental Health Week in Canada. Efforts were made to ensure maximum public interest and participation in mental health-related events organized to coincide with the week. These events included poster and essay contests in schools, special services and sermons in churches, invitations to the public to take "Come-See Tours" of mental hospitals, and articles on mental health written specially for publication in the press.¹³⁴

In addition to nation-wide education campaigns, Canadians learned about psychiatry and mental health issues because of the attention and publicity they received within the popular culture. Much of this information originated in the United States, reflecting the dominance of American popular culture in Canada during the postwar period and especially during the 1950s.¹³⁵ The Hollywood movie "The

¹³³ Francis and Francis, "Mental Health of Canada's Future Citizens," 22,23; "Distribution of Mental Health Material Increases," Canada's Mental Health 5,6 (June 1957), 19; Griffin, In Search of Sanity, 167.

¹³⁴ Donald J. McCulloch, "Mental Health Week 'Open House': A Critical Evaluation," Canada's Mental Health 10,2 (February 1962), 1-5; Griffin, In Search of Sanity, 169.

¹³⁵ J.M. Bumsted, "Canada and American Culture in the 1950s," in J.M. Bumsted, ed., Interpreting Canada's Past, Vol. II, After Confederation (Toronto: Oxford University

Snake Pit"¹⁰⁰ and television documentary "Out of Darkness"¹⁰¹ were just two of the many American films shown in Canada on the subject of psychiatry and mental health which helped heighten public awareness about the problem of mental illness.¹⁰² Dozens of books¹⁰³ and a flood of articles and cartoons in popular magazines and newspapers kept the public informed about such things as the latest scientific theories, therapeutic methods, and mental health statistics.¹⁰⁴ And, much to the displeasure of more scientifically-oriented psychiatrists, pseudo-psychologists such as newspaper lovelorn columnists and fortune tellers

Press, 1986), 399; Paul Rutherford, When Television Was Young: Primetime Canada, 1952-1967 (Toronto: University of Toronto Press, 1990), 13.

¹⁰⁰ "The Snake Pit" was based on a book by the same name written by Mary Jane Ward about her experience in an American mental hospital in the mid-1940s. For a discussion of the differences between the book and the Hollywood movie and what these changes reveal about contemporary views of psychiatry, mental health, and women in the postwar period, see Leslie Fishbein, "The Snake Pit (1948): The Sexist Nature of Sanity," American Quarterly 31,4 (Winter 1979), 641-65.

¹⁰¹ "Out of Darkness," Canada's Mental Health 4,7 (September 1956).

¹⁰² Griffin, In Search of Sanity, 168.

¹⁰³ For a sampling of some of these books, see the review article by John H. Yocom, "A Growing Interest in the Mind and Something of What It Does," Saturday Night, March 27, 1948, 19.

¹⁰⁴ For example, see Brian Bird, "Mental Health in Canada," Canadian Forum, May 1947, 34-5.

dispensed an abundance of psychiatric information and advice to eager consumers.¹⁰⁰

Like many of the distributors of this information, ordinary Canadians took the subject of mental health very seriously. According to journalist Jeann Beattie, mental health and psychiatric explanations for human motivation were popular topics of discussion among middle-class Canadians during the fifties.¹⁰¹ This public interest in and concern about mental health and mental health issues was conditioned in part by the extent to which Canadians placed their faith and trust in people who were in positions of authority. Writer Melinda McCracken was a teenager in Winnipeg during the 1950s. She remembered the postwar period as a time when authority figures and their ideas were respected because it was assumed that they alone had the power to guide Canadians along the path to health and happiness. "Authority per se was good," McCracken recalled.

It helped one live the good life. You obeyed the rules, and goodness followed naturally. There were authority figures at many levels -- fathers, teachers, principals, doctors, administrators, premiers and prime ministers, police chiefs, heads

¹⁰⁰ Yocom, "A Growing Interest in the Mind and Something of What It Does," 19; Tyhurst et al., More for the Mind, 11.

¹⁰¹ Jeann Beattie, "A Single Woman Looks At Wives," Chatelaine, July 1968, 62.

of companies. People believed in what they said and thought their intentions honourable.¹¹³

The increase in public awareness about mental health was quickly translated into, among other things, a growth in volunteer work with institutionalized patients.¹¹⁴ Volunteer services for the mentally ill had existed in Canada since the nineteenth century but volunteer-patient interaction had been sporadic and uneven at best. In the 1950s, community volunteers -- especially women volunteers -- were successfully organized by the Canadian Mental Health Association as part of its development of a national program of services for the mentally ill.¹¹⁵ As a result, more volunteers began to have more contact with patients in mental hospitals and the community as the 1950s progressed. The type of volunteer-patient contact varied. Some volunteers spent time just talking with individual patients, others made it their responsibility to remember patients on special occasions like birthdays and Christmas, others organized parties and special entertainments like picnics, sing-alongs, and bingo games, while still other volunteers

¹¹³ Melinda McCracken, Memories Are Made Of This (Toronto: James Lorimer, 1975), 16.

¹¹⁴ Leighton E. Cluff, "America's Romance with Medicine and Medical Science," Daedalus 115,2 (Spring 1986), 143.

¹¹⁵ Tyhurst et al., More for the Mind, 5; Griffin, In Search of Sanity, 170.

operated clothing centres in the hospitals which provided patients about to return to the community with suitable clothing.¹¹⁴ Along this line, a group of Regina housewives chartered a bus once a month in order to visit the mental hospital at Weyburn where they encouraged patients to participate in glee clubs, art lessons, and hat sales.¹¹⁵ Volunteers also had contact with patients who had been discharged from the hospital and were living in the community. This contact came through their work in White Cross Centres which had been set up independent of the hospitals and located in downtown areas for easy access. By 1958, there were eleven White Cross Centres operating in Canada whose main function was to provide a place for former patients to socialize with each other and earn a bit of money by doing small jobs such as simple assembly projects.¹¹⁶

¹¹⁴ "Volunteers For Mental Hospitals," Canada's Mental Health 5,4 (April 1957), 2; "Volunteers," Canada's Mental Health 6,4 (April 1958), 1-2; Griffin, In Search of Sanity, 171-3.

¹¹⁵ Dorothy Pechey, "How Regina Housewives Help the Mentally Ill," Chatelaine, May 1957, 9. In another example of voluntarism with the mentally ill, a number of beauty students went to the Fergus Falls State Hospital in Fergus Falls, Minnesota and in one day gave sixteen permanents to women in the geriatrics unit. "Beauticians and Mental Hospital Patients," Canada's Mental Health 5,3 (March 1957), 10.

¹¹⁶ "White Cross Centres' Report," Canada's Mental Health 8,7 (September 1960), 2-3; Griffin, In Search of

While psychiatrists and other mental health experts acknowledged that volunteer work with the mentally ill made an important contribution to the overall level of mental health in Canada, they remained primarily interested in the prevention, early detection, and treatment of neuroses in the community through the amelioration of social and environmental problems which they considered to be impediments to the achievement of individual and collective well-being. In particular, postwar experts were concerned about mental health in the home and placed a great deal of emphasis on the need for parents to create a familial environment which facilitated the raising of emotionally healthy and happy children. Their advice to parents with regards to what constituted the proper familial environment made a direct link between healthy parents, a healthy environment, and the strict adherence to proper gender roles. This connection was heavily influenced by two mutually-reinforcing concepts which permeated many aspects of academic and popular thought during the 1950s: Freudianism and functionalism.***

Sanity, 174.

*** For a brief description of the ways in which Freudianism and functionalism were mutually-reinforcing concepts during the 1950s, see Douglas Miller and Marion Nowak, The Fifties: The Way We Really Were (New York: Doubleday, 1977), 149-55. See also Fishbein, "The Snake Pit (1948)," 641-3; Veronica Strong-Boag, "Home Dreams: Women

Freudians assumed that men and women had an innate biological predisposition to perform different roles in life. According to this reasoning, men were by nature strong, aggressive, independent, rational, and competitive. As a result, men were by nature best suited to be breadwinners, protectors, and leaders of society. Women, on the other hand, were by nature soft, passive, emotional, obedient, gentle, and maternal. As a result, women were by nature best suited to be wives, mothers, and homemakers.¹⁰⁰ Men and women who followed their natural instincts, Freudians continued, were emotionally mature and able to achieve a deep sense of satisfaction both within themselves and in relation to those around them. By contrast, men and women who denied their natural instincts were emotionally immature and suffered from internal conflicts which made life difficult for all those with whom they came in contact.

Building on Freudianism, functionalism contended that

and the Suburban Experiment in Canada, 1945-1960," Canadian Historical Review 72,4 (December 1991), 477-8.

¹⁰⁰ J. Ronald Oakley, God's Country: America in the Fifties (New York: Dembner Books, 1986), 293-4. The extent to which postwar psychiatrists were influenced by Freudian ideas was demonstrated by American psychiatrist Leo Kanner who in 1954 gave brief history quizzes to about three hundred psychiatric residents from across the United States and found that the trainees were more familiar with the ideas and work of psychoanalysts than any other medical figures. Leo Kanner, "The Status of Historical Perspective in Psychiatric Instruction," Bulletin of the History of Medicine 29,4 (July-August 1955), 329-36.

the different roles played by men and women within the family also performed valuable functions within the larger society. Functionalism was originally a social science method that attempted to introduce objectivity into the analysis of non-Western cultures by simply describing how different behaviours "functioned" within a particular culture. By the 1950s, however, functionalism had come to be bent toward more nonobjective cultural purposes as its original intent to describe cultural-specific behaviours gave way among some proponents to a general attempt to prescribe culturally-appropriate ways of relating. American sociologist Talcott Parsons was one of the most influential academics of the functionalist tradition in the postwar period. Among other things, Parsons asserted that the family was necessary to the healthy emotional development of children and the "stabilization" of adults; its key role was socialization in an age when it no longer played important economic or political functions. He accepted the assumption that women played a central role in the socialization of children within the family, but also argued that professionals (like psychiatrists, psychologists, and social scientists) were necessary to help the family cope with the stress of modern living. Hence he linked a belief in "traditional" gender roles to principles of modern scientific management, thereby providing a theoretical base

for those who wished to draw connections between the adherence to proper gender roles, the development of healthy personalities, and, by implication, the maintenance of broader social stability.³³

While Freudian and functionalist schools of thought emphasized the need for both men and women to follow their biological destiny in the name of familial and social stability, it was assumed that women were ultimately responsible for the health and well-being of the family and the society at large. Only women who fulfilled their domestic roles, it was reasoned, were mature and well-adjusted enough to satisfy and keep a husband, produce and raise emotionally healthy children, and ensure a safe and secure future for society. As a result, women in the 1950s were continually reminded that their happiness and the happiness of their family and future generations was directly dependent upon their willingness and ability to follow their natural instincts and become devoted wives, mothers, and homemakers. The popular maternal and infant care manual, The Canadian Mother and Child, reinforced the idea that biology was destiny and that women could find true

³³ Talcott Parsons and Robert F. Bales, Family Socialization and Interaction Process (London: Routledge and Kegan Paul, 1956), 16-26; Lasch, Haven in a Heartless World, 115-7; Rochelle Gatlin, American Women Since 1945 (Jackson: University Press of Mississippi, 1987), 49-50.

happiness and fulfilment only in motherhood. For example, the opening lines of this government publication described the experience of childbirth as follows:

The birth of a baby is the most glorious achievement in the life of a woman, for, in becoming a mother, she completely fulfils the special purpose of her existence as a woman. It is also an event which should bring her great satisfaction and real joy.¹¹¹

In 1957, the Department of National Health and Welfare strengthened the assumption that the family was the most suitable environment in which to foster individual growth and emotional well-being when it chose to promote Mental Health Week in Canada with the theme "Mental Health Grows Best in Happy Family Life" (Illustration 4).¹¹² The photograph which accompanied this campaign featured a family unit consisting of a mother, father, boy child, and girl child leisurely relaxing together in what appeared to be their living room. The importance of the role of women as

¹¹¹ Ernest Couture, The Canadian Mother and Child, rev. ed. (Ottawa: Department of National Health and Welfare, 1949), 3. See also Rev. E.S. Lautenslager, "A Minister's Frank Talk to Brides and Grooms," Chatelaine, May 1954, 18. The Canadian Mother and Child was originally published in 1940 and by 1953 over two million copies of it had been distributed by Canadian public health nurses to new mothers. Alison Prentice et al., Canadian Women: A History, 2d ed., (Toronto: Harcourt Brace, 1996), 385.

¹¹² This photograph initially appeared as a pull-out poster. See "Mental Health Grows Best in Happy Family Life," Canadian Mental Health 4,9 (November 1956), pull-out poster.

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University of Ottawa

Mental

Health

Week

April 28th

to

May 4th

ILLUSTRATION 4: Theme of Mental Health Week, 1957: Mental health grows best in happy family life. Source: Canada's Mental Health 5,4 (April 1957), front cover.

wives and mothers in ensuring the welfare of the family and the health of individual family members was alluded to in the photograph by the fact that all eyes were on the woman as she responds to something that her daughter had given her. Other postwar experts were more direct in reminding women of their responsibilities within the family and the wider implications of their actions. Marion Hilliard, Chief of Obstetrics and Gynecology at Women's College Hospital in Toronto, asserted that wives were primarily responsible for maintaining and strengthening the marriage relationship which basically involved keeping their husbands happy at any cost. "The burden of creating a happy marriage falls mainly on the wife," she said.

A man's life is much more difficult than a woman's, full of the groaning strain of responsibility and the lonely and often fruitless search for pride in himself. A cheerful and contented woman at home, even one who must often pretend gaiety, gives a man enough confidence to believe he can lick the universe.²⁴

Members of the editorial staff of the American magazine Ladies' Home Journal also reiterated the idea that mothers were primarily responsible for childcare and for ensuring

²⁴ Marion Hilliard, A Woman Doctor Looks at Love and Life (Garden City, N.Y.: Doubleday, 1957; PermaBooks, 1960), 52-3. This book is actually an edited collection of a series of articles Hilliard wrote for Chatelaine magazine starting in January 1954. See also Dorothea Goetz, "How to Fight the Other Woman," Chatelaine, May 1952, 7; Signe Hammer, "Inventing Ourselves: The Class of 1958," Ms, December 1988, 54.

that their children developed into emotionally stable adults. As part of a 1956 Ladies' Home Journal panel set up to interview four contemporary mothers about their experiences in the home, one of the editors made it a point to impress on the women the very great extent to which "the welfare of society depends upon the type of children you young mothers, and others like you, are able to bring up."¹⁰ In effect, so completely were women encouraged to follow their natural instincts and become devoted wives, mothers, and homemakers during the 1950s that it seemed as if the ideal woman was a woman who had no needs of her own except the need to give of herself to others in the belief that it would bring ultimate happiness to herself, her family, and future generations.

While the public was very respectful of authority and shared with psychiatrists a belief in the feasibility and desirability of individual and social improvement, Canadians did not just sit back and allow the experts to unilaterally run their lives. The prevalence of information and publicity about psychiatry and mental health issues had given parents an opportunity to think and speculate for

¹⁰ "The Plight of the Young Mother," Ladies' Home Journal, February 1956, 60. See also Couture, The Canadian Mother and Child, 6.

themselves on how best to raise emotionally healthy children. Ultimately, these parents did not openly question the link between proper gender roles, mental health, and social stability but, in the face of expert opinion, they did display a degree of autonomy and trust in their own ability to know what was best for themselves and their children. This was particularly evident in the aftermath of the Forest Hill Village Project. Forest Hill was an upper middle class Toronto suburb of approximately twenty thousand people which became the subject of a psycho-social research project on the mental health of an entire community. Funded largely by a federal Mental Health Grant, the project involved between twenty and thirty social scientists at any one time and lasted from 1948 to 1953. University of Toronto sociologist John Seeley was the director of the project and a co-author of the final report which appeared in book form under the title Crestwood Heights.¹²⁷ Much to the surprise of researchers and residents alike, the study was widely publicized in the popular press under sensational headlines such as "Find Mental-Health Problems Prevalent" and "Children Spoiled by Rich Forest Hill Parents."¹²⁸ The

¹²⁷ John R. Seeley, R. Alexander Sim, and Elizabeth W. Loosley, Crestwood Heights (Toronto: University of Toronto Press, 1956).

¹²⁸ Robert Olsen, "The Suburb They Called Crestwood Heights," Maclean's, October 12, 1957, 25.

resulting scramble by social scientists and Forest Hillers to explain more fully the results of the study revealed some discrepancies between how the sociologists viewed Forest Hill parents and how the parents viewed themselves.

Generally speaking, Forest Hill residents agreed with the findings in Crestwood Heights. Nevertheless, some Forest Hillers took exception to what they saw as a tendency by Seeley and other researchers to find psychological significance where none existed. For example, they complained that the book suggested that they were unsure of themselves as parents and therefore inclined to seek and rely on the advice of experts. In their own defence, Forest Hill parents argued that they sent their children to teaching specialists, recreational directors, and psychologists not because they wanted to absolve themselves of their responsibilities as parents but because they wanted what they felt was best for their children.³³ In another instance, Forest Hill parents were irritated that the study implied that they regularly relegated their children to basements and back rooms because they were more interested in protecting their homes from rambunctious children than in furnishing the youngsters with a homey environment in which to live and grow. In response, parents asserted that they

³³ Ibid., 36.

were simply fortunate to own houses that were big enough to allow them the luxury of providing their children with separate rooms in which to play.³⁶ Therefore, as much as many middle class parents were respectful of postwar experts and intent on raising emotionally healthy children, they were also willing and able to interpret for themselves the wealth of mental health information available to the Canadian public after World War II.

In general, then, knowledge about psychiatry and psychiatric principles was widespread in Canada after the war even though there was no guarantee that these popularized ideas were entirely accurate. These ideas tended to emphasize the extent to which unhealthy behaviours threatened to undermine the future of the family and even the nation itself. They also assumed that it was possible to prevent these behaviours from occurring in the first place thus ensure unlimited individual and social well-being. Ordinary Canadians became concerned and knowledgeable about mental health and mental health issues and shared an optimism and trust in their own ability and the ability and good intentions of experts to enhance the emotional well-being of all community members. In the

³⁶ Ibid., 36.

1950s, it was relatively easy for Canadians to be optimistic about the future and trusting in members of the medical profession because it appeared that science in general and medical science in particular were helping to improve the quality of life for all Canadians.

CHAPTER TWO

Drugs, Doctors, and Medical Science

In 1956, Glenn Seaborg, a professor of chemistry and chemical engineering at the University of California, Berkeley, wrote a short article entitled "The Future through Science" in which he documented some of the ways in which science had contributed to America's postwar prosperity. For example, he observed

In medicine, we have seen the development of the sulfa drugs, the antibiotics such as penicillin, streptomycin, aureomycin, erythromycin, and the sterol derivations such as cortisone; the introduction of new operative techniques, a better understanding of viruses, and polio vaccine; the development of new drugs for the treatment of mental disease; and other developments too numerous or too technical to mention.

Seaborg was excited about the extent of the progress thus far and enthusiastic about the as-yet-untapped potential for growth that lay ahead. Nevertheless, he recognized that national well-being could not be taken for granted and therefore made a passionate plea for "the conservation of our most important natural resource --

: Glenn T. Seaborg, "The Future through Science," Science 124,3235 (December 28, 1956), 1275.

trained brainpower." Seaborg argued that the public school system needed to be maintained and expanded in order to ensure that a large proportion of the most gifted students received an education that fully prepared them to meet domestic and international challenges in the future while respecting "the scientific and intellectual basis of modern civilization."

This article by Seaborg was reflective in at least three ways of the esteemed position held by science in postwar North America. First, it was popularly believed that everything was possible through science. People believed in the promise that science would find answers to every personal and social problem facing the nation. They felt that science would guarantee long-term prosperity and, by extension, bolster national security.¹ And people accepted the idea that sustained progress through science was both desirable and achievable.

Second, North Americans were enchanted by the power and possibility of science. By the mid 1950s, few aspects of everyday life had been left untouched by the commercial

¹ Ibid., 1276.

² Ibid., 1278. See also Douglas W. Bray, "Man's Mental Resources And Tomorrow's Need," Saturday Night, April 9, 1955, 7-8.

³ Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), 335.

application of scientific developments. Some of these new products included chemicals for the control of growth and disease in poultry and cattle, plastics, synthetic soaps like Tide and Cheer, television, high-fidelity sound reproduction, colour photography, and fibres such as nylon, Dacron, and Orlon.⁵ People who benefitted from the introduction of these products came to support and admire the accomplishments and potential of scientific research and development.

Third, the general public was very interested in and highly aware of science and scientific developments. While Seaborg emphasized the importance of the school system in educating young people in intellectual and professional fields, the general public had learned most of what it knew about the latest scientific developments from the media. This information was written mainly by professional science writers. Science writing had become a specialty in North America in the 1920s and 1930s. The main goal of these writers was to inform the public about the latest scientific events and findings, to portray these events and findings in a positive light, and to make the work of scientists more accessible to lay audiences through the use of ordinary,

⁵ These and other new products are mentioned in Seaborg, "The Future through Science," 1275-6.

nontechnical terms and concepts.² As a result, newspaper columns, magazine articles, and later television news reports were a few of the places in which people were able to find the latest information from the world of science.

The esteemed position held by science in North America after World War II was a reflection of the optimistic image of science and its role in culture which had characterized Western thought since the Enlightenment. During the eighteenth century, science had begun to challenge religion as the foundation for all knowledge. According to this new approach, human reason, experiment, observation, and mathematics could reveal the natural laws which governed the ordered and harmonious operation of the universe. In this context, science was perceived as being something that was neutral, value-free, and, if followed closely, capable of ensuring ongoing social progress. By the twentieth

² B. Dixon, "Telling the People: Science in the Public Press Since the Second World War," in A.J. Meadows, ed., Development of Science Publishing in Europe (Amsterdam: Elsevier Science Publishers, 1980), 215-35. For an account that is critical of the role of science writers in the popularization of science and health in the twentieth century, see John C. Burnham, How Superstition Won and Science Lost: Popularizing Science and Health in the United States (New Brunswick, N.J.: Rutgers University Press, 1987).

Joyce Appleby, Lynn Hunt, and Margaret Jacob, Telling the Truth About History (New York: Norton, 1994), 15-51; Gerald Holton, Einstein, History, and Other Passions (Woodbury, N.Y.: American Institute of Physics, 1995), 91-4.

century, this impartial, disinterested, and progressive image of science still held sway in the Western world but it was seriously tested in August 1945 when the United States dropped atomic bombs on the Japanese cities of Hiroshima and Nagasaki to bring an end to World War II.² The initial horror over the destructive capabilities of atomic weaponry precipitated an agonized public debate about science and humanity. Concerns about the possibility of nuclear disaster were again heightened in the mid-1950s by a growing awareness of the dangers of radioactive fallout.³ If the heroic image of science was shaken by the dawn of the atomic age it was not toppled. Instead, North Americans uneasily embraced the bomb as a means of maintaining atomic superiority over the Soviet Union in the Cold War. They also turned more of their attention to the peacetime applications of atomic energy thanks in part to a concerted effort by politicians, scientists, and the media to ease

² Appleby, Hunt, and Jacob, Telling the Truth About History, 160-1.

³ For example, see Hugh MacLennan, "Is There Any Way Out Of This Jungle?" Chatelaine, June 1954, 10-1; Norman J. Berrill, "Have We Gone Too Far With The Atom Tests?" Maclean's, July 9, 1955, 7; Sidney Katz, "How Serious is the Threat of Radiation?" Maclean's, December 8, 1956, 18; Marion Hilliard, "The Hydrogen Bomb Should Be Outlawed," Chatelaine, January 1958, 6; Doris Anderson, "Let's Not Guess About Fallout," Chatelaine, June 1959, 16.

public fears over the potential uses of nuclear science.¹²

Through the 1950s, therefore, science continued to hold an esteemed position in the minds of the vast majority of North Americans.

What was true of science in the 1950s was also true of medicine. As respect for science grew and as medicine became more scientific, the North American public gave more and more prestige and power to medical science.¹³ Medicine had become increasingly identified with the advancement of modern science in the late nineteenth century.¹⁴ The gradual acceptance by the medical profession of the novel ideas which had emerged from scientific disciplines such as

¹² For example, see "Atomic Medicine: The Great Search for Cures on a New Frontier," Time, April 7, 1952, 54-7; "The Philosopher's Stone," Time, August 15, 1955, 46-51. The cultural impact of the atom bomb in the United States after 1945 is explored by Paul S. Boyer, By the Bomb's Early Light: American Thought and Culture at the Dawn of the Atomic Age (New York: Pantheon, 1985).

¹³ Dana W. Atchley, "The Healer and the Scientist," Saturday Review, January 9, 1954, 7. See also Eric J. Cassell, "The Changing Concept of the Ideal Physician," Daedalus 115,2 (Spring 1986), 193; Starr, The Social Transformation of American Medicine, 338-51.

¹⁴ This increasing identification with science was not a smooth transition but occurred amidst much debate and disagreement within the medical profession. See Colin D. Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism," in Charles G. Roland, ed., Health, Disease, and Medicine: Essays in Canadian History (Toronto: The Hannah Institute for the History of Medicine, 1984), 105-22.

physiology, bacteriology, and immunology, including antiseptics and the germ theory of disease, suggested that it was now possible for medical science to not only explain the functioning of the human body but actually cure diseases. Therefore, it is perhaps not surprising that for many people in the 1950s the introduction and widespread use of sulfa drugs and penicillin in the 1930s and 1940s seemed to confirm the scientific promise of progress in medicine in spite of the fact that deaths due to infectious diseases had actually been on the decline since the public health campaign for pure food, pure water, and pure air in the nineteenth century.¹² In addition to reflecting a general faith in science and scientific medicine, public willingness to believe that the effective control of infection had only begun with the appearance of these new drugs was reinforced by the media which understood that dramatic medical breakthroughs made good copy and by the medical profession itself which wanted to promote a positive public image in

¹² René Dubos, Mirage of Health: Utopias, Progress, and Biological Change (Garden City, N.Y.: Anchor Books, 1959), 129-30; Thomas McKeown, "A Sociological Approach to the History of Medicine," Medical History 14,4 (October 1970), 344-6; Ivan Illich, Medical Nemesis: The Expropriation of Health (London: Calder and Boyars, 1975), 15-28; Joel Lexchin, The Real Pushers: A Critical Analysis of the Canadian Drug Industry (Vancouver: New Star Books, 1984), 80-3.

order to win public support.¹⁴

During the 1950s, the quest for professional recognition and public support was of particular concern among general practitioners. With the establishment of the Royal College of Physicians and Surgeons of Canada in 1929 and the increase in the number of specialists during the 1930s and 1940s,¹⁵ general practitioners lost more and more hospital privileges and their status within the medical profession experienced a sharp decline over that same period of time.¹⁶ In response, general practitioners, like psychiatrists and other medical specialists, began to place a growing emphasis on education and professional autonomy in an attempt to identify their area of expertise more closely with the larger field of scientific medicine. In 1949,

¹⁴ Cassell, "The Changing Concept of the Ideal Physician," 196.

¹⁵ For figures on the growing number of specialists in Canada after 1929, see "Physicians in Canada," Canadian Doctor 21,9 (September 1955), 33-7.

¹⁶ William Victor Johnston, Before the Age of Miracles: Memoirs of a Country Doctor (Toronto: Fitzhenry and Whiteside, 1972), 201; David Woods, Strength in Study: An Informal History of the College of Family Physicians of Canada (Toronto: The College of Family Physicians of Canada, 1979), 74; S.E.D. Shortt, "'Before the Age of Miracles': The Rise, Fall, and Rebirth of General Practice in Canada, 1890-1940," in Charles G. Roland, ed., Health, Disease, and Medicine: Essays in Canadian History (Toronto: The Hannah Institute for the History of Medicine, 1984), 125; Leighton E. Cluff, "America's Romance with Medicine and Medical Science," Daedalus 115, 2 (Spring 1986), 149.

general practitioners succeeded in establishing a Section of General Practice within the Canadian Medical Association. Five years later, in 1954, they launched the College of General Practice of Canada with Dr. Victor Johnston from Lucknow, Ontario as its full-time Executive Director.¹⁷ The doctors who were involved in setting up the College focussed much of their attention on improving the training available to general practitioners in the hopes that a better education would place generalists on a solid academic and clinical footing with specialists, raise the status of general practice, and get general practitioners back into the hospitals.¹⁸ Therefore, during the 1950s, the College of General Practice of Canada worked at improving the training available to general practitioners in three ways. First, the College encouraged the inclusion of more general practice training in medical schools by pushing to have senior general practitioners made members of the teaching staff. Second, it aimed to have general practice recognized as a specialty in its own right by increasing the

¹⁷ H.E. MacDermot, History of the Canadian Medical Association, Vol. II (Toronto: Murray Printing and Gravure, 1958), 119-23.

¹⁸ For example, see William Victor Johnston, "The General Practitioner of Today," Canadian Medical Association Journal 61,2 (August 1949), 168-70. MacDermot, History of the Canadian Medical Association, 117; Johnston, Before the Age of Miracles, 203; Woods, Strength in Study, 74.

postgraduate training period for general practitioners to two or three years which was in keeping with the length of preparation required for the specialties. And, third, the College embarked on an ambitious program of continuous education for physicians in private practice which included the establishment of refresher courses in medical facilities all across Canada.¹⁹

While their status within the medical profession declined from the 1930s through to the 1950s, general practitioners, like scientific medicine in general, enjoyed increasing prestige in the eyes of the public during this period thanks in part to the development of sulfa drugs and penicillin and to the introduction of new diagnostic tools.²⁰ Numerous surveys confirmed that most patients felt that their general practitioners were good doctors.²¹ As well, the vast majority of people continued to go first to a

¹⁹ Johnston, Before the Age of Miracles, 203-4.

²⁰ David Coburn, George M. Torrance, and Joseph M. Kaufert, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" International Journal of Health Services 13,3 (1983), 417. In contrast, Victor Johnston argued that the public image of the general practitioner had declined steadily from the 1930s to the 1950s. See Johnston, Before the Age of Miracles, 196.

²¹ Johnston, Before the Age of Miracles, 201. For example, see Jerry L. Pettis, "How Does the Public Rate You, Doctor?" Canadian Doctor 22,7 (July 1956), 44-8.

general practitioner when they felt sick.²² Nevertheless, general practitioners, equally enamoured by the flood of new medical discoveries, were eager to associate themselves with the latest in scientific medicine as a means of enhancing their professional position both in relation to the specialists and in the minds of the general population. The final outcome was a greater trust in the promise and possibility of medical science and a greater demand for the latest in what medicine had to offer. As Canadian science writer Allan Fenton observed in 1957,

They call it a new "wonder drug." And within a few days of its general release, doctors and druggists are swamped with requests for this new weapon in the fight against disease.²³

Fenton also noted that in 1957 "the average patient takes victory over disease for granted."²⁴ This was in sharp contrast to only twenty years earlier when the news of a new German drug effective against streptococcal infection

²² MacDermot, History of the Canadian Medical Association, 119.

²³ Allan Fenton, "Pill-Making Wizards: They 'Manufacture' New Lives," Financial Post, April 13, 1957, 20.

²⁴ Ibid., 20. See also Donald Gray Cooley, The Science Book of Wonder Drugs (n.p.: Franklin Watts, 1954; reprint, Freeport, N.Y.: Books for Libraries Press, 1970), 74 (page citations are to the reprint edition).

seemed like nothing short of a miracle.¹⁵ North Americans first heard about Prontylin on December 17, 1936 when it was reported that the son of the president of the United States, Franklin D. Roosevelt Jr., had received the drug and been cured of a deadly "strep" throat infection.¹⁶ The report explained that young Roosevelt had been hospitalized in late November for a sinus condition which later developed into a serious infection. His personal physician, Dr. George Loring Tobey Jr., went public with the Roosevelt story when reports surfaced earlier that said he had "cured" Roosevelt Jr.'s sinus trouble with a new kind of treatment. "We were using Prontylin against the streptococcus, but that stage has passed," Dr. Tobey clarified. "We have only the sinus to worry about now."¹⁷ Expecting no serious setbacks, Dr. Tobey predicted that the youth would be well enough to spend Christmas with his family at the White House.

The public excitement and relief over the news that Franklin Jr. would make a full recovery was made all that

¹⁵ Walsh McDermott with David E. Rogers, "Social Ramifications of Control of Microbial Disease," Johns Hopkins Medical Journal 151,6 (December 1982), 303.

¹⁶ "Young Roosevelt Saved By New Drug," New York Times, December 17, 1936, 1,10; Waldemar Kaempffert, "The Coming Revolution in Medicine," American Mercury, July 1943, 69; Arthur J. Snider, "Medicine's Golden Era: 1937-1957," Science Digest 41,1 (January 1957), 33.

¹⁷ "Young Roosevelt Saved By New Drug," 1.

more poignant by the memory of another president's son, sixteen-year-old Calvin Coolidge Jr., who had died from blood poisoning twelve years earlier.⁴⁰ Coolidge Jr. had been playing tennis with his older brother at the White House when he developed a blister on the big toe of his right foot. The blister soon became infected. For one week, seven of the best doctors in the country worked tirelessly to save young Coolidge's life. The best they could do, however, was to surgically open the boy's leg and insert tubes in order to drain off the poisons. Unfortunately, what they discovered during the surgery was that the infection had spread to the bone. There was nothing else that could be done and Calvin Jr. died a few days later.

The drug that had made such a dramatic difference in the Roosevelt case, Prontylin, was one of a group of sulfanilamide-based drugs that had been proven to effectively combat streptococcic infections. The first and best known of this group, Prontosil, was discovered by accident in 1933 by chemists at the German dye trust, I.G. Farbenindustrie, in their efforts to develop a better fabric

⁴⁰ "President's Son, Calvin Jr., 16, Dies As Parents Watch," New York Times, July 8, 1924, 1,8. Snider, "Medicine's Golden Era," 33; Milton Silverman, Magic in a Bottle, 2d ed. (New York: Macmillan, 1948), 259; McDermott, "Social Ramifications of Control of Microbial Disease," 307.

dye.⁶ Promising reports of its ability to control the streptococci appeared now and again in German medical journals but it was not until February 1935, when a number of studies were published in other European journals, that interest in Prontosil became more widespread.⁷ Later that year, French researchers at the Pasteur Institute isolated the active ingredient in Prontosil, sulfanilamide.

Experiments with sulfanilamide continued in France, Germany, and England throughout 1935. American scientists began to study the drug and its applications in 1936. Much to the amazement and delight of researchers, their results consistently showed sulfanilamide to be a powerful agent in the fight not only against streptococcal infections but gonococcal and meningococcal diseases as well.⁸

The announcement that Prontylin had successfully treated Franklin Jr.'s deadly streptococcal infection shifted news of the power and potential of sulfanilamide out

⁶ Cooley, Science Book of Wonder Drugs, 28; Silverman, Magic in a Bottle, 243-5.

⁷ Silverman, Magic in a Bottle, 249.

⁸ Harold Orr, "Sulfanilamide in the Treatment of Gonorrhoea," Canadian Medical Association Journal 37,4 (October 1937), 364-6; Perrin H. Long and Eleanor A. Bliss, "Observations Upon the Experimental and Clinical Use of Sulfanilamide in the Treatment of Certain Infections," Canadian Medical Association Journal 37,5 (November 1937), 457-65; McDermott, "Social Ramifications of Control of Microbial Disease," 307.

of the professional arena and into the public domain.³¹ It also legitimized, in the minds of many North Americans, the use of the new sulfa drugs.³²

The public response was swift. As soon as reports surfaced claiming that Dr. Tobey had cured Franklin Jr. of his sinus condition, the manufacturer of Prontylin and Prontosil, Winthrop Chemical Company, was inundated by sinus sufferers looking for relief from their troubles.³³ The public statement by Dr. Tobey, given under pressure from the Winthrop Chemical Company, clarified the medical value of Prontylin but did not halt public demand for the drug. According to prominent American physician and author Milton Silverman, "people read [the article on young Roosevelt], marvel[ed] at the new wonders of science, and beseeched their own doctors to use the drug on their sick and dying mothers, sons, cousins, and friends."³⁴ Subsequent articles in Newsweek and Time magazines only served to heighten the growing feeling that medical science was finally able to

³¹ "Cure By Chemicals," Fortune, September 1939, 138; Snider, "Medicine's Golden Era," 33.

³² Silverman, Magic in a Bottle, 359; Walsh McDermott, "Pharmaceuticals: Their Role in Developing Societies," Science 209,4453 (July 11, 1980), 241.

³³ "Young Roosevelt Saved By New Drug," 1.

³⁴ Silverman, Magic in a Bottle, 259.

bring at least some bacterial infections under control."

Many physicians responded to public demand and readily prescribed sulfanilamide. As one popular American magazine reported,

Doctors all over the country, pestered by their patients, rushed to buy the new drug. Demand ran far ahead of the capacity of chemical houses to supply it.³⁷

Still other physicians were initially more cautious in their use of the drug. Dr. E.H. Evans, a family practitioner in Nova Scotia, remembered how difficult it was in the early thirties to believe that medical science could ever find a long-wished-for drug to control bacterial infections:

We really thought that the vanguard of medicine had come up against an insurmountable wall. Nothing could ever shake the stranglehold that established bacterial infections had upon living tissue."³⁸

Dr. William Parsons, an Albertan who entered into family practice with his father and brother in 1935, also noted how a number of cure-alls for infection had been announced over

³⁷ "New Drug Arrests Roosevelt Jr.'s Sinus Trouble," Newsweek, December 26, 1936, 36; "Prontosil: Cure For Streptococcic Infections," Time, December 28, 1936, 21. William B. Parsons, "The Day Sulfanilamide Came To Town," Canadian Doctor 45,10 (October 1979), 61.

³⁸ "Cure By Chemicals," 138.

³⁹ E.H. Evans, "Thoughts on Therapy after Twenty-Five Years in General Practice -- Part 1," Applied Therapeutics 3,9 (September 1961), 726.

the years only to be discredited shortly thereafter.³⁹

Therefore, when Parsons was faced with the impending death of a patient with childbed fever and told his father about the Roosevelt Jr. story in Time magazine, his father's immediate response was to dismiss the claims for sulfanilamide by observing that "most sore throats get better but they're not as sick as this girl. I doubt if the drug had anything to do with [Roosevelt Jr.'s recovery]."⁴⁰

The official editorial response of the Canadian Medical Association Journal was to counsel caution in the face of extraordinary claims for sulfanilamide but even then it was difficult to disguise the obvious excitement that the drug had generated among many medical professionals. In a May 1937 editorial, Dr. Arnold Branch reminded readers that streptococcal infections had to date been "notoriously unresponsive" to treatment which explained why news of sulfanilamide had been received within medical circles with "a hopeful if justifiable scepticism."⁴¹ That said, Branch reviewed the impressive literature on sulfanilamide that had

³⁹ Parsons, "The Day Sulfanilamide Came To Town," 62.

⁴⁰ Ibid., 62. See also Walsh McDermott, "Early Days of Antimicrobial Therapy," in Gladys L. Hobby, ed., Antimicrobial Agents and Chemotherapy -- 1968 (Bethesda, Md.: American Society for Microbiology, 1969), 5-6.

⁴¹ Arnold Branch, "Chemotherapy in Streptococcal Infections," Canadian Medical Association Journal 36,5 (May 1937), 522.

emerged from Germany, France, and England since 1935. He concluded his editorial with a recognition that more research was needed but predicted that "if further clinical trial substantiates the present results the discovery will rank as one of the major therapeutic 'finds' of our time."⁴¹ In November 1937, an editorial by Dr. A.G. Nicholls surveyed some of the reported side effects of sulfanilamide which included nausea, fever, and skin rashes.⁴² The purpose of his article was to encourage physicians to be aware that potentially dangerous side effects could accompany sulfanilamide use, though in the end Nicholls had to concede that "up to the present there is no evidence to show that the commoner toxic effects of sulphanilamide are specially serious or threatening to life."⁴³

As sulfanilamide continued to prove itself as an effective means of controlling many infections, sceptics were transformed into believers.⁴⁴ When William Parsons'

⁴¹ Ibid., 523.

⁴² A.G. Nicholls, "The Toxicity of Sulfanilamide and Allied Compounds," Canadian Medical Association Journal 37,5 (November 1937), 493-4.

⁴³ Ibid., 494. See also E.H. Bensley and J.B. Ross, "Methaemoglobinaemia Due To Sulfanilamide Therapy," Canadian Medical Association Journal 37,1 (July 1937), 62.

⁴⁴ Gordon C. Draeseke and Everett F. Raynor, "A Case of Streptococcal Meningitis Treated with Prontosil," Canadian Medical Association Journal 36,6 (June 1937), 618-9; B.F. MacNaughton, "Reports of Cases of Severe

patient with childbed fever survived, his father was dumbfounded and could not believe that Prontosil had been the deciding factor in her recovery.⁴⁶ Then a farmer came in with a blister on his heel that had become infected. The infection had already spread to the bone so the father recommended surgery to drain the abscess. Parsons and his brother pressed for the use of sulfanilamide instead. When the farmer recovered, the father was astonished but finally convinced that the day had arrived when streptococcal infection would readily respond to medical intervention.⁴⁷

The success of sulfanilamide and a desire for safer and more powerful drugs led researchers to develop new and more effective sulfanilamide-related compounds.⁴⁸ These efforts yielded a wide variety of sulfonamides including sulfapyridine, sulfathiazole, sulfaguanidine, and sulfadiazine that helped to better combat infectious diseases and further reduce the mortality rates associated with cases of pneumonia, childbed fever, gonorrhea,

Streptococcus Haemolyticus Infection Treated with Prontosil," Canadian Medical Association Journal 37,2 (August 1937), 155-6; Kaempffert, "The Coming Revolution in Medicine," 69.

⁴⁶ Parsons, "The Day Sulfanilamide Came To Town," 65.

⁴⁷ Ibid., 65; William B. Parsons, "Medicine in the Thirties," Canadian Doctor 46,1 (January 1980), 73.

⁴⁸ Cooley, Science Book Of Wonder Drugs, 33.

meningitis, acute rheumatic fever, and blood poisoning, to name a few.⁴²

Together, the sulfa drugs had a profound impact on patients and the practice of medicine because, up until their introduction, bacterial infections had been the greatest killers and crippers of young and old alike.⁴³ More than half of the hospital beds were filled at any one time by patients suffering from some sort of infectious disease.⁴⁴ Family physicians also saw their share of infections.⁴⁵ Without the sulfa drugs to help control infection, however, the best a doctor could do was treat the symptoms in hopes of bringing a measure of comfort to the patient.⁴⁶ According to William Parsons, the doctor could

⁴² Fred J. Bandelin, Our Modern Medicines: Their Origin and Impact (Hankinson, N.Dak.: Woodbine, 1986), 9.

⁴³ Parsons, "The Day Sulfanilamide Came To Town," 61; Johnston, Before the Age of Miracles, 69.

⁴⁴ McDermott, "Social Ramifications of Control of Microbial Disease," 306. See also Evans, "Thoughts on Therapy after Twenty-Five Years in General Practice -- Part 1," 726. For a more thorough account of hospital life before sulfa drugs, see McDermott, "Social Ramifications of Control of Microbial Disease," 304-6.

⁴⁵ For a more detailed account of general practice in Canada prior to the sulfa drugs, see W. Truax, "Reminiscences of a Country Doctor," Canadian Medical Association Journal 60,4 (April 1949), 411-5; Johnston, Before the Age of Miracles; Shortt, "'Before the Age of Miracles'," 123-54.

⁴⁶ Shortt, "'Before the Age of Miracles'," 130.

only do so much:

Rest, fluids, and control of temperature with the aim of keeping up the patient's strength. The doctor's and the nurses's chief function was to bolster morale. If the patient recovered, it was his own defensive forces which had won out. Medical treatment had merely aided the work of this vis medicatrix naturae.⁵⁴

On the other hand, sulfonamides allowed the doctor to treat the infection directly, often with dramatic results. Dr. E.H. Evans remembered how sulfa drugs could mean the difference between life and death. One incident in particular came to mind:

One of our younger surgeons scraped his hand on a sharp piece of rib while draining a chest [of a patient suffering from pneumonia]. First he lost his arm and then his life. Today he would scarcely have missed a day's work.⁵⁵

In spite of their limitations and side effects, the sulfonamides had given the public and the medical profession an indication of the possibilities of medical science and the experience had left them wanting more. American Waldemar Kaempffert believed that the sulfa drugs had only foreshadowed the effective potential of medical science and felt that it was high time for this potential to be actualized:

⁵⁴ Parsons, "The Day Sulfanilamide Came To Town," 61. See also Johnston, Before the Age of Miracles, 66, 70.

⁵⁵ Evans, "Thoughts on Therapy after Twenty-Five Years in General Practice -- Part 1," 726.

Good as our doctors are, they are still "medicine men" in the savage sense. Fully half of their practices are based not on scientific knowledge but on tradition. The age-old wheeze that "medicine is an art as well as a science" speaks for itself.

We want more science and less art in medicine. Crude as chemotherapy may be, it is the harbinger of a new medical day.⁵⁶

Scientists had also been encouraged by the success of the sulfa drugs which made them even more determined to continue their research into new and more powerful therapeutic agents. Already by 1939 there was "a distinct 'on the verge' feeling in the laboratories."⁵⁷ As if on cue, reports of yet another, more efficient anti-bacterial drug soon appeared in the news. This drug was penicillin and it quickly overshadowed and eventually replaced the sulfonamides as the treatment method of choice in the control of infectious diseases.

Penicillin was more powerful, more versatile, and less toxic than the sulfonamides. Yet penicillin was not just a better sulfa drug. Penicillin was the first in a series of new drugs called antibiotics.⁵⁸ The word "antibiotic" means

⁵⁶ Kaempffert, "The Coming Revolution in Medicine," 71.

⁵⁷ "Cure by Chemicals," 146.

⁵⁸ The term "antibiotic" was first coined in 1940 by Selman Waksman, the discoverer of streptomycin, to describe "a chemical substance of microbial origin possessing

"against life" and penicillin worked by employing an active chemical substance from one living microorganism to destroy or inhibit the growth of another microorganism.⁵⁹ Writing in Saturday Night magazine in 1952, science writer Robin Coutts noted that penicillin and the other antibiotic drugs were the most publicized and the most readily accepted medical discovery to that point in history.⁶⁰ They became the archetype of the modern drug -- the wonder drug. Moreover, their ability to safely and effectively control a wide spectrum of serious infections both confirmed and reinforced North Americans' belief and trust in the power and potential of medical science to enhance their quality of life.

Public and professional interest in penicillin was initially stimulated by the need for a better means of treating military and civilian infectious casualties during World War II.⁶¹ When war broke out in 1939, the work of

antimicrobial powers." Henry Welch and Felix Marti-Ibanez, The Antibiotic Saga (New York: Medical Encyclopedia, 1960), 32.

⁵⁹ Louis Weinstein, "Antibiotics: Curative Drugs," in Samuel Proger, ed., The Medicated Society (New York: Macmillan, 1968), 70-1.

⁶⁰ Robin Coutts, "The New Drugs: Their Serious Aspect," Saturday Night, August 16, 1952, 20.

⁶¹ Johnston, Before the Age of Miracles, 139; Gladys L. Hobby, Penicillin: Meeting the Challenge (New Haven: Yale University Press, 1985), 233; Cluff, "America's Romance

Howard Florey and Ernst Chain at Oxford University took on increased significance. Florey and Chain had been attempting to produce penicillin in their laboratory. Their research was an extension of the experiments done ten years earlier by Alexander Fleming at St. Mary's Hospital in London. In 1928, Fleming had observed that an extract of a blue-green mold belonging to the species Penicillium notatum destroyed staphylococci and other infectious disease-causing germs.⁶⁴ Fleming named this new antibiotic substance "penicillin" but was unable to produce the extract in sufficient quantity and quality to properly test it on humans.

At Oxford, Florey, Chain, and others worked hard to improve the manufacturing process and by 1941 they had accumulated enough concentrated penicillin to treat one human patient.⁶⁵ Encouraging clinical results with this

with Medicine and Medical Science," 143-4.

⁶⁴ Fleming published his findings the following year. See Alexander Fleming, "On the Antibacterial Action of Cultures of a Penicillium, with Special Reference to their Use in the Isolation of B. Influenza," British Journal of Experimental Pathology 10 (June 1929), 226-36. For Chain's own account of the discovery of penicillin, see Ernst Chain, "A Short History of the Penicillin Discovery from Fleming's Early Observations in 1929 to the Present Time," in John Parascandola, ed., The History of Antibiotics: A Symposium (Madison, Wis.: American Institute of the History of Pharmacy, 1980), 15-29.

⁶⁵ Florey and his colleagues published the impressive results of clinical trials with their first twelve patients

limited amount of penicillin allowed Florey and his fellow Oxford workers to turn their attention to their greatest challenge yet -- the development and large-scale production of penicillin. It would be a formidable obstacle to overcome because the demands of war made it impossible for Britain to invest precious time and resources in what appeared to be a medical long-shot. Therefore, in summer 1941, Florey and his assistant, Norman Heatley, went to the United States and asked government officials and private pharmaceutical firms to help investigate the development and commercial production of penicillin. They agreed. Florey had similar success during his visit to Canada. The result was an extensive research and development program that involved an unprecedented degree of cooperation among government, university, and industrial laboratories in Canada, the United States, and Great Britain.⁶⁴ By spring 1943, enough penicillin had been produced worldwide to treat only about 400 patients.⁶⁵ That summer, however,

in Howard W. Florey et al., "Further Observations on Penicillin," Lancet 241 (August 16, 1941), 177-88.

⁶⁴ Weinstein, "Antibiotics," 75. On a smaller scale, this was also true in Canada. See Ken W. MacTaggart, "It's Penicillin," Maclean's, December 1, 1943, 45; Hobby, Penicillin, 210-1.

⁶⁵ John E. McKeen, "The Role of Industry in the Mass Production of Antibiotics," in Iago Galdston, ed., The Impact of the Antibiotics on Medicine and Society (New York: International Universities Press, 1958), 96.

investigators succeeded in improving the strains, media, and methods for producing penicillin so that by the end of 1943 both Canada and the United States were able to meet the demands of their Armed Forces at home and abroad.⁶⁷ In 1945, increasing production levels made it possible to finally release penicillin for use by the civilian population.⁶⁸

The extensive efforts made to develop and produce penicillin during World War II had a major impact on the drug industry. For example, the factory began to replace the drug store as the place where pharmaceuticals were prepared. This shift reflected in part the need to use more sophisticated technological processes in compounding these

⁶⁷ MacTaggart, "It's Penicillin," 47; Rica McLean Farquharson, "Penicillin -- And Canada's Wounded," Canadian Home Journal, May 1945, 73; Henry Welch, "Antibiotics 1943-1955: Their Development and Role in Present-Day Society," in Iago Galdston, ed., The Impact of the Antibiotics on Medicine and Society (New York: International Universities Press, 1958), 70.

⁶⁸ "The Supply of Penicillin," Canadian Medical Association Journal 50,5 (May 1944), 457; Farquharson, "Penicillin -- And Canada's Wounded," 73; A.N. Richards, "The Impact of the War on Medicine," Science 103,2680 (May 10, 1946), 578; Hobby, Penicillin, 211. Canadian science writer H. Dyson Carter felt that it was scandalous that penicillin had not been made more readily available to the civilian population. In August 1944, he wrote an article in which he argued that the apparent monopoly on penicillin production threatened to further delay the release of the drug for civilian use and to unnecessarily inflate its final cost to the consumer. See H. Dyson Carter, "You Can't Have Penicillin!" National Home Monthly, August 1944, 5.

new drugs. In a number of cases, the production of penicillin during the war also made it more affordable to manufacture drugs on a large scale.⁶⁰ Connaught Laboratories was one of the Canadian firms which produced penicillin during the war. It had been established at the University of Toronto in 1914 in order to meet the nationwide need for vaccines and to strengthen medical research at the university. When Frederick Banting and Charles Best discovered that insulin was effective against diabetes in Toronto in 1922, Connaught Laboratories became the first laboratory to make the product available on a commercial basis. In order to mass produce and deliver penicillin, however, Connaught Laboratories first had to overcome a number of significant production problems which the industry up until that point had not been forced to address. The fact that the firm had succeeded in solving these problems put the industry in general and Connaught Laboratories in particular in a good position to mass produce and distribute penicillin in the 1940s.⁶¹

⁶⁰ Lexchin, The Real Pushers, 32.

⁶¹ Myron J. Gordon and David Fowler, The Drug Industry: A Case Study of the Effects of Foreign Control on the Canadian Economy (Toronto: James Lorimer, 1981), 18, 35 fn 19. The story of Connaught Laboratories lends support to the argument advanced by Jonathan Liebenau that, contrary to many historical treatments of pharmaceutical manufacturing, the postwar growth of the drug industry was due not only to the introduction of a number of new therapeutic drugs but to

Breakthroughs in penicillin production and the results of ongoing clinical trials regularly made news headlines in Canada.⁶⁰ Press reports were particularly enthusiastic, however, about the use of penicillin for the treatment and control of infectious diseases among Allied military personnel.⁶¹ Even before the drug became available for large-scale military use, Canadian science writer H. Dyson Carter relished the thought that penicillin would prevent a repeat of the experience of World War I when a large number of deaths were the direct result of infection:

Penicillin will see to it that after this war none of our boys will die slowly and horribly, agonized by chronic infected wounds. It won't happen.

industrial developments prior to World War II which had laid a solid foundation upon which this subsequent growth could be based. Jonathan Liebenau, Medical Science and Medical Industry: The Formation of the American Pharmaceutical Industry (London: Macmillan, 1987), 1-2. This point is also made in passing by Gordon and Fowler, The Drug Industry, 12.

⁶⁰ One of the first popular accounts of the discovery and early clinical trials of penicillin to appear in a Canadian publication was H. Dyson Carter, "Smashing a Bacteria Blitz," National Home Monthly, May 1942, 12. See also Wilson Popham, "Penicillin So Far Bears Out Its Early Promise," Saturday Night, October 9, 1943, 16; H. Dyson Carter, "Four Startling Medical Advances," Saturday Night, November 20, 1943, 14; MacTaggart, "It's Penicillin," 7, 44-7.

⁶¹ For a discussion of the very positive coverage penicillin received in popular American magazines, especially during the war, see David P. Adams, "The Penicillin Mystique and the Popular Press (1935-1950)," Pharmacy in History 26,3 (1984), 134-42.

Science is mercifully ending these miseries."

Journalist Rica McLean Farquharson reported on the actual impact that penicillin was having on the treatment of Canadian casualties overseas. According to her, penicillin was "the star of Modern Medicine" that was responsible for fewer infected wounds, fewer deaths due to infection, and excellent morale among the wounded.⁷³ The article was written in order to reassure Canadian women that injured soldiers were receiving the best that modern medicine had to give and that that included receiving penicillin.

Farquharson illustrated her point with a few words from Brigadier J.A. MacFarlane, Consultant in Surgery to the Canadian Army Overseas and Chairman of the Overseas Joint Services Committee on Penicillin:

The women of Canada can be confident that Penicillin, combined with the most advanced methods of treatment and hospitalization, will ensure the recovery of thousands of wounded and the saving of innumerable lives.⁷⁴

Again and again press reports appeared attesting to the remarkable contribution penicillin made to the Allied war

⁷² H. Dyson Carter, "Today Death Itself is in Retreat," Saturday Night, August 14, 1943, 12. See also Farquharson, "Penicillin -- And Canada's Wounded," 73.

⁷³ Farquharson, "Penicillin -- And Canada's Wounded," 16, 71. See also, "New Drug May Check Casualties," Maclean's, October 15, 1944, 38.

⁷⁴ Farquharson, "Penicillin -- And Canada's Wounded," 16.

effort and suggesting that, "viewed in terms of human life, [penicillin] may well be considered the greatest single development to emerge from this war."⁷⁵

Public demand for penicillin increased as its wide range of practical applications received more and more media attention.⁷⁶ The general public was particularly impressed by the way in which penicillin had helped check infections during the war because it had brought home to many civilians, in a very immediate and concrete way, the power and potential of antibiotic medicine.⁷⁷ By the time the war was over and penicillin was more readily available to non-military personnel, "the public 'knew all' about penicillin."⁷⁸ And the public knew it wanted penicillin, along with a host of other new antibiotic drugs. "The patient has become his own diagnostician and advocatus diaboli," complained one doctor.⁷⁹ "It has reached the point where the physician can tell his patient -- but he can't tell him much!" complained another:

⁷⁵ William E. Craft, "The Miracles of Penicillin," American Mercury, August 1944, 157.

⁷⁶ Silverman, Magic in a Bottle, 292, 293; Welch, "Antibiotics 1943-1955," 85.

⁷⁷ Cluff, "America's Romance with Medicine and Medical Science," 143-4.

⁷⁸ Welch and Marti-Ibanez, The Antibiotic Saga, 75.

⁷⁹ Ibid., 139.

The patient advises the doctor that he does not want antibiotic "A" because he's heard it's dangerous; he wants antibiotic "B" because a friend of his was cured with it. It makes no difference to him that his friend had an entirely unrelated infection. It's a "miracle" drug -- let it perform its miracle."²⁰

As this statement suggested, a number of people possessed a great deal of misinformation about the true capabilities of antibiotic drugs. Unsubstantiated studies, enthusiastic reporting, faith in medical science, and, perhaps, a good dose of wishful thinking led many patients to inappropriately demand penicillin and other antibiotics for relief from such conditions as a fever, chicken pox, mumps, measles and the common cold."²¹ Canadian science writer Robin Coutts even went so far as to argue that patient pressure on doctors to prescribe combined with threats to go to another doctor if a prescription was not forthcoming were important factors in the rapid rate by which antibiotics achieved widespread acceptance and distribution."²²

Doctors in general shared their patients' enthusiasm for antibiotic medicine. As was the case with the general public, professional enthusiasm was rooted in the experience

²⁰ Welch, "Antibiotics 1943-1955," 85-6. See also Welch and Marti-Ibanez, The Antibiotic Saga, 139.

²¹ Weinstein, "Antibiotics," 86-7; Coutts, "The New Drugs," 1,20,22. For an example of a couple fanciful claims, see Carter, "Four Startling Medical Advances," 14.

²² Coutts, "The New Drugs," 20.

of World War II. Military and civilian doctors began to ask for supplies of penicillin shortly after Florey and his colleagues published their first report in 1941 and their requests increased in frequency and urgency over the next few years.⁷³ Those fortunate enough to work with penicillin on a first-hand basis during this time were often amazed at the thoroughness and speed with which the drug overcame a number of serious bacterial infections. The end of the war and the increased availability of penicillin and other new antibiotic drugs allowed more physicians to treat more people suffering from a wider variety of infectious diseases. American physician and former president of the Infectious Diseases Society of America Walsh McDermott remembered the early years of antibiotic medicine as a heady time when many medical doctors were completely swept away by the impact of these new advances in medical science. He also suggested that the medical advances represented by the introduction of antibiotic drugs made such a deep and lasting impression on the medical profession that many doctors were compelled to abandon an otherwise rational and sceptical approach to therapeutic innovation in favour of an almost unquestioning faith in the power and potential of new drugs:

⁷³ Silverman, Magic in a Bottle, 291,292,293.

The bringing of each disease under control was in itself a separate miracle. These were thrilling events. If traditionally the medical profession was slow to embrace the new, it soon lost all such shyness. Therapeutic triumphs coming rapidly one after another imprinted the physicians with almost too great a readiness to believe. Faced with the tale of some new remedy an impulse to seek proof would arise from the science-based portion of their education, only to be met by the internal rejoinder, "why not believe?" And, among the most poignant and enduring recollections would be those of the distressing terminal illness of the last patient on "the old" treatment, as contrasted with the "recovery" of the first patient on the "new" treatment.⁶⁴

If frequent and often-fanciful reporting coupled with a general faith in medical science led many patients to demand prescriptions from their doctors, it was also true that these same factors led many doctors to indiscriminately and inappropriately prescribe antibiotics for their patients.⁶⁵ In his study of medical education and practice in Ontario and Nova Scotia in the late 1950s, Kenneth Clute found that only 41 percent of Ontario general practitioners and 12 percent of Nova Scotia general practitioners were skilled in their prescribing of antibiotics and sulfonamides. By contrast, 27 percent of the doctors in Ontario and 45

⁶⁴ McDermott, "Social Ramifications of Control of Microbial Disease," 308. See also Coutts, "The New Drugs," 20.

⁶⁵ Weinstein, "Antibiotics," 86; James C. Whorton, "'Antibiotic Abandon': The Resurgence of Therapeutic Rationalism," in John Parascandola, ed., A History of the Antibiotics: A Symposium (Madison, Wis.: American Institute of the History of Pharmacy, 1980), 127-31.

percent of the doctors in Nova Scotia demonstrated very little knowledge of the general principles involved when using these drugs."⁶ For example, Clute cited the case of one doctor who gave a dose of penicillin to a young adult the morning after this individual had developed acute food poisoning, a condition for which penicillin would have no therapeutic value."⁷ In another example of indiscriminate prescribing of antibiotic medicine, the story was reported in an American medical journal of one doctor who was so enchanted by the antibiotics that he routinely prescribed them for all of his patients under the erroneous assumption that the drugs would act in a preventative manner and keep them healthy."⁸ In 1957, a study of the medical records of a South Dakota community showed that over a five year period more than ninety percent of the population had received a prescription for an antibiotic drug. On closer inspection of the records, however, it was revealed that just over half of these prescriptions were given to patients whose

⁶ Kenneth F. Clute, The General Practitioner: A Study of Medical Education and Practice in Ontario and Nova Scotia (Toronto: University of Toronto Press, 1963), 300.

⁷ Ibid., 285.

⁸ Hobart A. Reimann, "The Misuse of Antimicrobics," Medical Clinics of North America 45,4 (July 1961), 853. See also "Abuse of Penicillin," New England Journal of Medicine 233,26 (December 27, 1945), 830-2.

condition had not warranted antibiotic therapy."⁷ In recognition of the widespread and often unnecessary prescribing of antibiotics, the editorial staff of the British medical journal the Lancet jokingly announced the introduction of a new antibiotic drug which it named 3 blindmycin.⁸

Central to the public and professional enthusiasm over penicillin was the knowledge that penicillin represented a significant improvement over the sulfonamides in that it was less toxic and had a wider range of usefulness than the sulfa drugs. In fact, penicillin proved to be the least toxic antibiotic and produced virtually no side effects.⁹ Nevertheless, penicillin did cause allergic reactions of varying intensities in a small percentage of patients who had become sensitized to the drug but, as of 1952, only one death had been reported in Canada from such a reaction.¹⁰ Penicillin was similarly impressive in its ability to

⁷ William A. Nolen and Donald E. Dille, "Use and Abuse of Antibiotics in a Small Community," New England Journal of Medicine 257,1 (July 4, 1957), 34.

⁸ "In England Now," Lancet 271 (December 1, 1956), 1155.

⁹ Cooley, Science Book of Wonder Drugs, 82; Perry A. Sperber, Drugs, Demons, Doctors and Disease (St. Louis, Miss.: Warren H. Green, 1973), 123.

¹⁰ Welch and Marti-Ibanez, The Antibiotic Saga, 101-5; Coutts, "The New Drugs," 20.

overcome many infectious diseases against which the sulfa drugs had little or no impact. For example, penicillin was very effective in treating the highly virulent staphylococcus germ which produced severe boils, abscesses, and other pus-forming infections.³³ Penicillin reduced the death rate in scarlet fever, a common illness due to the streptococcus, from five percent to zero.³⁴ And, penicillin was responsible for lowering the mortality rate in subacute bacterial endocarditis, a usually fatal infection of the heart valves, to about ten percent.³⁵ Even when it came to infections over which the sulfonamides had had a measure of success, penicillin performed that much better. For example, prior to the sulfa drugs, patients with bacterial pneumonia had a thirty-three percent chance of dying from the disease. Sulfa drugs lowered that rate to about twelve percent and penicillin reduced it further to less than five percent.³⁶ Penicillin also made the treatment and cure of the venereal diseases a relatively quick and efficient

³³ Cooley, Science Book of Wonder Drugs, 41; Craft, "The Miracles of Penicillin," 158.

³⁴ Welch and Marti-Ibanez, The Antibiotic Saga, 129; Weinstein, "Antibiotics," 80.

³⁵ Welch and Marti-Ibanez, The Antibiotic Saga, 130; Weinstein, "Antibiotics," 78, 79.

³⁶ Welch and Marti-Ibanez, The Antibiotic Saga, 128-9; Sperber, Drugs, Demons, Doctors and Disease, 123; Cooley, Science Book of Wonder Drugs, 75.

process. The gonococcal bacteria were destroyed after only one day of penicillin therapy and all uncomplicated cases of syphilis were cured within ten days."

The popularity and sometimes indiscriminate use of penicillin and other antibiotic drugs in Canada prompted the administrators of the federal Food and Drugs Act in 1944 to recommend that the government assume more direct regulation-making authority over the sale and conditions of sale of drugs." Even though antibiotics were on the prescription list and demonstrated little toxicity and very few side effects, concerns were raised when it became known that penicillin was being misused in the treatment of self-diagnosed venereal diseases." In response, the regulatory authority of the federal government was enhanced with the addition of a section to the Food and Drugs Act which gave the government the power "to define the conditions of sale of any drug in the interests of or for the protection of

" Ann Foster, "Penicillin Can Wipe Out Canada's Number One Health Scourge," Saturday Night, July 21, 1945, 22-3; Weinstein, "Antibiotics," 80-1.

" L.I. Puglsey, "The Administration and Development of Federal Statutes on Foods and Drugs in Canada," Medical Services Journal: Canada 23,3 (March 1967), 413.

" Grant L. Kalbfleisch, "Prescription Drug Legislation," Canadian Pharmaceutical Journal 85,3 (February 1, 1952), 88; Robert Emmet Curran, Canada's Food and Drug Laws (Chicago: Commerce Clearing House, 1953), 130.

public health."¹⁰⁰

The willingness of the federal government to take responsibility for regulating the sale of drugs was a relatively recent phenomenon although it was consistent with the growing involvement of the federal government in many aspects of Canadian life during World War II. The federal government first became involved in limiting the sale of drugs in 1939 when it amended the Food and Drugs Act to give itself the authority to regulate the conditions of sale of any drug likely to be injurious to health. Prior to 1939, the handling of the sale of drugs was controlled entirely by provincial legislation. The distinction between federal and provincial jurisdiction had been established in the British North America Act in 1867. This Act gave the federal government jurisdiction over criminal matters. On this basis, the federal government first began to regulate manufacturers or distributors of drugs with the Adulteration Act in 1884 and the Food and Drugs Act in 1920. By contrast, the British North America Act gave provincial governments jurisdiction over matters pertaining to property and civil rights which included the authority to regulate a trade or profession. Therefore, each provincial government had its own Pharmacy Act which set down the qualifications

¹⁰⁰ Pugsley, "The Administration and Development of Federal Statutes on Foods and Drugs in Canada," 413.

for the practice of pharmacy and the regulations for the handling and sale of drugs within the province.¹³³ However, because each province could decide for itself which drugs required a prescription, there was a lack of uniformity among provincial prescription lists. It was concern over this lack of uniformity from province to province which eventually led to the amendment of the federal Food and Drugs Act in 1939.¹³⁴ This initial introduction of prescription requirements at the federal level was significant in that it meant that the sale of drugs on prescription in any province was now subject to both the federal legislation and the legislation of that province.¹³⁵ Thus, when penicillin was introduced to the Canadian market, the basic regulating framework was already in place.

Penicillin was invaluable for the treatment and control of infectious diseases during World War II but it was not the only contribution to scientific medicine to emerge from

¹³³ For more information about federal and provincial jurisdictional rights under the British North America Act as they related to the sale and distribution of drugs in Canada, see Department of National Health and Welfare, "Provision, Distribution, and Cost of Drugs in Canada," Royal Commission on Health Services (Ottawa: Queen's Printer, 1965), 15-22.

¹³⁴ Pugsley, "The Administration and Development of Federal Statutes on Foods and Drugs in Canada," 412.

¹³⁵ "Report Concerning the Manufacture, Distribution, and Sale of Drugs," Restrictive Trade Practices Commission (Ottawa: Queen's Printer, 1963), Appendix Q, 8.

the war. Other developments included a synthetic antimalarial drug as well as vaccines against typhus, cholera, influenza, and tetanus. Scientists were also able to separate the therapeutically-useful derivatives of blood such as plasma and gamma globulin while military medical personnel developed a number of new surgical techniques for treating war-inflicted injuries.¹⁰⁴ In addition to the advances in war medicine, a number of other significant medical developments took place during the 1940s and 1950s. For example, this period witnessed a great deal of research on soil bacteria which eventually yielded a number of new antibiotic drugs including the first antituberculosis drug, streptomycin.¹⁰⁵ Antihistaminic drugs gave much relief to patients suffering from hay fever.¹⁰⁶ And hormones such as cortisone and ACTH proved very effective in alleviating the

¹⁰⁴ These and other wartime developments are discussed more fully in Carter, "Today Death Itself is in Retreat," 12; Richards, "The Impact of the War on Medicine," 577; L.C. Montgomery, "Progress in War Medicine Since 1939," Canadian Medical Association Journal 59,3 (September 1948), 211-6; Starr, The Social Transformation of American Medicine, 340-1; Cluff, "America's Romance with Medicine and Medical Science," 144.

¹⁰⁵ Sperber, Drugs, Demons, Doctors, and Disease, 123; Hobby, Penicillin, 232. For the story on the discovery of the similarly-produced antibiotic drug gramicidin, see H. Dyson Carter, "Miracles from Mud," Maclean's, August 15, 1941, 13.

¹⁰⁶ "The Anti's in 1949," Saturday Night, January 10, 1950, 17; Cooley, Science Book of Wonder Drugs, 225-9.

crippling effects of rheumatoid arthritis.¹⁰⁰

Even more than the sulfonamides, penicillin demonstrated to North Americans the power of medical science.¹⁰¹ Moreover, its remarkable performance during World War II convinced many people that scientific medicine held the key to a healthy and happy postwar period. For Canadian journalist Rica McLean Farquharson, this meant the reuniting of loved ones at war's end:

His homecoming may be one precious gift of modern medical science to Canada. Perhaps too, somewhere a civilian may be here for "him to come home to" because of Penicillin.¹⁰²

For two officials involved in the development and commercial production of penicillin, it meant the possibility of international harmony because penicillin had helped "establish a better understanding among nations, which should aid in the establishment of world peace."¹⁰³ Thus,

¹⁰⁰ "The Anti's in 1949," 17; "Chemistry's Role in Nation's Health," Financial Post, June 23, 1951, 22; Cooley, Science Book of Wonder Drugs, 114-9.

¹⁰¹ Cluff, "America's Romance with Medicine and Medical Science," 139.

¹⁰² Farquharson, "Penicillin -- And Canada's Wounded," 73.

¹⁰³ R.D. Coghill and R.S. Koch, "Penicillin: A Wartime Accomplishment," Chemical and Engineering News 23,24 (December 25, 1945), 2310-6. See also J. Merton England, "Dr. Bush Writes a Report: 'Science -- The Endless Frontier'," Science 191,4222 (January 9, 1976), 46; Eric J. Cassell, "Ideas in Conflict: The Rise and Fall (and Rise and Fall) of New Views of Disease," Daedalus 115,2 (Spring

government, the public, and scientists themselves entered the postwar period with the unprecedented recognition of science as a national asset.¹¹¹

As North Americans became more enchanted with scientific medicine, they also came to expect more from it.¹¹² Based on past successes, both the public and the medical profession assumed that it would just be a matter of time before medical science developed effective treatment methods for many of the as yet untreatable diseases such as mental illness and cancer. Speaking at a 1959 meeting of the Pharmaceutical Manufacturer's Association in Chicago, the general manager of a prominent drug treatment firm encouraged such optimism when he predicted that by 1962 scientific medicine would develop a heart disease drug, an effective vaccine for the common cold, and some major new drugs for mental illness while by 1965 he speculated that scientific medicine would be able to produce a cure for cancer.¹¹³ Moreover, this strong belief in the potential of medical science led lay and medical people alike to trust

1986), 27-8.

¹¹¹ Richards, "The Impact of the War on Medicine," 578; Starr, The Social Transformation of American Medicine, 335.

¹¹² Cluff, "America's Romance with Medicine and Medical Science," 147.

¹¹³ This speech was reported in Canada in "Forecast in Drugs," Canadian Doctor 25,7 (July 1959), 54.

that the introduction of a new "wonder drug" was synonymous with medical progress. This in turn made the latest drug therapy that much more desirable. According to Canadian science writer Robin Coutts,

the general public [is] eager to take antibiotics on the slightest excuse....The newer the drug and the more expensive, the more some patients take pride in being among the first to try it out.¹¹⁴

In the early 1950s, North Americans' belief in the power and possibility of medical science was further reinforced when it was announced that there had been a significant breakthrough in the treatment of mental illness.

Postwar peace and economic prosperity coincided with a growing public interest in issues of mental illness and mental health as was noted in Chapter One.¹¹⁵ Moreover, North Americans were hopeful that if medical science could develop drugs to effectively treat and cure many infectious diseases then medical science could also develop drugs for

¹¹⁴ Coutts, "The New Drugs," 20. See also Fenton, "Pill-Making Wizards," 20. On the trust of the medical profession, see McDermott, "The Social Ramifications of Control of Microbial Disease," 308; Weinstein, "Antibiotics," 88-9.

¹¹⁵ James Stuart Tyhurst et al., More for the Mind: A Study of Psychiatric Services in Canada (Toronto: Canadian Mental Health Association, 1963), 5; Starr, The Social Transformation of American Medicine, 336-7; William Ray Arney and Bernard J. Bergen, Medicine and the Management of Living: Taming the Last Great Beast (Chicago: University of Chicago Press, 1984), 162.

use in treating serious psychiatric illnesses.¹³⁷ For psychiatrists, the popularity of psychodynamic and milieu therapies after World War II was not necessarily incompatible with the use of drugs and other somatic interventions. In fact, the prevailing view was that drugs might actually make some of the more seriously ill patients responsive to psychotherapies and environmental treatment.¹³⁸ Prior to the early 1950s, sedatives were sometimes used to treat psychoses but these drugs tended to cause drowsiness and therefore were valuable mainly for their ability to facilitate sleep in violent or agitated patients.¹³⁹ Other treatment methods included electroconvulsive therapy (ECT), insulin shock, lobotomy, psychotherapy, and social, recreational, and vocational activities.¹⁴⁰ Overall, however, these treatments were unsatisfactory in part because their effects were often minimal or temporary, they

¹³⁷ Erik Jacobsen, "The Early History of Psychotherapeutic Drugs," Psychopharmacology 89 (1986), 142.

¹³⁸ Gerald N. Grob, From Asylum to Community: Mental Health Policy in Modern America (Princeton: Princeton University Press, 1991), 146, 148.

¹³⁹ Ibid., 138.

¹⁴⁰ Helen H. Stacey, "What Can Be Done For Mental Casualties?" Saturday Night, May 5, 1945, 16; Sidney Katz, "A Day in a Mental Hospital," Maclean's, October 15, 1953, 82; Jonathan O. Cole, "The Drug Approach to Mental Illness," in Samuel Proger, ed., The Medicated Society, (New York: Macmillan, 1968), 107-8.

were expensive to administer in terms of staff, facilities, and equipment, and, occasionally, they were simply dangerous.¹⁰⁰ In 1953, chlorpromazine was introduced in Canada and the United States as the first effective antipsychotic or "major" tranquilizing drug on the market. Its ability to alleviate a wide range of psychotic symptoms generated a lot of media attention and started a "revolution" in North American psychiatry.¹⁰¹ To many people, the success of chlorpromazine and the other major tranquilizing drugs in the treatment of psychoses also reinforced their belief in the power of medical science and gave them further hope that a new drug would soon be found to treat neuroses.¹⁰²

Dr. Heinz Lehmann, clinical director at the Verdun Protestant Hospital in Montreal, was one of the first

¹⁰⁰ Katz, "A Day in a Mental Hospital," 87; Cole, "The Drug Approach to Mental Illness," 107-8.

¹⁰¹ This shift has variably been described as a "revolution in medical therapeutics," a "tranquilizer revolution," a "psychiatric revolution," and a "psychopharmacological revolution." Sidney Katz, "The New Wonder Drugs That Fight Insanity," Maclean's, November 12, 1955, 11; Donald Gray Cooley, "The Story of Tranquilizers," Today's Health, November 1960, 33; "What Tranquilizers Have Done," Time, April 24, 1964, 43; Dorothy Eber, "In Montreal, One Day in 1953, They Started the Psychopharmacological Revolution," Saturday Night, May 1969, 32.

¹⁰² Charles A. Roberts, "Thirty-Five Years of Psychiatry in Canada, 1943-1978," The Psychiatric Journal of the University of Ottawa 4,1 (March 1979), 36.

psychiatrists in North America to experiment with chlorpromazine.¹⁴³ In 1952, he read an article by French psychiatrists who had given chlorpromazine for the first time to a group of patients with acute psychoses.¹⁴⁴ Up until that point, chlorpromazine had been used primarily as a means of inducing a lower body temperature, or "artificial hibernation," in patients about to undergo major surgery, a procedure that greatly reduced the incidence of surgical shock. Lehmann was impressed by the French results which suggested that chlorpromazine dramatically reduced psychotic symptoms with only minor side effects. In April 1953, Lehmann and his assistant, Gorman Hanrahan, began their own study with chlorpromazine when they administered the drug to seventy patients at the Verdun Protestant Hospital. "Within a week," said Lehmann, "we both realized that we had something."¹⁴⁵ Yet it took considerably longer for the two to fully appreciate the fact that chlorpromazine not only calmed excited patients while allowing them to remain alert

¹⁴³ Frank J. Ayd, Jr., "The Early History of Modern Psychopharmacology," Neuropsychopharmacology 5,2 (September 1991), 72.

¹⁴⁴ Jean Delay, P. Deniker, and J.-M. Harl, "Traitment des états d'excitation et d'agitation par une méthode médicamenteuse dérivée de l'hibernothérapie," Annales Médico-Psychologiques 110,2 (June 23, 1952), 267-73.

¹⁴⁵ Katz, "The New Wonder Drugs That Fight Insanity," 114.

but also freed them of symptoms such as hallucinations, paranoia, and confusion:

We didn't believe that a simple pill could act against psychosis. We had to be careful not to have another "cancer cure," and we were only reluctantly convinced by the drug. Eventually we started saying, "It's hard to believe we have a drug that can do anything about psychosis -- but it does rather seem like it."¹⁰

In February 1954, Lehmann and Hanrahan published their results in what became the first North American article on the therapeutic usefulness of chlorpromazine in psychiatry.¹¹ By mid-1957, over five thousand research papers had been published on chlorpromazine alone -- very few of them negative.¹²

The lay press was quick to report on the early clinical findings. Four months after the Lehmann and Hanrahan

¹⁰ Eber, "In Montreal," 33.

¹¹ Heinz E. Lehmann and Gorman E. Hanrahan, "Chlorpromazine: New Inhibiting Agent for Psychomotor Excitement and Manic States," A.M.A. Archives of Neurology and Psychiatry 71,2 (February 1954), 227-37; Francis Bello, "The Tranquilizer Question," Fortune, May 1957, 162; Ayd, "The Early History of Modern Psychopharmacology," 72.

¹² Bello, "The Tranquilizer Question," 166. For more thorough accounts of the development, manufacture, and impact of chlorpromazine, see Anne E. Caldwell, Origins of Psychopharmacology from CPZ to LSD (Springfield, Ill.: Charles C. Thomas, 1970); Judith P. Swazey, Chlorpromazine in Psychiatry (Cambridge: MIT Press, 1974); Anne E. Caldwell, "History of Psychopharmacology," in William G. Clark and Joseph del Giudice, eds., Principles of Psychopharmacology, 2d ed. (New York: Academic Press, 1978), 9-40.

article appeared in print, Time magazine named chlorpromazine "wonder drug of 1954," borrowing a term that was mainly applied to antibiotics and generalizing it to include antipsychotic medication.¹²⁷ Hundreds of articles appeared in popular magazines and newspapers documenting the dramatic impact that chlorpromazine was having on patients institutionalized in psychiatric hospitals across the country. The emphasis in many of these stories was on the extent to which chlorpromazine had either eliminated or modified symptoms of acute and chronic schizophrenia including hyperactivity, aggression, agitation, hallucinations, delusions of persecution, withdrawal from reality, and lack of self-care.¹²⁸ There was the story of a man who had a history of being excitable, aggressive, and belligerent. On March 17, 1955, soon after beginning treatment with chlorpromazine, he happened to walk by the Montreal Forum and get caught in the middle of the Maurice Richard hockey riot. In the confusion, he was taunted,

¹²⁷ "Wonder Drug of 1954?" Time, June 14, 1954, 55-7.

¹²⁸ "Pills for the Mind: New Era in Psychiatry," Time, March 7, 1955, 53-6; Katz, "The New Wonder Drugs That Fight Insanity," 11; "Pills vs. Worry -- How Goes the Frantic Quest for Calm in Frantic Lives?" Newsweek, May 21, 1956, 68-70; Reva Gerstein, "Canada Pioneers in New Clinics and Drugs to Help Mentally Ill," Chatelaine, August 1956, 4; "How Tranquilizers Work," Newsweek, December 24, 1956, 47; Bello, "The Tranquilizer Question," 57; Anthony Horder, "The Tranquilizer Problem," Science Digest 52,2 (August 1962), 80.

shoved, and hit by flying toe rubbers and ice. Undisturbed by the experience, the man continued on his way.¹³³ It was also emphasized in these articles that chlorpromazine made it possible for many longer-term hospital patients to return to the community.¹³⁴ "The average patient's chance of improving enough to go home was never brighter," said Joan Smith, chief psychiatric social worker at the Verdun Protestant Hospital.¹³⁵ And, as an example, she told the story of one woman who had been a violent and assaultive patient at the hospital for five years but had recovered enough after receiving chlorpromazine that she was able to secure work in Montreal as a domestic.¹³⁶

In spite of all the encouraging media coverage, there was some initial opposition to chlorpromazine from within the psychiatric profession. Heinz Lehmann recalled that

¹³³ Katz, "The New Wonder Drugs That Fight Insanity," 13. For a more detailed description of the Maurice Richard hockey riot, see Sidney Katz, "The Richard Hockey Riot," Maclean's, September 17, 1955, 11.

¹³⁴ Katz, "The New Wonder Drugs That Fight Insanity," 13, 113; "Return to Sanity in 12 Weeks," Life, October 15, 1956, 148-56; "I Live Again After Eleven Years Of Insanity," Chatelaine, April 1957, 13; John W. Robinson, "A Chance for the Mentally Ill," Science News Letter 71, 17 (April 27, 1957), 266; "What You Ought To Know About Tranquilizers," U.S. News and World Report, June 21, 1957, 67-8.

¹³⁵ Katz, "The New Wonder Drugs That Fight Insanity," 13.

¹³⁶ Ibid., 13.

some psychiatrists were doubtful that a drug could have such a dramatic effect on psychotic symptoms and still be safe:

It was a time when one had to have the courage of one's convictions....Nobody stopped me giving chlorpromazine but I think many were grateful I did it rather than they.¹³³

Just the same, the overall response of the psychiatric profession towards the introduction of chlorpromazine and other major tranquilizing drugs was favourable and enthusiastic.¹³⁴ Dr. D.O. Lynch, superintendent of the Ontario Hospital in Toronto, confessed, "I have never seen a drug that provides so much relief from the frightening symptoms of mental illness."¹³⁵ Dr. R.A. Gleghorn of McGill's Allan Memorial Institute of Psychiatry in Montreal described the impact of major tranquilizers as "spectacular, even lurid."¹³⁶

The new antipsychotic drugs did not cure mental illness but they did make some of the more seriously ill patients more receptive to psychotherapies and environmental

¹³³ Eber, "In Montreal," 33.

¹³⁴ Grob, From Asylum to Community, 146-50. For an exception to the general rule, see Thomas Szasz, "Some Observations on the Use of Tranquilizing Drugs," A.M.A. Archives of Neurology and Psychiatry 77 (January 1957), 86-92.

¹³⁵ Katz, "The New Wonder Drugs That Fight Insanity," 114.

¹³⁶ Ibid., 12.

treatment. As a 1955 editorial in the American Journal of Psychotherapy pointed out, "the new drugs have only a symptomatic effect on psychic disorders and ... cannot replace psychotherapy; all they accomplish is to render the patient more amenable to psychotherapy."¹³³ True to this observation, the new antipsychotic drugs dramatically altered the way in which psychiatric hospitals operated. Because major tranquilizers controlled many of the more severe psychotic symptoms, hospitals were able to rely less and less on the use of shock treatments, insulin comas, lobotomies, straight jackets, and isolation rooms.¹³⁴ Instead, they placed more emphasis on psychotherapy and social, recreational, and vocational therapies.¹³⁵ The improved atmosphere in the hospitals was a real boost to staff morale. Staff had increased enthusiasm for their work and more energy to spend with patients who could now be

¹³³ "New Drugs and Psychotherapy," American Journal of Psychotherapy 9,2 (April 1955), 193.

¹³⁴ Katz, "The New Wonder Drugs That Fight Insanity," 113,115; "Pills vs. Worry," 70; Robinson, "A Chance for the Mentally Ill," 266; Bello, "The Tranquilizer Question," 162.

¹³⁵ Katz, "The New Wonder Drugs That Fight Insanity," 13; "New Avenues Into Sick Minds," Life, October 22, 1956, 119-24; Robinson, "A Chance for the Mentally Ill," 266; Bello, "The Tranquilizer Question," 162.

helped.¹⁴² And, in order to effectively manage those patients who had become well enough to return to their homes and jobs, hospitals established aftercare treatment programs. Among other things, these programs ensured that discharged patients continued to take their medication on a regular basis and therefore avoid a relapse and possible readmission to hospital.¹⁴³

The success of chlorpromazine as an antipsychotic drug added to North America's already deep enchantment with scientific medicine. It sparked medical researchers to search for more versatile and less toxic drugs with which to treat the mentally ill.¹⁴⁴ And, it made the public and the medical profession more optimistic that through these drugs medical science would one day discover the causes of mental

¹⁴² Katz, "The New Wonder Drugs That Fight Insanity," 113; Robinson, "A Chance for the Mentally Ill," 266; Horder, "The Tranquilizer Problem," 80, 82-3.

¹⁴³ Katz, "The New Wonder Drugs That Fight Insanity," 13; Gerstein, "Canada Pioneers in New Clinics and Drugs to Help Mentally Ill," 4; "The New Mental Health Frontier," Canada's Mental Health 5,1 (January 1957), 1; "Ontario Makes New Approach To Mental Health Problem," Canadian Doctor 25,4 (April 1959), 66-7; Cooley, "The Story of Tranquilizers," 33; Eber, "In Montreal," 33; D.L. Goldman and K. Arvanitakis, "D. Ewen Cameron's Day Hospital and the Day Hospital Movement," Canadian Journal of Psychiatry 26,2 (August 1981), 365-8.

¹⁴⁴ Katz, "The New Wonder Drugs That Fight Insanity," 118; "Pills vs. Worry," 70.

illness and, from there, a cure.¹⁴ In 1955, medical science came through again with the first in a series of anti-anxiety agents, or "minor" tranquilizing drugs, aimed at treating the worried well. North Americans, convinced of the promise and possibility of medical science, clamoured to be the first to take them. Physicians, also convinced of the promise and possibility of medical science, were more than willing to prescribe them. The result was an unprecedented strain on pharmaceutical companies to keep up with the demand. Even concerns about the safety and ethics of these drugs for "normal" people could not tarnish the firm belief in the minds of many North Americans that medical science could and would come up with a pill to treat every individual and social ill.

¹⁴ Katz, "The New Wonder Drugs That Fight Insanity," 118; Robinson, "A Chance for the Mentally Ill," 266; "What You Ought To Know About Tranquilizers," 72; Eber, "In Montreal," 33; Cole, "The Drug Approach To Mental Illness," 122.

CHAPTER THREE

The Popularization and Legitimization of Minor Tranquilizing Drugs

In the April 2, 1955 edition of Maclean's magazine the pharmaceutical company Parke-Davis ran an advertisement which promoted wonder drugs as a "universal boon to mankind" (Illustration 5). The ad consisted of three short paragraphs of text situated just below a much larger illustration of a bubble gum machine that was filled almost to capacity with gumballs of different colours and promoted by a label affixed to the glass which read "NEW WONDER DRUGS (Serve Yourself)." Overall, the ad painted a very positive and promising picture of the new wonder drugs, a term the ad appears to have used to denote all new therapeutic drugs and not just the antibiotics. Among other things, the accompanying text suggested that wonder drugs were the product of scientific research and modern medical progress; that wonder drugs were more effective than traditional remedies; that wonder drugs were capable of curing almost any illness or disease; that the latest wonder drugs could be obtained from medical doctors who, by virtue of their position, possessed the knowledge and skill to make accurate

If they're so wonderful—why not? Maybe you've read about the miracle-working properties of a newly developed drug; or heard about the staunch incredible cure it worked for some friend. You try to buy it, and find you can't without a doctor's prescription. And you wonder why they make such a "universal law to mankind" so hard for you to get!

As makers of more than seven hundred pharmaceutical products, including a number of these "wonder drugs", we at Parke-Davis know how effective the newer drugs can be—when properly used. We know also that no drug will work "miracles" for everyone, and that only the skill and knowledge of a physician can make it work effectively for you.

Medical research today is writing one of the most heartwarming chapters in the history of mankind. Today—in addition to all the older established remedies—your doctor has at his service the many new discoveries of medical and pharmaceutical science. The surest way to take full advantage of modern medical progress is to see your doctor—and see him promptly—when you become ill.

PARKE, DAVIS & CO., LTD.

Manufacturing Laboratories, Warrington, Ontario

Makers of medicines since 1866

ILLUSTRATION 5: Advertisement promoting new drug therapies by Parke-Davis. Source: Maclean's, April 2, 1955, inside front cover.

clinical diagnoses and follow them through with a prescription for the appropriate drug; that newer wonder drugs were more effective than earlier wonder drugs; and, that new wonder drugs were as safe to consume as gum was to chew.

While the Parke-Davis advertisement in Maclean's magazine was clearly a marketing strategy designed to publicly associate the company with the latest in drug therapy and the promise of scientific medicine, the story of new drug discoveries as it unfolded in both the medical and the popular press was actually much more complex and often less rosy than Parke-Davis was willing to admit. For example, interspersed among glowing accounts of the latest drugs to appear on the market were more sombre articles which, among other things, suggested that new drugs were the product of chance and a desire for economic profit; that new drugs were not necessarily more effective than traditional remedies or earlier drugs; that many drugs did not cure illnesses so much as they masked symptoms; that the latest drugs could be obtained from medical doctors who often prescribed them on demand and/or for patients who displayed symptoms of a nonmedical nature; and, that some new drugs could be addictive, toxic, and even fatal.

Meprobamate is a prime example of a drug which became very popular in spite of the fact that it received

relatively mixed reviews in both professional and lay publications following its introduction into general use in North America during the 1950s. Technically speaking, meprobamate was not a wonder drug but it did seem to benefit from appearing during a period when, as noted in Chapter Two, reports of new drug discoveries generated a great deal of attention and excitement both within the medical profession and among the general population. Meprobamate had been developed over the course of almost ten years by former pediatrician, bacteriologist, and pharmacologist Frank Berger (Illustration 6), Medical Director at Wallace Laboratories, the ethical or prescription drug division of Carter Products, Inc. located in New Brunswick, New Jersey. Berger described meprobamate, a white and distinctly bitter-tasting pill, as a mild sedative with muscle-relaxant properties which acted selectively on the central nervous system to safely and effectively reduce anxiety, tension,

For his own description of the discovery, development, and significance of meprobamate, see Frank M. Berger, "Anxiety and the Discovery of the Tranquilizers," in Frank J. Ayd, Jr. and B. Blackwell, eds., Discoveries in Biological Psychiatry (Philadelphia: J.B. Lippincott, 1970), 115-29.

"Ethical" drugs refer to those drugs which were by law not advertized to the general public and available only upon the prescription or original recommendation of a physician. Ethical drugs were also referred to as prescription drugs. The "ethical drug division" of a pharmaceutical company refers to that section of the company which focussed primarily on the research and development of new ethical or prescription drug products.

Illustration 6: Dr. Frank M. Berger, Medical Director at Wallace Laboratories. Source: Oscar Schisgall, Carter-Wallace, Inc.: One Hundred Years (1880-1980) (np: Carter-Wallace, Inc., 1980), 33.

and mental stress without inducing drowsiness. Significantly, meprobamate appeared to be a pharmacologically unique anti-anxiety agent in that it was neither toxic nor addictive like the barbiturates which had been the drugs of choice in the treatment of anxiety since the turn of the century.⁴ Therefore, from a medical standpoint, it was hoped that meprobamate would be a useful therapeutic tool in the treatment of anxiety and tension states. But, almost immediately, the use of this drug became something of a mass cultural phenomenon. In spite of mixed reviews in both professional and lay publications, the number of conditions involving anxiety and tension for which meprobamate was said to provide symptomatic relief grew dramatically. Soon, the drug was being used to alleviate the common anxieties and routine tensions of everyday life.

In May 1955, Wallace placed meprobamate on the pharmaceutical market under the brand name Miltown.⁵ A few

⁴ Frank M. Berger, "The Tranquilizer Decade," Journal of Neuropsychiatry 5,7 (September-October 1964), 405-6.

⁵ Marvin E. Lickey and Barbara Gordon, Drugs for Mental Illness: A Revolution in Psychiatry (New York: Freeman, 1983), 222.

⁶ It was customary at Wallace to code name experimental products after towns and villages in the area. The code name for Berger's product was "Milltown," the name of a town about a mile away from New Brunswick. When it came to deciding on a proprietary/brand name for Berger's new drug, Carter president Henry Hoyt simply dropped an "l" (because place names could not be trademarked) and went with

months later, Carter president Henry Hoyt signed a licensing arrangement with Wyeth Laboratories, a subsidiary of American Home Products, Inc. of New York, whereby Carter Products would supply the much larger company with meprobamate powder and Wyeth would tablet and market the compound under the brand name Equanil.⁷ Henry Hoyt originally licensed Fine Chemicals and Delmar Chemicals to manufacture meprobamate in Canada and to supply the drug to licensees of Carter as designated by Carter. Delmar Chemicals subsequently discontinued production of meprobamate which left Fine Chemicals as the principle Canadian supplier. Initially, Carter's Canadian subsidiary and Wallace Laboratories' representative in Canada, N.S. Carter Products, Ltd., sold meprobamate in Canada under the brand name Miltown while American Home Products' Canadian subsidiary, Wyeth Laboratories, sold the drug under the brand name Equanil. In 1958, Wallace Laboratories stopped selling Miltown in Canada when Henry Hoyt licensed Ayerst, McKenna, and Harrison, another Canadian subsidiary of

the name "Miltown." Thomas Whiteside, "Onward and Upward with the Arts: Getting There First With Tranquility," New Yorker, May 3, 1958, 108.

⁷ For an account of how Wyeth went about getting the licensing agreement with Wallace, see "Alvin Brush's Specialty House," Fortune, April 1958, 143. The proprietary/brand name "Equanil" is a contraction of the words "equanimity" and "tranquil."

American Home Products, to sell meprobamate under the brand name Miltown. Therefore, by 1958 Henry Hoyt had made licensing arrangements in Canada whereby Fine Chemicals of Toronto was responsible for supplying meprobamate to both Ayerst and Wyeth who were in turn responsible for selling the drug in Canada as Miltown and Equanil respectively.⁶

The manufacture and distribution of meprobamate represented a departure for both Carter and American Home Products. Prior to 1955, Carter was best known for its innovative over-the-counter products such as the general tonic Carter's Little Liver Pills, the deodorant Arrid, the hair remover Nair, and the aerosol shaving cream Rise. In the 1940s, Henry Hoyt decided to venture into the field of prescription drugs and looked for ways to expand the

⁶ "Report Concerning the Manufacture, Distribution, and Sale of Drugs," Restrictive Trade Practices Commission (Ottawa: Queen's Printer, 1963), Appendix Q, 191-2; "Now Under the Ayerst Label," Canadian Doctor 24,4 (April 1958), 44-5. Meprobamate was also sold in Canada by other drug companies under different brand names but these companies and names were never mentioned in the medical or lay press. For example, Neo Drug sold meprobamate under the brand name Neo-Tran, Elliott-Marion sold it as Trelmar, and Intra sold it as Tranquiline. It is not clear whether these pharmaceutical companies sold their brands of meprobamate under license from Wallace Laboratories. "Report Concerning the Manufacture, Distribution, and Sale of Drugs," Appendix Q, 193.

⁷ The story behind the development of these products is told in Oscar Schisgall, Carter-Wallace, Inc.: One Hundred Years (1880-1980) (np: Carter-Wallace, Inc., 1980), 1-29.

otherwise limited operations of Wallace Laboratories. In 1949 he hired Frank Berger to head Wallace's research staff and, over the next six years, invested \$2 million towards the successful production of meprobamate.⁸ In contrast to Carter, American Home Products had a number of food and household items on the market before it entered into the ethical drug business. Some of these products included Chef Boy-Ar-Dee Ravioli with Beef in Sauce, Burnett's Vanilla, Easy-Off oven cleaner, Wizard Pink Wick Deodorizer, and the pain-relieving drug Anacin.⁹ During World War II, American Home chairman Alvin Brush recognized the profit potential of the latest advances in drug research and Wyeth Laboratories became one of the first commercial producers of bulk penicillin in the United States. In 1955, Brush negotiated a deal with Hoyt to license meprobamate and, one year later, Wyeth came out with its own major tranquilizing drug by the name of promazine hydrochloride (Sparine).¹⁰

The decision to enter into the ethical drug field during the 1940s resulted in big profits for Carter and American Home Products during the 1950s and made drug companies in general some of the most profitable businesses

⁸ Ibid., 29-30.

⁹ "Alvin Brush's Specialty House," 141.

¹⁰ Ibid., 205.

in Canada and the United States. Canadian sales figures for Miltown and Equanil are not available but the Canadian drug industry as a whole enjoyed healthy profits during the 1950s. For example, between 1958 and 1960, the profit margin of the drug industry was proportionately larger than that of all manufacturing industries in Canada combined.²² In the United States, Carter Products sales grew from \$1.1 million in 1935 to \$14.6 million in 1955. Sales of Miltown and meprobamate powder consistently accounted for more than half of all net sales recorded by Carter between 1955 and 1961. In 1957, the peak year for tranquilizer sales in North America, Miltown sales made up fifty-nine percent of Carter's net sales of \$41.8 million. In 1959, Carter recorded sales of \$48 million, with net earnings after taxes of \$7 million or 14.5 percent of sales.²³ American Home Products sales grew from \$16 million in 1935 to \$35 million in 1940 to \$164 million in 1950. In 1956, sales of Equanil and Sparine accounted for almost \$40 million out of a total Wyeth volume of about \$110 million. In 1957, American Home

²² Department of National Health and Welfare, "Provision, Distribution, and Cost of Drugs in Canada," Royal Commission on Health Services (Ottawa: Queen's Printer, 1965), 32.

²³ Whiteside, "Onward and Upward," 120; "Tranquilizer Trends," Canadian Medical Association Journal 83,25 (December 17, 1960), 1328; Schisgall, Carter-Wallace, Inc., 19,34.

announced sales of \$346 million, with net earnings after taxes of \$38 million or 11 percent of sales.¹³

In their quest for greater profits, the drug industry behaved in much the same way as other large and powerful industries operating in similar markets. Unlike other industries, however, the drug industry chose to publicly promote itself as an industry that was not only moral and ethical but on the cutting edge of scientific progress. Industry image-makers began to promote the drug industry in this way at the end of the nineteenth century.¹⁴ As the Parke-Davis wonder drug advertisement in Maclean's magazine would suggest, drug companies continued into the twentieth century to deliberately exploit their association with the supposedly high standards and ongoing advances of scientific and pharmaceutical medicine.

While American-owned drug companies profited greatly from their entry into the expanding ethical drug market during and after World War II, the therapeutic revolution and subsequent transformation of the drug industry spelled the end for many Canadian-owned firms.¹⁵ The difficulty

¹³ "Alvin Brush's Specialty House," 142,205.

¹⁴ Jonathan Liebenau, Medical Science and Medical Industry: The Formation of the American Pharmaceutical Industry (London: Macmillan, 1987), vii-viii,7.

¹⁵ This information on the Canadian pharmaceutical industry was drawn from Myron J. Gordon and David J. Fowler,

encountered by domestic companies was that they were relatively modest operations which were unable to carry out research, development, and marketing on the same scale as their larger foreign-based competitors. As a result, most Canadian firms fell under foreign control after 1940, leaving Connaught Laboratories as the only domestically-owned firm of any significance after 1965. Given the circumstances, however, this turn of events proved to be profitable for both the Canadian-owned and the foreign-owned companies. The story of Ayerst is a case in point. Prior to World War II, Ayerst, McKenna, and Harrison of Montreal boasted a healthy research and development organization that was, by Canadian standards, very successful in discovering new products. One of its most promising drugs was the hormone preparation Premarin which was used to treat menopausal disorders. Unfortunately, the gross profits generated by the small Canadian market made it financially impossible for Ayerst to continue its research and development activity while Ayerst's small size made it financially too risky for the company to make further investments that would allow it to expand into foreign

The Drug Industry: A Case Study of the Effects of Foreign Control on the Canadian Economy (Toronto: James Lorimer, 1981), 34-5; Joel Lexchin, The Real Pushers: A Critical Analysis of the Canadian Drug Industry (Vancouver: New Star Books, 1984), 32-3.

markets. At the same time, American Home Products was looking to enter into the ethical drug field and had the resources and expertise needed to help Ayerst enter into American and other markets. In 1943, American Home bought Ayerst. The acquisition was mutually beneficial because as an independent company the future of Ayerst had been in some doubt but as a subsidiary of American Home Products Ayerst grew quickly from annual sales of \$2 million in 1943 to an estimated \$20 million in sales for 1956.¹⁰ Perhaps not surprisingly, one of Ayerst's most advertised products after 1955 was a drug which combined Premarin and meprobamate for the treatment of menopausal women who experienced a great deal of anxiety and tension.

Medical doctors formally learned about meprobamate from medical journals and pharmaceutical companies. They also learned about meprobamate from the same popular sources that were available to members of the general population. Either way, doctors were presented with conflicting and even contradictory assessments of the therapeutic value of meprobamate.

Medical journals published a number of clinical studies and articles which championed meprobamate as a

¹⁰ "Alvin Brush's Specialty House," 145,205.

pharmacologically unique non-barbiturate anti-anxiety agent with muscle-relaxing features and a minimum of accompanying drowsiness. In some cases, Wallace Laboratories and Frank Berger were closely associated with these positive results. For example, in April 1955, on the eve of the introduction of meprobamate into general use, Drs. Lowell Selling and Joseph Borrus published the results of separate clinical studies which found that meprobamate effectively reduced levels of anxiety and tension while remaining relatively nontoxic and nonhabit forming.¹⁷ Selling was a psychiatrist practising in Orlando, Florida and Borrus was a psychiatrist from New Brunswick, New Jersey. Both men knew Frank Berger personally and kept in contact with him throughout their research. The footnotes to their articles indicate that Wallace supplied the psychiatrists with meprobamate for the studies, a relationship highlighted once again by the inclusion of the name Miltown in the titles and texts of the articles.¹⁸ The footnotes also indicate that Berger

¹⁷ Lowell S. Selling, "Clinical Study of a New Tranquilizing Drug: Use of Miltown (2-methyl-2-n-propyl-1, 3-propanediol dicarbamate)," Journal of the American Medical Association 157,18 (April 30, 1955), 1594-6; Joseph C. Borrus, "Study of Effect of Miltown (2-methyl-2-n-propyl-1, 3-propanediol dicarbamate) on Psychiatric States," Journal of the American Medical Association 157,18 (April 30, 1955), 1596-8.

¹⁸ The practice of including the proprietary/brand name of a drug in the title and text of a published clinical study became less common as the fifties decade progressed.

provided Selling and Borrus with published and unpublished references to related clinical studies including many of his own. In fact, Berger regularly sent Selling new compounds to try with his office patients. Meproamate was the first compound from Berger that Selling had felt was worthwhile. Selling died in January 1955 before he could put the finishing touches on his study. The report was most likely completed for him by Berger and then published in its present form three months later.

Initially, these reports attracted little attention but as promising stories about Miltown began to circulate within

This change occurred in part because it came to be regarded as unethical for researchers to promote a particular company's brand of drug. This shift in thinking, however, did not stop researchers from carrying out clinical trials on behalf of pharmaceutical companies or acknowledging drug company support of their work in subsequent publications.

For more information about Selling, his study, and his friendship with Berger, see Milton Silverman, "First Aid for Alcoholics," Saturday Evening Post, November 17, 1956, 114-5; Whiteside, "Onward and Upward," 107. In March 1956, Selling published posthumously another very positive assessment of meproamate. See Lowell S. Selling, "A Clinical Study of Miltown, A New Tranquilizing Agent," Journal of Clinical and Experimental Psychopathology 17,1 (March 1956), 7-14. A footnote reveals that Frank Berger of Wallace Laboratories had helped edit this paper after Selling's death. And, while the scientific objectivity of these studies and their authors was clearly open to question, the two articles by Selling and the one by Borrus were regularly cited in journal advertisements as clinical proof of the scientific and therapeutic value of meproamate. For example, see "Miltown," Canadian Doctor 22,2 (February 1956), 16; "Equanil," Canadian Doctor 23,8 (August 1957), 6; "Premarin with Meproamate," Canadian Doctor 23,8 (August 1957), 46-7.

the medical and lay communities, the uniformly positive conclusions reached by Selling and Borrus were frequently cited in professional and popular journals and set the tone for literally hundreds of equally encouraging studies in subsequent years. The increase in the number of clinical studies and articles which reinforced the therapeutic value of Miltown was orchestrated in part by Wallace Laboratories. In late summer 1955, Henry Hoyt asked the promoter of Carter's Little Liver Pills, the big New York advertising agency Ted Bates and Company, to take on Miltown. Among other things, the "Miltown men" at Ted Bates were heavily involved in sponsoring scientific research on Miltown and mass marketing the glowing results. According to one Miltown man,

We applauded [Wallace's] research grants to people at various institutions. The more work done on the product, the more papers published in medical journals, where the doctors could see them. [Wallace] must have spent a couple of million bucks backing this independent research on meproamate and cashing in on the results -- getting reprints from the medical press sent around to the profession, and so on. Of course, we were able to feed summaries of a lot of these papers to the newspapers, too, and plenty of them made good copy....

This observation was made by Ayd, "The Early History of Modern Psychopharmacology," 73; Victor G. Laties and Bernard Weiss, "A Critical Review of the Efficacy of Meproamate (Miltown, Equanil) in the Treatment of Anxiety," Journal of Chronic Diseases 7,6 (June 1958), 501,503.

Whiteside, "Onward and Upward," 112.

Not to be outdone, Wyeth Laboratories also sponsored clinical studies of meprobamate. On June 1, 1956, the first study of meprobamate to be published in a Canadian medical journal appeared in the Canadian Medical Association Journal. The author, Dr. S.E.C. Turvey of Vancouver, employed the Equanil brand name in the title and throughout the text of his article and acknowledged that Wyeth had supplied the Equanil used in his study. Turvey had tested meprobamate with ninety-three patients including eighty-three alcoholics, three drug addicts, three patients with nervous tension and tremors, and four psychoneurotics. Like Selling and Borrus, Turvey concluded that meprobamate was a safe, nonhabit-forming, and, except for two patients who developed hives, relatively nontoxic relaxant for use in the relief of anxiety and nervous tension. In particular, Turvey noted that meprobamate was more effective than the barbiturates in relaxing alcoholic patients.

In October 1956, the image of meprobamate as an "ideal" tranquilizer was reinforced by studies presented at the high-profile Conference on Meprobamate and Other Agents Used in Mental Disturbances held in New York and sponsored by the New York Academy of Sciences, Section of Biology and

S.E.C. Turvey, "Meprobamate (Equanil) for Relief of Anxiety and Nervous Tension from Various Causes," Canadian Medical Association Journal 74,11 (June 1, 1956), 863-5.

Psychology. Delegates to the conference agreed that meprobamate was effective, safe, and not habit-forming when taken as directed for the treatment of conditions such as motion sickness, insomnia, emotional instability, headaches, postoperative anxiety and depression, and alcohol withdrawal symptoms like delirium tremens. Wallace Laboratories did not contribute directly to the event but Frank Berger was one of two conference chairmen and acted as consulting editor when the proceedings were published by the Academy in paperback form a few months later.⁴ More importantly, the Bates agency capitalized on the encouraging results presented at the two day meeting by mailing 153,000 free copies of the proceedings to physicians throughout the United States, compliments of Wallace Laboratories.

In April 1964, the safety and therapeutic value of

⁴ "'Ideal' in Tranquility," Newsweek, October 29, 1956, 63.

⁵ The proceedings were published as "Meprobamate and Other Agents Used in Mental Disturbances," Annals of the New York Academy of Science 67,10 (May 9, 1957), 671-894. A report on the conference was submitted by Ralph W. Gerard, "Drugs for the Soul: The Rise of Psychopharmacology," Science 125,3240 (February 1, 1957), 201.

The encouraging results of a number of papers presented at the conference were also reported in several different medical publications. For example, see "See Help for Hangovers in One Relaxing Drug," Science News Letter 70,18 (November 3, 1956), 280; "Can Drive Tranquilized," Science News Letter 70,18 (November 3, 1956), 287; "Tranquilizer," Scientific American 196,1 (January 1957), 67-8.

⁶ Whiteside, "Onward and Upward," 113.

meprobamate was affirmed yet again at a Symposium on Anxiety and a Decade of Tranquilizer Therapy held in New York and sponsored by Wallace Laboratories. A number of prominent medical professionals, including Frank Berger, attended the symposium and the general consensus among them was that the true value of meprobamate lay in both its safety and its versatility. Indeed, in the years following its introduction, meprobamate, alone or in combination with other drugs, had been credited by researchers with providing symptomatic relief for dozens of conditions, including peptic ulcer, stuttering, asthma, premenstrual tension, and allergies."

In contrast to these very favourable reports about meprobamate, medical journals also published a number of

The proceedings of the symposium were reproduced as an entire issue of the Journal of Neuropsychiatry. See "Symposium on Anxiety and a Decade of Tranquilizer Therapy," Journal of Neuropsychiatry 5,7 (September-October 1964), 386-489. See also Frank J. Ayd, Jr., "Meprobamate: A Decade of Experience," Psychosomatics 5 (March-April 1964), 82-7.

For example, see Berger, "The Tranquilizer Decade," 403-10; John C. Krantz, Jr., "The Pharmacology of Tranquilizing Agents," Journal of Neuropsychiatry 5,7 (September-October 1964), 434-5; Julius Michaelson, "The General Practitioner's Role in the Control of Anxious and Neurotic Patients," Journal of Neuropsychiatry 5,7 (September-October 1964), 440-1.

For a list of over thirty conditions for which meprobamate was claimed to provide symptomatic relief, see David J. Greenblatt and Richard I. Shader, "Meprobamate: A Study of Irrational Drug Use," American Journal of Psychiatry 127,10 (April 1971), 34,36.

clinical studies and articles which argued that meprobamate did not represent a major therapeutic advance over the barbiturates in the alleviation of anxiety and tension states and that the studies which made such claims were unscientific. In addition to a cautious attitude toward meprobamate, these clinical studies and articles shared the distinction of not having been funded with drug company money. As if to highlight the apparent link between pharmaceutical sponsorship and clinical results, the Wyeth-funded work of Dr. S.E.C. Turvey in the Canadian Medical Association Journal was followed less than fifty pages later by an independent report on three cases of meprobamate poisoning. Drs. Aubrey Shane and Solomon Hirsch of the Department of Psychiatry at Dalhousie University argued that, contrary to the available literature, meprobamate might actually be toxic when taken in large doses. Shane and Hirsch presented case studies of three patients who had taken from two to four times the recommended daily dose of meprobamate. The researchers found that this much meprobamate could result in coma, significant muscle relaxation with absent reflexes, and a dangerous fall in blood pressure. Shane and Hirsch concluded that a high dosage might even cause death and therefore recommended that doctors exercise caution when prescribing meprobamate to

potentially suicidal patients."

In a speech that was delivered at the annual meeting of the Canadian Medical Association on June 20, 1957, internal medicine specialist from Victoria, B.C., Dr. T.F. Rose, reviewed the clinical literature on tranquilizing drugs contained in twenty of the leading English-language medical journals. Much to his dismay, Rose found that many of the more positive clinical studies were too uncritical and uncontrolled for their results to be considered statistically significant. Moreover, he discovered that there was virtually no independent research to support the popular belief that meprobamate and other minor tranquilizing drugs were effective in treating patients experiencing mild-to-moderate states of anxiety and tension. Instead, Rose noted that independent observers had found meprobamate to be potentially toxic, habit-forming, and no more effective than the barbiturates. Based on this evidence, Rose concluded that it was important for

Aubrey M. Shane and Solomon Hirsch, "Three Cases of Meprobamate Poisoning," Canadian Medical Association Journal 74,11 (June 1, 1956), 908-9. Similarly, the subsequent issue of the Canadian Medical Association Journal included a letter to the editor from Dr. W. Karlinsky of the Winnipeg Clinic. In the letter, Karlinsky drew attention to the case of a patient who had developed an allergic reaction to meprobamate which included the appearance of a number of bruise-like eruptions around the pelvic area. W. Karlinsky, "Allergic Purpura Due to Meprobamate," Canadian Medical Association Journal 74,12 (June 15, 1956), 1012-3.

meprobamate and other minor tranquilizing drugs to be administered only in suitable doses for appropriate conditions under the close supervision of the prescribing physician.''

In 1958, clinical pharmacologists Victor Laties and Bernard Weiss from the Johns Hopkins University School of Medicine wrote a review article with the financial sponsorship of the United States Public Health Service in which they evaluated the scientific literature on the efficacy of meprobamate in the management of anxiety. They discussed the work of Selling and Borrus in some detail because of its impact on subsequent studies. Laties and Weiss concluded that methodologically it had been too uncritical and uncontrolled to guarantee valid results. For example, they noted that both Selling and Borrus had given their patients regular sessions of psychotherapy in addition to treatment with meprobamate. However, the uncontrolled nature of the research design had made it impossible for the researchers to determine the extent to which the glowing results of the clinical trials were due to the ability of

T.F. Rose, "The Use and Abuse of the Tranquilizers," Canadian Medical Association Journal 78,2 (January 15, 1958), 144-8. See also Maurice Lattey, "The Misuse of Tranquilizing Drugs," Canadian Medical Association Journal 77,9 (November 1, 1957), 900-1.

the psychotherapist or to the potency of the drug.⁴¹ Of the almost one hundred studies on meprobamate that they reviewed, Laties and Weiss found that only about a handful of them actually exercised a suitable degree of experimental control. As a result, Laties and Weiss concluded that there was no reliable evidence to support the popular claim that meprobamate was more effective than a placebo and more effective and less addictive than the barbiturates in treating anxiety.⁴²

In a 1960 review article, Dr. Alan Davidson from the Department of Psychiatry, University of Toronto, and the Toronto Psychiatric Hospital picked up where Laties and Weiss had left off. Inspired by their work, Davidson undertook an extensive review of the clinical literature pertaining to the ability of meprobamate to alleviate anxiety. He concluded that very few carefully controlled studies had been carried out and that the scientific value of the drug had yet to be established. In the face of these results, Davidson went one step further and suggested that the popularity of drugs like meprobamate was mainly the result of two important factors: physicians who were unaware of the placebo effect involved in the prescribing of these

⁴¹ Laties and Weiss, "A Critical Review," 501-3.

⁴² Ibid., 515-7.

drugs and pharmaceutical companies which unwittingly reinforced this medical ignorance in their advertisements directed at the doctors.³³ The conclusions of Rose, Laties, Weiss, and Davidson were further reinforced by the appearance of a number of clinical studies and other review articles which argued that meprobamate was no more effective at reducing anxiety than a placebo but just as potentially toxic and addictive as the barbiturates.³⁴

Although the results of clinical studies were mixed, on the whole the psychiatric profession responded favourably toward the introduction of minor tranquilizing drugs. As was the case with respect to the major tranquilizers, however, psychiatrists also expressed some concern about the appropriate use and possible misuse of these drugs. In keeping with the prominence of psychodynamic therapies after the war, the psychiatric profession tended to maintain that minor tranquilizing drugs like meprobamate were not so much a substitute for psychotherapy as an adjunct to the

³³ Alan Davidson, "Placebos, Pills, and Physicians," Canadian Medical Association Journal 83,25 (December 17, 1960), 1310-3. For a short history of placebos and the placebo effect, see Suzanne White, "Medicine's Humble Humbug: Four Periods in the Understanding of the Placebo," Pharmacy in History 27,2 (1985), 51-60.

³⁴ For example, see "Tranquilizer Makes Addicts of Animals," Science News Letter 71,18 (May 4, 1957), 278; M. Weatherall, "Tranquilizers," British Medical Journal 1,5287 (May 5, 1962), 1219-24.

therapeutic process." Given that the majority of minor tranquilizing drugs were prescribed by general practitioners, however, this position may have also reflected the existence of some sort of power struggle between psychiatrists and general practitioners for the same clientele. At the professional level, some general practitioners certainly worked hard to enhance their public and professional image in the face of increased specialization by emphasizing the ability of general practitioners to do basic psychotherapy. Dr. H.B. Etziony of Montreal argued in the Canadian Medical Association Journal that general practitioners were best suited to treat the majority of their patients' psychoneurotic complaints in part because they were in close and frequent contact with their patients and therefore in a good position to detect psychiatric problems in their early stages." Etziony also recognized that a lack of access to trained psychiatrists in some areas meant that general practitioners had no choice but to treat the bulk of their neurotic clientele

" For example, see Heinz E. Lehmann, "Tranquilizers and Other Psychotropic Drugs in Clinical Practice," Canadian Medical Association Journal 79,9 (November 1, 1958), 707.

" M.B. Etziony, "Psychiatry and the General Practitioner," Canadian Medical Association Journal 60,4 (April 1949), 366-7. See also "The New Mental Health Frontier," Canada's Mental Health 5,1 (January 1957), 1-2; "Mental Illness and the General Practitioner," Canada's Mental Health 5,10 (December 1957), 5-6.

themselves. On a more practical level, however, a number of general practitioners did not welcome the opportunity to do psychotherapy. In his study of general practice in Ontario and Nova Scotia in the late 1950s, Kenneth Clute found that the vast majority of practitioners tried to help their emotionally troubled patients not because they were interested in their patients' general well-being or adequately trained to deal with their emotional problems but because they felt that they had no other options.¹ In fact, Clute observed that it was extremely rare for physicians to attempt to get a clear and in-depth understanding of their patient's problems. Instead, the doctors usually prescribed sedatives, gave brief, direct advice, and sent the patients on their way.² Therefore, the tendency of psychiatrists to reiterate that minor tranquilizing drugs were not substitutes for but adjuncts to psychotherapy may have rested in part on a desire to maintain their authority in the field of psychiatric

¹ Kenneth F. Clute, The General Practitioner: A Study of Medical Education and Practice in Ontario and Nova Scotia (Toronto: University of Toronto Press, 1963), 307. Clute reported that 82 percent of the physicians in Ontario and 55 percent of the physicians in Nova Scotia felt that their medical education had been inadequate in preparing them for general practice in terms of providing them with the necessary skills to deal with the emotional problems of their patients. Ibid., 399.

² Ibid., 308.

medicine and in part on the recognition that many general practitioners found it easier to prescribe drugs than to treat the emotional problems of their patients through the application of psychotherapeutic techniques.

In terms of drug misuse, the problem of widespread tranquilizer consumption was addressed by the psychiatric profession in the summer of 1956 when the American Psychiatric Association took a formal stand against the indiscriminate use of tranquilizing drugs. The Association issued a public statement in which it reported that psychiatrists were "enthusiastic" about the new tranquilizing drugs, especially those used in the treatment of psychiatric disorders, but also "concerned" that the casual use of tranquilizers for the relief of everyday tension and anxiety was both "medically unsound" and "a public danger" because the drugs were relatively new and not enough was yet known about potential long-term side effects. The statement also warned physicians to be aware of "subtle pressures" from pharmaceutical companies and the public to prescribe tranquilizers for conditions of a nonmedical nature. In order to get the word out to psychiatrists, the Association mailed a copy of the statement to its 9353 members in Canada and the United States. The content of the statement was also widely reported in the medical and lay

press in both countries.³⁹

Seattle psychiatrist Frederick Lemere was one of the first physicians to express concern over the apparent indiscriminate consumption of meprobamate and other tranquilizing drugs. In 1956, Lemere confessed that he had been so disturbed by the popular demand for meprobamate and the claims that it was not habit-forming that he felt compelled to inform the medical community that he had studied the drug with over six hundred patients and observed that nineteen of his subjects (3.2 percent) had become physically or psychologically dependent on it.⁴⁰ By the

³⁹ For example, see "Misuse of Tranquilizers," Science News Letter 70,2 (July 14, 1956), 19; "Peace Pills," Science 124,3213 (July 27, 1956), 167; "A.P.A. Criticizes Wide Use of Tranquilizing Drugs," Canada's Mental Health 4,8 (October 1956), 4-5; Dorothy Sangster, "Should You Take A Happy Pill?" Chatelaine, April 1957, 21; "Tranquilizers and Ethics," America, October 11, 1958, 32.

⁴⁰ Frederick Lemere, "Habit-Forming Properties of Meprobamate (Miltown or Equanil)," A.M.A. Archives of Neurology and Psychiatry 76,2 (August 1956), 205-6. Lemere was one of the first researchers to suggest that meprobamate was habit-forming and, as a result, his work received a great deal of press coverage. Lemere first made his findings known four months earlier in a letter to the editor of the Journal of the American Medical Association. See Frederick Lemere, "Drug Habituation," Journal of the American Medical Association 160,16 (April 21, 1956), 1431. In both cases, Lemere was quick to point out that his current findings amounted to a repudiation of his earlier research in which he argued that meprobamate was not habit-forming. See Frederick Lemere, "New Tranquilizing Drugs," Northwest Medicine 54 (October 1955), 1098. In spite of his new findings, advertisements for meprobamate regularly quoted his earlier work. For example, see Illustration 7 and Illustration 11.

beginning of 1957, professional concern about widespread tranquilizer use became more frequent. In February 1957, psychiatrists Herman Dickel and Henry Dixon of the University of Oregon Medical School cautioned physicians that tranquilizers, like all drugs, could constitute a threat to the physical and emotional well-being of patients if not prescribed wisely. In a study of the effects of tranquilizing drugs on 8,200 anxious patients, Dickel and Dixon observed that almost four hundred patients (5 percent) experienced toxic side effects or habituation while 1,700 essentially normal patients (21 percent) developed emotional problems, another 827 patients (10 percent) already suffering from emotional illness had their conditions aggravated by the drugs, and 1,200 to 1,300 patients (15 to 16 percent) were able to cope but not thrive while on the medication. The approximately 4,100 remaining patients (50 percent) experienced no adverse effects from taking tranquilizers. Dickel and Dixon concluded that it was the responsibility of the physician to be aware of the indications and limitations of tranquilizing drugs.⁴²

⁴² Herman A. Dickel and Henry H. Dixon, "Inherent Dangers in Use of Tranquilizing Drugs in Anxiety States," Journal of the American Medical Association 163,6 (February 9, 1957), 422-6. The conclusions of Dickel and Dixon were also reported in the popular press. See "Tranquilizers Endanger Emotional Health," Science News Letter 71,8 (February 23, 1957), 121.

At a more official level, in March 1957 the World Health Organization Expert Committee on Addiction-Producing Drugs drew attention to the growing use of tranquilizing drugs, warned that they were potentially habit-forming, and suggested that these drugs should be subjected to careful national control.⁴¹ One month later, the Committee on Public Health of the New York Academy of Medicine issued a statement deploring the indiscriminate use of tranquilizing drugs. The Committee was particularly critical of drug advertising which it said promoted the use of tranquilizers for the relief of nonmedical conditions and did not adequately emphasize potential side effects, contraindications, and the problem of long-term tranquilizer consumption. The Committee also noted that meprobamate had been shown to have adverse effects on patients.⁴² The findings of both of these committees were reported in the Canadian Medical Association Journal.

In 1957, some members of the Committee on Pharmacy of the Canadian Medical Association felt that the time had come for changes to be made to the way in which tranquilizing drugs were sold in Canada. In contrast to the situation in

⁴¹ "Drug Addiction," Canadian Medical Association Journal 76,9 (May 1, 1957), 774.

⁴² Rose, "The Use and Abuse of the Tranquilizers," 148; Whiteside, "Onward and Upward," 117-8.

the United States, meprobamate had not been placed on the federal prescription list in Canada after it was introduced into general use in 1955 because the Drug Advisory Committee in the Food and Drug Division of the Department of National Health and Welfare did not feel that the drug was likely to be misused or abused.⁴⁴ Nevertheless, meprobamate was placed on some provincial lists. This meant that meprobamate was available over the pharmacy counter in some provinces like Ontario while it was available only on prescription in other provinces like British Columbia. The issue of the sale of anti-anxiety agents in Canada was brought to a head by the increasing popularity of these new

⁴⁴ The Drug Advisory Committee was originally established by a Cabinet Order in Council in June 1942 as the Committee on Pharmaceutical Standards. The Committee advised the Department of Pensions and National Health regarding modifications to the British Pharmacopoeia and regulations on drugs in Canada. In 1944, the administration of the Food and Drugs Act was delegated to the newly-created Department of National Health and Welfare. In 1953, the Committee on Pharmaceutical Standards was renamed the Canadian Drug Advisory Committee. This Committee was composed of representatives from the medical profession, the academic and practising pharmacists, and the pharmaceutical industry. It was responsible for deciding which new drugs should be placed under Schedule F of the 1953 Act. The Committee based its decision not on the toxicity of the drug but on its potential for misuse or abuse. Following a recommendation by the Canadian Medical Association Committee on Pharmacy in 1958, a small subcommittee was set up to advise the Minister of National Health and Welfare on all matters relating to prescription drugs. This new subcommittee consisted of the Chairman of the Committee on Pharmacy, a representative of the Canadian Pharmaceutical Manufacturers Association, and the permanent officials of the Food and Drug Division.

drugs and the dangers associated with their indiscriminate use. With a flood of new tranquilizing drugs appearing on the market each year, the Committee on Pharmacy felt that the most effective way to control the sale of these drugs was to place them all on the prescription list (Schedule F) of the 1953 federal Food and Drugs Act.⁴ Therefore, at the annual meeting of the Canadian Medical Association in June 1957, the Committee on Pharmacy formally recommended to the Food and Drug Division of the Department of National Health and Welfare that all current and new tranquilizers, sedatives, and hypnotics be placed on the federal prescription list.⁴ The recommendation was endorsed by the

⁴ In 1951, a project was initiated to revise the 1920 Food and Drugs Act in order to correct some of its deficiencies. On April 24, 1953, a completely rewritten and revised Food and Drugs Act was passed in the House of Commons. The 1953 Food and Drugs Act retained the basic principles of the 1920 Act but presented the subject matter in a more orderly and consistent fashion and gave the federal government greater powers to oversee the production and manufacture of commodities. The 1953 Food and Drugs Act is dealt with in more detail by Clarence A. Morrell, "Government Control of Food and Drugs -- Part I," Canadian Pharmaceutical Journal 90,5 (May 1957), 27-31; Clarence A. Morrell, "Government Control of Food and Drugs -- Part II," Canadian Pharmaceutical Journal 90,6 (June 1957), 36-8; Clarence A. Morrell, "Government Control of Food and Drugs - Part III," Canadian Pharmaceutical Journal 90,7 (July 1957), 27-30.

⁴ The situation was recounted in the report of the Committee on Pharmacy that was submitted at the Nineteenth Annual Meeting of the Canadian Medical Association held in Edmonton, Alberta June 17-21, 1957. See K.J.R. Wightman, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 77,5 (September 1, 1957), 417.

11,700-member Canadian Medical Association.⁴ More than two years later, on July 30, 1959, meprobamate and thirty-one other drugs were added to Schedule F of the Food and Drugs Act, making them available in Canada only with the presentation of a prescription from a licensed medical practitioner.⁴

In addition to information disseminated through medical journals and professional associations, doctors learned about meprobamate from both Wallace and Wyeth who launched aggressive marketing campaigns aimed directly at family physicians, the medical professionals most likely to come in contact with the tense and anxious on a daily basis. In terms of strategy, the promotional activities of pharmaceutical companies in Canada were comparable to those

⁴ "Canadian Medical Association Again Condemns Widespread Use Of Tranquilizers," Canada's Mental Health 5,8 (October 1957), 7-8.

⁴ "Additions to Prescription Drugs," Canadian Medical Association Journal 81,7 (October 1, 1959), 599. See also "Watch for the 'Big Sell' in Sleepy Tranquilizers," Financial Post, September 26, 1959, 1. For more information about the dealings of the Committee on Pharmacy with the Department of National Health and Welfare, see K.J.R. Wightman, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 79,5 (September 1, 1958), 345-6; K.J.R. Wightman, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 81,5 (September 1, 1959), 321-2; K.J.R. Wightman, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 83,10 (September 3, 1960), 505-6.

in the United States."¹¹ These promotional activities included placing advertisements in medical journals, mailing information directly to physicians, sending sales representatives or "detail men" to meet personally with doctors, and giving physicians free samples of Miltown and Equanil. Because the bottom line for both drug houses was primarily economic, their main purpose in engaging in these promotional activities was to inform the prescribing physician of the existence of their particular brand of meprobamate, to convince the physician of the superiority of their product over other anti-anxiety agents, and to persuade the doctor to prescribe the drug on a regular basis.¹² The early advertisements for meprobamate were significant in that they not only encouraged the use of a particular brand-named product but they introduced the medical profession to the concept of anti-anxiety agents and the conditions for their use.¹³ Theoretically, all pharmaceutical advertisements for meprobamate in Canada were bound by Section 9 of the 1953 Food and Drugs Act which

¹¹ This point was made in the "Report Concerning the Manufacture, Distribution, and Sale of Drugs," Appendix Q, 112.

¹² M. Falco, "The Pharmaceutical Industry and Drug Use and Misuse," in Stanley Einstein, ed., The Community's Response to Drug Use (New York: Pergamon Press, 1980), 325.

¹³ Mickey C. Smith, Small Comfort: A History of the Minor Tranquilizers (New York: Praeger, 1985), 101.

stated that "no person shall label, package, treat, process, sell, or advertise any drug in a manner that is false, misleading, or deceptive or is likely to create an erroneous impression regarding its character, value, quality, composition, merit, or safety."¹⁰ In reality, some advertisements for Miltown and Equanil seemed to contravene these restrictions. Nevertheless, in 1961, the Director of the Food and Drug Directorate, Dr. Clarence Morrell, admitted that his department had not yet interfered in any way with drug company advertising aimed directly at members of the medical profession either in journals such as the Canadian Medical Association Journal or through the mail.¹¹

Meprobamate was consistently advertised in medical journals as a safe means of effectively reducing anxiety, tension, and mental stress. This emphasis on safety persisted even after 1957 when an increasing number of clinical studies began to appear which suggested that meprobamate was potentially both toxic and habit forming. In face of conflicting scientific evidence, pharmaceutical advertisers employed at least three techniques in order to

¹⁰ "Report Concerning the Manufacture, Distribution, and Sale of Drugs," 529.

¹¹ Morrell made his comments when he appeared before the Restrictive Trade Practices Commission looking into the manufacture, distribution, and sale of drugs in Canada. "Report Concerning the Manufacture, Distribution, and Sale of Drugs," 170.

maintain the idea that meprobamate was a remarkably safe anti-anxiety agent.⁴⁴ First, many advertisements avoided the subject of side effects altogether. One Wyeth advertisement (Illustration 7) focused on the effectiveness of Equanil in reducing anxiety associated with hypochondriasis but did not mention the issue of adverse effects. Similarly, a Wallace advertisement (Illustration 8) asserted that Miltown was safe but did not discuss any possible problems associated with meprobamate consumption. Second, some advertisements indirectly implied that meprobamate was nontoxic and nonaddictive. The contention by Wallace that Miltown was "well suited for prolonged therapy" (Illustrations 9 and 10) gave the distinct impression that the drug was virtually free from side effects and habituation. This idea was further supported by the inclusion in one advertisement (Illustration 9) of a selected quotation from the medical journal General

⁴⁴ An in-depth analysis of all meprobamate advertisements during the 1950s is beyond the scope of this dissertation. The following comments simply serve to highlight some of the dominant themes found in these advertisements. For some thoughtful considerations about pharmaceutical advertisements in general, see Charles D. May, "Selling Drugs by 'Educating' Physicians," Journal of Medical Education 36,1 (January 1961), 1-23; Robert Seidenberg, "Drug Advertising and Perception of Mental Illness," Mental Hygiene 55,1 (January 1971), 21-31; Jane Prather and Linda S. Fidell, "Sex Differences in the Content and Style of Medical Advertisements," Social Science and Medicine 9,1 (January 1975), 23-6.

... part of every illness

ANXIETY

is a source of

HYPOCHONDRIASIS

EQUANIL

MEPROBAMATE

(2-methyl-2-n-propyl-1,3-propanediol dicarbamate)
Patented 1957, No. 537437

*Trade Mark

*"Many neglected anxiety neurotics become a medical and social burden. Confirmed hypochondriacs fill our offices and clinics clamouring for intervention by the doctor . . . They create instability and unhappiness at home and communicate their own anxiety to their intimates."*¹

Hypochondriasis is a manifestation of emotional unrest. EQUANIL relieves the patient's anxiety, lessens his muscular tension, encourages restful sleep², providing an improved attitude and wholesome rapport.

Supplied: Tablets, 400 mg., bottles of 50.

Usual Dose: 1 tablet, t.i.d.

1. Brace land, F.J.: Texas State J. Med. 51:299 (June) 1955.

2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.

anti-anxiety factor with muscle-relaxing action

Wyeth

Registered Trademark
WILMINGTON, DELAWARE
RADNOR, PENNSYLVANIA

Illustration 7: Equanil advertisement by Wyeth Laboratories.
Source: Canadian Doctor 23,8 (August 1957), 6.

*safe,
wide-range coverage
wherever
tranquilization
is indicated*

WALLACE LABORATORIES

360 Adelaide Street West, Toronto, Ontario

Illustration 8: Miltown advertisement by Wallace Laboratories. Source: Canadian Doctor 23,10 (October 1957), 25.

WHEN ANXIETY
NEEDS CONTROL

MILTOWN

Ayerst
No. 748

the
original
meprobamate

Each tablet contains 400 mg.

DOSAGE

One tablet three times daily, or
as prescribed by the physician

"MILTOWN" IS WELL SUITED FOR PROLONGED THERAPY

*"Complications associated with long-term
therapy are probably seen in lowest
incidence with meprobamate."*

Fairfax, J. F. et al.: GP 14:75, 1956.

Ayerst, McKenna & Harrison Limited, Montreal

Illustration 9: Miltown advertisement by Ayerst. Source:
Canadian Doctor 24,5 (May 1958), 45.

for the quiet mind and relaxation

"MILTOWN"

AYERST No. 748

- reduces psychic as well as skeletal muscle tension.
- acts in 30 minutes for 5 - 6 hours.
- is well tolerated, nonaddictive, essentially nontoxic.
- is without side effects at moderate dosage.
- permits normal sleep without barbiturates.

WELL SUITED FOR PROLONGED THERAPY

INDICATIONS: Anxiety and tension states, muscle spasm, pre- and post operative sedation.

SUPPLIED: 400 mg. tablets.

ADULT DOSAGE: One tablet three times daily, or as directed by the physician.

"The safety of 'Miltown' and its almost complete lack of side effects . . . make it an anaxaxic of choice."
Pennington, V.M.: *Am.J.Psychiat.* 114:257, 1957.

Ayerst, McKenna & Harrison Limited, Montreal

"the original meprobarbital"

67-58

Illustration 10: Miltown advertisement by Ayerst. Source: Canadian Doctor 24,6 (June 1958), 45.

Practitioner which strongly suggested that Miltown was the safest anti-anxiety agent to use when needed over an extended period of time. Third, some advertisements promoted meprobamate as a particularly safe minor tranquilizing drug by explicitly stating that the drug did not produce serious side effects or addiction. The advertisement shown in Illustration 10 championed the safety of Miltown with the assertion that it was "well tolerated, nonaddictive, essentially nontoxic" and "without side effects at moderate dosage." It also contained a selected quotation from an American Journal of Psychiatry study which contended that Miltown was safe and virtually without side effects. Therefore, in spite of conflicting scientific evidence, Wallace and Wyeth continued to run drug advertisements which overtly and covertly suggested that meprobamate remained a very safe and effective means of alleviating anxiety and tension.

Meprobamate was also advertised as a very versatile anti-anxiety agent. Underlying this claim of versatility was a definition of anxiety so broad that it encompassed the psychodynamic and organic models of mental illness, as well as various psychosomatic conditions. Therefore, depending on the advertisement, anxiety was depicted as anything from a symptom of the stresses and strains of everyday life to a symptom of an underlying psychiatric or physical illness to

an illness in its own right. Wyeth Laboratories took the definition issue to its logical extreme in a series of Equanil advertisement which asserted that "anxiety is part of every illness" (emphasis in original) (Illustration 11). These advertisements promoted Equanil as the appropriate remedy for anxiety associated with psychosomatic conditions such as gastrointestinal disorders, hypertension, and hypochondriasis (Illustration 7). More importantly, the ads implied that Equanil was not only useful but necessary in the treatment of virtually every illness seen by the prescribing physician. A broad definition of anxiety was also met with an equally broad definition of meprobamate's capabilities in a Wallace advertisement which contended that Miltown provided "wide-range coverage wherever tranquilization is indicated" (Illustration 8). The point that Miltown provided "wide-range coverage" was reinforced by the layout of the advertisement which superimposed the outline of a series of open umbrellas over the brand name "Miltown." Overall, this, combined with the phrase, "wherever tranquilization is indicated," strongly suggested that Miltown could be used effectively under practically any circumstances.

Advertisements in medical journals also gave the distinct impression that women were in greater need of meprobamate than men. In part, this impression was

anxiety is part of **EVERY ILLNESS**

The physically sick patient faces two stresses—the sickness and the anxiety that it brings.¹ All too often, the anxiety is a threat to the patient's progress. It may intensify symptoms, give uncertainty to therapy, and impair rapport.

To combat the anxiety component of physical illness, EQUANIL promotes equanimity, relieves muscle tension, and encourages normal sleep.² By these specific actions, EQUANIL gives breadth to the treatment program — expands the physician's resources.

Supplied: Tablets, 400 mg., bottles of 50.

Usual Dose: 1 tablet, t.i.d.

1. Braceland, F. J.: Texas State J. Med. 51:287 (June) 1955.

2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.

WYETH
REGISTERED TRADEMARK
WALKERVILLE, ONTARIO
MONTREAL
WINNIPEG
VANCOUVER

Equanil
*Trade Mark

Meprobamate
(2-methyl-2-n-propyl-1, 3-propanediol dicarbamate)

anti-anxiety factor with muscle-relaxing action

Illustration 11: Equanil advertisement by Wyeth Laboratories. Source: Canadian Doctor 23,2 (February 1957), 84.

encouraged by the fact that women were disproportionately represented in meprobamate advertisements. During the seven-and-a-half year period between May 1955 and December 1962, the independent monthly journal The Canadian Doctor³¹ published 91 advertisements for meprobamate, both alone and in combination with other drugs. In terms of a breakdown by gender, 30 of the 91 advertisements (33 percent) featured a photograph of a female patient. By contrast, only 11 of the 91 advertisements (12 percent) depicted men in the role of patient. The remaining 50 advertisements (55 percent) did not include photographs of either men or women.

In addition to placing advertisements in medical journals, Wallace and Wyeth promoted their particular brand of meprobamate by mailing promotional material directly to prescribing physicians. It was common practice for pharmaceutical companies to advertise their latest product by sending doctors a steady stream of brochures, free samples, and complimentary gifts. Much of the promotional literature consisted of elaborate, multi-coloured spreads designed to appeal to the doctor on both a scientific and an emotional level. Dr. John White, a general practitioner

³¹ The Canadian Doctor was an independent journal published by National Business Publications and distributed free of charge in Canada to registered medical doctors, medical superintendents of recognized public hospitals, and university faculties.

from Welland, Ontario, was so overwhelmed by the amount of direct mail he received that he decided to keep track of it for an entire year. He found that between November 10, 1958 and November 9, 1959 he received 2187 separate mailings from over 105 different drug companies. During that time, he also received 452 free samples in the mail." Some companies attempted to draw greater attention to their product by packaging the drugs in disproportionately large boxes." Many pharmaceutical companies included complimentary gifts with their literature and samples. For example, J.B. Roerig and Company, a Division of Chas. Pfizer and Company, promoted its new minor tranquilizing drug Atarax (hydroxyzine) by sending striped slipper socks with the word "Atarax" stitched on the side to a hundred thousand physicians. The slippers arrived stretched over a foot-shaped brochure on which was written "For your own PEACE and

John L. White, "That Drug Company Mail," Canadian Medical Association Journal 82,16 (April 16, 1960), 486,487. Section 14 of the federal Food and Drugs Act allowed pharmaceutical manufacturers to distribute free drug samples to physicians unsolicited. On July 23, 1963 and in the wake of the thalidomide tragedy, section 14 of the Food and Drugs Act was amended. Now pharmaceutical manufacturers could distribute free samples only upon receiving a written request from the physician. See L.I. Pugsley, "The Administration and Development of Federal Statutes on Foods and Drugs in Canada," Medical Services Journal: Canada 23,3 (March 1967), 435-6.

Katherine E. Richter, "Pharmaceutical Advertising," Canadian Medical Association Journal 83,10 (September 3, 1960), 553.

comfort, Doctor..." followed by a long list of indications for the drug.¹⁷ One Canadian drug company paid for the graduating classes of some medical schools to tour its parent plant in the United States. Another company provided each Canadian medical school graduate with a supply of calling cards.¹⁸ Other promotional gifts included elaborately illustrated pens, prescription pads, desk calendars, rulers, pillows, and paper weights.¹⁹

Unlike Wallace, Wyeth Laboratories also advertised its brand of meprobamate directly to doctors by sending detail men to meet with prescribing physicians on a one-to-one basis. The importance of a detail force was not lost on an official connected with the sale of Miltown who conceded that "What news the doctor doesn't get from Time or hear from his patients, he'll get from the detail men."²⁰ As sales representatives for a particular pharmaceutical company, detail men were expected to promote the drugs sold by their respective companies. They did this by regularly visiting doctors, establishing friendly working

¹⁷ Whiteside, "Onward and Upward," 99.

¹⁸ "Report Concerning the Manufacture, Distribution, and Sale of Drugs," Appendix Q, 112.

¹⁹ Whiteside, "Onward and Upward," 99; Alek A. Rozental, "The Strange Ethics of the Ethical Drug Industry," Harper's, May 1960, 79.

²⁰ Whiteside, "Onward and Upward," 111-2.

relationships with them, informing them about new products, and providing them with free drug samples and gifts. In 1957, it was estimated that there were approximately 2,000 detail men in Canada or about one detailer for every eight physicians.⁶⁰ In one year, Dr. John White had 141 visits from detail men representing 42 different companies.⁶¹ Dr. J.S. Sharp, a physician from Lachine, Quebec, complained that many of the detail men that he had encountered were able to deliver a slick sales pitch for a new drug but were less able to knowingly discuss the scientific advantages and disadvantages of the product.⁶² Nevertheless, detail men were an integral part of the promotional activities carried out by many pharmaceutical companies. During the 1950s, they were also considered to be the primary reason why Wyeth's Equanil consistently outsold Wallace's Miltown by a margin of two to one.⁶³

Medical doctors were not necessarily deterred from

⁶⁰ A.C. Emelin, "The Detail Man," Canadian Pharmaceutical Journal 91,1 (January 1958), 21.

⁶¹ White, "That Drug Company Mail," 847.

⁶² J.S. Sharp, "Doctors and Drugs," Canadian Medical Association Journal 80,11 (June 1, 1959), 919.

⁶³ Francis Bello, "The Tranquilizer Question," Fortune, May 1957, 164; "Alvin Brush's Specialty House," 143.

prescribing meprobamate by the absence of conclusive scientific evidence or by the flood of conflicting claims and misleading statements they received from medical journals and pharmaceutical companies about its therapeutic value. Ultimately, doctors chose whether or not to prescribe meprobamate and other anti-anxiety agents for very personal reasons. They made their decision based on a complex interaction between internal and external pressures including their own hopes, fears, prejudices, and self-interest, the volumes of information they received from medical journals and drug manufacturers, the realities of daily practice, and the patients themselves.⁶ More importantly, underlying their decision to prescribe tranquilizing drugs seemed to run an attitude of acceptance toward new drugs and a general sense of therapeutic optimism with respect to the ability of medical science to develop safe and effective drugs that would provide symptomatic relief in the treatment of mental illness, emotional instability, and anxiety.⁷

⁶ For this type of assessment of the pressures on physicians in Canada to prescribe tranquilizing drugs, see Morgan Martin, "Pressures on Practitioners to Prescribe Tranquilizers," Canadian Medical Association Journal 82,3 (January 16, 1960), 133-5.

⁷ Ayd, "Meprobamate," 82; Murray Katz, "Thalidomide -- Can It Happen Again? Part 2: The Selling of the Doctor," Montreal Star, July 23, 1973, D1.

For example, some physicians prescribed meprobamate because it appeared to fill the therapeutic need for a non-barbiturate sedative. This need was created in the early 1950s when clinical studies conclusively demonstrated that barbiturates were potentially toxic and addictive. Following this belated "discovery," Leo Hollister, Senior Medical Investigator at the Veterans Administration Medical Centre in Palo Alto, California, remembered that doctors became reluctant to prescribe barbiturates and began to eagerly search for non-barbiturate substitutes with which to treat the high number of tense and anxious patients who filled their offices each day. According to Hollister, meprobamate appeared at a most opportune time.¹⁰ In addition to good timing, however, the attractiveness of meprobamate was no doubt enhanced by the dissemination of promotional material which suggested that meprobamate was a safe, non-barbiturate sedative. Market research carried out by drug companies during the 1950s confirmed that doctors were hesitant about using barbiturates as sedatives.¹¹

¹⁰ Leo E. Hollister, "The Pre-Benzodiazepine Era," Journal of Psychoactive Drugs 15,1-2 (January-June 1983), 11. See also Ronald L. Katz, "Drug Therapy: Sedatives and Tranquilizers," New England Journal of Medicine 286,14 (April 6, 1972), 758.

¹¹ Market research also showed that doctors were concerned about the safety of drugs taken during pregnancy. As if in direct response to these surveys, advertisements for thalidomide promoted the drug primarily as a non-

While it is unclear whether or not Wallace and Wyeth Laboratories were aware of these research results, the likelihood that they knew about such survey information is quite high. Either way, early clinical studies, like the Wallace-sponsored work of Borrus and Selling, concluded that meprobamate was a nontoxic and nonhabit forming drug that alleviated anxiety, tension, and emotional stress without causing drowsiness. As well, pharmaceutical advertisements reinforced the therapeutic value and non-barbiturate nature of meprobamate by promoting it as "a pharmacologically unique anti-anxiety agent with muscle-relaxing features" (Illustration 12) that "permits normal sleep without barbiturates" (Illustration 10).

Other doctors prescribed meprobamate because they had busy schedules, high patient case loads, and a general inability to do psychotherapy which made it quicker and easier for them to treat symptoms of anxiety with tranquilizing drugs rather than treat the underlying physical or psychological cause of the anxiety by taking the time needed to talk to patients about their problems. In 1957, one American general practitioner complained to Time magazine that some doctors too readily prescribed tranquilizing drugs because of their own inability or

barbiturate sedative that was safe for women to take during pregnancy. Katz, "Thalidomide -- Can It Happen Again?" D1.

TO
THOSE PATIENTS
ANXIETY
CALM AND RELAX
EXHIBITING
AND TENSION STATES

the new
anti-anxiety
factor
valuable
in everyday practice

EQUANIL
TABLETS

MEPROBAMATE, WYETH

Appropriate to an age of mental and emotional stress, EQUANIL has demonstrated remarkable properties for promoting equanimity and release from tension, without mental clouding.

EQUANIL is a pharmacologically unique anti-anxiety agent with muscle-relaxing features. Acting specifically on the central nervous system, it has a primary place in the management of patients with anxiety neuroses, tension states, and associated conditions.^{1,2}

In clinical trials, patients respond with "... lessening of tension, reduced irritability and restlessness, more restful sleep, and generalized muscle relaxation."²

It is a valuable adjunct to psychotherapy.

Clinical use is not limited by significant side-effects, toxic manifestations, or withdrawal phenomena.^{1,2}

The recommended starting dose is one tablet (400 mg.) three times daily, and, if indicated, an additional tablet an hour before retiring. The dose may be adjusted, either up or down, according to the clinical response of the patient.

BOTTLES OF 48

1. Selling, L. S.: J.A.M.A. 157:1594 (April 30) 1955.

2. Borrus, J. C.: J.A.M.A. 157:1596 (April 30) 1955.

Illustration 12: Equanil advertisement by Wyeth Laboratories. Source: Canadian Doctor 22,2 (February 1956), 71.

unwillingness to talk with their patients: "Some doctors seem to prescribe a pill for almost any talkative patient -- for people who aren't true neurotics. But what such people often need is precisely a chance to talk." On top of it all, doctors who had little time to devote to their patients also had little time to devote to keeping abreast of the latest scientific literature on the many new tranquilizing drugs introduced annually.⁵⁹ As a result, argued Mark Nickerson, Professor of Pharmacology and Therapeutics at the University of Manitoba, and John Gemmell, Professor of Medicine at the University of Manitoba, these doctors were forced to rely more and more on pharmaceutical advertisements, direct mailings, and detail men for their information about new drugs.⁶⁰ As previously demonstrated, however, a reliance on drug company information would only further encourage busy doctors to continue to focus on the anxiety component of patient complaints, to treat anxiety as

⁵⁹ "Happiness by Prescription," Time, March 11, 1957, 59. See also Rose, "The Use and Abuse of the Tranquilizers," 146-7.

⁶⁰ Mark Nickerson, "Report of the Committee on Pharmacy," Canadian Medical Association Journal 85,10 (September 2, 1961), 559; Clute, The General Practitioner, 455-8; "Report Concerning the Manufacture, Distribution, and Sale of Drugs," 200-7.

⁶¹ Mark Nickerson and John P. Gemmell, "Doctors, Drugs, and Drug Promotion," Canadian Medical Association Journal 80,7 (April 1, 1959), 520; See also Ian Stevenson, "Tranquilizers and the Mind," Harper's, July 1957, 25.

the primary problem rather than as a symptom of a potentially more serious illness, and to make tranquilizing drugs their treatment of choice for patient anxiety or discomfort.

Some doctors prescribed meprobamate because patients, often brandishing clippings from magazines like Time and Reader's Digest, demanded to have the latest in drug therapy. Dr. Morgan Martin, Director of the Monroe Wing at the Regina General Hospital, was quick to dismiss demanding patients on the grounds that they would probably not benefit from tranquilizing drugs because "patients with great and unrealistic expectations from life have the same expectations from new pills."³ Other doctors, however, were more willing to comply with patient requests. According to Maclean's journalist Sidney Katz, while gathering information for a story about patient overmedication, some doctors openly admitted to him that they prescribed certain drugs on demand because they were afraid of losing their patients to physicians who prescribed drugs more freely.⁴ Similarly, two different American

³ Martin, "Pressures on Practitioners to Prescribe Tranquilizers," 134.

⁴ Sidney Katz, "Overmedication -- Part 1: Your Health and the Almighty Pill," Maclean's, December 1, 1962, 59. According to at least one survey, this fear was well-founded. See also Jerry L. Pettis, "How Does the Public Rate You, Doctor?" Canadian Doctor 22,7 (July 1956), 45;

science writers observed that some doctors prescribed anti-anxiety agents on demand because they believed that having the reputation as a physician who used the latest wonder drugs gave them an important competitive edge over their more cautious colleagues."

Still other doctors prescribed meprobamate because their medical education had not adequately prepared them to critically evaluate the direct and indirect claims made for new drugs. In his study of medical education and practice in Ontario and Nova Scotia in the late 1950s, Kenneth Clute found that a substantial number of physicians were not well trained to evaluate the claims made for new drugs and even admitted it. For example, he found that 57 percent of the Ontario doctors he questioned thought that their medical training had prepared them "very well" to evaluate new drug claims while only 26 percent of the Nova Scotia doctors he questioned felt the same way." Several doctors who were

Rozental, "The Strange Ethics of the Ethical Drug Industry," 79.

Charles E. Silberman, "Drugs: The Pace is Getting Furious," Fortune, May 1960, 275; Rozental, "The Strange Ethics of the Ethical Drug Industry," 79.

The doctors were asked, "How well did your medical training prepare you to evaluate the claims made for new drugs? Very well? Fairly well? Or not very well?" In Ontario, 57 percent replied "Very well," 9 percent "Fairly well," and 32 percent "Not very well." The corresponding percentages in Nova Scotia were 26 percent, 33 percent, and 40 percent, respectively. Clute, The General Practitioner,

aware of their inability to critically evaluate new drugs also did not appreciate the need for a healthy degree of scientific scepticism as was illustrated by the general practitioner who commented, "It didn't matter that the pharmacology course at --- was no good because you learn all the new stuff from [drug] travellers." The evaluation process was made that much more difficult by the rapid rate at which new drugs and new drug combinations were introduced and the enormous number of clinical studies and pharmaceutical advertisements that followed. Given the generally confusing state of affairs, it was probably not surprising that one woman reported that her doctor had switched her prescription from Miltown to Equanil because "he had read a couple of medical papers on the side effects of Miltown."

354.

Ibid., 354. In order to address this general deficiency in pharmacologic training, some staff members at Albany Medical College in 1957 set up an experimental teaching project designed to help second year medical students think more critically about the claims made by drug advertisers. For a description of the project and its outcome, see Solomon Garb, "The Reaction of Medical Students to Drug Advertising," New England Journal of Medicine 259,3 (July 17, 1958), 121-3.

"Tranquilizing Drugs," American Journal of Medicine 27,5 (November 1959), 767; Wightman, "Report of the Committee on Pharmacy," [September 3, 1960], 505.

Whiteside, "Onward and Upward," 118.

Regardless of the perceived quality of their medical education, some doctors like John White believed that they and many of their colleagues could not be persuaded by drug company advertisements. According to White,

Certainly a glossy brochure, making extravagant claims for a drug, doesn't induce me to prescribe it. This is on the level of cake or automobile advertising in the weekly magazines. Both the manufacturer and the consumer know the claims are extravagant, and both ignore them."

In reality, however, drug companies had learned that physicians responded on the same subconscious, emotional, non-rational level in the ordering of drugs as did their lay counterparts in the selecting of cakes and automobiles."

Pierre Garai, senior writer for the New York advertising firm Lennen and Newell, brought this point home in 1963 when he asserted that

As an advertising man, I can assure you that advertising which does not work does not continue to run. If experience did not show beyond doubt that the great majority of doctors are splendidly responsive to current ethical advertising, new techniques would be devised in short order."

Therefore, some doctors probably prescribed meprobamate and

" White, "That Drug Company Mail," 847. See also, A.D. Kelly, "Pharmaceutical Advertising," Canadian Medical Association Journal 83,10 (September 3, 1960), 553.

" Silberman, "Drugs," 275; Rozental, "The Strange Ethics of the Ethical Drug Industry," 79.

" Pierre R. Garai, "Advertising and Promotion of Drugs," in Paul Talalay, ed., Drugs in Our Society (Baltimore, Md.: Johns Hopkins Press, 1964), 195.

other minor tranquilizers because their medical education had not adequately prepared them to critically evaluate all the claims made for these drugs which in turn left them more vulnerable to the tide of popular opinion, methodologically questionable clinical studies, drug advertisements, and the widespread belief that new drugs were valuable by virtue of their status as the latest in drug therapy.

Members of the North American public learned about meprobamate and other anti-anxiety agents from radio, television, newspapers, and national magazines. Medical doctors also learned about new drugs from these sources. The main difference between these two groups in this respect was that the public did not have direct access to the information about meprobamate that was contained in medical journals and disseminated directly to prescribing physicians by drug manufacturers. Instead, the public read journalistic reports about the various clinical studies and professional debates found in medical journals. They read stories and background information about Miltown that had been planted in the lay press by Wallace Laboratories. And they read about the extent to which Miltown and its consumption had become something of a mass cultural phenomenon. Nevertheless, the public, like doctors, were presented with sometimes confusing and often conflicting

assessments of the therapeutic value of meprobamate.

Even though it was illegal in both Canada and the United States for pharmaceutical companies to advertise prescription drugs directly to the public, it was common practice for companies to attempt to create a popular demand for their products by planting information about them in the lay press. This process was boldly revealed in 1956 when Wyeth's attempt to generate some premature publicity for its new major tranquilizing drug, Sparine, backfired. In early February of that year, Robert Wilder, of Lewis and Gilman, a Philadelphia advertising agency that had been hired by Wyeth, sent a telegram to a number of newspaper and magazine science writers in the United States. The telegram invited the writers to attend a February 16 staff meeting at the District of Columbia General Hospital in Washington, D.C. where information was going to be made available about the hospital's clinical work on a promising new tranquilizing drug named Sparine. The telegram also promised the writers a free lunch, limousine service to the hospital, and a tour of the wards where they would be able to witness Sparine in action. A number of science writers took advantage of the offer and returned home to write articles about the new drug.⁶³

⁶³ The attempt by Wyeth to create a popular demand for Sparine before its official release date was detailed in

As part of the Wyeth strategy, a few days prior to the February 16 staff meeting, thousands of doctors received a confidential letter from the president of Wyeth Laboratories. The letter attempted to distance the company from the forthcoming stories written by the above-mentioned science writers. It stated in part:

Dear Doctor:

You may have read or may be reading in your newspaper about a potent new ataractic drug called [Sparine]....

It is almost impossible to control publicity on an important new scientific achievement. Busy reporters are finding out about Sparine in locations where it is being clinically investigated. A few articles have appeared and more will be published as applications of this drug are revealed.

Because we want you to know about Sparine from us, and not from the newspaper, I am writing you this letter to give you the gist of the preliminary findings.

Pre-release publicity is unfortunate because we are not quite ready to make Sparine available....⁶⁴

Wyeth officially announced the introduction of Sparine on February 20 when it issued a 753 word press release which began "A new drug which calms and controls acutely agitated mental patients, alcoholics and drug addicts and facilitates their physical and psychiatric rehabilitation was disclosed here today at a medical staff conference of the District of

John Troan, "Premature Publicity," Journal of the American Medical Association 161,7 (June 16, 1956), 643; Whiteside, "Onward and Upward," 100.

⁶⁴ Whiteside, "Onward and Upward," 100.

Columbia General Hospital." The deliberate attempt by Wyeth to manipulate the media in order to garner some premature publicity and create a popular demand for Sparine was only made public after some of the science writers who had attended the February 16 staff meeting obtained copies of the letter that had been sent to physicians. In response, John Troan, Chairman of the Committee on Information at the National Association of Science Writers in Port Washington, New York, published a letter in the Journal of the American Medical Association in June 1956 in which he publicly deplored the "indefensible methods" used by Wyeth to promote its product and bolstered his point by including excerpts from the relevant documents."

With respect to the favourable publicity given meprobamate in the popular press, the Ted Bates advertising agency, on behalf of Wallace Laboratories, was directly responsible for the appearance of a number of newspaper and magazine articles extolling the therapeutic virtues of Miltown. In addition to placing advertisements in medical journals and sending out brochures to doctors, the Bates agency issued publicity releases about Miltown to the

" Troan, "Premature Publicity," 643.

" Ibid., 643. The premature promotion of drugs in Canada during the 1950s was discussed in the "Report Concerning the Manufacture, Distribution, and Sale of Drugs," 196-9.

popular press. At the beginning of 1958, one advertising executive at Bates recalled that

We supplied dope on Miltown for pieces in Time, Newsweek, the Saturday Evening Post, and so many I could hardly name them....Our press clippings on Miltown so far fill eight huge, heavy scrapbooks, and they don't even include most of the wire-service stories that appeared in a whole raft of papers."

Given the efforts of the Ted Bates advertising agency, perhaps it is not surprising that the initial reports about Miltown in the popular press were uniformly positive and depicted the drug as a very effective, safe, and versatile anti-anxiety agent. One of the first and most impressive pieces about Miltown was written by science writer Lawrence Galton for Cosmopolitan magazine in August 1955. Probably composed using information provided by Wallace, the article summarized, but did not mention by name, the results published by Selling and Borrus in the April 30 edition of the Journal of the American Medical Association and briefly traced the history of the development of Miltown. Like Selling and Borrus, Galton concluded that Miltown was the most "ideal" drug to date for the alleviation of tension and anxiety because, unlike the barbiturates, it achieved this effect without toxic or unpleasant side effects."

" Whiteside, "Onward and Upward," 112.

" Lawrence Galton, "New Drug Brings Relief for the Tense and Anxious," Cosmopolitan, August 1955, 82-3.

Subsequent articles reported that meprobamate was also effective in relieving a variety of conditions including wry neck, nail biting, tension headaches, stuttering, menstrual stress, and muscular rheumatism, as well as helping alcoholics get through the initial stages of withdrawal and remain sober, and calming family pets prior to a visit to the veterinarian." These reports emphasized the safety of Miltown and were reinforced by other reports which also suggested that Miltown did not impair driving ability or potentiate the effects of alcohol and by talk of selling the drug in the United States without a prescription."

In these articles, popular writers coined a number of catch phrases for Miltown and subsequent anti-anxiety agents in an attempt both to attract the attention of lay readers

"New Drug is Calming," Science News Letter 69,1 (January 7, 1956), 7; "Sobering Up," Newsweek, January 9, 1956, 64-5; "Pills for the Mind," Time, June 11, 1956, 69; "Tranquilizing Drugs and Behavioural Disorders," Science 124,3215 (August 10, 1956), 259; Michael Welles, "Combatting Nervous Tension," Farm Journal 80,10 (October 1956), 109; Silverman, "First Aid for Alcoholics," 30; "Tranquilizers Make Pets Easier to Handle," Science News Letter 71,3 (January 19, 1957), 41; J. Bourne, "We Turn, Nervously, to Canine Neuroses," New York Times Magazine, January 20, 1957, 27; Helen Buechl, "Animal Tranquilizers," Science News Letter 74,7 (August 16, 1958), 106-7; Lawrence Galton, "Aid for Stutterers," Chatelaine, September 1958, 7-8.

"Soothing - But Not for Drug Men," Business Week, March 10, 1956, 32; "Can Drive Tranquilized," 287; "Tranquilizers Not Shown Dangerous to Driving," Science News Letter 72,6 (August 10, 1957), 89.

and to make the complicated workings of these tranquilizing drugs more comprehensible. Some of these euphemisms included "Happy Pills," "Aspirin for the Soul," "Don't-Give-a-Damn Pills," "Mental Laxatives," "Pills for the Mind," "Emotional Aspirin," "Calming Pills," "Pacifier for the Frustrated and Frenetic," "Happiness Pills," "Psychiatric Aspirins," and "Peace of Mind Pills."³ The phrases were catchy and they did communicate to the reader the idea that minor tranquilizers acted on the brain to produce a calming or relaxing effect. However, the phrases also narrowly defined the workings of these drugs in terms of their supposed positive effects. As a result, the phrases gave the impression that tranquilizers did not produce undesirable side effects. They also suggested that anti-anxiety agents produced their calming or relaxing effect regardless of the symptoms for which the drug was originally consumed. What's more, these kind of catch phrases tended to be repeated over and over again in the literature where they perpetuated the idea that minor tranquilizing drugs were safe, effective, and versatile, even in the face of the appearance of evidence to the contrary.

Toward the end of 1955 and beginning of 1956, the popularity of Miltown and its reputation as an effective,

³ Smith, Small Comfort, 67.

safe, and versatile anti-anxiety agent were given a significant boost by its association with Hollywood celebrities and rapid transformation into an object of humour.⁹² During this period, stories circulated in the popular press that Miltown was becoming fashionable in the show business community. Kendis Rochlen, movie columnist for the Los Angeles Mirror-News, reported "I went from Ginger Rogers' party to Jose Ferrer's party to a dinner party, and everywhere they were talking about [Miltown]."⁹³ Publicist Frances Kaye also reported that Miltown had been plentiful at a party in Palm Springs where they "were passed around like peanuts" and "some of the people drank what they called a Miltown cocktail -- a tranquilizing pill mixed with a Bloody Mary."⁹⁴

The prevalence of jokes about Miltown reinforced the general belief that it was effective and safe to use and also indicated the extent to which knowledge about the drug had already become ingrained in the popular culture. In February 1956, comedian Milton Berle gave the product one of

⁹² For a more extensive treatment of the popularity of Miltown within the entertainment community, see Leona Crabb, "'Mother's Little Helper': Minor Tranquilizers and Women in the 1950s," M.A. thesis, Concordia University, 1992, 46-51.

⁹³ "Don't-Give-a-Damn Pills," Time, February 27, 1956, 98.

⁹⁴ Whiteside, "Onward and Upward," 110.

its earliest gratuitous public endorsements when he mugged for Time magazine (Illustration 13) and was quoted as saying "It's worked wonders for me. In fact, I'm thinking of changing my name to Miltown Berle."⁹⁶ A few months later, Newsweek took note of the growing number of Miltown jokes and included the following witticism from comedian Red Skelton which again spoke to the drug's renowned relaxing effects: "One of the Miltowns in my pillbox said to the other: 'I feel so terrible I think I'll take a Perry Como'."⁹⁷ In the spring of 1956, Miltown made the move to television when comedian Bob Hope included the following Miltown material as part of his stand-up routine for an NBC television special:

Hope: Whether you like them or not, Khrushy and Bulgy are two of the smartest Russians alive. [Laughter.] The fact that they're alive still proves it. Now they want to come to the United States and sell us peace. Is this a switch? They must be spiking their vodka with Miltown. [Laughter.]

Have you heard about Miltown? The doctors call Miltown the "I-don't-care" pill. The government hands them out with your income-tax blanks. [Laughter.]⁹⁸

⁹⁶ "Don't-Give-a-Damn Pills," 100.

⁹⁷ "Pills vs. Worry -- How Goes the Frantic Quest For Calm in Frantic Lives?" Newsweek, May 21, 1956, 68. Of course the humour in this joke came from the fact that singer Perry Como had a reputation for being particularly low-keyed and laid back.

⁹⁸ Whiteside, "Onward and Upward," 111.

Illustration 13: Milton "Miltown" Berle. Source: "Don't-Give-a-Damn Pills," Time, February 27, 1956, 98.

The rapidity with which Miltown had caught on in the show business community came as a surprise to the people at Wallace Laboratories. The popularity of the drug appeared to have benefitted from an extensive advertising campaign but the introduction of Miltown in and of itself also seemed to have touched an important cultural chord which unleashed a wellspring of spontaneous enthusiasm for the idea of a drug that could manipulate human emotions. It was almost as if the Miltown phenomenon quickly took on a life of its own. As one executive at the Ted Bates advertising agency observed,

Of course, we don't claim credit for anything like all the publicity. It was partly slugging away in there, partly just letting the thing roll on its own -- you couldn't have stopped it. It got to the point where all a Broadway press agent had to do to get mention of a client in a column was to link the name somehow with Miltown. You know...."Ronnie's Steak House has a Miltini; instead of an olive they use a Miltown." Stuff like that. As I say, it was a dream campaign, and, of course, we had a dream product."

Just the same, the free publicity Miltown received from its association with Hollywood celebrities made a deep impression on Carter Products president Henry Hoyt who had spent millions of dollars over the years on brief commercial plugs for his Little Liver Pills. "I was frankly amazed at all the exposure we were getting," he said.

" Ibid., 112.

We had never anticipated such a development. Those television actors -- hell, we hadn't even sent them free Miltown, or anything."¹¹¹

The popularity of Miltown among show business celebrities coincided with the news that public demand for Miltown had outstripped the supply and led to dramatic shortages of the drug in many parts of the United States. Some druggists in cities like Boston, New York City, Washington, D.C., and Houston had run so short of Miltown that they refused to fill prescriptions for strangers and limited regular customers to a dozen tablets on account while they waited for the arrival of an overdue shipment from Wallace Laboratories.¹¹² In New Brunswick, New Jersey, Wallace's modest facilities for tableting and bottling were stretched to the limit in an attempt to deliver over one million dollars worth of unfilled orders. The people at Wyeth were also feeling pressured to meet the growing demand for Equanil but the best they could do was to wait patiently for Wallace to supply them with even a few barrels of meprobamate powder for tableting and bottling at their plant in New York.¹¹³ The demand for meprobamate was so great in the United States that the arrival of a fresh shipment could

¹¹¹ Ibid., 111.

¹¹² "Don't-Give-a-Damn Pills," 98.

¹¹³ Whiteside, "Onward and Upward," 109.

become a major local event. Some drug stores even went so far as to display windowfront signs announcing "Yes, we have Miltown!" "We now have plenty of Miltown and Equanil," "Bring your prescriptions here," and "Yes - We Have Miltown and Equanil" (Illustration 14).¹⁰⁰

Stories in the popular press about meprobamate shortages included testimonials from men and women who had had positive experiences with the drug. These testimonials implied that widespread demand for Miltown was due primarily to its therapeutic value as a safe and effective anti-anxiety agent. They also suggested that individuals did not have to tolerate unwanted stress and anxiety as long as such versatile drugs as Miltown were available. Newsweek told the story of a haggard newspaper executive who asked his doctor for something to get him through a publishers' convention in New York. His doctor recommended "peace pills" and wrote him a prescription for Miltown. The executive made it through the five day meeting and gave his colleagues a glowing report on Miltown. "The pills are harmless," he told them.

They are not strong sedatives. They are not habit forming; I could stop taking them tomorrow, but I don't want to. They make me happy. I still have my worries, but now I don't worry about my

¹⁰⁰ "Don't-Give-a-Damn Pills," 98; "Pills vs. Worry," 68, 70.

Illustration 14: Storefront sign announcing recent arrival of Miltown and Equanil. Source: "Pills vs. Worry -- How Goes the Frantic Quest for Calm in Frantic Lives?" Newsweek, May 21, 1956, 70.

worries.¹⁰³

Kendis Rochlen felt that her husband had also greatly benefitted from taking Miltown:

My husband is on [Miltown] now. He used to be very nervous, really just miserable. Now he doesn't get mad as quick or stay mad as long.¹⁰⁴

A busy Beverly Hills psychiatrist took tranquilizing drugs in order to better tolerate the difficult daily drive home from the office and even went so far as to recommend the institution of trouble-free access to all anti-anxiety agents. "I wish the Government would subsidize slot machines for tranquilizers on every corner," he said.¹⁰⁵

Miltown and other tranquilizing drugs were enjoying unprecedented popularity in the summer of 1956 when reports in the medical and lay press began to voice concerns about the health and social implications of widespread tranquilizer use. These concerns in turn became themes that were repeated throughout the literature in one form or another in subsequent years. More often than not in the pages of the popular press, individual psychiatrists and other medical professionals informed by the principles of psychodynamic and psychoanalytic psychiatry were the first

¹⁰³ "Pills vs. Worry," 68.

¹⁰⁴ "Don't-Give-a-Damn Pills," 98, 100.

¹⁰⁵ "Happiness by Prescription," 59.

to counsel caution when it came to the consumption of tranquilizing drugs. For example, in a 1957 interview for U.S. News and World Report, psychiatrist Dr. Robert Felix, director of the National Institute of Mental Health, warned against indiscriminate tranquilizer use on the grounds that the drugs were still relatively new and not enough was known yet about their potential long-term side effects.¹⁰⁷ Other commentators like American psychiatrist Dr. Donald Jackson were concerned that too many people took tranquilizers in order to "cure" themselves of unwanted emotions. They observed that while drugs like Miltown were able to alleviate the symptoms of anxiety, stress, and tension, they were not able to eliminate the underlying cause of these symptoms.¹⁰⁸ As a result, Jackson and others argued, tranquilizing drugs served as potentially useful adjuncts to psychotherapy and psychoanalysis but they were not valid substitutes or replacements for these therapeutic

¹⁰⁷ "What You Ought To Know About Tranquilizers," U.S. News and World Report, June 21, 1957, 65-6. See also, "Soothing," 32; "Pills vs. Worry," 68; "Medical Trade Gets Jumpy as Use of Tranquilizers Spreads," Business Week, June 30, 1956, 78; Roland H. Berg, "The Unhappy Facts About 'Happy Pills'," Look, July 24, 1956, 92.

¹⁰⁸ Don D. Jackson, "Beware Ataraxes in the Attic," New Republic, October 22, 1956, 22. See also, "Soothing," 32; "Happiness Pills Are No Answer," Christian Century, September 12, 1956, 1044.

processes.¹³⁷ McGill psychiatrist Dr. H. Azima made this point forcefully in a July 1956 article for the Nation designed to counter what he considered unsubstantiated enthusiasm for the new tranquilizers.¹³⁸ His emphasis on the use of tranquilizers only as adjuncts to and not substitutes for psychotherapy and psychoanalysis was appropriately illustrated by a drawing of a bottle of Miltown tablets perched on top of books by Sigmund Freud and Carl Jung (Illustration 15). Still other medical professionals were concerned that too much tranquility might be detrimental to individual and social well-being. "Could [tranquilizers]," wondered a Boston pharmacologist, "make millions of people significantly indifferent to politics -- or to their responsibilities as automobile drivers?"¹³⁹ These individuals based their concern on the belief that a certain degree of tension and anxiety was normal and even beneficial

¹³⁷ For example, see Berg, "Unhappy Facts About 'Happy Pills'," 92; Eric Hodgins "The Search Has Only Started," Life, October 22, 1956, 142; "Happiness by Prescription," 59; Stevenson, "Tranquilizers and the Mind," 21-2.

¹³⁸ H. Azima, "Drugs for the Mind: Evaluating the Tranquilizers," Nation, July 21, 1956, 56-9.

¹³⁹ "Happiness by Prescription," 59. See also "Questions Driving Safely While on Tranquilizers," Science Digest 40,3 (September 1956), 37; Hodgins, "The Search Has Only Started," 140,142; "You Can Be Too Tranquil," Science Digest 42,2 (August 1957), 46; Whiteside, "Onward and Upward," 119; Arthur J. Snider, "Pills Could Replace Demagogue In Bending Mind," Science Digest 49,1 (January 1961), 49-50.

Illustration 15: Miltown as useful adjunct to psychotherapy.
Source: H. Azima, "Drugs for the Mind: Evaluating the
Tranquilizers," Nation, July 21, 1956, 56.

because it stimulated and challenged people to be creative, to seek solutions to problems, and to mature as individuals. In short, they believed that anxiety and tension were the wellspring of social progress.¹¹¹ According to Dr. T.F. Rose, a specialist in internal medicine from Victoria, B.C.,

Our civilization has been built on the divine discontent of tense men. Had they not in every generation become anxious over problems, we might still be ploughing with pointed sticks. Perhaps Columbus could have discovered the New World while taking tranquilizers, and Beethoven might have been able to compose his symphonies, but I submit that if they had been full of meprobamate they wouldn't have bothered.¹¹²

While more and more a minority voice in the pages of the popular press after 1957, not everyone shared these growing concerns about the health and social implications of widespread tranquilizer use. Writing in Saturday Night magazine in May 1957, Brian Cahill argued that Canadians who were worried about the apparent widespread use of minor tranquilizing drugs by a tense and anxious public needed to

¹¹¹ For example, see "No Peace for Tranquilizers," Business Week, September 1, 1956, 32; "Tranquil Extinction," Business Week, October 27, 1956, 204; "What You Ought To Know About Tranquilizers," 63-4; Jess Raley, "That Wonderful Frustrated Feeling," American Mercury, July 1957, 20-4; Stevenson, "Tranquilizers and the Mind," 26-7; Henry A. Davidson, "The Doctor's Personality -- A Factor in Medical Care," Canadian Doctor 25,1 (January 1959), 38; "To Tranquilize or Not to Tranquilize?" American Mercury, September 1960, 153.

¹¹² Rose, "The Use and Abuse of the Tranquilizers," 148.

put these drugs into proper perspective. According to Cahill, the use of artificial substances by essentially normal people to reduce unwanted stress has always characterized human existence: "To my mind the tranquilizers are merely one more agent through which modern man seeks to ease his difficult way in an age of increasingly complex relationships with himself and the world about him."¹³³ While he recognized the potential problems of indiscriminate tranquilizer use, Cahill predicted that the consumption rate of anti-anxiety agents would eventually stabilize itself once people realized that these drugs could not provide them with intellectual or physical capabilities that they did not already possess.¹³⁴ Many of Cahill's sentiments were echoed one year later in a Financial Post article by J.B. McGeachy. McGeachy asserted that, contrary to growing public opinion, the use of tranquilizers for either pleasure or relief from anxiety was neither wicked nor degenerative. He pointed out that drugs in one form or another had been consumed throughout history by individuals who wanted an occasional escape from the cares of the world. McGeachy believed that people should feel free to enjoy life to its fullest -- even if that meant taking tranquilizing drugs to achieve their

¹³³ Brian Cahill, "Those Happiness Pills," Saturday Night, May 11, 1957, 15.

¹³⁴ Ibid., 38.

goal. In short, McGeachy argued that

[Man] has always used anodynes -- whether the scientists call them stimulants, depressants, opiates, or narcotics matters to him very little - - to damp down his pains and dreads, elevate his spirit, and sustain his confidence. It's only common sense to recognize this need as normal and legitimate, and to make rational use, without guilt, of any and every mental healer nature offers.***

Apart from an occasional comment from writers like Cahill and McGeachy, by early 1957 more and more articles began to appear in the popular press which challenged the widespread belief that Miltown and other anti-anxiety agents were remarkably safe, effective, and versatile drugs. Newsweek reported that in April the United States Army had grounded all of its airplane pilots who were using tranquilizing drugs and forbade them to fly again until four weeks after they had stopped taking them. Navy and Air Force fliers were under a similar order which forbade them from taking any drugs without the knowledge of flight surgeons. "This entire group of [medications]," explained Captain Robert B. Muffly of the Army Medical Corps, "interferes with the individual's ability to react, to coordinate, to use good judgement, [and to] remember."*** In

*** J.B. McGeachy, "Are Tranquilizers Wicked?" Financial Post, July 12, 1958, 7.

*** "Pills -- And Perils?" Newsweek, May 6, 1957, 105. The Associated Press report of the grounding of military pilots was reproduced in Raley, "That Wonderful Frustrated

June 1957, Time magazine reported that researchers at the University of California had found that, contrary to the results of earlier clinical studies, meprobamate potentiated the effects of alcohol which made driving a motor vehicle or operating heavy machinery under the influence of meprobamate and even a modest amount of alcohol a much more dangerous activity than previously thought.¹⁰⁰ Articles also reported that researchers had found that meprobamate was actually habit-forming and addictive. According to these articles, clinical studies demonstrated the addictive potential of meprobamate when it was observed that the test subjects experienced withdrawal symptoms such as tension, hyperexcitability, insomnia, and even convulsive seizures after they suddenly stopped taking the drug.¹⁰¹

Negative reports about anti-anxiety agents were soon accompanied by warnings against their indiscriminate use. In April 1957, journalist Dorothy Sangster strongly advised

Feeling," 22.

¹⁰⁰ "Miltown? No Martinis!" Time, June 3, 1957, 63.

¹⁰¹ "Tranquilizer Makes Addicts of Animals," 278; "Pills -- And Perils?" 105; "Beware Tranquilizer Addiction," Science Digest 55,3 (March 1964), 40-1; "Tranquility -- and After," Newsweek, April 20, 1964, 111. The addictive potential of meprobamate remained open to debate. See "Tranquilizer May Not Be Habit-Forming," Science News Letter 73,10 (March 8, 1958), 153; "Tranquil Pills Stir Up Doctors," Business Week, June 28, 1958, 28-30; "No Basis for Addiction in Study with Miltown," Science News Letter 74,25 (December 20, 1958), 399.

Chatelaine readers to avoid taking minor tranquilizing drugs as much as possible. She argued that even though the pills were available without a prescription in some provinces, they had yet to be proven completely safe and effective. Nevertheless, to those Canadian women who really thought they needed tranquilizing drugs, she urged them to first consult their doctors and then consume the drugs only under close medical supervision.¹³⁹ In September 1957, Pope Pius XII addressed the International College of Neuro-Psychopharmacology and urged individuals to demonstrate ethical sensitivity and responsibility in their use of the drugs.¹⁴⁰ One year later, the Director of the Child Study Centre at Yale Dr. Milton Senn urged doctors to be more cautious in prescribing and using tranquilizers with children. Senn spoke as the chair of a meeting of the U.S. Public Health's National Institute of Mental Health held in Washington, D.C. Experts at the conference agreed that tranquilizers had been successful in treating some of the most serious juvenile emotional difficulties but cautioned

¹³⁹ Sangster, "Should You Take A Happy Pill?" 21. See also Ruth Boyer Scott, "Don't Misuse Tranquilizers," Today's Health, July 1957, 23; Leroy E. Burney, "Unsettling Facts About Tranquilizers," Consumer Reports, January 1958, 4.

¹⁴⁰ "Tranquilizers and Ethics," 33. Two years earlier, Pope Pius XII himself was given the major tranquilizing drug chlorpromazine in order to cure a particularly severe bout of the hiccups. See Sidney Katz, "The New Wonder Drugs That Fight Insanity," Maclean's, November 12, 1955, 12.

that there was also a danger that use of the drugs with children could mask the underlying cause of the disturbance or even impede the natural maturation process resulting in an entire generation of intellectually and emotionally immature citizens.¹⁰¹

In 1957, articles also began to appear in the lay press which were critical of the pharmaceutical industry, its advertising techniques, and its high profit margins. These articles were inspired in part by the information made available during high-profile federal inquiries into drug marketing and pricing in both Canada and the United States. In April 1958, the Director of Investigation and Research of the Restrictive Trade Practices Commission began an inquiry into the manufacture, distribution, and sale of drugs in Canada under Section 42 of the Combines Investigation Act. In February 1961, he submitted his initial report. This report was followed by a series of public hearings and a final report in January 1963. Both of these reports concluded that drug patents kept Canadian drug prices

¹⁰¹ "Pills to Lull Children?" Newsweek, November 10, 1958, 82; "Tranquilizers Pacify Patient and Doctor," Science News Letter 75,9 (February 28, 1959), 136. One mother of an emotionally troubled child urged other parents to follow her and her husband's lead and avoid giving tranquilizers to their children as a substitute for making concrete improvements to their parenting skills. She was particularly concerned that these drugs might have damaging long-term side effects. See E.H., "Drugs for Children?" Ladies' Home Journal, February 1960, 4.

unnecessarily high which in turn discouraged greater scientific research and development.

In the United States, Senator Estes Kefauver began hearing testimony on July 9, 1957 before his Antitrust and Monopoly Subcommittee of the Senate Committee on the Judiciary which was convened in order to investigate pricing and competition within the American pharmaceutical industry. These proceedings revealed, among other things, that drug companies invested inordinate amounts of time and money into promoting their particular tranquilizing drugs which they then sold to consumers at prices that were significantly higher than the costs of manufacturing them. Wallace Laboratories and Miltown came away from the investigations looking particularly unsavoury. During the Kefauver hearings, it became known and was widely reported in the popular press that Miltown advertisements consistently omitted warnings about potential side effects for the drug

Department of Justice, "Material Collected for Submission to the Restrictive Trade Practices Commission in the Course of an Inquiry Under Section 42 of the Combines Investigation Act Relating to the Manufacture, Distribution, and Sale of Drugs," (Ottawa: Queen's Printer, 1961), 257-8; "Report Concerning the Manufacture, Distribution, and Sale of Drugs," 523; Gordon and Fowler, The Drug Industry, 37; Lexchin, The Real Pushers, 166-8.

For example, see David L. Cowen, "Ethical Drugs and Medical Ethics," Nation, December 26, 1959, 479-82; Rozental, "The Strange Ethics of the Ethical Drug Industry," 73.

in spite of clinical evidence which strongly indicated that Miltown was habituating, addictive, and overprescribed. Frank Berger was angry that Miltown had been singled out for special attention and, in defence of Wallace and Miltown, asserted that there was "no evidence indicating any abuse of tranquilizers."¹⁴ The less than ethical business dealings of Wallace were also in the headlines when it was revealed that the company made enormous profits from Miltown. Carter president Henry Hoyt told Kefauver's senate subcommittee that it cost Wallace Laboratories .7 cents to make one Miltown tablet which American pharmacists purchased for 3.3 cents and sold to the consumer for 10.6 cents. Hoyt explained that the generous 2.6 cent mark-up to druggists represented research costs of .4 cents, promotion costs of 1 cent, and profit of 1.2 cents. As for company profits, in 1959 Carter Products made 44 percent profit based on net worth while the United States manufacturing average was only 11 percent. In total, Carter's 1959 sales and royalties reached \$51 million, it spent \$1,032,000 on research, and posted earnings of \$7 million.¹⁵

¹⁴ Smith, Small Comfort, 161-6.

¹⁵ "Trouble in Miltown," Time, February 8, 1960, 83; Schisgall, Carter-Wallace, Inc., 31. For some examples of the coverage of the Kefauver hearings in the Canadian and American popular press, see Cowen, "Ethical Drugs and Medical Ethics," 479-82; "Tranquilizer Makers Put On Spot," Business Week, February 6, 1960, 32; Marquis Childs,

Canadians and Americans continued to consume meprobamate in spite of the flood of conflicting claims about its therapeutic value contained in the popular press. Whether they asked their doctors for Miltown by name, received a prescription for it on the initiative of their doctors, or, in some provinces in Canada prior to August 1959, purchased the drug over-the-counter at a drugstore¹⁴, men and women took meprobamate and other anti-anxiety agents during the 1950s for a wide variety of reasons which involved the weighing of a number of internal and external factors. These factors included their own curiosity, hopes, and fears, the information they received about tranquilizers from radio, television, newspapers, and national magazines, the authority of the prescribing physician, and a desire to rid themselves of unwanted emotional stress. Moreover, underlying the public's decision to consume tranquilizing drugs was a concern about the potential problems of anxiety left unchecked, an attitude of natural acceptance towards new drug therapies, and a general sense of therapeutic

¹⁴"Senate Drug Costs Probe May Cost Kefauver Seat," Toronto Daily Star, February 11, 1960, 7; "Big Pill Bill to Swallow," Life, February 15, 1960, 97-103; David L. Cowen, "Those Pretty Little Pills," Nation, April 16, 1960, 335.

¹⁵I have not found any statistics to indicate the extent to which Canadians bought meprobamate and other minor tranquilizing drugs over-the-counter prior to the changes to Schedule F of the federal Food and Drugs Act in July 1959.

optimism with respect to the ability of medical science to develop safe and effective drugs that would provide symptomatic relief in the treatment of mental illness, emotional instability, and anxiety.

For example, some North Americans took meprobamate because it was fashionable to consume the latest wonder drug. A general practitioner in Toronto told the story of a female patient of his who had returned from a trip to the United States with a purse full of Miltown. The woman dumped the pills on his desk, explained at great length just how well the drug had alleviated her tension, and expressed considerable interest in acquiring more of the stuff now that she was back in Canada.¹⁷ Similarly, Time magazine reported the story of a Boston woman who had asked her druggist for some "happiness pills." "I just got back from Florida," she explained, "and everybody down there gets them."¹⁸ The fact that so many people were willing to try new medications solely because they were new was a testimony to just how deeply they trusted the products of modern medical science and how strongly they equated new drugs with safe, effective, and beneficial drugs. Some people were so trusting of these drugs that they didn't think twice about

¹⁷ Sangster, "Should You Take A Happy Pill?" 61.

¹⁸ "Happiness by Prescription," 59.

sharing their minor tranquilizers with friends and neighbours or trying tranquilizing drugs that were offered to them but which had originally been prescribed for someone else.¹⁴⁹ Sari Tudiver, a policy and program officer for the Manitoba Council for International Cooperation, remembered that during the 1950s and early 1960s people were more than willing to take new and "experimental" drugs. "There was an aura of scientific progress and positive results," she said, "the risks were hardly considered."¹⁵⁰

Other people took meprobamate because drug taking had become a legitimate means of maintaining personal health and well-being. The introduction of important drugs such as the sulfonamides, antibiotics, and major tranquilizers demonstrated to the public in very dramatic fashion the power and potential of drug therapy to improve their quality of life. It also encouraged the belief that medical science would eventually develop a pill to alleviate every conceivable ill. Therefore, when meprobamate and other anti-anxiety agents became available for general use in the mid-1950s, it may have seemed perfectly logical to many

¹⁴⁹ "Pills vs. Worry," 68; Karlinsky, "Allergic Purpura Due to Meprobamate," 1012; Scott, "Don't Misuse Tranquilizers," 23, 61.

¹⁵⁰ Sari Lubitsch Tudiver, "In Search of the Right Prescription," in Joan Turner, ed., Living the Changes (Winnipeg: University of Manitoba Press, 1990), 158.

North Americans that these drugs would become their first line of defence against anxiety, tension, and emotional stress.¹⁴ One Toronto advertising executive did not think twice about taking "happy pills" in order to help her reduce stress and remain productive. The woman justified her decision to consume the drugs by arguing that they were completely safe because they could be bought over the drugstore counter. "The pills are harmless," she insisted.

They have no bad side effects and they're not habit-forming. Any druggist will sell you as many as you want without a prescription.¹⁵

A number of cartoons in the popular press also captured in a humourous way the extent to which many people accepted drug use as a valid and valuable method of reducing emotional distress and discomfort. For example, New Yorker magazine published a cartoon which featured a business man who had just noticed a coin operated vending machine on the subway platform selling pills for a nickel each (Illustration 16). Miltown was one of the selections available. Two sedatives, phenobarbital and Doriden, and the stimulant Benzedrine rounded out the options. In the background were other machines selling "gum" and "ice cold drinks." Having a choice between three methods of reducing

¹⁴ "Medical Trends Criticized," Canadian Doctor 25,12 (December 1959), 47-8.

¹⁵ Sangster, "Should You Take A Happy Pill?" 21.

Illustration 16: Choosing effective means of reducing stress. Source: Charles Addams, "Get Thru The Day," New Yorker, August 11, 1956, 15.

stress, the cartoonist, Charles Addams, appeared to be critical of a public which considered pill consumption to be an equally legitimate and effective means of getting through a very busy and hectic day as chewing gum and drinking Coca-Cola. A cartoon in Newsweek pictured a golfer who had just hit his golf ball into some high grass (Illustration 17). After surveying the difficult shot that he now must make, he held out his hand and asked his caddy not for a particular golf club but for some "tranquilizers." This cartoon, like the previous cartoon, implied that many people believed that drug consumption in general and tranquilizer consumption in particular was a valid and effective therapy of choice against stress and anxiety -- even if the cartoonists may have felt otherwise.

Still other North Americans took meprobamate because they accepted, without question, their doctor's decision to prescribe it for them. During the 1950s, patients trusted that their physicians knew what was best for them. For example, in 1949, Dorothy Morrow of Portage La Prairie, Manitoba told her physician that she had been experiencing excessive and irregular bleeding. Her doctor performed a quick medical examination and sent her home with a prescription for some pills. It became evident only later that Morrow had uterine cancer. Three years and four operations after her initial appointment, Morrow wrote an

Illustration 17: Consuming tranquilizers in preparation for golf shot. Source: "Pills," Newsweek, February 1, 1960, 66.

open letter to her now-former doctor. In the letter, Morrow revealed the extent to which she had trusted in the wisdom and good intentions of her physician:

I had such faith in you, Doctor, because you were rated as one of the best in the city where we lived at that time. Even when the bleeding became almost continuous, I wouldn't listen to my husband. I'd tell him "the doctor says everything's okay -- it's just that I'm at a difficult age, so don't worry about me."¹³³

In a note which accompanied the letter, a terminally-ill Morrow asserted that she continued to greatly admire the medical profession but that she hoped that the letter might deter other busy doctors from skimping on medical examinations and making snap diagnoses. By extension, patients believed that the decision by their physicians to prescribe tranquilizing drugs was backed by the authority of medical science. As Tudiver recalled, during the 1950s "we were all swept along by the common belief that medical science, doctors, and the pharmaceutical industry could be trusted."¹³⁴ In addition, the esteemed position of the prescribing physician was reinforced again and again in the popular press by doctors and journalists who reminded the public that they were supposed to consume tranquilizing

¹³³ Dorothy Morrow, "A Letter to a Doctor from a Woman Dying of Cancer," Chatelaine, January 1952, 7. See also Tudiver, "In Search of the Right Prescription," 165.

¹³⁴ Tudiver, "In Search of the Right Prescription," 159.

drugs only on the advice of their physicians because only trained medical doctors were qualified to properly diagnose and treat medical conditions.¹³⁵

Meprobamate was introduced into the pharmaceutical market in Canada and the United States in April 1955 as a new and unique product for the relief of anxiety and tension states. Its popularity was almost instantaneous. As news of the anti-anxiety agent spread, demand for the drug grew, and pharmaceutical company sales figures skyrocketed. A number of factors contributed to the popularity of meprobamate including aggressive advertising campaigns launched by drug companies aimed at both the medical profession and the public, indiscriminate prescribing practices by doctors, a demand by anxious patients for the latest in drug therapy, and a general belief in the power and possibility of medical science to enhance the quality of postwar North American life. In spite of its popularity, some medical and lay people voiced concerns about the extent to which meprobamate and other minor tranquilizing drugs were being consumed by essentially normal people to alleviate the common anxiety and ordinary tension of everyday life. What was rarely mentioned, however, was the

¹³⁵ Sangster, "Should You Take A Happy Pill?" 63; Scott, "Don't Misuse Tranquilizers," 61.

fact that women were twice as likely a men to receive a prescription for these drugs.

CHAPTER FOUR

Gender, Women, and Minor Tranquilizing Drugs

In September 1953, the British medical journal the Lancet published a brief, tongue-in-cheek article by London lawyer Marguerite Sieghart entitled "How Do I Treat My Doctor?"¹ The article was an amusing account of the supposed trials and tribulations of the doctor-patient relationship as experienced by the female patient. Sieghart based her commentary on the assumption that, contrary to popular belief, doctors did not know everything there was to know about medicine. Instead, she asserted jokingly, doctors relied on a few tried and true diagnoses against which they attempted to classify all of their patients. Given this situation, Sieghart felt that it was imperative that female patients knew how to treat their doctors. That is, it was important that women learned how to provide their physicians with medical case-histories that allowed the doctors to arrive at a correct diagnosis. Using extreme

¹ Marguerite A. Sieghart, "How Do I Treat My Doctor?" Lancet 265 (September 26, 1953), 671-2. Parts of this article were later reprinted in Time magazine. See, Marguerite A. Sieghart, "How to Treat a Doctor" Time, October 12, 1953, 69.

examples to reinforce her point and heighten the humour, Sieghart described how the experienced patient handled the delicate task of presenting her medical history while at the same time preventing her doctor from making an inappropriate diagnosis.

At first glance this article looked like an exercise in entertainment but below the surface of the humour Sieghart also provided readers with a biting critique of the gendered nature of medicine in the 1950s. She was particularly disturbed by male physicians whose preconceived and socially constructed notions about women and women's nature made it difficult for them to hear or take seriously the medical concerns raised by their female patients. These doctors, she argued, habitually assumed that all women's symptoms were the result of biological changes specific to being a woman, such as menopause, and/or emotional instability as evidenced by the presence of early emotional trauma, assertiveness as an adult, or an inability to find fulfilment in marriage and motherhood. Other than going

Nancy Walker argues that during the 1950s domestic humour was one of the few acceptable means by which American middle-class women could vent their frustrations about rigid role definitions and exacting social expectations. See Nancy Walker, "Humour and Gender Roles: The 'Funny' Feminism of the Post-World War II Suburbs," American Quarterly 37,1 (Spring 1985), 98-113. Walker explores the issue of women and humour in more detail in her monograph entitled A Very Serious Thing: Women's Humour and American Culture (Minneapolis: University of Minnesota Press, 1988).

from doctor to doctor, Sieghart was not overly optimistic that even the experienced patient would obtain the kind of medical attention she needed and deserved. After all, Sieghart concluded, "a cure can result only from the fortuitous encounter of a disease with a doctor embodying the correct diagnosis, and is thus an incredible fluke."

In her critique of the gendered nature of medicine, Sieghart implied that female patients lacked direct control over the therapeutic process. In the face of diagnoses and treatments meted out by doctors who based their decisions exclusively on their own preconceived and socially constructed notions about women and women's nature, she even went so far as to covertly counsel women on how to manipulate their physicians into providing them with the medical care they required. Clearly Sieghart wanted women to play a more active role in their own health care but the humorous design of the article and the wily nature of her advice also indicate that Sieghart was aware that the relationship between female patients and their predominantly male doctors was much more complex than women simply asking for what they wanted and doctors readily complying with their requests. In this context, the possibilities and limitations within dominant social constructions of gender,

¹ Sieghart, "How Do I Treat My Doctor?" 671-2.

medicine/mental health, and anti-anxiety drugs also conditioned how doctors diagnosed and treated their female patients and how women recognized and responded to their own health issues.

During the 1950s, a great deal of emphasis was placed on the primacy of marriage, home, and family. The expectation was that men and women would marry and settle down to raise children. Thereafter, the role of the husband was to work at a job or profession in order to provide financial security for his family. The role of the wife was to maintain the day-to-day operation of the home and to take major responsibility for the raising of the children.⁴ Moreover, it was assumed that this arrangement alone would guarantee personal satisfaction, the health and happiness of the children, and social stability.

By all accounts, many Canadians seemed quite content with marriage, home, and family. For example, Chatelaine magazine received over five hundred letters from women protesting an article it ran in March 1950 in which business

⁴ Melinda McCracken, Memories Are Made Of This (Toronto: James Lorimer, 1975), 12; Franca Iacovetta, "Making 'New Canadians': Social Workers, Women, and the Reshaping of Immigrant Families," in Franca Iacovetta and Mariana Valverde, eds., Gender Conflicts: New Essays in Women's History (Toronto: University of Toronto Press, 1992), 263.

woman Beverly Gray described housewives as "a sorry lot."¹ According to Gray, housewives were unhappy people who had nothing better to do with their time than to complain about poverty, loneliness, drudgery, and poor health. The respondents accused Gray of being narrow-minded and prone to generalizations about women who worked in the home. They were particularly resentful that Gray had questioned their happiness, their work ethic, and their mental health. As one housewife quipped,

If all housewives were as moronic, lazy, and lacking in imagination as pictured [by Gray], how could they raise their daughters to grow into such smart, intelligent, and very self-assured young business girls?²

Other respondents went to greater lengths to illustrate the apparent falsity of Gray's assumptions about housewives.

According to one woman,

In our village the women are clever and kind, some more efficient than others. Our children are healthy and usually very happy. We like our husbands. We give service to our community. We understand municipal affairs and work to improve them. We have political opinions and we don't fight over disagreements. When we are in trouble we help one another.

¹ Beverly Gray, "Housewives Are A Sorry Lot," Chatelaine, March 1950, 26. Some of the letters to the editor were reproduced in "Housewives Blast Business Girl," Chatelaine, June 1950, 14.

² "Housewives Blast Business Girl," 68.

³ Ibid., 69.

Contentment with marriage, home, and family was also the experience of many women who lived in the suburbs. In her study of suburban life in Canada after World War II, historian Veronica Strong-Boag made contact with a number of suburban women who had embraced the domestic ideal during the 1950s. She found that the majority of these women remembered their years in suburbia as an eminently satisfying time characterized by happy children, satisfying marriages, comfortable homes, and close-knit communities.⁷ Americans were also generally satisfied with marriage, home, and family during the 1950s. At the end of the decade, Gerald Gurin, Joseph Veroff, and Sheila Feld headed a study group at the University of Michigan's Survey Research Centre. The group interviewed a representative sample of 2460 Americans about how they viewed their own mental health. The results showed that just over sixty percent of those interviewed cited children, marriage, or family in general as their major source of happiness.⁸

⁷ Veronica Strong-Boag, "Home Dreams: Women and the Suburban Experiment in Canada, 1945-1960," Canadian Historical Review 72,4 (December 1991), 502-3; Veronica Strong-Boag, "'Their Side of the Story': Women's Voices from Ontario Suburbs, 1945-1960," in Joy Parr, ed., A Diversity of Women: Ontario, 1945-1980 (Toronto: University of Toronto Press, 1995), 52-8.

⁸ Gerald Gurin, Joseph Veroff, and Sheila Feld, Americans View Their Mental Health: A Nationwide Interview Survey (New York: Basic Books, 1960), 24-7. This was the fourth in a series of monographs published by the Joint

In spite of the numerous occasions on which postwar experts and middle-class women championed the belief that women could find true happiness only if they became full-time mothers, wives, and homemakers, the fact of the matter was that both the activities of women and the popular postwar ideology about women were much more varied and complex than this narrowly-defined stereotype of postwar women would suggest.¹⁰ For example, the 1950s produced women who, by choice or circumstances, disliked domestic life, entered the paid labour force, never married, lost their husbands to legal separation, divorce, or death, and became politically active in organizations such as labour

Commission on Mental Illness and Health as part of a national mental health survey in accordance with the provisions of the Mental Health Study Act of 1955. The stories of some American women who found happiness in domesticity during the fifties are included in Edith Fierst, "Careers and Kids," Ms, May 1988, 62; Signe Hammer, "Inventing Ourselves: The Class of 1958," Ms, December 1988, 55.

¹⁰ For example, see Elizabeth Bott, "Urban Families: Conjugal Roles and Social Networks," Human Relations 8,4 (November 1955), 345-84; Birmingham Feminist History Group, "Feminism as Femininity in the Nineteen-Fifties?" Feminist Review 3 (1979), 48-65; Wini Breines, "The 1950s: Gender and Some Social Science," Sociological Inquiry 56,1 (Winter 1986), 69-92; Kathryn Urbanowitz Keller, "Mothers and Work as Presented in Popular American Magazines, 1950-1989," Ph.D. thesis, New School for Social Research, 1991, 17-70; Joanne Meyerowitz, "Beyond the Feminine Mystique: A Reassessment of Postwar Mass Culture, 1946-1958," Journal of American History 79,4 (March 1993), 1455-82; Alison Prentice et al., Canadian Women: A History, 2d ed. (Toronto: Harcourt Brace, 1996), 378-408.

unions and peace groups. In keeping with the diversity of women's activities, the lay press ran articles and stories which voiced ambivalence about domesticity, supported women's involvement outside of the home, and celebrated women who succeeded in the public arena. Nevertheless, the domestic ideology which gave primacy to marriage, home, and family remained the dominant ideology throughout the 1950s. Moreover, it became the favoured bench mark against which postwar experts judged women and women judged themselves. Even the relatively few North Americans who openly questioned or outright rejected the tenets of the domestic ideal could not help but be aware of the lack of desirable options available to women outside of marriage and motherhood and the degree to which society in general disapproved of women who deviated from the norm. Most Canadian (and American) women, however, did not openly question or outright reject domesticity -- the ideal was taken for granted. Instead, they worked within its limitations and possibilities the best they could to meet their own, often conflicting, needs including the need for a family, security, approval, meaningful work, and acceptance. For their part, regardless of how contented women were with the different choices they made, postwar experts focussed most of their attention on women who seemed unhappy with their lives as full-time wives, mothers, and homemakers.

In contrast to women who achieved a great sense of satisfaction from being wives, mothers, and homemakers during the 1950s, some women found the responsibilities of domestic life to be both emotionally and physically challenging. Some of the women included in Strong-Boag's study of the Canadian suburban experience felt burdened by the responsibility of being primary caregivers to demanding children without the benefit of adequate support from friends, relatives, and sometimes husbands. As a result, they remembered their time in the suburbs as a period of great isolation, frustration, domestic drudgery, and social constraint. As one woman recalled, the combination of high expectations and intense loneliness could lead to a sense of desperation: "I began to feel as if I were slowly going out of my mind. Each day was completely filled with child and baby care and keeping the house tidy and preparing meals. I felt under constant pressure."²² To make matters worse, some of these women felt guilty for being so unhappy because, by all accounts, their lives were filled with all of the things that were supposed to bring them joy and contentment: an employed husband, healthy children, and a good standard of living.²³ Along these same lines, Ruth

²² Strong-Boag, "Home Dreams," 503.

²³ Ibid., 503-4.

Moulton, a psychoanalyst in the United States during the 1950s, remembered that all of her female patients at that time had sought treatment for family-related problems including problems surrounding sex, marriage, and child rearing.¹² Similarly, Gerald Gurin and his colleagues who investigated how Americans viewed their mental health discovered that more women than men admitted to being unhappy in their marriages and having had personal problems within them. They also discovered that more women than men experienced feelings of inadequacy and distress in their role as parent. In particular, these mothers tended to feel guilty when they became frustrated or lost their tempers with their children after having spent a lot of time together. They also felt burdened by the way in which childcare responsibilities made them feel confined to the house.¹³

Postwar experts in particular and society in general tended to assume that discontentedness among wives, mothers,

¹² Ruth Moulton, "Some Effects of the New Feminism," American Journal of Psychiatry 134,1 (January 1977), 2. See also Fierst, "Careers and Kids," 62; Elaine Tyler May, Homeward Bound: American Families in the Cold War Era (New York: Basic Books, 1988), 173-4.

¹³ Gurin, Veroff, and Feld, Americans View Their Mental Health, 115,129,133,140. See also Mirra Komarovsky, Women in the Modern World: Their Education and their Dilemmas (Boston: Little, Brown, 1953), 126-7.

and homemakers was a sign of personal deficiency.¹⁷ This was particularly true when it came to motherhood, the role in which women were expected to achieve their greatest fulfilment. For example, in two separate clinical studies reported in the lay press, Drs. Theodore Mandey of Mount Sinai Hospital in Toronto and William Saul Kroger of Chicago suggested that sterility in women could be largely psychological in origin and represent nature's way of avoiding the birth of offspring to unsuitable parents. Kroger found that many women who were unable to conceive were also ambivalent about becoming mothers. Drawing on the ideas of Freud, he argued that their ambivalence stemmed from either their emotional immaturity and dependence or their more aggressive, masculine personality make-up.¹⁸ In these and similar studies, the researchers did not attempt to investigate some of the more practical reasons for why these women might be ambivalent about becoming mothers nor did they consider the possibility that physiological sterility was causing these women to experience psychological anxiety. Instead, the researchers assumed

¹⁷ Komarovsky, Women in the Modern World, 116; Eugenia Kaledin, Mothers and More: American Women in the 1950s (Boston: Twayne, 1984), 182.

¹⁸ "Sterility and Neurotics," Time, June 16, 1952, 81; Joan Morris, "If You Can't Have A Baby," Chatelaine, May 1959, 37. See also "Fears and Babies," Newsweek, December 28, 1953, 49.

that because motherhood was natural for women that any woman who did not embrace the role wholeheartedly must have been psychologically unstable.¹⁷

In apparent contrast to the sanctity of the domestic ideal, more and more married, middle-class women entered the paid labour force in Canada after World War II. In 1941, married women made up only 4.5 percent of the labour force and 12.7 percent of all women in paid employment. By 1951, married women represented 11.2 percent of the labour market and 30 percent of all women working for wages. Ten years later, in 1961, married women comprised 22 percent of the labour force and 49.8 percent of all women in paid labour.¹⁸ The majority of married women found work in clerical, sales, and service occupations while many of the remainder were employed as factory workers, managers, nurses, and teachers.¹⁹ For the most part, these jobs did not pay well and there was little room for advancement but married women

¹⁷ This point was also made by Wendy Mitchinson, "The Medical Treatment of Women," in Sandra Burt, Lorraine Code, and Lindsay Dorney, eds., Changing Patterns: Women in Canada, 2d ed. (Toronto: McClelland and Stewart, 1993), 398; May, Homeward Bound, 149.

¹⁸ Byron G. Spencer and Dennis C. Featherstone, Married Female Labour Force Participation: A Micro Study (Ottawa: Dominion Bureau of Statistics, 1970), 12.

¹⁹ Veronica Strong-Boag, "Canada's Wage-Earning Wives and the Construction of the Middle Class, 1945-60," Journal of Canadian Studies 29,3 (Fall 1994), 7.

took this kind of work because it was available to them and because the money it generated was often needed in order to make it possible for their family to acquire basic material comforts such as an adequate home, a car, appliances, and decent clothing. Moreover, married women who worked outside of the home continued to identify their primary role as being within the home as wives, mothers, and housekeepers. In this sense, many married women saw their paid labour as a means by which they could more effectively create a home environment in which all members of the family would benefit.

Canadians differed in their opinion as to whether or not married women should work outside the home but everyone seemed to agree that, employed or not, women were first and foremost responsible for the maintenance of family life. Opponents of married women in the labour force argued that such behaviour went against women's basic nature and therefore threatened family and social stability. They were

Ibid., 8. On the subject of women and paid employment in Canada, see Pat Armstrong and Hugh Armstrong, The Double Ghetto: Canadian Women and their Segregated Work, 3d ed. (Toronto: McClelland and Stewart, 1994).

Zoe Bieler, "White-Collar Wife," Chatelaine, August 1953, 22; Meg Luxton, Harriet Rosenberg, and Sedef Arat-Koç, Through the Kitchen Window: The Politics of Home and Family, 2d ed., rev. and enl. (Toronto: Garamond Press, 1990); William Henry Chafe, The Paradox of Change: American Women in the 20th Century (New York: Oxford University Press, 1991), 24.

particularly concerned that these women would not have enough time and energy left over at the end of the day to properly meet the needs of their husbands and children.⁴⁴ On the other hand, supporters of married women in the labour market stressed the psychological benefits for women of working outside the home and the potential for families with a second income to improve their material well-being. They also voiced confidence in the ability of working wives and mothers to juggle the demands of paid work and the responsibilities of home life. Like the opponents, however, supporters of married women workers felt that it was best if women with small children stayed at home though they were more likely to approve of mothers with older children being employed if the women made suitable alternative childcare arrangements. For example, in 1960, a Canadian Gallup Poll found that 65 percent of Canadians thought that married women should take a job outside of the home if they wanted to work and if they had no young children. By contrast, the poll also found that 93 percent of Canadians did not think women should take a job outside of the home if they wanted

⁴⁴ For an analysis of these arguments, see Komarovsky, Women in the Modern World, 40; Ann Porter, "Women and Income Security in the Post-War Period: The Case of Unemployment Insurance, 1945-1962," Labour/Le Travail 31 (Spring 1993), 111-44; Strong-Boag, "Canada's Wage-Earning Wives," 10-4.

to work and if they had young children.⁴

American free-lance writer and public relations counsellor Madelon Bedell was a working wife and mother during the 1950s who struggled to reconcile these mixed messages with her desire to have both a job and a family. She remembered how difficult it was for her and other women like her who had decided to combine work and family:

That [decision to obtain paid work] made us instant pariahs, outcasts from society. All sorts of authorities told us in no uncertain words that in leaving home (you were presumed to have "left home" permanently even if it was only between the hours of nine and five every day), we were behaving in an Unnatural Way. Sigmund Freud and [United States President] Dwight Eisenhower told us that, and I am sorry to say we believed them.⁴

To alleviate her guilt, Bedell gravitated towards those experts who said that it might be all right for married women to work for wages if they did not neglect their children, husbands, and homes. "They threw us a crumb of hope," she said,

The Canadian Gallup Poll findings were listed in Gertrude Joch Robinson, "The Media and Social Change: Thirty Years of Magazine Coverage of Women and Work (1950-1977)," Atlantis 8,2 (Spring 1983), 108. For an analysis of the arguments for and against married women in the workforce, see "The Married Woman in Employment," Canada's Mental Health 4,5 (May 1956), 6-7; Susan M. Hartmann, "Women's Employment and the Domestic Ideal in the Early Cold War Years," in Joanne Meyerowitz, ed., NOT JUNE CLEAVER: Women and Gender in Postwar America, 1945-1960 (Philadelphia: Temple University Press, 1994), 84-100; Strong-Boag, "Canada's Wage-Earning Wives," 15-9.

⁴ Madelon Bedell, "Supermom!" Ms, May 1973, 84,86.

the stock phrase of the times offered to the working mother, "It's not the quantity of time you spend with your children, it's the quality."

Oh, how I snatched at that crumb and tried to turn it into a cake, the one that I might eat and have, too."

In response to this glimmer of hope offered her, Bedell read extensively about nutrition, child psychology, and homemaking, followed the advice given to working mothers, and discussed her situation with teachers, doctors, and other women in similar circumstances. In short, she attempted to become "the ideal Super Mom."

The strength of the belief that women would naturally marry and have children led many postwar experts and social commentators to suggest that women who remained single had psychological problems. Journalist Eileen Morris was typical of Canadians who believed that it was emotionally unhealthy for women to avoid marriage. She concluded that single women might go through the motions of looking for a husband but deep down their real desire was to avoid marriage altogether." In effect, Morris was so convinced that marriage was a sign of psychological stability that she

Ibid., 86.

Ibid., 86.

Gurin, Veroff, and Feld, Americans View Their Mental Health, 91-2, 117-8.

Eileen Morris, "Why Some Women Never Marry," Chatelaine, November 1954, 20.

was unable to accept that some women might actually have liked being single. More so than the question of marriage, experts were concerned about the potential damage women might cause themselves and society by remaining childless. In no uncertain terms, American Dorothy Thompson contended that middle-class women who went against their biological natures by not having children posed a serious threat to the intellectual future of the race."

During the 1950s, such importance was placed on marriage, home, and family that less than ten percent of Americans believed that an unmarried person could be happy." Canadian writer Jeann Beattie remembered that the general public, reinforced by articles in the popular press, viewed unmarried women as somewhat deficient human beings:

Single, working women ... were neurotic, bitter, unfulfilled, and unfeminine. We were studied, analyzed, probed and reported on by a dizzying range of experts who solemnly intoned in mass media that we were a mess."

" Dorothy Thompson, "Race Suicide of the Intelligent," Ladies' Home Journal, May 1949, 12. The concern about women and childlessness was directed equally at married women. See Hannah Gavron, The Captive Wife: Conflicts of Housebound Mothers (London: Routledge and Kegan Paul, 1966), 125.

" Cited in Stephanie Coontz, The Way We Never Were: American Families and the Nostalgia Trap (New York: Basis Books, 1992), 25.

" Jeann Beattie, "A Single Woman Looks At Wives," Chatelaine, July 1968, 27.

Contrary to these pronouncements, Beattie and many of her friends were satisfied with their lives even if they were not wives and mothers.⁶ This was not the case for other women who were convinced that to remain single was to opt for a life that was lonely, empty, and joyless.⁷ The undesirability of such a fate strengthened the pull towards domesticity for women like Beattie's twenty-year-old secretary who lamented "I'm tired of being an old maid, I'll marry anybody."⁸

In terms of how medical experts viewed women during the 1950s, the prevalence of Freudian ideas was reinforced by the growth in popularity of the psychosomatic approach to medicine.⁹ This approach sought to understand the exact nature of the relationship between the mind and the body on the assumption that mental health and physical health were not separate entities. While priority was always given to the influence of the mind over the body, psychosomatic

⁶ Ibid., 27; See also "Housewives Blast Business Girl," 68; Jeanine Locke, "Why I Hate Wives," Chatelaine, March 1956, 11.

⁷ Brett Harvey, The Fifties: A Women's Oral History (New York: HarperCollins, 1993; HarperPerennial, 1994), 86-7.

⁸ Beattie, "A Single Woman Looks At Wives," 63. See also C. Fred Bodsworth, "Man: The Vanishing Sex," Chatelaine, May 1950, 32.

⁹ Prentice et al., Canadian Women, 384.

medicine asserted that emotional problems could lead to physical illness or disease and that physical illness or disease often caused serious emotional problems.⁴ The importance of the mind-body connection was confirmed during World War II. After the war, some medical researchers were interested in exploring in more detail the way in which emotional issues manifested themselves as physical symptoms. Generally speaking, these researchers traced emotional problems to either an inadequate personality, an inadequate environment, or a combination of the two. For example, it was found that some people developed emotional problems because of a personality defect which made them rigid, sensitive, or insecure and therefore unable to sufficiently cope with everyday stresses. On the other hand, some people without a personality defect were found to have developed emotional problems due to the sheer weight of the environmental stresses under which they were expected to operate at work, at home, and in social situations.⁵

Endocrinologist and Director of the Institute of

⁴ For a discussion of the mind-body problem during the early part of the twentieth century, see John C. Burnham, "The Mind-Body Problem in the Early Twentieth Century," Perspectives in Biology and Medicine 20,2 (Winter 1977), 271-84.

⁵ R.A. Palmer, "The Physician's Approach to Management of the Psychoneuroses," British Columbia Medical Journal 5,2 (May 1960), 307.

Experimental Medicine and Surgery at the University of Montreal, Dr. Hans Selye was a pioneer in psychosomatic research during the 1950s. While Selye believed it was important and useful for people to experience a moderate degree of stress in their daily lives, he acknowledged that too much stress could cause disease through what he termed the "general adaptation syndrome."³⁷ According to this theory, when the human body was exposed to intense emotional or physical stress over a prolonged period of time, it attempted to adapt itself to the change and restore balance to the organism. Sometimes, however, the body overadapted, underadapted, or improperly adapted itself to the stress which left the individual more susceptible to illness and disease.³⁸ In recognition of his contribution to the field of psychosomatic research, the Canadian Broadcasting Corporation aired a television program in 1956 entitled "The Problems of Stress" which focussed on Selye and his work over the previous twenty years.³⁹

The psychosomatic approach to medicine dovetailed with

³⁷ Selye first published his theory of how stress caused disease in 1950. See "The Life of Stress," Time, October 9, 1950, 46.

³⁸ Ibid., 46; "Stress and Strain," Time, January 18, 1954, 40-1; Hans Selye, "From the Notebook of Dr. Hans Selye," Maclean's, October 13, 1956, 26.

³⁹ "The Problems of Stress," Canada's Mental Health 4,5 (May 1956), 10.

Freudian and functionalist schools of thought to further strengthen widespread assumptions about the nature of men and women. For example, regardless of possible similarities in early childhood experiences, emotional stress leading to physical symptoms in men tended to be attributed to environmental factors they experienced as adults while emotional stress leading to physical symptoms in women tended to be attributed to personality factors exhibited in adulthood.⁴² As demonstrated in a 1955 article in Maclean's magazine, a number of clinical studies carried out during the 1950s which explored the possible link between emotions and vulnerability to cancer clearly illustrated these gender differences. For example, Drs. H.W. Jones and F.R. Miller of the Jefferson Medical College Hospital in Philadelphia believed that prolonged exposure to emotional stress may at times be the direct cause of leukemia. As evidence of their theory, they related two case histories of men who had been chronic worriers all their lives. The first man worried about money and whether or not he would ever make enough to be financially secure. The second man worried that he was not a good enough worker. Both men died of leukemia. Jones and Miller argued that the worry experienced by these men

⁴² Joan Morris, "Why More Women Than Men Have High Blood Pressure," Chatelaine, May 1957, 26; Palmer, "The Physician's Approach to Management of the Psychoneuroses," 307.

was not a sign of emotional instability but the product of environmental stress caused by "the increased tempo of life in the last forty years."⁴² By contrast, several studies which focussed on women concluded that there was a possible link between cancer of the uterus, cervix, or breasts and a history of psychosexual disturbance. For example, Drs. James Stephenson and William Grace of the Cornell Medical School in Ithaca, New York compared one hundred women who had cervical cancer with one hundred women who had cancer in other sites. They found that the women with cervical cancer did not adjust well to marriage, motherhood, and sex. In particular, these women were often divorced or separated, sexually unfulfilled, and previously married to a man who had been unfaithful or alcoholic.⁴³

In terms of gender and minor tranquilizer use during the 1950s, the popular press gave the impression that meprobamate and other anti-anxiety agents were consumed equally by both men and women. In keeping with contemporary gender role definitions, however, almost every account of minor tranquilizer use in the lay press associated stress in men with pressures and problems related to work and stress

⁴² Sidney Katz, "Does Worry Cause Cancer?" Maclean's, March 5, 1955, 50.

⁴³ Ibid., 49.

in women with pressures and problems related to children and the home. Canadian journalist Dorothy Sangster informed Chatelaine readers that meprobamate was considered "made to order for the man in the street, his nervous wife, and fretful baby."⁴⁴ American author John Brooks identified high rates of meprobamate consumption among stressed business executives, harried mothers, and shy but pretty young women about to meet new people at a dinner party.⁴⁵ Even writers who focussed more on the specific workings of the anti-anxiety agents illustrated their discussion with gender-specific examples of how the drugs had calmed anxiety in men and women from all walks of life.⁴⁶

In reality, more women than men received prescriptions for minor tranquilizing drugs during the 1950s. Research pertaining to gender and minor tranquilizer consumption in

⁴⁴ Dorothy Sangster, "Should You Take A Happy Pill?" Chatelaine, April 1957, 60. For mention of minor tranquilizer use among both men and women in Canadian suburbs, see Alastair MacLeod, "The Sickness Of Our Suburbs," Chatelaine, October 1958, 96.

⁴⁵ John Brooks, The Great Leap: The Past Twenty-Five Years in America (New York: Harper and Row, 1966), 141.

⁴⁶ For example, see "Happiness By Prescription," Time, March 11, 1957, 59; Francis Bello, "The Tranquilizer Question," Fortune, May 1957, 163; "What You Ought To Know About Tranquilizers," U.S. News and World Report, June 21, 1957, 62; "Domestic Tranquility," New Republic, June 24, 1957, 5; Ian Stevenson, "Tranquilizers and the Mind," Harper's, July 1957, 21-7; Harold E. Himwich, "Psychopharmacologic Drugs," Science 127, 3289 (January 10, 1958), 61.

Canada for this period does not exist but in the first American study of its kind, Sam Shapiro from the Health Insurance Plan of Greater New York and Seymour Baron from the National Institute of Mental Health studied the age and sex of patients who had received a prescription for a mood-modifying drug during the week of April 7-13, 1959 under the Health Insurance Plan of Greater New York.⁴ Shapiro and Baron found that, regardless of age, women were twice as likely as men to be prescribed a minor tranquilizing agent. They also found that prescription rates increased with age for both men and women to the extent that women between the ages of forty-five and sixty-four were twice as likely as women between the ages of fifteen and forty-four to receive a minor tranquilizer prescription.^{4*} In another study, Dr.

⁴ In this study, mood-modifying, or psychotropic, drugs included major tranquilizers, minor tranquilizers, anti-depressives, and sedative-relaxants. Sam Shapiro and Seymour H. Baron, "Prescriptions for Psychotropic Drugs in a Noninstitutional Population," Public Health Reports 76,6 (June 1961), 481-8. The first Canadian study to look at the relationship between sex and prescription rates was based on data from Metropolitan Toronto during 1965 and 1966. It was found that women received sixty-nine percent of all mood-modifying drug prescriptions. Because of the records consulted, it was impossible to determine the age and marital status of recipients. See Ruth Cooperstock and Mary Sims, "Mood-Modifying Drugs Prescribed in a Canadian City: Hidden Problems," American Journal of Public Health 61,5 (May 1971), 1007-16.

^{4*} The rate reflects the estimated number of prescriptions written per 100 population per year.

<u>women</u>	<u>rate per 100</u>	<u>men</u>	<u>rate per 100</u>
15-44 yrs	6	15-44 yrs	3
45-64 yrs	10	45-64 yrs	4

A.W.S. Thompson, director of Clinical Services in the New Zealand Department of Health, investigated the relationship between marital status and drug use among women in New Zealand. The study found that in 1958 married women received twice as many prescriptions for tranquilizers and hypnotics as either non-married women or men.⁴⁴ Therefore, statistics available for the 1950s suggest that age, sex, and marital status were important determinants as to whether or not patients received a prescription for an anti-anxiety agent with women, especially married women between forty-five and sixty-four years of age, being the most likely candidates.

This striking gender imbalance in the distribution of minor tranquilizing drugs was in part a function of the gendered nature of medicine and its tendency to draw connections between women, neuroses, and the need for anti-anxiety agents. In keeping with the uneven distribution pattern of minor tranquilizing drugs, studies of the incidence of neuroses in general practice in Canada during the 1950s consistently found that women were twice as likely

These differentials could not be explained by the fact that women went to see the doctor more often than men. Shapiro and Baron, "Prescriptions for Psychotropic Drugs in a Noninstitutional Population," 484-5.

⁴⁴ A.W.S. Thompson, "Prescribing of Hypnotics and Tranquilizers in New Zealand," Pharmaceutical Journal of New Zealand 35 (April 1973), 15.

as men to be diagnosed as neurotic.⁵⁰ These studies also suggested that women between the ages of about forty and sixty were more likely than either younger women or men to receive such a diagnosis.⁵¹ Moreover, in terms of treatment methods, studies demonstrated that general practitioners considered minor tranquilizing drugs to be a popular and effective means of treating neurotic patients. In 1960, Lea Associates surveyed the diagnostic and prescription patterns of 330 Canadian physicians over a two day period. The survey found that seven-eighths of the patients diagnosed as psychoneurotic were given a prescription.⁵² In 1962, Dr. Colin Smith and his colleagues from Saskatoon surveyed 250 general practitioners in Saskatchewan. They asked the doctors about mental illness and its treatment. The study

⁵⁰ Palmer, "The Physician's Approach to Management of the Psychoneuroses," 309; Edward Llewellyn-Thomas, "The Prevalence of Psychiatric Symptoms Within an Island Fishing Village," Canadian Medical Association Journal 83,5 (July 30, 1960), 201,203.

⁵¹ John Fry, "Five Years of General Practice: A Study in Simple Epidemiology," British Medical Journal 2 (December 21, 1957), 1455; W.I. Neil Kessel, "Psychiatric Morbidity in a London General Practice," British Journal of Preventive and Social Medicine 14,1 (January 1960), 18; John Fry, "What Happens To Our Neurotic Patients?" Practitioner 185, 1105 (July 1960), 88; W.I. Neil Kessel and Michael Shepherd, "Neurosis in Hospital and General Practice," Journal of Mental Science 108,453 (March 1962), 163.

⁵² Alex Richman, "Psychiatric Care in Canada: Extent and Results," Royal Commission on Health Services (Ottawa: Queen's Printer, 1966), 296.

found that ninety-two percent of the physicians surveyed considered drugs to be the treatment of choice for patients with emotional disturbances. Eighty-nine percent of respondents also provided support and assurance while eighty-six percent attempted to give their patients insight and understanding of the conflicts underlying the illness. Only fifty-five percent of physicians made the effort to help patients make changes to their environment.⁵³

Journal advertisements for meprobamate and other minor tranquilizing drugs during the 1950s reinforced dominant notions about gender and mental health. In particular, advertisements tended to promote anti-anxiety agents as the preferred treatment for women who displayed symptoms of anxiety, tension, and mental stress. This marketing strategy perpetuated the popular belief that women were more emotionally unstable than men, a belief that was articulated most clearly by British Columbian physician Dr. R.A. Palmer who concluded that "the female is indeed the weaker sex as far as psychoneuroses is concerned."⁵⁴ More specifically,

⁵³ Colin M. Smith, Robin F. Badgley, and D. Griffith McKerracher, "Study of Mental Illness: The General Practitioner," in D. Griffith McKerracher, "Trends in Psychiatric Care," Royal Commission on Health Services (Ottawa: Queen's Printer, 1966), Appendix 1, 243. See also Palmer, "The Physician's Approach to Management of the Psychoneuroses," 309.

⁵⁴ Palmer, "The Physician's Approach to Management of the Psychoneuroses," 306. See also Kaledin, Mothers and

drug ads reflected professional and popular assumptions about the nature of anxiety in men and women.¹ The few advertisements which featured photographs of men tended to show their subjects suffering from anxiety, tension, and emotional stress as the result of pressures from work or accompanying physical illness. For example, advertisements for the relaxant drug Suvren regularly featured men who worked in stressful occupations including air traffic controllers, bus drivers (Illustration 18), or newspaper reporters. The ads suggested that Suvren was particularly suitable for use by men because it effectively reduced work-related nervous tension without compromising job performance. Another advertisement for the combination drug Equanitrate (Illustration 19) featured a man who was emotionally upset as the result of a heart condition. The use of an outline of a heart organ superimposed over the photo of the man's temple strengthened the message that at the source of his anxiety was a physical, rather than an

More, 181.

The issue of gender and journal advertisements is explored by Jane Prather and Linda S. Fidell, "Sex Differences in the Content and Style of Medical Advertisements," Social Science and Medicine 9,1 (January 1975), 23-6. For an example of how the gender of the patient determined the diagnosis and prescribing practices of the physician, see Julius Michaelson, "The General Practitioner's Role in the Control of Anxious and Neurotic Patients," Journal of Neuropsychiatry 5,7 (September-October 1964), 440-1.

ALERT?
YES!
NERVOUS?
NO!

Relax with "SUVREN"

NERVOUS TENSION RELAXANT

NON-HYPNOTIC

"The patients were calm without being drowsy."

NON-TOXIC

No toxic reactions, side-effects or habituation were observed in 103 patients treated for ten months.

REDUCES ANXIETY

Effects were reported by patients to be better than with barbiturates.

RELAXES SMOOTH MUSCLE

Spasmolytic properties provide release from tension without dulling alertness.

Now in two potencies:

Tablets of 50 mg. and 100 mg.

*Ayerst, McKenna & Harrison
Limited, Montreal*

Now available:

"BEMINAL" with "SUVREN" No. 320
(vitamin B factors and vitamin C
- combined with "SUVREN")

87-S

Illustration 18: Advertisement for Suvren by Wyeth Laboratories. Source: Canadian Doctor 23,6 (June 1957), 46.

protects against pain
by sustained
coronary vasodilatation
and control
of complicating and
triggering emotions

reduces fear of attacks
reduces severity of attacks
reduces frequency of attacks
reduces dependence on nitroglycerin
increases workload tolerance

Two potencies for greater flexibility of dosage
Tablets Equanitrate 10, bottles of 50 and 500. Each tablet contains 10 mg. of pentaerythritol tetranitrate and 200 mg. of meprobamate.
Tablets Equanitrate 20, bottles of 50. Each tablet contains 20 mg. of pentaerythritol tetranitrate and 200 mg. of meprobamate.

Meprobamate and Pentaerythritol, Wyeth

available on prescription only

*Reg. Trade Mark

Illustration 19: Advertisement for Equanitrate by Wyeth Laboratories. Source: Canadian Doctor 26,4 (April 1960), 2.

emotional, problem. This ad also touched on the theme of men and work in that it promised that Equanitrate would not only control the physical and emotional components of the man's heart condition but allow him to tolerate a greater workload than was possible even prior to the onset of the medical problem.

On the other hand, the numerous advertisements for anti-anxiety agents which featured photographs of women tended to portray their subjects as experiencing diffuse emotional symptoms, indicating the presence of deeper psychological problems. For example, one advertisement for Equanil featured a picture of a distressed-looking older woman with a furrowed brow and her hand held tight against the side of her face in an apparent attempt to contain the anxiety (Illustration 20). A box to one side of her head announced that "anxiety is the voice of stress" while a quoted passage directly below the photograph informed doctors that anxiety was the most common symptom encountered in daily practice. The photograph itself did not make it clear what events may have precipitated the woman's intense emotional response. However, the ambiguous photo together with descriptions of anxiety that were both vague and all-encompassing suggested that Equanil was particularly suitable for use by women because it effectively alleviated the more generalized feelings of anxiety, tension, and

**"Anxiety, in one form or another,
is the most common symptom
confronting the practising physician"**¹

1. Hollister, L. H., et al.: Dis. Nerv. System 17:289 (Sept.) 1956.

Whether anxiety is primary or secondary to organic illness, it is an obstacle to successful treatment. EQUANIL alleviates stress reactions; reduces anxiety, tension, and insomnia, and thus contributes to total patient management. Of all ataractic drugs, EQUANIL has the broadest usage in the common problems of everyday practice.

Reg. Trade Mark
WALKERVILLE, ONTARIO
MONCTON - MONTREAL
WINNIPEG - VANCOUVER

Relieves tension — mental and muscular

*Reg. Trade Mark

Supplied: EQUANIL, 400 mg., regular, scored white tablets, bottles of 50.

Also available: WYSEALS/EQUANIL — sealed yellow tablets — specially coated — unidentifiable by patient — 400 mg., bottles of 50.

Illustration 20: Advertisement for Equanil by Wyeth Laboratories. Source: Canadian Doctor 24,7 (July 1958), 2.

emotional stress routinely expressed by female patients.

More than just a means of alleviating diffuse emotional symptoms in women, some advertisements for meprobamate and other minor tranquilizing agents also suggested that these drugs were able to return anxious women to emotional stability. These advertisements drew on the popular Freudian belief that many women suffered from poorly integrated or inadequate personalities because they were torn between the desire to accept their feminine role as nurturers within the home and the desire to pursue more masculine-oriented career interests outside its walls. In this context, anxiety was regarded as a manifestation of unresolved inner conflict and therefore a characteristic of women who were more likely to deviate from their biologically ordained tasks as wives, mothers, and homemakers. In response to this sort of reasoning, some ads for minor tranquilizers suggested that these drugs, by relieving anxiety, were able to help women compensate for their psychological inadequacies. This point was reinforced by psychiatrist Frank Orland from the University of Pennsylvania who noted that tranquilizers served to "compensate a personality which has decompensated, bringing it back to the previous level of functioning prior to the

onset of the emotional disturbance." This idea of emotional balance was central to Wallace Laboratories advertisements for the drug Deprol (Illustration 21). The drug was a meprobamate-benactyzine combination designed to simultaneously calm anxiety and lift depression. The balanced action of Deprol was illustrated on the second page of the ad by a drawing of a scale which remained level supposedly because the drug reduced anxiety and alleviated depression in just the right combination. The fact that this drawing was situated inside a silhouette of a human brain which in turn was superimposed over a profile photo of a female patient reinforced the message that at the root of her emotional difficulties was a psychological, rather than an environmental or a physical, problem. The effectiveness of Deprol was also illustrated on the first page of the ad by a photograph of a happy-looking woman and her doctor at the end of what appears to have been a very worthwhile medical appointment. The accompanying caption described her as "an emotionally balanced patient" thanks to her doctor and Deprol. Evidence of her emotional stability was highlighted by the fact that she now "eats well, sleeps

Frank Orland, "Use and Overuse of Tranquilizers," Journal of the American Medical Association 171,6 (October 10, 1959), 634. See also Thomas Whiteside, "Onward and Upward with the Arts: Getting There First With Tranquility," New Yorker, May 3, 1958, 117; "Tranquilizing Drugs," American Journal of Medicine 27,5 (November 1959), 767.

Lifts depression...as it calms anxiety!

**Deprol helps balance the mood
by lifting depression as it
calms related anxiety**

to "see-saw" effect of amphetamine- withdrawals and energizers

Tall amphetamines and energizers may stimulate the patient—they *can* aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation—they often *open* depression.

contrast to such "seesaw" effects, *propranolol* lifts depression as it calms anxiety—both at the same time.

**First choice of medication than
tested drugs**

prol does not produce hypotension, liver damage, psychotic reactions or changes in sexual function.

Deprol⁴¹

DOSE: Usual starting dose is 1 tablet 3 times a day. When necessary, this may be gradually increased up to 3 tablets 4 times a day. **CONTRAINDICATIONS:** 1 mg, 2-diethylaminoethylsuccinate hydrochloride (benactyl-HCl) and 400 mg, meprobramate. **APPLIED:** Bottles of 60 light-pink, round tablets. Write for literature and samples.

An emotionally balanced patient
Thanks to your treatment and the help of Deprol, her depression is relieved and her anxiety and tension are calmed. She eats well, sleeps well, and can return to her normal activities.

**Now
Available**

WALLACE LABORATORIES/Toronto, Ontario

Illustration 21: Advertisement for Deprol by Wallace Laboratories. Source: Canadian Doctor 26,1 (January 1960), 78-9.

well, and can return to her normal activities."

A number of advertisements went one step further and explicitly emphasized a three-fold relationship between the calming effects of anti-anxiety agents, the emotional stability of women, and the maintenance of normal family life. In particular, these ads implied that by reducing anxiety levels in women, minor tranquilizing drugs made women more accepting of their natural role as mothers, wives, and homemakers.⁵⁷ One way in which drugs were supposed to do this was by counteracting women's anxiety and ambivalence surrounding pregnancy and motherhood. According to one tranquilizer manufacturer, its product would put prospective mothers in a state of "placid expectation."⁵⁸ For women who already had children, this same manufacturer maintained that its tranquilizing drug was also useful when the stress of caring for children became particularly acute. On these occasions, the company's anti-anxiety agent promised to bring women "complete and dramatic relief [of pain] set off or aggravated by loud noises and by ...

⁵⁷ Philip Kurtz, "The Current Status of the Tranquilizing Drugs," Canadian Medical Association Journal 78,3 (February 1, 1958), 214; P. Susan Penfold and Gillian A. Walker, Women in the Psychiatric Paradox (Montreal: Eden Press, 1983), 199; Mickey C. Smith, Small Comfort: A History of the Minor Tranquilizers (New York: Praeger, 1985), 101.

⁵⁸ Whiteside, "Onward and Upward," 90.

children playing around the house."⁴

Quite apart from their purported benefits for mothers, tranquilizing agents were also marketed as enabling women to become better wives and homemakers. For example, meprobamate in combination with the natural estrogen product Premarin was recommended for the tense and anxious menopausal woman who found it difficult to bring herself to perform her daily domestic duties (Illustration 22). The ability of the drug to effect significant change in the behaviour of the patient was reinforced in the advertisement by the display of dramatic "before treatment" and "after treatment" photographs. In the "before" photo, the woman was shown with a pained look on her face as she rested her head on her arm over the back of a sofa. By contrast, the much larger "after" photo of the woman showed her happily pushing a shopping cart full of groceries. The advertisement suggested that the woman's willingness to resume her regular household duties was directly related to the ability of meprobamate and Premarin to alleviate her anxiety and restore her to mental health as evidenced by her "gratifying 'sense of well-being' and greater enjoyment of everyday living."

As this last example indicates, meprobamate and other

⁴ Ibid., 90.

Every woman suffering from estrogen deficiency deserves "Premarin"
 Prompt symptomatic relief (often with an initial dosage as low as 1.25 mg. daily) gives the patient
 a gratifying "sense of well-being" and greater enjoyment of everyday living.

"PREMARIN"

STILL LEADING IN ESTROGEN REPLACEMENT THERAPY

And when the menopausal syndrome
 is complicated by excessive tension...

"PREMARIN"

with

MEPROBAMATE

Provides extra relief from mental
 and muscular tensions

Ayerst, McKenna & Harrison
 Montreal

Illustration 22: Advertisement for Premarin with meprobamate
 by Ayerst. Source: Canadian Doctor 24,1 (January 1958), 44.

minor tranquilizing drugs in combination with hormone preparations were directly marketed for use by women as an effective means of relieving anxiety and other emotional symptoms associated with menopause. While menopause was primarily a physiological process, advertisements for combination drugs tended to imply that anxiety, tension, and emotional stress in menopausal women were not manifestations of hormonal changes so much as an indication of the presence of deeper psychological problems. This assumption was in sharp contrast to the opinion held by Kay Crowe, Director of the Department of Family Life and Parent Education at the Mental Hygiene Institute in Montreal. Crowe argued that the emotional uncertainty experienced by many menopausal women did not so much reflect a psychological problem as it reflected a cultural problem. She observed that a number of women found it very difficult to enjoy their later years because after they had finished raising their children, society was unable to offer them another equally satisfying role.⁶⁰ In contrast to both combination drug advertisements and Crowe, Dr. Marion Hilliard of Women's College Hospital in Toronto argued that anxiety, tension, and emotional stress in menopausal women were common psychological symptoms resulting from changes in hormone levels. Hilliard

⁶⁰ June Callwood, "Could YOU Have A Nervous Breakdown?" Chatelaine, December 1959, 62.

noted that some women did develop severe emotional problems during menopause but she believed that these women had always had personalities with deep neurotic tendencies which the onset of menopause had simply made more apparent.²¹ In spite of some unpleasant symptoms, Hilliard reassured women that menopause did not mean that they were leaving the best years of their lives behind them. In fact, Hilliard referred to menopause as a "woman's greatest blessing" because it marked the point after which women, for the first time since adolescence, were able to depend upon their moods, bodies, and energy levels to be constant.²²

The psychogenic approach of the pharmaceutical industry to the issue of anxiety and other emotional symptoms associated with menopause was highlighted in an advertisement designed to promote the advantages of Premarin in combination with meprobamate (Illustration 23). The ad used a cut away photograph of the face of the same woman who had been happily pushing a shopping cart full of groceries in Illustration 22. To the right of the photo was a

²¹ Marion Hilliard, A Woman Doctor Looks at Love and Life, (Garden City, N.Y.: Doubleday, 1957; PermaBooks, 1960), 119.

²² Ibid., 126-8. See also Marion Hilliard, "The Menopause Is Woman's Greatest Blessing," Chatelaine, April 1955, 16; Oliver Spurgeon English and Gerald Hamilton Jeffrey Pearson, Emotional Problems of Living: Avoiding A Neurotic Pattern, 2d ed. (New York: Norton, 1955), 432-4.

Orientation Therapy . . . to remove the psychogenic overlay when unusual emotional stress complicates the menopausal picture

- when the patient is by temperament "high strung" and tense
- when psychogenic manifestations are acute, prominent or prolonged
- when more rapid emotional adjustment is desired in the initial stage of therapy

"PREMARIN" with MEPROBAMATE

To remove the psychogenic overlay . . .
Meprobamate reduces tension, lessens irritability and restlessness, promotes more restful sleep and generalized muscle relaxation.
(Borrus, J. C. P.: J.A.M.A. 157:1596 (Apr. 30) 1955.)

To treat the basic estrogen deficiency . . .
"Premarin" supplements declining endogenous-estrogen levels and provides prompt symptomatic relief of distressing symptoms plus a gratifying "sense of well being."

**Ayerst, McKenna & Harrison Ltd.,
Montreal**

Illustration 23: Advertisement for Premarin with meprobamate by Ayerst. Source: Canadian Doctor 23,9 (September 1957), 45.

description of some of the occasions on which this combination drug was indicated. The description was vague and open to interpretation as in the case of the recommendation to prescribe Premarin and meprobamate for the patient who experienced emotional symptoms which were "acute, prominent, or prolonged." It also tended to attribute women's emotional distress to personal shortcomings with the suggestion that the drug was appropriate for use by the female patient who was "by temperament 'high strung' and tense" and more prone to manifest "unusual emotional stress." In short, this advertisement assumed that emotional symptoms experienced by menopausal women were "psychogenic." That is, the symptoms had their origin not in any physical or cultural conditions but in the patient herself. As a result, the ad suggested that the onus was on menopausal women to make any necessary emotional adjustments and recommended Premarin with meprobamate as the combination drug best able to ensure that these women made it through this adaptation period with a minimum of emotional discomfort.

Similarly, meprobamate and other tranquilizing agents were promoted for use by women who suffered from anxiety and other emotional symptoms prior to menstruation. As was the case with menopause, journal advertisements implied that premenstrual anxiety, tension, and emotional stress in women

indicated the presence of deeper psychological problems. This assumption was reinforced by the appearance of clinical studies. In December 1958, psychiatrists J.N. Fortin and E.D. Wittkower, and dermatologist F. Kalz of Montreal published a preliminary report in which they concluded that psychological well-being was directly related to the presence or absence of premenstrual symptoms. The research team had taken a psychosomatic approach to the problem of the premenstrual tension syndrome in an attempt to determine the role of personality factors in the onset and clinical course of the syndrome. They found that women who experienced premenstrual symptoms such as irritability, fatigue, depression, and headaches were more likely to resent or reject the feminine role, to envy men, and to display poor sexual adjustment.⁶³ Lawrence Galton, writer of the "Here's Health" column in Chatelaine magazine, also reported that emotional disturbances in women were the most important factor in producing premenstrual symptoms. As a result, Galton suggested that tranquilizing drugs were probably the most effective means of treating the

⁶³ J.N. Fortin, E.D. Wittkower, and F. Kalz, "A Psychosomatic Approach to the Pre-Menstrual Tension Syndrome: A Preliminary Report," Canadian Medical Association Journal 79,12 (December 15, 1958), 978-81. See also Prentice et al., Canadian Women, 384.

condition."⁴ This was certainly the message that Wyeth Laboratories attempted to convey in the Equanil advertisement it placed in the October 1957 edition of Canadian Doctor (Illustration 24). The ad featured a photograph of the face of a young woman who appeared somewhat tense and anxious as she leaned her head against her arm for support. Above her head was a reminder that anxiety, worry, headaches, and tension were four "characteristic premenstrual symptoms." According to this advertisement, the advantage of using Equanil to alleviate these symptoms was that it "relaxes both mind and muscle" (emphasis in original). In other words, Equanil was effective because it was able to get at the psychological and the physical source of the premenstrual problem. Nevertheless, the nondescript discomfort on the face of the female patient, the choice of premenstrual symptoms which were typically associated with emotionally unstable women, and the allusion to the importance of the mind-body connection popularized by the psychosomatic approach to medicine left the overall impression that women who suffered from premenstrual symptoms had an underlying psychological problem which made them more likely to not only exhibit symptoms of an emotional nature but need the kind of

⁴ Lawrence Galton, "What Causes Premenstrual Tension?" Chatelaine, November 1960, 13.

ANXIETY • WORRY • HEADACHE • TENSION
... characteristic premenstrual symptoms

Equanil

MEPROBAMATE
(2-methyl-2-propyl-1-propanediol dicarbamate)
Patented 1957; No. 537437
Supplied: Equanil (scored) tablets, 400 mg., bottles of 50.

RELIEVES BOTH
MIND AND MUSCLES

"Because of relief both physical and psychic... I consider meprobamate an important addition to the useful armamentarium of the general practitioner and gynecologist."

V.M. Pennington, M.D.
J.A.M.A. Vol. 164, No. 6 (June 1957)
Comprehensive literature on request

Wyeth

REG. TRADE MARK
WALKERVILLE, ONTARIO
MONCTON • MONTREAL
WINNIPEG • VANCOUVER

*Reg. Trade Mark

Illustration 24: Advertisement for Equanil by Wyeth Laboratories. Source: Canadian Doctor 23,10 (October 1957), 59.

symptomatic relief that was provided by a minor tranquilizing drug like Equanil.

As noted in Chapter Three, general practitioners were motivated by a number of factors when deciding whether or not to prescribe the new tranquilizing drugs during the 1950s. Some of these factors included the desire to use a non-barbiturate sedative, convenience, patient demand, and strong marketing tactics. This chapter suggests that the marked gender differential in diagnostic categories and prescription rates indicate that physicians were also heavily influenced by the mutually-reinforcing social constructions of gender, medicine/mental health, and minor tranquilizers which forged a strong link between dominant ideas about women, emotional instability, and the need for anti-anxiety medication. While no doubt there were doctors who rose above these conservative medical and cultural stereotypes, the sketchy evidence that is available implies that deviators from the narrow norm were likely few and far between. For example, University of Pennsylvania School of Medicine psychiatrist Frank Orland believed that tranquilizers were especially useful when women needed help over a period of emotional stress. Ironically, it was also his belief that these drugs should be prescribed for women

who were about to be married.⁶³ In another instance of marital stress, American physician Julius Michaelson even advocated tranquilizer use by women who did not want to have sex with their husbands. According to Michaelson,

Dyspareunia is a symptom complex which may be precipitated by many etiological factors, such as fear of pregnancy or subconscious sexual taboos. Often, especially after the second or third pregnancy in a young, attractive woman, we hear this comment: "Doctor, I love my husband but I can't stand for him to touch me." In this situation reassurance plus expert advice in the use of contraceptive devices or drugs plus the use of meprobamate with its tranquilizing as well as muscle relaxing properties have proved very effective.⁶⁴

There were probably very real and legitimate reasons why the women in these examples were feeling so much anxiety and emotional stress. However, the fact that their symptoms were viewed as a manifestation of individual pathology in need of individual drug treatment highlighted once again the extent to which medicine and society at large during the 1950s assumed that emotional discontent in women was an indication of deeper psychological problems.

If doctors were more likely to perceive married, middle-aged women as anxious, neurotic, and unable to cope

⁶³ Orland, "Use and Overuse of Tranquilizers," 634.

⁶⁴ Michaelson, "The General Practitioner's Role in the Control of Anxious and Neurotic Patients," 441.

with daily life, married, middle-aged women were also more likely to perceive themselves in the same way. Between May 1954 and February 1955, Dr. F.M. Martin and his colleagues from the Department of Public Health at the University of London invited 750 families from a nearby housing estate to volunteer information about their own health. As part of the study, individuals were given a check-list of symptoms and asked whether they were troubled by or subject to any of them. The results showed that women were at least twice as likely as men to complain of depression, "nerves," and sleeplessness but only marginally more inclined than men to complain of undue irritability. Moreover, the study indicated that women but not men complained more frequently about each of these symptoms as they got older with a sharp decline in incidence appearing after age sixty-five."

F.M. Martin, J.H.F. Brotherston, and S.P.W. Chave, "Incidence of Neurosis in a New Housing Estate," British Journal of Preventive and Social Medicine 11,4 (October 1957), 199-200. For further evidence to suggest that women were more likely than men during the 1950s to perceive themselves as anxious, neurotic, and unable to cope with daily life, see Alex C. Sherriffs and John P. McKee, "Qualitative Aspects of Beliefs About Men and Women," Journal of Personality 25,4 (June 1957), 460-3; Callwood, "Could YOU Have A Nervous Breakdown?" 21,60; Palmer, "The Physician's Approach to Management of the Psychoneuroses," 306; Gurin, Veroff, and Feld, Americans View Their Mental Health, 271,295,310; Ann Cartwright, "Prescribing and the Relationship Between Patients and Doctors," in Ruth Cooperstock, ed., Social Aspects of the Medical Use of Psychotropic Drugs (Toronto: Alcoholism and Drug Addiction Research Foundation of Ontario, 1974), 64.

Perhaps one of the main reasons why more women than men felt anxious and unsure of themselves during the 1950s was because dominant social values which emphasized competitive individualism were very much at odds with women's prescribed social role which emphasized family sentimentality. This point was highlighted by Barnard College sociologist Mirra Komarovsky in her 1953 book entitled Women in the Modern World: Their Education and Their Dilemmas. Komarovsky had discovered in the course of her research that many middle-class, college-educated women found it difficult to take pride in themselves and their status as mothers and homemakers in part because the society in which they lived more readily rewarded economic independence and advancement in the occupational hierarchy. Komarovsky argued that curriculum changes in post-secondary institutions alone would not solve the uneasiness experienced by these people or the ongoing tensions between men and women. What was needed, she asserted, was a dramatic social re-orientation towards a system of values which affirmed the nurturing activities traditionally performed by women:

It is quite true that building bridges, writing books, and splitting the atom are no more essential to society or more difficult than child rearing. But, in our opinion, women cannot be made to believe it unless men believe it too; unless, that is, the whole of our society becomes oriented towards values quite different from those

which dominate it today."

Still, some women managed to find workable solutions to their problems which brought a degree of satisfaction to their lives. When Eileen Morris, housewife, regular contributor to Chatelaine magazine, and mother of two small boys, realized that she needed to have some time just to herself during the day, she decided that the best way to accomplish this was to lower her expectations of herself. For example, Morris stopped worrying if she was unable to do the laundry every day, she tolerated the fact that her house was not completely spotless, and she resisted the temptation to run after her kids with a damp cloth and remove all evidence of dirt from their faces. As a result, Morris completed her housework by one o'clock and spent a couple of hours each afternoon reading while her children played." In another instance, Vancouver housewife Joan Greenwood felt herself becoming more and more depressed as her children became older and more independent and as she obtained less and less satisfaction from her domestic responsibilities.

" Mirra Komarovsky, Women in the Modern World, 291. Her argument is elaborated on pages 288-300. See also Margaret Mead, "What Makes Women Unhappy?" Chatelaine, March 1960, 25. For a broader historical discussion of the twentieth-century tension between female domesticity and male individualism, see Coontz, The Way We Never Were, 42-67.

" Eileen Morris, "Housework is a Part-Time Job!" Chatelaine, March 1960, 28.

In order to break away from a situation in which she was beginning to feel trapped, Greenwood got out of the house and went hiking with Duffy the family dog. "My walking trips are my private route to self-respect," she explained. "They are one woman's answer to the 'back number blues,' those frustrations and depressions that too easily overwhelm middle-aged housewives like myself."

By contrast, women who remained dissatisfied in life often blamed themselves for their inability to conform to the popular image of the happy and contented wife and mother who lived to meet the needs of others. As one young mother wrote to Mirra Komarovsky,

What is wrong with me that home and family are not enough? ...I see all my friends fighting some phase of this problem, each in her own way, wanting to find the family the complete source of happiness and satisfaction but unable to, and consequently feeling guilty."

Phyllis Bray, who lived in the single industry town of Manitouwadge, Ontario from 1956 to 1968, also attributed her difficulties to deficiencies within herself. Bray was caught in a situation where publicly the town was promoted as an ideal environment but privately she had trouble adjusting to a place which made room for her only as a wife

Joan Greenwood, "Don't Shoot...It's the Hiking Housewife," Chatelaine, June 1954, 24.

Komarovsky, Women in the Modern World, 127.

and mother. She reconciled these contradictory interpretations by finding fault in herself. After all, she remembered,

who was I to question a solution to the single industry town which was approved by governments, companies, planners, and, indeed, seemed acceptable to many of the woman residents? I could only assume that mine was a personal problem of adjustment.

Fortunately for Bray, she managed to create work for herself by founding a local library, but not all women were so lucky. In September 1951, Chatelaine magazine published an article by an unnamed woman who had tried to commit suicide two years earlier. Her suicide attempt had followed another unhappy Sunday dinner. The woman had hoped that in preparing an elaborate meal for her family that she could alleviate some of the inter-generational tensions within it. This was not to be the case and, in the face of continuous squabbling among family members, the woman had found fault in herself for her inability to live up to the high expectations society had placed on her and she had placed on herself. "As always," she recalled,

I was miserably in the middle of it all, the

Margaret Phyllis Nunn Bray, "'No Life For A Woman': An Examination and Feminist Critique of the Post-World War II Instant Town with Special Reference to Manitouwadge," M.A. thesis, Queen's University, 1989, 127. See also McCracken, Memories Are Made Of This, 16; Hammer, "Inventing Ourselves," 54; Strong-Boag, "Home Dreams," 503-4; Harvey, The Fifties, 126.

hopeless referee, trying to resolve the differences of three generations. A wiser woman would have seen the humour of four teens and twenties, a middle-aged man, and an old woman trying to reorganize the world. A more dominant woman would have shut them up. A weaker woman would have wept and found relief. But this endless wrangling seemed to me a humiliating exposure of our failure as a family, by which I really meant the failure of my husband and my children to live up to the ambitions I had for them all. And for this failure I blamed myself entirely.¹³

For women who felt anxious, neurotic, and unable to cope with daily life, going to a doctor during the 1950s was a popular and socially acceptable means of dealing with emotional distress. For example, Chatelaine reporter June Callwood interviewed a number of psychiatrists and social workers in Montreal and Toronto for a story about the high incidence of nervous breakdown, especially among housewives. The mental health professionals she talked to argued that the apparent increase in the number of breakdowns among women was due in part to the fact that emotional problems no longer had the same degree of social stigma attached to them which helped encourage more distressed women to seek professional help rather than attempt to cope with their

¹³ "I Tried to Commit Suicide," Chatelaine, September 1951, 5. See also, Margaret Ecker Francis, "Return from the Shadows," Chatelaine, April 1952, 18; Callwood, "Could YOU Have A Nervous Breakdown?" 60, 64.

difficulties on their own."⁴ Kay Crowe, Director of the Department of Family Life and Parent Education at the Mental Hygiene Institute in Montreal also observed that help-seeking behaviour was particularly prominent among middle and upper income women who seemed more likely than poorer women to recognize psychoneurotic symptoms and expect appropriate treatment."⁵ The readiness with which women in particular were willing to consult a doctor about emotional problems was supported by the experience of Victoria, B.C. physician Dr. R.A. Palmer who not only saw more women than men suffering from psychoneurosis but found that some patients would even arrive at his office openly suggesting the possibility of psychoneurosis."⁶

Once at their doctors' offices, women who blamed themselves for their inability to find happiness and contentment in marriage and motherhood were probably more willing to accept medical diagnoses which also located the

⁴ Callwood, "Could YOU Have A Nervous Breakdown?" 21. When Gerald Gurin and his colleagues conducted interviews with 2460 Americans about their mental health, they found that eighty-eight percent of those who had sought professional help in order to alleviate feelings of an impending nervous breakdown had chosen to see a medical doctor. Gurin, Veroff, and Feld, Americans View Their Mental Health, 310-1.

⁵ Callwood, "Could YOU Have A Nervous Breakdown?" 62.

⁶ Palmer, "The Physician's Approach to Management of the Psychoneuroses," 306.

source of their problems within themselves. Bolstered by a medical explanation from an authority figure which confirmed and legitimated their experiences, these women were in turn probably more willing to accept a medical solution like minor tranquilizing drugs which promised to confer on their condition the power, potential, and legitimacy of medical science. As prominent American psychiatrist Ian Stevenson pointed out in 1957, doctors who prescribed tranquilizing drugs could not help but also communicate at least two important messages to their patients. First, the act of giving medication said to the patient, "I am interested in you and I will care for you." Second, giving a pill implied, "If you take this medicine you will become better."¹⁷ For some women who felt personally responsible for their own unhappiness and at the same time were unable to conceive or realize better alternatives to their present situations, the interest and hope offered by their doctors in the form of a pill made tranquilizer therapy an attractive solution to difficult circumstances, no less so because minor tranquilizing drugs during the 1950s represented some of the best of what medical science had to offer in the ongoing march of social and medical progress.

¹⁷ Stevenson, "Tranquilizers and the Mind," 23.

Regardless of the deciding factors which prompted men and women to visit their family physicians about a particular emotional symptom or problem, one characteristic that was often true about individuals who sought medical attention was their belief that the doctor could cure or relieve whatever ailed them. In the 1950s, the authority of the doctor was near absolute. As has been argued, professional and public interest in and knowledge about mental health was at a peak. It was assumed that medical science was capable of treating any emotional ailment and minor tranquilizing drugs were proof to many that unwanted emotions could be effectively and safely eliminated. Men and women still visited their doctors at the same rate but more women than men reported problems relating to home and family and understood these issues in psychological terms. Doctors were also more likely to interpret women's complaints as a sign of emotional instability and treat the condition by writing them a prescription for an anti-anxiety agent like meprobamate. While the long-term physical and emotional consequences of this prescription pattern would require another study in itself, it is quite possible that in the 1950s minor tranquilizing drugs represented to some women an option which not only provided them with immediate relief of unpleasant and potentially disruptive anxiety, tension, and emotional stress but a hope that through the

latest that modern medicine had to offer they would find the happiness and satisfaction they so desperately desired from their role as wives, mothers, and homemakers.

CONCLUSION

In 1955, meprobamate became the first minor tranquilizing drug to appear on the pharmaceutical market in both Canada and the United States. It was promoted as a safe and effective means of alleviating mild to moderate anxiety, tension, and mental stress, and was originally intended for use in clinical practice to treat conditions of a medical nature. But, almost overnight, the consumption of meprobamate became quite fashionable, especially in the show business community and among the middle class. Demand for the drug increased, sales figures grew, and the conditions for which it was used expanded to include minor worries and everyday upsets. Significantly, women were twice as likely as men to receive a prescription for this new product.

The introduction and widespread use of meprobamate and other minor tranquilizing drugs in English-speaking Canada during the 1950s are representative of larger patterns in the process of medicalization -- a process whereby more and more aspects of everyday life, including gender roles, were deemed to be appropriate venues for the intervention of medical science. What can an investigation of meprobamate reveal about the medicalization process itself? In her study of upper- and middle-class birthing women in the

United States from 1750 to 1950, Judith Walzer Leavitt argued that changes in childbirth practices and procedures prior to childbirth moving to the hospital during the early part of the twentieth century were the result of long-term negotiations between birthing women and their physicians. Significantly, Leavitt recognized women's active involvement in the medicalization process and attempted to explain their choices in light of the wider historical context in which these choices were made. While understanding the medicalization process as largely the product of an encounter between the medical profession/doctors and patients at different historical junctures may help explain the medicalization of childbirth prior to 1950, a study of the introduction and popularity of meprobamate suggests that the medical profession/doctor-patient framework is unable to account fully for the increased medicalization of everyday life in English-speaking Canada after World War II. Instead, the example of meprobamate indicates a need to include at least a third dimension to any postwar analysis of the medicalization process: the expanded role of pharmaceutical companies. After the war, the drug industry grew dramatically and assumed more and more responsibility for informing and educating both doctors and the general public about the latest in drug therapy. In turn, the industry promoted new pharmaceutical products in a

particularly aggressive manner, demonstrating sophisticated marketing skills that tapped deeply into popular culture. Specifically, drug companies capitalized on the widespread belief in the potential for unlimited personal and social improvement through medicine and medical science as well as strong popular support for the strict adherence to narrowly-defined gender roles. This advertising clearly had an important bearing on the decisions of doctors to prescribe and patients, especially female patients, to consume meprobamate and other minor tranquilizing drugs for conditions of a non-medical nature.

Wallace Laboratories and Wyeth Laboratories were interested ultimately in profiting as much as possible from the sale of meprobamate and therefore aggressively marketed Miltown and Equanil for the symptomatic relief of anxiety and anxiety-related illnesses. In marketing meprobamate to general practitioners through medical journal advertisements, direct mailings, and visits from detail men, Wallace and Wyeth attempted to get doctors to prescribe tranquilizers for their tense and anxious patients not by forcing them to act but by persuading them that the ready distribution of these drugs was in their professional and personal best interest. Therefore, drug company-sponsored advertising appealed to everything from doctors' desire to be associated with the latest in drug therapy to their

desire to alleviate patient distress and suffering to their desire to rid the office of demanding or unpleasant individuals. In general, these ads presented doctor-patient scenarios that would have been familiar to practising physicians, implied that the patients in question were suffering from a medical condition in need of medical intervention, and suggested that a prescription for meprobamate was an intervention that would satisfy both doctors and patients alike.

In marketing meprobamate to the general public through stories planted in the popular press, Wallace and Wyeth also relied on the power of persuasion. Above all, the company-sponsored articles in newspapers and magazines attempted to persuade Canadians that mild to moderate anxiety did not have to be tolerated because medical science had developed a safe and effective pill to do away with this unwanted and unpleasant emotion. The drug companies made sure that the information about meprobamate that appeared in the press was uniformly positive. They often included descriptions of industry-funded research as well as stories from men and women who had taken the drug. In each case, meprobamate was reported to have dramatically reduced anxiety levels in tense and anxious individuals without displaying any addictive or toxic side effects. However, the conditions for which meprobamate was shown to provide symptomatic

relief were so diverse and the definition of anxiety was so broad that virtually everyone could identify at some level with the subjects in the articles and therefore come to believe that happiness and contentment were only a pill away. The company-sponsored stories also legitimized meprobamate in the public mind because they appealed to a number of sometimes contradictory social values. For example, these stories couched meprobamate's discovery and distribution in the context of the ongoing march of medical progress, announced that meprobamate was so safe that it could be purchased over the counter in some provinces, and reminded readers that only a medical doctor was qualified enough to properly dispense such a valuable addition to the arsenal of modern medicine.

In contrast to the profit-seeking interests of the drug companies, general practitioners were interested in treating their anxious and tense patients in the most effective way they knew which sometimes included writing prescriptions for minor tranquilizing drugs like meprobamate. Doctors may have found anti-anxiety agents particularly attractive if they did not have the patience, time, or ability to do psychotherapy or even talk with their distressed patients in a meaningful and supportive way. Regardless of their interpersonal skills, practitioners may have also found tranquilizing drugs attractive because they

shared in the sense of therapeutic optimism which characterized the postwar period. This optimism was reinforced from every quarter. Drug company literature and detail men emphasized the safety and effectiveness of meprobamate. Clinical studies and articles in the popular press gave mixed reviews of meprobamate but on the whole were relatively positive about the new drug. Patients, brandishing clippings from newspapers or magazines, demanded the latest in drug therapy which would supposedly eliminate their unpleasant and unwanted emotional pain. So strong was their trust in scientific medicine, it is quite probable that doctors did not even consider the possible short-term or long-term effects of minor tranquilizer use. In addition to their limited professional skills and overall trust in medical science, physicians may have found tranquilizers attractive, especially for their female patients, because they were unable to critically analyze the scientific and promotional literature available on meprobamate and other new anti-anxiety agents. This was the case in part because doctors were not trained to think critically about scientific evidence and new medical discoveries. It was also true in part because some of the images presented in drug company advertisements -- like the idea that more women than men were anxious and in need of minor tranquilizing drugs -- recreated situations that would have been familiar

to practising physicians and/or reinforced socially constructed notions about gender and anxiety which remained virtually unchallenged during the fifties. Together, these factors encouraged general practitioners to indiscriminately and inappropriately prescribe anti-anxiety agents for all of their tense and anxious patients but especially for their emotionally-stressed female patients.

Fitting nicely with the interests of the pharmaceutical companies and general practitioners, a number of Canadians wanted relief from anxiety, tension, and emotional stress and believed that minor tranquilizing drugs like meprobamate were the quickest and most effective means of achieving this goal. The Canadian public became informed about anxiety and other emotional problems in part because of the popularization of psychiatry and psychiatric principles after World War II. The dissemination of these ideas probably did not create anxiety in people so much as it made some people more aware of its existence and more afraid that anxiety and emotional instability left unchecked would have detrimental individual and social consequences. Thanks to the popularization of psychiatric ideas and the appearance of a number of powerful new drug therapies since the mid 1930s, the public also became increasingly optimistic that medicine and medical science held the key to unlimited personal and social fulfilment. This may help explain the

apparent spontaneous nature of some of the enthusiasm expressed by the public for meprobamate following its introduction in 1955. It certainly suggested that the public did not feel that it needed to tolerate unwanted emotions when safe and effective drugs were available to eliminate them. This public awareness about anxiety and enthusiasm for the latest in modern medicine was certainly reinforced by Wallace and Wyeth with their very positive stories about meprobamate in the popular press. Equally important, Canadians placed a great deal of trust in the authority and intentions of their family doctors and would not have questioned their doctors' decision to give them a prescription for a minor tranquilizing agent. Nevertheless, some Canadians seemed to trust more in their own experiences and the promise of medical science than in the supposed inherent wisdom of their doctors as sometimes it was members of the lay community who took the initiative in obtaining these new drugs. For example, some Canadians, having determined for themselves that they needed an anti-anxiety agent, purchased meprobamate over the counter at their local drugstores. Others went to their doctors, insisted on a prescription, and threatened to switch to another doctor if their demands for the drug were not met. It is impossible to determine the extent to which Canadians who consumed minor tranquilizing drugs were acting in their own best

interests and the extent to which they were acting in what they were told were their best interests by drug companies, and a variety of experts, including general practitioners. But the consumption of these drugs probably gave people exactly what they were looking for -- a measure of symptomatic relief from disruptive emotions which in turn made it easier for them to cope with life and avoid the need to make more constructive changes.

While it is not clear whether more women than men demanded meprobamate for the relief of anxiety, tension, and emotional stress, it is certainly clear that more women than men received prescriptions for this and other minor tranquilizing drugs during the 1950s. This gender differential in the distribution of tranquilizers was partly the result of professional interests dovetailing with the postwar assumption that anxiety in women was a symptom of emotional instability and a threat to familial and social well-being. Wallace and Wyeth highlighted the relationship between women, anxiety, and the need for meprobamate in their drug advertisements aimed at general practitioners. Popular mental health ideas, focussing primarily on children and their home environment, emphasized the importance of the emotional health of women and made a direct link between gender role conformity, mental health, and social stability which likely contributed to the fact that women were more

likely than men to understand and discuss their problems in psychological terms. And general practitioners, influenced by drug company advertising and interested in treating emotional symptoms as quickly and effectively as possible, prescribed more minor tranquilizing drugs for women than men in part because more women than men came to them with problems of an emotional nature.

But if the gender differential in the distribution of tranquilizers was partly the product of professional interests and postwar social constructions of womanhood, it was not a conspiracy and women were not entirely passive recipients of these drugs as some earlier feminist historians who conceived medicalization as a form of social control had suggested. Women, like men, shared in the hope for unlimited personal and social fulfilment through medicine and medical science. Women, like men, also bought meprobamate over the drugstore counter, asked their physicians to prescribe this new product for them, and accepted prescriptions from their doctors for meprobamate and other anti-anxiety agents. Therefore, the medicalization of gender was facilitated in part by women who actively negotiated their health care needs as Leavitt has argued, but it remains impossible to know for sure just how freely they were able to act given the relatively narrow confines of postwar society.

In addition to its contribution to the discussion of the medicalization process, what can an investigation of the introduction and widespread use of meprobamate in English-speaking Canada during the 1950s contribute to the historical interpretation of Canada and the postwar period? As noted above, a study of the meprobamate phenomenon and the medicalization of every day life reveals that Canadians at the time embodied at least two apparently conflicting desires: the desire for progress and change as symbolized by the belief in the potential for unlimited personal and social improvement through medicine and medical science, and the desire for stability and status quo as symbolized by the belief in the strict adherence to narrowly-defined gender roles. This simultaneous rush forward and retreat backward suggests that the fifties decade in Canada was a time of great paradox. Underlying this paradox, however, was a common attempt to overcome and prevent the recurrence of the political uncertainty, economic hardship, social dislocation, and physical and emotional pain and suffering which had accompanied the depression and World War II.

On the one hand, the postwar period was a very hopeful time and something of a golden age for Canadians as Robert Bothwell, Ian Drummond, and John English have argued. Canadians enjoyed relative political stability, continued economic growth, and the expansion of the welfare state

which at the time was seen as a positive step. There was also the sense that the future held unlimited potential for ongoing improvement. Medicine and medical science were at the forefront of fifties optimism. Canadian psychiatrists repeatedly assured the public that the profession had learned from past experience and had developed the tools necessary to ensure individual happiness, social stability, and global peace in the years to come. As the latest in a long line of new drug therapies which had helped to control infectious diseases and psychotic symptoms in ways that appeared at the time almost miraculous, the introduction of meprobamate in 1955 seemed to confirm the power and possibility of medical science to improve the quality of life for all Canadians in that it promised to reduce unpleasant and unwanted feelings of anxiety, tension, and emotional stress which threatened to interfere with the attainment of individual and social well-being. For men, the consumption of meprobamate promised more energy for work and professional advancement. For women, the consumption of meprobamate promised healthier and more satisfying relationships with their husbands and children. The idea of a healthier and more secure future through medicine and medical science was particularly attractive to Canadians who were just emerging from almost two decades of unprecedented political, economic, and social disruption. In this

context, meprobamate and other minor tranquilizing drugs represented all that was good about Canada during the fifties and all that was possible for Canadians in the future.

On the other hand, the postwar period was also a very fearful and repressive time for Canadians as Reg Whitaker and Gary Marcuse have argued. Canadians were confronted with continued uncertainty in a postwar world that was worried about communism, the threat of nuclear war, and the potential effects of radioactive fallout. Therefore, while the 1950s seemed to promise ongoing political, economic, and social progress, the period also seemed to offer ongoing political, economic, and social upheaval. Either way, Canadians faced the prospect of yet another decade of constant and unpredictable change. Amidst this climate of instability, narrowly-defined gender roles seemed to promise to deliver a degree of order and predictability to the lives of ordinary Canadians. The idea of personal, familial, and social stability through the strict adherence to proper gender roles was particularly attractive to Canadians for at least two reasons. First, gender role conformity provided a sense of finally being able to return to a way of life that had been lost or disrupted by depression and war. Canadians longingly looked back to what they believed was a more simple and happy time when men and women knew their places

and society was more orderly because of it. They may have had overly romantic notions about the past but Canadians were drawn to the idea of narrowly-defined gender roles because it fed their desire to settle down and resume "normal" lives after the war while it reassured them that their choices would help create a measure of individual and social stability in an otherwise unpredictable postwar world. Second, gender role conformity was attractive to Canadians because it allowed them to feel more in control of their lives and the world around them. In the face of an ever-changing and uncertain future, clearly-defined gender roles appeared refreshingly immediate, familiar, and predictable. If Canadians felt helpless to make a direct impact on global issues like the threat of nuclear war, gender role conformity was seen as a concrete means by which men and women could contribute to ensuring personal, familial, and social well-being in the name of world peace. Ultimately, then, the strict adherence to proper gender roles appealed to Canadians because they wanted to take advantage of postwar progress while enjoying a degree of postwar stability.

If both men and women were attracted to the idea of narrowly-defined gender roles during the 1950s, postwar social and economic conditions placed added pressures on women to conform. Public opinion held that women could find

happiness and fulfilment only as mothers, wives, and homemakers. For women who deviated from this norm, their future appeared to hold nothing but personal failure and social ostracism. Even as public opinion began to soften near the end of the decade and more and more married, middle-class women entered the paid labour force, the majority of Canadians remained opposed to the idea of married women with young children working outside the home. This seemed to be the case even though most of the women in question continued to identify themselves primarily as wives and mothers and channelled their money mainly towards acquiring necessities for home and family. With very few real options available to them outside of the home, middle-class Canadian women were often held responsible for any discontent they may have experienced and given little room to respond other than to find themselves at fault for their own unhappiness. There were certainly exceptions to this general rule but overall there was little room to overtly question the value of gender role conformity during the 1950s. In this context, some women may have found meprobamate and other anti-anxiety agents particularly appealing because these drugs represented one of a relatively few socially acceptable and effective means of coping with very real feelings of anxiety, unhappiness, and helplessness.

In a paradoxical decade like the 1950s, meprobamate and other minor tranquilizing drugs promoted by pharmaceutical companies appealed to both the desire for progress and change and the search for stability and status quo. The belief in the potential for individual and social improvement through medical science prevailed in spite of the appearance of medical evidence which challenged the therapeutic value of meprobamate. Similarly, the belief in the importance of strict gender role conformity made middle-class women more likely than men to consume this new product. Together, these apparently conflicting desires contributed to the medicalization of everyday life in general and the medicalization of gender in particular in English-speaking Canada after World War II.

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