

The Concept of Schizophrenia in Ottawa:
Perspectives of Psychiatry, the Public, and Patients
1883-2013

by

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Abstract

The way in which we have thought about mental disability has changed over time. This work examines conceptions of one particular disorder, “schizophrenia” (originally known as “dementia praecox”), from the perspectives of psychiatry, the public, and patients, from 1883 to 2013. It compares shifts in the way the public conceptualizes schizophrenia, using Ottawa as a case example, to developments within Canadian psychiatry, notably the standardization of diagnosis. It then looks at the personal accounts of individuals who experience schizophrenia in order to reconsider public and psychiatric representations of the disorder. The general purpose of this research is to call attention to the various ways in which “schizophrenia” has been conceptualized historically, based on different types of information and by different actors, in order to challenge contemporary representations of mental disability that consider a mental disorder to be equivalent to individual identity.

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INTRODUCTION

“There once was an elephant and two blind men,” a psychiatrist at the Ottawa Civic Hospital told me. “One held the trunk of the elephant and the other held its tail. They described the elephant in different ways, yet in the end they both described the same elephant.” I lived at the hospital for eight months and my doctor often told me stories when I became confused. He told me this particular story when I became confused about the various ways in which different doctors described “what was wrong.”

Several suspected it was “schizophrenia” or “psychosis.” A few suggested it was “anxiety.” One labelled it “depression.” Some doctors never told me what they thought. The doctors that knew me best called it developmental, and labelled it a “cognitive disorder of a developmental nature” and compared me to an eight-year old. Yet even they disagreed about the implications. As in the story of the elephant and the blind men, the doctors were attempting to describe the same condition, which I called “confusion.”

I relate this story because it shows the multiplicity of ways in which people can think about the same mental disorder at one time and in one place. The way in which we conceptualize mental disorders has changed over time. In the present, we typically define mental disability through lists of symptoms that have been identified by psychiatrists. In the case of schizophrenia, we might think of “paranoia, delusions, hallucinations, disordered thinking and bizarre behavior.”¹ This representation, however, is a historical product. The way in which we define mental disability in the

¹ “Dialysis No Cure for Schizophrenia,” *Ottawa Citizen*, March 24, 1983, 87.

early twenty-first century differs from the way in which mental disability was defined in the late nineteenth century.

Not only have the symptoms changed. Rather, the type of information we associate with mental disability as well as the way we use this information is different, and with that comes a different perspective of mental disability that is not necessarily for the better. This work will examine the ways in which we have thought about mental disability over time. It will examine conceptions of one particular disorder, “dementia praecox” or “schizophrenia,” from the perspective of psychiatry, the public, and patients, from 1883 to 2013.

Developments within psychiatry have contributed to present definitions of “schizophrenia,” although we tend to disregard the impact of the medical profession on cultural thought. This work will compare shifts in the way the public conceptualizes schizophrenia to developments within psychiatry, notably the standardization of diagnosis and the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published in 1952 and subsequently revised four times. The circulation of medical terminology within the public domain coincided with changes in the way in which the public conceptualizes schizophrenia. Rather than serving as an explanation for certain behaviours, schizophrenia has become something to be defined, a shift that has gradually taken place since 1950. Increasingly, it has been defined according to its consequences, such as “hallucinations” or “delusions,” with less attention paid to causation.

The appearance of these psychiatric terms of assessment in the public domain has ramifications for individuals living with mental disability in the present. The

public continues to identify mental disability through lists of psychiatric symptoms, which involve the assessment of an individual's way of thinking, feeling or behaving and thus locates disability within the individual. This work will problematize and contextualize this conceptual shift by comparing the perspectives of the public and of individuals who experience schizophrenia. The purpose of this research is to call attention to the various ways in which "schizophrenia" has been conceptualized historically, based on different types of information and by different actors, in order to challenge contemporary representations of mental disability that connect a mental disorder and individual identity.

Chapter 1 Introduction

1.1 SCHIZOPHRENIA AS A CONCEPT

What is a mental disorder? What are ways of looking at mental disorders? First and foremost, a mental disorder is a concept. Mental disability is not a static entity. As in the case of the elephant, which could be identified by different characteristics by the blind men, there are different ways of describing mental disability. The elephant could be described by its trunk, its tail, its tusk, etc. As gestalt theory would suggest, the whole is the sum of its parts. Not every piece of information, however, is always used. The story of the elephant and the blind men shows our role in describing the world. Just as we select characteristics to describe an elephant, we determine the way in which we think about schizophrenia.

American psychiatrist Marshall Edelson stresses this point in his 1971 philosophical discussion which he titled *The Idea of a Mental Illness*. Speaking to psychiatrists and medical professionals more broadly, Edelson criticized what he

denounced as the reification of diseases, “whether tuberculosis...or schizophrenia, as if they were tangible entities to be finally discovered and directly observed.”² According to Edelson, “any disease represents an imagined sequence of events” and is therefore a “*concept*.”³

Edelson’s notion of intangibility became central to historian Mikkel Borch-Jacobsen, who called for a re-examination of psychiatric history thirty years later. Jacobsen takes Edelson’s notion of intangibility one step further. Whereas Edelson considers the role of the psychiatrist in diagnosing mental disorders, Jacobsen examines the role of the patient in the “construction...of the pathologies from which they are said to suffer.”⁴

The works of Edelson and Borch-Jacobsen emphasize the historicity,⁵ and by extension, what could be considered the malleability of thinking about psychiatric disorders. It is important to note that these scholars do not deny the existence of mental impairment. Some groups within the disability community highlight discrepancies between historical and contemporary classifications of mental disorders in order to challenge the medicalization of certain experiences. The Icarus Project, for example, defines the experiences of their members as “mad gifts needing cultivation and care, rather than diseases or disorders.”⁶ Edelson and Borch-Jacobsen, on the other hand, acknowledge the existence of impairment but they likewise insist on the

² Marshall Edelson, *The Idea of a Mental Illness* (New Haven: Yale UP, 1971), 39.

³ Ibid.

⁴ Mikkel Borch-Jacobsen, “Making Psychiatric History: Madness as Folie à Plusieurs,” *History of the Human Sciences* 14.2 (May 2001): 26.

⁵ Edelson, *The Idea of a Mental Illness*, 39.

⁶ The Icarus Project, “The Icarus Project: Summary of Ideas and Plans” (Ottawa: March-August 2013).

importance of the role of psychiatry and patients in describing, and therefore making tangible, mental disorders.

This section will examine the ways in which psychiatrists and historians, particularly in Canada and the United States, have written about mental disability. As will be seen, histories of psychiatry, psychiatric institutions and the institutionalized, and psychiatric disorders have largely disregarded the conceptual nature of mental disorders until recently. Reviewing and critiquing these works offers a starting point for this analysis, which is based on the premise that mental disability is a concept. This section will suggest ways of viewing the conceptual nature of mental disability across time and across different populations.

1.1.1 Psychiatry and the History of Mental Disorder

Psychiatrists as well as psychologists have sought to record the history of their professions. In addition to the extensive records left by organizations such as the National Committee for Mental Hygiene or the Canadian Psychiatric Association, which will be examined in a later chapter, these organizations have also produced a body of secondary literature which purport to speak for their members. The publication of such works often coincided with institutional milestones and therefore appeared earlier in the American context.

In 1944, the American Psychiatric Association (APA) published *One Hundred Years of American Psychiatry* to mark the one hundredth anniversary of the organization. Though the book discusses the foundation of the organization, it relates developments within the discipline more broadly, suggesting the authors conceived of

psychiatry and the organization as interrelated.⁷ Despite its medical content, the endeavor was nevertheless a form of history writing. The book relates the various ways in which psychiatrists have diagnosed and thought about psychiatric disorders.⁸ Psychiatric thought is related chronologically and situated within a social context.⁹ Though it shows the evolution of medical thought over time, it does not show the historicity and conceptual nature of psychiatric disorders. The text shows the evolution of medical thought over time, but the mental disorder maintains a static presence. The book does not interrogate the use of medical information in conceptualizing mental disability. Like liberal notions of progress, it assumes the inaccuracy and incompleteness of previous thought and characterizes the development of new practices as advancements within the profession,¹⁰ rather than showing the continuously reconstructed constitution of mental disorders.

On its fiftieth anniversary, the Canadian Psychiatric Association (CPA) published *Psychiatry in Canada: 50 Years (1951 to 2001)*, edited by psychiatrist Quentin Rae-Grant, a former president of the organization. Like *One Hundred Years of American Psychiatry*, this book examines psychiatric developments since the foundation of the professional organization. Though it focuses on treatment methods, it also traces psychiatric thought about mental disorders.¹¹ Like the work by the APA, this book focuses on justifying and explaining the forward progression of psychiatric thought without challenging the way in which psychiatrists have conceptualized the

⁷ American Psychiatric Association, *One Hundred Years of American Psychiatry* (New York: Columbia UP, 1944): 28.

⁸ *Ibid.*, 367-443.

⁹ *Ibid.*

¹⁰ *Ibid.* 441.

¹¹ Canadian Psychiatric Association, *Psychiatry in Canada: 50 Years (1951-2001)*, ed. Quentin Rae-Grant (Ottawa: Canadian Psychiatric Association, 2001): 1-16.

disorder over time.¹² Rather than dismissing previous ways of thinking about mental disability as inaccurate, what are ways of comparing conceptions of schizophrenia over time?

Michel Foucault, writing a decade before Marshall Edelson, emphasizes the conceptual nature of thinking about mental disorders, without denying their existence. Perhaps his background informs his approach. Though Foucault is most often recognized as a “philosopher, social theorist, historian of ideas, and literary critic,”¹³ his educational background also included psychology, which he practised at the Hôpital Sainte-Anne in the early 1950s.¹⁴ He has been included in this section because of his medical background. For Foucault, the “primitive purity”¹⁵ of a mental disorder is always overshadowed by “a form of knowledge” that will “enclose” it.¹⁶ Like Edelson, he is particularly critical of “the language of psychiatry,” which he argues is “a monologue by reason *about* madness.”¹⁷

Unlike the histories written by the APA and CPA, Foucault is concerned with studying change over time, though his focus is on processes which generate meaning. Of particular concern is the way in which certain beliefs that are said to constitute ‘unreason’ operate within wider social discourses that focus on ‘reason.’ For Foucault, this process is historical and specific to a particular period of time and place, though he makes comparisons across time. Examining the production of meaning, as I try to

¹² Ibid.

¹³ “Michel Foucault,” Wikipedia: The Free Encyclopedia, accessed 10 November 2012, http://en.wikipedia.org/wiki/Michel_Foucault.

¹⁴ Michel Foucault, *History of Madness*, ed. Jean Khalifa, transl. Jean Khalifa and Jonathon Murphy (New York: Routledge, 2006): v.

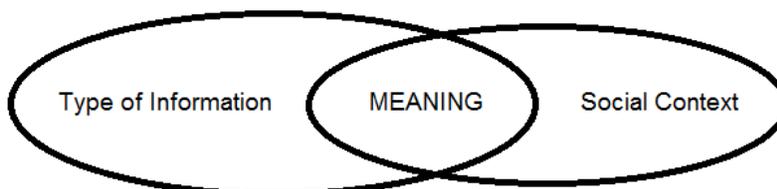
¹⁵ Ibid., xxxiii.

¹⁶ Ibid., 462.

¹⁷ Ibid. xxviii.

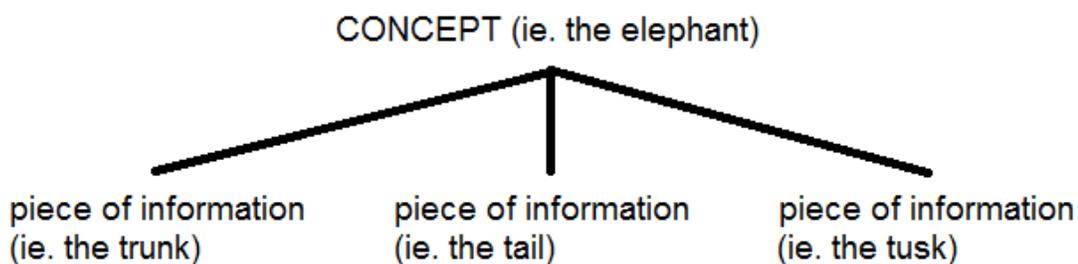
show in Figure 1, however, leads Foucault to neglect the information being used to describe the “primitive purity” of the mental disorder.

Figure 1 The Production of Madness in Foucault’s Work



This thesis, in contrast, is concerned with the information being used to derive the concept of mental disability, as I show in Figure 2. This work will examine the characteristics (such as the trunk, the tail, or the tusk) being used to describe ‘the elephant in the room.’

Figure 2 The Concept of Mental Disability



1.1.2 Historians and the History of Mental Disorder

Professional historians have neglected to write the history of mental disorders until recently. Early accounts written by historians such as Gerald Grob focused on more tangible objects, such as the infrastructure developed to care for individuals

affected by mental disorders and did not explore conceptions of mental disability over time. In the introduction to *Mental Illness and American Society, 1875-1940*, published in 1983, Grob suggests a mental disorder should be seen as “both a social and medical problem.”¹⁸ Yet his work does not examine social conceptions of mental disorders, but rather traces the social and medical forces that shaped the asylum. In doing so he gives patients some form of agency by attributing certain developments to changing demographics within the institution.¹⁹ Grob pays more attention to patients than the insular histories compiled by medical professionals but though Grob depicts a reciprocal relationship between the institution and patients, he looks at patients en masse and does not consider individual agency, individual personality, or the perspective of the individual patient, which are topics of more recent works by historians such as Geoffrey Reaume.

The only occasion Grob looks beyond the walls of the asylum to examine the relationship between the institution and broader society is in one chapter on the mental hygiene movement, which deals with “non-institutional problems.”²⁰ Even this chapter, however, focuses on medical discourse through an examination of the practices and policies of one unique institution: the National Committee for Mental Hygiene. Like the histories compiled by the APA and CPA, Grob’s work does not consider the influence of the medical profession within the larger public domain nor does it acknowledge the historicity and conceptual nature of mental disability.

¹⁸ Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton UP, 1983): 3.

¹⁹ Ibid.

²⁰ Ibid.

The institution remains a topic of discussion in recent historiography. Like Gerald Grob, Canadian historian Janet Miron similarly depicts a reciprocal relationship between patients and the institution. Her 2011 publication, *Prisons, Asylums, and the Public*, examines institutional visiting practices in the nineteenth century. Her work goes beyond the work of Grob, who she acknowledges, and focuses on the infrastructure of the institution and examines interconnected experiences of various groups that occurred within the institution. Miron explores the relationship between the asylum and society and describes a more dynamic relationship. She pits herself against Michel Foucault and David J. Rotham.²¹ The asylum, according to Miron, did *not* exist “on the margins of society” as she contends Foucault and Rotham would suggest.²² She argues that visitation practices had “implications for employees, the public, and the institutionalized.”²³ Unlike other studies, Miron’s work draws connections between these groups and, like more contemporary work, it considers the experiences of patients. Though her work goes beyond the infrastructure of the institution, it centres on the institution as a site of contact. Still, this approach neglects larger questions of beliefs and conceptions about mental disorders, the aim of this project. It is unclear whether Grob or Miron would acknowledge the conceptual nature of mental disability.

Madness in America, written by Lynn Gamwell and Nancy Tomes in 1995, goes further than the work of either Gerald Grob or Janet Miron in examining perceptions of mental disorders in the United States. The influence of professional

²¹ Janet Miron, *Prisons, Asylums, and the Public: Institutional Visiting in the Nineteenth Century* (Toronto: University of Toronto Press, 2011): 5.

²² *Ibid.*

²³ *Ibid.*

historiography is apparent in this book, which is largely organized, once again, around the institution.²⁴ Yet it goes beyond the realm of the medical and examines the intersection of medical and social beliefs about mental disorders and beliefs about individuals with mental disorders. Like the histories produced by the APA and CPA, this work focuses on beliefs about causation. In the case of Native American beliefs, for example, mental disability could be attributed to breaking a cultural taboo. Anglo-American colonists, according to Gamwell and Tomes, intertwined “both natural and supernatural explanations for madness with little sense of contradiction.”²⁵ Unlike the histories by the APA and CPA, it also deals with the treatment of individuals living with mental disability by medical figures, by society, and by various social groups.²⁶

Like the histories produced by psychiatric organizations such as the APA or CPA, this work does little to document changing conceptions of mental disability. Gamwell and Tomes give a deeper context to their study by relating beliefs about mental disorders to wider social trends of their time, including cultural and religious norms.²⁷ Their approach focuses on particular mental disorders at particular moments in history. Though the authors present a chronological examination of mental disorders, they do not make broader connections between ways of thinking about mental disorders over time. Is there similarity between beliefs about mental disorders? Establishing connections or remarking on discrepancies between beliefs would further emphasize the historicity, and therefore the conceptual nature, of mental disorders.

²⁴ Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (New York: Cornell UP, 1995): 11, 37-117.

²⁵ *Ibid.*, 15.

²⁶ *Ibid.*, 13.

²⁷ *Ibid.*, 13, 15, 53.

1.1.3 Research Implications of a Conceptual Approach

Psychiatrist Alexander Leighton's work, "A Comparative Study of Psychiatric Disorder in Nigeria and Rural North America," provides insight into ways of studying mental disorders using a conceptual framework. While Marshall Edelson and Michel Foucault remark on the conceptual nature of mental disability, Leighton actively uses conceptual categories to find similarity between different cultural conceptions of mental disorders, though he contrasts underlying beliefs about mental disorders in *Changing Perspectives in Mental Illness*.²⁸ This book is a compilation of works produced by medical professionals and explores intersections between mental disorders and social factors.²⁹ Like the histories of psychiatry, these works outline historical thoughts about mental disorders, yet these articles are innovative and intended to add to the field of knowledge about mental disorders. The authors' clinical approach makes the content of this book ideal for a practising physician.

Leighton's work, in particular, takes a more theoretical approach. It is a comparative study situated in Nova Scotia and Nigeria written by Leighton. The editors suggest his research is significant because it points to similarity between conceptions of mental disorders in two diverse regions, which they further contend has implications for studies on the effect of culture on mental disorders.³⁰ The editors, like most of the studies in this book, take a very clinical approach in that they are concerned with collecting information about mental disorders. While Leighton's work

²⁸ Alexander Leighton, "A Comparative Study of Psychiatric Disorder in Nigeria and Rural North America," in *Changing Perspectives in Mental Illness*, ed. Stanley C. Plog and Robert B. Edgerton (New York: Holt, Rinehart and Winston, 1969): 179.

²⁹ *Ibid.*, 7.

³⁰ *Ibid.*

has ramifications for the medical profession, it can also be read as a social study of categories.

The goal of Leighton's work is to compare the ways in which different cultural groups recognize mental disorder. It compares "subdivisions" made by the Yoruba to describe psychiatric disorders³¹ and contrasts them with "diagnostic categories" developed by psychiatry.³² Despite apparent differences, Leighton suggests that by taking a step back and taking a more abstract perspective, he is able to note similarities in both cultures that remark on symptoms, degree of impairment, theories concerning causation, and response to treatment.³³

Leighton does not describe his methodology further. But it could be said that Leighton develops categories (such as "symptoms" or "causation") based on types of information used to describe the mental disorder. He organizes his study around these categories and finds similarity between the categories and difference among specific beliefs about mental disorders. The focus of the comparison is the information used by different cultural groups to define mental disorders. In other words, we see the construction of mental disability across place. Could the same method be used for a historical comparison, to compare use of information over time? Did particular categories of information dominate in particular periods? And how were they used? Rather than assuming the forward progression of medical knowledge, comparing and contrasting the characteristics we have used to describe mental disability over time emphasizes our role in conceptualizing mental disability.

³¹ Ibid., 180-181.

³² Ibid., 185.

³³ Ibid.

Recently, American psychiatrist Jonathon Metzl, who specializes in the history of psychiatry and gender, has examined changes to the way in which we think about schizophrenia in *Protest Psychosis: How Schizophrenia Became a Black Disease*. Like most historiography, his work emphasizes the effect of society on medical diagnostic practices, charging that the “idea of ‘racial schizophrenia’” came about in the 1960s and 1970s.³⁴ Reviews of this book focus on the effect of social protest movements on psychiatric diagnostic practices and on the implications of this analysis, namely accusations of alleged racism within the profession.³⁵ Yet this book is also important for its study of the way in which the media construct the disorder over time. It challenges the dominant narrative of schizophrenia as a ‘dangerous’ disorder by emphasizing the use of particular sets of information, namely racial and gender characteristics, in thinking about schizophrenia.³⁶ His work frames schizophrenia as a concept by questioning the association of schizophrenia with particular gender and racial characteristics.

Metzl’s history emphasizes the construction of schizophrenia over time and among different actors, namely the medical profession and the public. He does not consider the construction of mental disability among a third actor, the patients themselves, though he examines the effect of medical conceptions on patient identity. Though he examines the use of racial and gender characteristics in thinking about schizophrenia, he does not problematize the use of more basic medical information, such as diagnostic descriptions of “hallucinations” and “delusions,” within the public sphere.

³⁴ Jonathon Metzl, “The Protest Psychosis,” *Michigan Today*, June 9, 2010, <http://michigantoday.umich.edu/2010/06/story.php?id=7776#.UlwfLRjj4a4>.

³⁵ Suman Fernando, “Review,” *h-madness* <<http://historypsychiatry.com/2010/09/29/review-jonathan-m-metzl-the-protest-psychosis-how-schizophrenia-became-a-black-disease-beacon-2009/>>.

³⁶ Metzl, “The Protest Psychosis.”

The relationship between medicine and society is most notable in discussions concerning medicalization, such as Peter Conrad and Joseph W. Schneider's work, *Deviance and Medicalization: From Badness to Sickness*. This work debates the impact of medicalization on public conceptions of disability. As other scholars have noted, medicalization “removes blame from the individual for deviant actions.”³⁷ Their work could also be said to examine, “more simply, [the transition] from ‘badness to sickness.’”³⁸ Conrad and Schneider also debate the “darker side” of medicalization as well as the benefits associated with medicalization. While medicalization can reduce blame, it can also entail the “domination of expert control” and the “individualization of social problems.”³⁹ The authors conclude, however, that medicalization “can be viewed as portraying an *optimistic* outcome for the deviant.”⁴⁰

Like the histories produced by the APA and CPA, this work also provides a chronological history of the development of psychiatry. Unlike their accounts, however, Conrad and Schneider's work acknowledges the conceptual nature of mental disability by comparing theories of causation over time. They note, for example, a shift that occurred in the 1970s whereby medicine, rather than “searching society or the community for the causes of madness,” refocused on “organic and biomedical theories of madness.”⁴¹ Their research also remarks on shifts in public understandings

³⁷ Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization: From Badness to Sickness* (New York: MacMillan, 1980), 246.

³⁸ *Ibid.*, 17.

³⁹ *Ibid.*, 248-250.

⁴⁰ *Ibid.*, 245.

⁴¹ *Ibid.*, 70.

of mental disability, which they suggest began to incorporate medical psychiatric testimony after 1954, though “public conceptions remain less medicalized.”⁴²

Conrad and Schneider’s work is limited, however, in several respects. First and foremost, their work neglects the impact of medicalization on individual identity. Their work argues that medicalization “*removes blame* from the individual” and “allows for the extension of the *sick role*.”⁴³ Their focus is on the role granted to the individual by society and how their role affects public attitudes towards madness. But what is the relationship between the disability and the individual? When theories concerning causation shifted back to “focus on the individual,” rather than the community, what did this mean for individual identity? Did medicalization also impact the way in which disability is located in relationship to the individual?

Though Conrad and Schneider compare psychiatric models of thinking about mental disability over time, their focus is on the ideas underlying psychiatry, rather than on the language of psychiatry and the ways in which psychiatrists sought to describe mental disability amongst themselves and to others. They charge that psychiatry increasingly looked to the individual, rather than to the community, to identify psychiatric disorders. But what did this mean for the ways in which psychiatrists described mental disability? What type of information did psychiatry use to describe mental disability? Though different theories of causation circulated within psychiatry, did other models of describing mental disability gain precedence? Again, what did this mean for individual identity?

⁴² Ibid., 72, 58.

⁴³ Ibid., 246.

Finally, their discussion concerning the impact of medicalization on public conceptions of mental disability is limited. Conrad and Schneider focus on the meaning of madness in the public sphere through their discussion of whether madness was regarded as deviance or sickness. They conclude that the influence of medicine in the public sphere was limited. They do not address the type of information used by the public to describe mental disability. Did psychiatric ways of defining mental disability surface in the public domain? And what did this mean for individual identity?

1.1.4 Assessing Public Opinion

Perhaps the most comprehensive and direct assessment of twentieth-century public opinion concerning mental disorders has been compiled by professionals within public health services and published in books such as *Public Image of Mental Health Services*, published in 1967. This book purports to deal with knowledge and “popular perceptions” of mental illness.⁴⁴ It is limited, however, by its use of hypothetical scenarios in which members of the public are asked to identify cases of mental illness. This study shows what behaviours are attributed to mental illness. It does *not* show where knowledge of mental disorders originates from or which information is used by the public in order to think about mental disability.

Similarly, B. J. Link examines the public’s knowledge and perception of several mental disorders in conjunction with attitudes towards individuals living with mental disorders. Like Elinson, the authors of this study administered hypothetical vignettes and asked members of the public to identify cases of mental illness as well as

⁴⁴ Jack Elinson et al, *Public Image of Mental Health Services* (New York: Mental Health Materials Centre, 1967): xv.

to comment on their causes.⁴⁵ Their work consequently focuses on the public's knowledge of mental disorders without interrogating how this knowledge is organized when the individual seeks to describe (to themselves or others) the mental disability. In other words, which specific categories of knowledge are used by the public to conceptualize mental disorders?

Published in the same year as B. J. Link's study, "Dispelling the Stigma of Schizophrenia" likewise examines the public's knowledge of mental disorders. This article correlates knowledge of the most acute symptoms of a mental disorder with stigmatization, as opposed to information about living arrangements for the person living with the disorder.⁴⁶ This finding is significant if the public bases its conceptions of schizophrenia on this particular category of information about schizophrenia. But this study likewise stops short at assessing the public's ability to recognize schizophrenia, as opposed to the way in which the public actively defines the disorder. These studies form an alternative to Metzl's approach of examining public venues for information circulating within the public domain, yet they have their limits.

1.2 THE IMPACT OF CONCEPTIONS OF SCHIZOPHRENIA ON PATIENTS

It is not enough, however, to view schizophrenia as a fluid, ever-changing concept. Schizophrenia has been defined by different sets of information throughout history. We need to acknowledge the role of medical professionals, society, and

⁴⁵ B. J. Link et al, "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness and Social Distance," *American Journal of Public Health* 89, no. 9 (September 1999), Accessed March 2013, <http://www.ncbi.nlm.nih.gov/pubmed/10474548>.

⁴⁶ David Penn et al, "Dispelling the Stigma of Schizophrenia: What Sort of Information is Best?" *Schizophrenia Bulletin* 20, no. 3 (1999), Accessed March 2013, <http://schizophreniabulletin.oxfordjournals.org/content/20/3/567.short>

patients in defining the disorder and making it tangible. But we also need to examine how the way in which we think about schizophrenia affects individuals who experience the disorder. As in the case of other disabilities, schizophrenia is socially constructed as well as conceptualized. Of particular concern is how we define the relationship between the individual and the mental disorder. Disability theorists question ways of thinking about disability that attribute disability to individuals or locate disability within the individual. Instead of locating disability within the individual, they attempt to separate disability and the individual.

Disability theorists, such as Peter Conrad, author of *Deviance and Medicalization: From Badness to Sickness*, have articulated several models to explain the various ways in which we think or should think about disability which they labelled the moral, medical, and social models of disability.⁴⁷ The moral model describes cases in which disability is attributed to moral failure of the individual. At one time, leprosy was attributed to sin. Although the moral model of disability is considered archaic, disability continues to be associated with morality within popular culture. This way of thinking about disability is problematic because blame rests on the individual.

In the medical model of disability, disability is not attributed to moral failure. While this model removes blame from the individual, it continues to locate disability within the individual. Medical professionals, for example, will identify an individual's impairment as the source of their disability. Consequently, the individual is the focus

⁴⁷ Deborah Kaplan, "The Definition of Disability," The Centre for an Accessible Society, Accessed November 26, 2013, <http://www.accessiblesociety.org/topics/demographics-identity/dkaplanpaper.htm>.

of rehabilitation efforts. This model became popular following the Second World War and the return of veterans with disabilities, which coincided with the rise of the medical profession.

The social model of disability challenges the medical model of disability. Disability is not said to reside in the individual, but rather to be a social construction. This model attributes disability to social obstacles. In the case of a physical impairment, for example, this model would emphasize the barriers that prevent an individual from participating in life. Disability theorist Susan Wendell notes the difficulty of recognizing barriers before they are experienced as such.⁴⁸ In an illustrative and personal example, she notes that a heavy door was never an obstacle before her impairment.⁴⁹ In this case, the social model of disability would say that the problem rests with the heaviness of the door, or inaccessibility of the building, and not because of Wendell's impairment. Other barriers, such as expectations concerning pace of work, for example, exist for individuals living with mental disability. While the social model of disability assigns social responsibility, its focus is removing barriers, such as a heavy door, so that individuals with impairment can participate in society.

The social model of disability is often critiqued. In particular, the social model of disability does not acknowledge the role of impairment in creating disability. More recent studies have therefore attempted to combine elements of the social model of disability with the experiences of individuals with impairments. These studies have

⁴⁸ Susan Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* (New York: Routledge, 2004), 46.

⁴⁹ *Ibid.*

tended to focus on physical and sensory impairments, yet their principles may be translated to this study of schizophrenia, which will be discussed further in chapter four.

While it has been critiqued, the social model of disability teaches us that attitudes towards schizophrenia have an impact on individuals who experience the disorder. Are individuals being blamed? Are individuals the centre of rehabilitation efforts? Is disability being used to identify a person? As in the case of other disabilities, schizophrenia is socially constructed as well as conceptualized. This work will examine the various ways in which we conceptualize schizophrenia and the consequences of the way in which we think about and therefore construct the disorder, especially as it concerns individual identity. As in the case of professionals dealing with public attitudes, this work emphasizes the importance of selecting a way of thinking about schizophrenia that does not contribute to stigmatizing individuals with mental disability.

1.3 SOURCES AND METHODOLOGY

I have chosen “dementia praecox” or “schizophrenia” as the focus of this study, partly as a result of having lived in a group home where most of the residents experienced schizophrenia. As a resident in the home, I was expected to attend various classes, one of which was devoted to coping with stigmatization. I had never paid much attention to the issue before. I disliked considering that it existed. I was, however, struck by the response of the other individuals. Their concern is not unwarranted. In 2005, the Canadian Psychiatric Association warned that

stigmatization continues to surround schizophrenia and individuals who experience schizophrenia.⁵⁰ This work is aimed at challenging current ways of conceptualizing schizophrenia.

Chapters 2 and 3 will begin by looking at the standardization of diagnosis and psychiatric conceptions of “dementia praecox,” which later became known as “schizophrenia,” through a discourse analysis of the minutes of two central organizations concerned with mental disability, the National Committee for Mental Hygiene before 1950 and the Canadian Psychiatric Association after its development in 1951. While Gerald Grob’s study of the asylum referenced the National Committee for Mental Hygiene, the records of the Canadian Psychiatric Association have remained largely untouched by historians, with the exception of psychiatrist Quentin Rae-Grant, a former president of the organization.

The latter part of these chapters will examine public conceptions of “insanity” or “schizophrenia” through a discourse analysis of press articles. Compared to surveys, which elicit knowledge, press descriptions show the *type* of information circulating within the public domain. Unlike cultural histories of mental disability which sporadically reference newspapers along with other cultural sources, this longitudinal study will compare qualitative descriptions of “insanity” or “schizophrenia” in articles published by the *Ottawa Citizen* preceding the development of the Diagnostic and Statistical Manual of Mental Disorders, from 1883 to 1950, and

⁵⁰ Canadian Psychiatric Association, “Clinical Practice Guidelines – Treatment of Schizophrenia,” *The Canadian Journal of Psychiatry* 50, no. 1 (2005): 33S.

articles published in the *Ottawa Citizen* after the standardization of diagnosis, from 1950 to 2013.

The fourth and final chapter will examine the perspective of individuals who experience schizophrenia as recorded in autobiographies and non-fiction stories published or posted within the public domain. It will exclude documents created within a therapeutic environment, including testimonials that were specifically intended for other patients, that have not entered the public domain in order to respect the authors' privacy. The fourth chapter will discuss concerns with using these accounts, which are nevertheless valuable sources which offer a different way of thinking about schizophrenia.

This work will differ from the institutional accounts produced by Gerald Grob and Janet Miron by focusing on the intangible mental disorder, or more specifically, the ways in which it is made tangible and discussed. It will also differ from Michel Foucault's work, which emphasizes the production of meaning by situating beliefs within their social context. Instead, it will focus on the ways in which we describe mental disability. Like Edelson's work, it will focus on the mental disorder as a "concept," or as the sum of various pieces of information, but it will go further and examine the information involved in conceptualizing schizophrenia over time and by different actors. Whereas the histories produced by the APA, the CPA, and historians such as Nancy Tomes and Lynn Gamwell contextualize specific beliefs about mental disorders, this study will examine trends of information over time and among different groups using similar categories as those developed by Alexander Leighton. Like Tomes and Gamwell, Metz, and Conrad and Schneider, this work will explore the

intersection of medicine and society, yet it will also incorporate a third actor, individuals living with schizophrenia. It will trace the circulation of medical models within the wider public sphere and its incorporation into the press' method of describing mental disability. The purpose is not to critique medical ways of looking at mental disorders, but to problematize the use of similar structures by the public as it concerns individual identity.

The purpose of this study is to examine the use of different categories of information involved in conceptualizing schizophrenia over time. As we have seen, Alexander Leighton proposed to divide information into four categories: symptoms, degree of impairment, theories concerning causation, and response to treatment. Leighton privileges "symptoms," which he defines as the "complaints and behaviors that are *thought by Yoruba people* to indicate or constitute mental or emotional illness."⁵¹ He does not define the other three categories. For Leighton, these categories remain distinct ways of describing a disorder.

Yet this paper will treat these categories as quite dissimilar. "Symptoms" could be defined as characteristics that are observable to medical professionals (such as "eccentric behaviour") or characteristics that act against established norms (such as failure to relate to other individuals). However "symptoms" could also be defined more simply in relationship to the disorder to encompass phenomenon or behaviour resulting from its presence. Based on this definition, symptoms are consequences that follow the onset of a mental disorder, while theories concerning causation deal with the origins and conditions that underlie a mental disorder. To what extent do these

⁵¹ Leighton, "A Comparative Study of Psychiatric Disorder in Nigeria and Rural North America."

categories of information appear in psychiatric, public, and patient discussions of mental disorders? Do these categories of information impact the identity of patients differently?

Leighton does not critique the implication of these categories of information. But again, there are ramifications for patients. How is information associated with schizophrenia framed in relation to the patient? And how does this information portray individual experience? And what does this mean for individual identity? This study will examine the implications of different ways of conceptualizing mental disability.

This study will focus on the effect of medical practices on social conceptions of mental disorders. However, it will not view changes to social conceptions as a strictly linear process. Psychiatric practices can be viewed within a broader social context and so can conceptions of mental disorders. Mary Douglas dismisses the notion of “medical materialism” in her work, *Purity and Danger*.⁵² Notions of pollution, she argues, are informed by the relationship between “matter” and broader systems of classification.⁵³ “Shoes,” she points out, “are not dirty in themselves, but it is dirty to place them on the dining-table.”⁵⁴ Our notions of pollution, she concludes, can be defined as “matter out of place,”⁵⁵ as depicted in Figure 3.

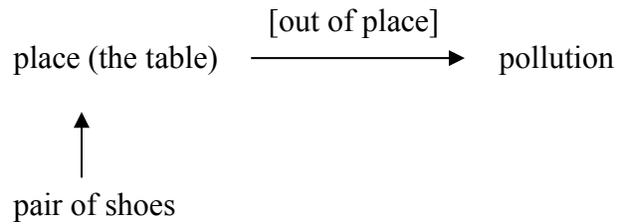
⁵² Mary Douglas, *Purity and Danger: An Analysis of Concepts of Pollution and Taboo* (London: Routledge & Kegan Paul, 1966), 31.

⁵³ *Ibid.*, 35.

⁵⁴ *Ibid.*

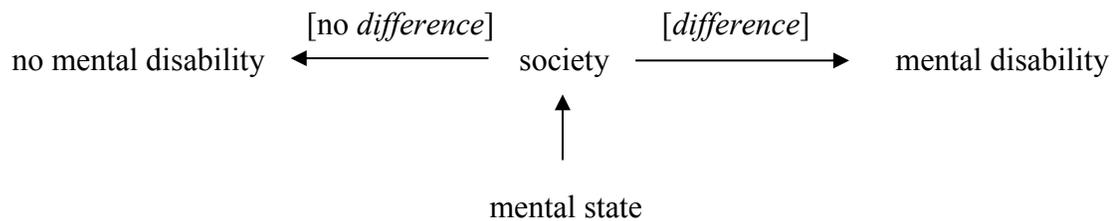
⁵⁵ *Ibid.*

Figure 3: The Concept of Pollution in Mary Douglas' Work



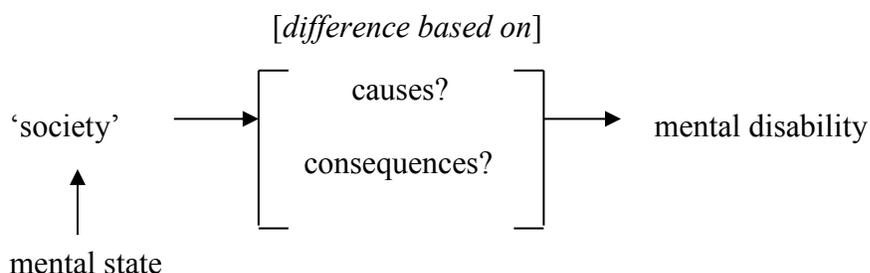
Similarly, a mental state within a social group does not constitute a mental disability unless there is something “out of place,” or different, as I show in Figure 4. Foucault, as mentioned earlier, similarly focuses on the production of meaning, or madness, through the interplay of ‘reason’ and ‘unreason.’

Figure 4: The Concept of Mental Disability



But what is the basis of this discrepancy? This paper will suggest that the development of standardized classification systems within the medical community influenced this social process by normalizing particular ways of framing difference, as I suggest in Figure 5. What type of information formed the basis of the difference that distinguished mental disability?

Figure 5 The Information Used to Conceptualize Mental Disability



Though the emphasis of this study is the relationship between medical and social conceptions of schizophrenia, in some ways it could be read as a study of the intersection of national ways of thinking, as put forward by the Canadian Psychiatric Association, and local ways of thinking, as exemplified through a reading of the *Ottawa Citizen*. Though the readership of the *Ottawa Citizen* may have extended beyond the capital and though the content of the *Ottawa Citizen* sometimes originated outside the capital, this newspaper cannot be considered representative of the Canadian public's way of conceptualizing schizophrenia. Nor does it represent the most informed public discourse either. The existence of the provincial asylum and the National Committee for Mental Hygiene in Toronto, for example, might have influenced the way in which schizophrenia was represented by newspapers circulating in Toronto. The point is not to study 'informed' public discourse. Surveying the *Ottawa Citizen* provides an example of the way in which schizophrenia is conceptualized by the public. It also offers an entry point into discussions concerning stigmatization and ways of changing public conceptions of this disorder.

Chapter 2: Psychiatry and the Public before 1950

2.1 PSYCHIATRIC CONCEPTIONS OF “DEMENTIA PRAECOX”

2.1.1 European Diagnostic Texts up to 1883

In the mid-seventeenth century, English neurologist Thomas Willis (1621-1675) began his work on the anatomy of the brain, attributing mental disorders to the impairment of nerve transmission.⁵⁶ Though he was concerned with the anatomy and function of the brain, he nevertheless expanded his gaze to include “behavioral consequences.”⁵⁷ He commented on cases in which “young persons, lively and spirited, and at times even brilliant in their childhood, passed into obtuseness and hebetude during adolescence.”⁵⁸ His observation foreshadowed the work of French-Austrian psychologist Benedict Morel (1809-1873).⁵⁹ More than a century later, Benedict Morel documented the case of a fourteen-year-old boy. He used the term “dementia praecox” (démence précoce) to describe what he believed to be a degenerative process with an early onset.⁶⁰

The work of Willis and Morel was part of a wider trend. Psychiatrists began to systematically track the history of their patients during this period.⁶¹ They also developed a series of diagnostic categories which were later systematized by German psychiatrist⁶² Emil Kraepelin in the *Compendium of Psychiatry*, first published in 1883

⁵⁶ Theodore Millon, *Masters of the Mind: Exploring the Story of Mental Illness from Ancient Times to the New Millennium* (Wiley: 2004), 73.

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ “Benedict Augustin Morel,” *Encyclopaedia Britannica*, accessed November 24, 2013, <http://www.britannica.com/EBchecked/topic/392085/Benedict-Augustin-Morel>.

⁶⁰ Millon, *Masters of the Mind*, 171.

⁶¹ Ibid., 179

⁶² The term “psychiatrist” was used by German physician Johann Christian Reil in 1808. Andreas Marneros, “Psychiatry’s 200th Birthday,” *The British Journal of Psychiatry* 193, no. 1-3 (2008), Accessed April 2014, <http://bjp.rcpsych.org/content/193/1/1.abstract>.

and subsequently revised. Emil Kraepelin's description of dementia praecox foreshadowed contemporary conceptions of the condition which was renamed "schizophrenia" by 1911.

The way in which we define mental disability in the present can be traced back to the work of European professionals, including Willis, Morel, and Kraepelin, though before 1950 Canadian conceptions of "dementia praecox" or "schizophrenia" did not always mirror their international counterparts. The way in which Canadian psychiatry and the public conceived of "dementia praecox" or "schizophrenia" evolved over a period of time and has a distinct history. This section will examine the standardization of psychiatric diagnosis within an international context and its impact (or lack of impact) on psychiatric conceptions of "dementia praecox" or "schizophrenia" in Canada before 1950.⁶³ Beginning with the work of Willis, Morel, and Kraepelin offers a point of departure and comparison for tracing Canadian psychiatric conceptions of mental disability across time and within a broader context. How did international diagnostic texts influence Canadian psychiatric conceptions of mental disability? What type of information did Canadian psychiatry associate with "dementia praecox" or "schizophrenia?" Moreover, what ramifications did diagnostic texts have on Canadian conceptions of mental disability?

The works of Thomas Willis, Benedict Morel, and Emil Kraepelin have been heralded as advancements within medicine and speak to a historical tradition of concern over the welfare of individuals affected by mental disability. Both Benedict Morel and Emil Kraepelin were concerned with reform within the asylum. Yet praise

⁶³ As far as I have read, Canadian psychiatry does not exert an influence on international psychiatry in the late nineteenth or early twentieth centuries.

of this tradition needs to be tempered with a more critical examination of their work and their attitude towards individuals living with mental disability. Thomas Willis reputedly condoned beatings and the use of restraints on patients.⁶⁴ Though Benedict Morel sought reform within the institutions that he managed, his work laid the foundation for eugenic programs that promoted sterilization.⁶⁵ Emil Kraepelin advocated for individualistic treatment, yet he supported claims that criminality was the result of “biological, not social causes.”⁶⁶ His method of observing individuals led him to condone the “pathbreaking idea of regarding the criminal no longer as a loathsome monster...but as an object of scientific research and of making his development, his personality, as well as his life the subject of careful study.”⁶⁷

The works of Willis, Morel, and Kraepelin may have resulted from a concern over the welfare of individuals living with mental disability, yet at the same time they pose problems for individuals living with mental disability. Looking back at their work challenges contemporary observers to be both appreciative, but at the same time critical, of medical ‘knowledge’ and practices in the twenty-first century.

2.1.2 Critiques of Kraepelin’s *Compendium of Psychiatry*

Originally published in 1883, Kraepelin’s medical text included the term dementia praecox.⁶⁸ Like medical professionals before him, Kraepelin similarly distinguished dementia praecox as a degenerative and incurable disorder.⁶⁹ But he expanded this category to include three previously distinct syndromes: catatonia,

⁶⁴ Millon, *Masters of the Mind*, 74.

⁶⁵ Ernest L. Abel, “Benedict-August Morel,” *The American Journal of Psychiatry*, 161, no. 12 (December 2004), Accessed March 2013, <http://ajp.psychiatryonline.org/article.aspx?articleid=177211>.

⁶⁶ Andrew Lees, *Cities, Sin, and Social Reform in Imperial Germany* (Michigan: University of Michigan Press, 2002), 151.

⁶⁷ *Ibid.*

⁶⁸ Millon, *Masters of the Mind*, 181.

⁶⁹ *Ibid.*

hebephrenia, and paranoia. These syndromes were related, according to Kraepelin, by early and irreversible mental deterioration.⁷⁰

Historian Roy Porter notes that Kraepelin “‘approached his patients as symptom carriers” and “privileged prognosis (likely outcome) as definitive of the disorder.”⁷¹ In his attempt to describe dementia praecox, Kraepelin noted that the disorder caused “discrepancies between thought and emotion, negativism and stereotyped behaviors, wandering or unconnected ideas, hallucinations, delusions, and a general mental deterioration.”⁷² Kraepelin therefore focused on conditions specific to the disorder. This way of conceptualizing dementia praecox is similar to the cases documented by Willis and Morel, who contrasted the initial “lively and spirited” nature of their patients and their subsequent “obtuseness and hebetude.”⁷³ Yet Willis and Morel described a *process* of degeneration, whereas Kraepelin emphasized the final stages of the disorder.

Critics of the *Compendium of Psychiatry* condemned its “fatalism,” its focus on “overt symptoms,” and its disregard of patients’ “inner thoughts and feelings.”⁷⁴ This critique, like the medical model of disability which was discussed in the first chapter, questioned the degree to which a mental disorder is constructed by medical professionals. It contrasts the type of information which formed the basis of Kraepelin’s diagnostic criteria (“overt symptoms”) against other forms of information (the patients’ “inner thoughts and feelings”). The critics of the *Compendium of Psychiatry* highlighted competing perspectives. Yet there is another layer. Not only

⁷⁰ Ibid.

⁷¹ Ibid., 179.

⁷² Ibid., 181.

⁷³ Ibid., 73.

⁷⁴ Ibid., 181.

did the *Compendium of Psychiatry* disregard the patient's perspective by focusing on "overt symptoms" as opposed to the patient's "inner thoughts and feelings," but the process of diagnosing had ramifications for individual identity.

Psychiatrist Ronald David Laing continued the work of Kraepelin and others concerned with the welfare of individuals living with mental disability. Laing, however, turned his attention inward and began critiquing medical practices. Laing was a Scottish psychiatrist who is often identified as a leading figure in the anti-psychiatry movement, which gained strength in the late 1960s and coincided with the civil rights and feminist movements. This movement gave rise to the independent living movement and eventually a new model of looking at disability as socially constructed, or the social model of disability, as was discussed in chapter one.

Laing did not go so far as to say that mental disability was the result of social barriers. However, Laing was a vocal critic of clinical terminology. For Laing, diagnostic terminology was not "moralistic" because it "implies a standard way of being human to which the psychotic cannot measure up."⁷⁵ Laing denounces Kraepelin's diagnostic methods, which he contends focus on the "'signs'" of the disorder:⁷⁶

It is not a question here of affixing predetermined meanings to this behaviour in a rigid way. If we look at his actions as 'signs' of a 'disease', we are already imposing our categories of thought on to the patient ... If one is adopting such an attitude towards a patient, it is hardly possible at the same time to understand what he may be trying to communicate to us.⁷⁷

⁷⁵ Ronald David Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Harmondsworth: Penguin, 1960), 27.

⁷⁶ *Ibid.*, 33.

⁷⁷ *Ibid.*, 33.

This approach is problematic, Laing argues, because it obscures the patient's perspective. He relates the story of Kraepelin and a "patient showing the signs of catatonic excitement" as an example. Kraepelin charges that the patient "has not given us a single piece of useful information" in response to his questions.⁷⁸ Laing reverses the situation and asks: "What is the boy's experience of Kraepelin?"⁷⁹ He suggests the individual does respond to Kraepelin, though he does not respond to his questions, because the patient objects to being objectified. He thus interprets the patient's behaviour, taking into account the patient's perspective. Rather than taking the words of the patient as symptoms of the disorder, he attributes the words (or lack of words) of the patient to the individual's experience. He recommends this model: "What is necessary, though not enough, is a capacity to know how the patient is experiencing himself and the world, including oneself [the psychiatrist]."⁸⁰

Though Laing criticizes diagnostic terminology and contrasts the clinician's observation and the patient's experience, Laing conflates individual identity with the disorder. His reference to individuals as "the psychotic" intertwines disability and individual identity. To call someone "psychotic" implies that the person is in a state of "psychosis," a medical condition that in the United States is synonymous for schizophrenia, but in Canada may be distinguished from schizophrenia. Rather than saying that the person is experiencing psychosis, to label the person as "psychotic" intertwines disability and individual identity, making disability the dominant characteristic. Furthermore, he suggests "No one *has* schizophrenia, like having a

⁷⁸ Ibid., 30.

⁷⁹ Ibid., 31.

⁸⁰ Ibid., 34.

cold. The patient has not ‘got’ schizophrenia. He is schizophrenic.”⁸¹ Schizophrenia, according to Laing, is a “way of being in the world.”⁸² Interestingly, while Laing critiques the work of Kraepelin, he too can be critiqued for his medicalized conceptions of schizophrenia wherein he observes that schizophrenia is the dominant characteristic of the individual. Laing therefore locates disability within the individual, as in the case of the medical model of disability.

In recent decades, the medical model of disability has been scrutinized by disability theorists, such as Michael Oliver who has lived experience of disability. Disability theorists criticize the medical model of disability for locating disability in the individual rather than linking the disablement of people with impairments to social, political, economic, and cultural barriers, which limit this population’s life opportunities. As a disability consultancy group suggests, “disabled people are likely to feel more comfortable to define themselves as a disabled person ie. someone whom may experience discrimination on grounds of impairment – rather than being the problem itself.”⁸³ Disability theorists criticize assessments which ask the question: “what is wrong with you?” and thus locate disability within the individual. Michael Oliver, for example, suggests that professionals rephrase the question. Rather than asking “Can you tell me what is wrong with you?” the question should be “Can you tell me what is wrong with society?”⁸⁴ For example, a physician could ask “Are your difficulties in understanding people mainly due to their inability to communicate with

⁸¹ Ibid.

⁸² Ibid.

⁸³ GB Disability Training and Consultancy, “Applying the Social Model of Disability to Health and Social Care Services,” January 2007, Accessed November 25, 2013
<http://www.brainhe.com/documents/applyingsocialmodeltohealthcare.pdf>.

⁸⁴ Michael Oliver, *Politics of Disablement* (London: Macmillan Press, 1990), 7-8.

you?”⁸⁵ In this way, Michael Oliver turns his attention to broader social forces, and not just the individual. Oliver’s work goes further than Laing’s work, which continues to locate disability within the individual, because it suggests disability is constructed by society, not the result of individual impairment.

These critics acknowledge that diagnostic questions are predicated on a system that locates disability within the individual. But what about the actual process of diagnosing and the use of diagnostic terminology? To take Laing’s criticism of diagnostic terminology one step further, and to connect it with problems identified by disability theorists using the social model of disability, raises issues of identity.

As history shows us, the art and science of diagnosing not only informs the way in which a mental disorder is defined, but it also determines the way in which we think about a patient with a disorder and even the way in which patients think about themselves. Diagnosis raises the issue of identity.

Thomas Scheff theorizes about the internalization of labels, suggesting “caution in making these judgements [diagnoses] because of the effect they are likely to have on the social relationship, feelings of rejection and embarrassment.”⁸⁶ While his work demonstrates some concern for the welfare of patients, he makes individuals complicit in their disability by cautioning against “both labeling and enabling.” He suggests that individuals assume the roles that are ascribed to them, an argument which gives limited agency to patients.⁸⁷

⁸⁵ Ibid., 8.

⁸⁶ Thomas Scheff, “Normalizing as the Opposite of Labeling,” Accessed January 7, 2014, <http://www.soc.ucsb.edu/faculty/scheff/77.pdf>.

⁸⁷ Linda J. Morrison, *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement* (New York: Routledge, 2005), 172.

Linda Morrison critiques Thomas Scheff's work in *Talking Back to Psychiatry*, which explores resistance to psychiatry and psychiatric diagnosis, or as people opposed to diagnosis call it, "labelling."⁸⁸ Morrison argues that resistance to labelling does not support Scheff's argument that labels are necessarily internalized,⁸⁹ though she acknowledges the personal nature of labelling. She describes resistance against "the totalizing identity of their psychiatric label."⁹⁰

While Morrison problematizes the use of labels as the defining attribute of an individual, she mostly problematizes labelling in terms of "the right to negotiate for power and recognition."⁹¹ Individuals, according to Morrison, resist "the label...precisely because inherent in the label (and the labeling) is a disempowerment and discrediting that are not only stigmatizing, but also remove the right to self-determination."⁹² She frames the process of labelling in terms of an imbalance of power between the professional and the person being labelled.

While labelling is an act of power that informs identity and affects agency, the process of diagnosing also locates disability within the individual, in a similar fashion to questions premised on the medical model of disability, such as "what is wrong with you?" Using the *Compendium of Psychiatry* in order to make the diagnosis of dementia praecox involved observation of the individual. Kraepelin's work listed symptoms, such as hallucinations and delusions, which could only be identified through observation of how the individual thought, expressed their emotions, and behaved. Observation is an integral part of diagnosis in the present, which is based on

⁸⁸ Ibid., 9-10.

⁸⁹ Ibid., 9.

⁹⁰ Ibid., 166.

⁹¹ Ibid.

⁹² Ibid.

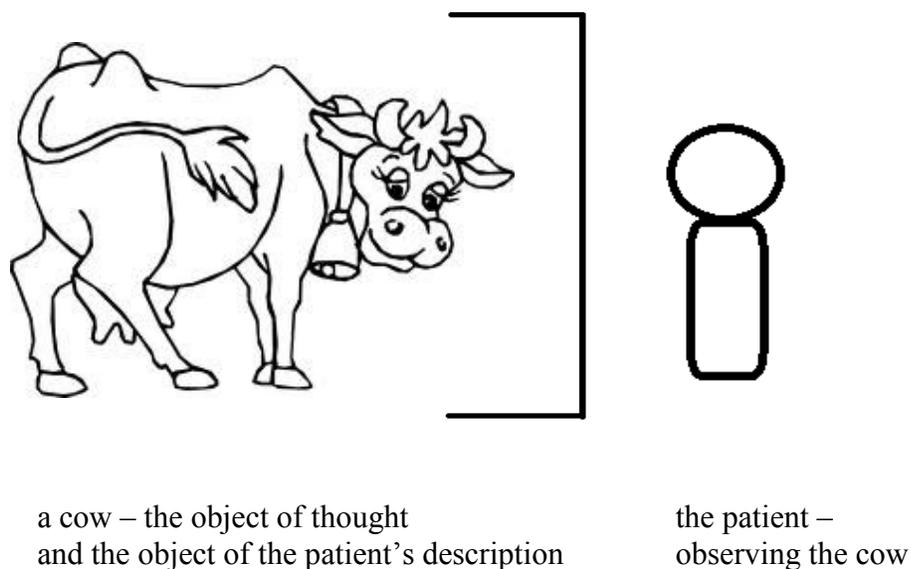
direct observation and what the patient reports. Observation of patients' outward behaviour, as well as what Laing might describe as the patient's "inner thoughts and feelings," has become a central part of a clinical process. But observation, as a tool for assessment and diagnosis, can also be critiqued.

Observation locates mental disability, such as dementia praecox or schizophrenia, within the individual by connecting an individual's thought, mood, and behaviour to the disorder. This point became clear in a conversation I had with a psychiatrist. As I sat in his office, I described the ghosts that surrounded me. The psychiatrist responded that I "thought" there were ghosts. My response reiterated that there were ghosts surrounding me, even though I did not believe in ghosts. We continued in this manner for a while. While the presence of the ghosts was relevant to me, the psychiatrist did not validate my experience. Rather, he assessed my thinking on the basis of information that he thought should not be there. What I took from this conversation is the dichotomy between experience and observation. Through observation, my experience of the ghosts was made into an assessment of my way of thinking.

Diagnostic terminology requires observation. Overarching assessments (such as "hallucination") could be predicated on information derived from patients' statements (such as "I see a cow"), yet they further marginalize the experiences of the patient through the act of observation and assessment, which locates disability in the individual. Patient statements (such as "I see a cow") acknowledge the relationship between thought and the individual. It is clear through the statement "I see" that thought is generated by the individual. Yet these statements focus on providing a

description of the individual's surroundings. They are less concerned with the interpretive nature of the description. In other words, they are not dissecting the process of thinking. The presence of "a cow" is central to the meaning of the statement. Figure 6 depicts a cow, the object of thought and the object of the patient's description, as well as a patient describing the cow. The individual is not an object of observation.

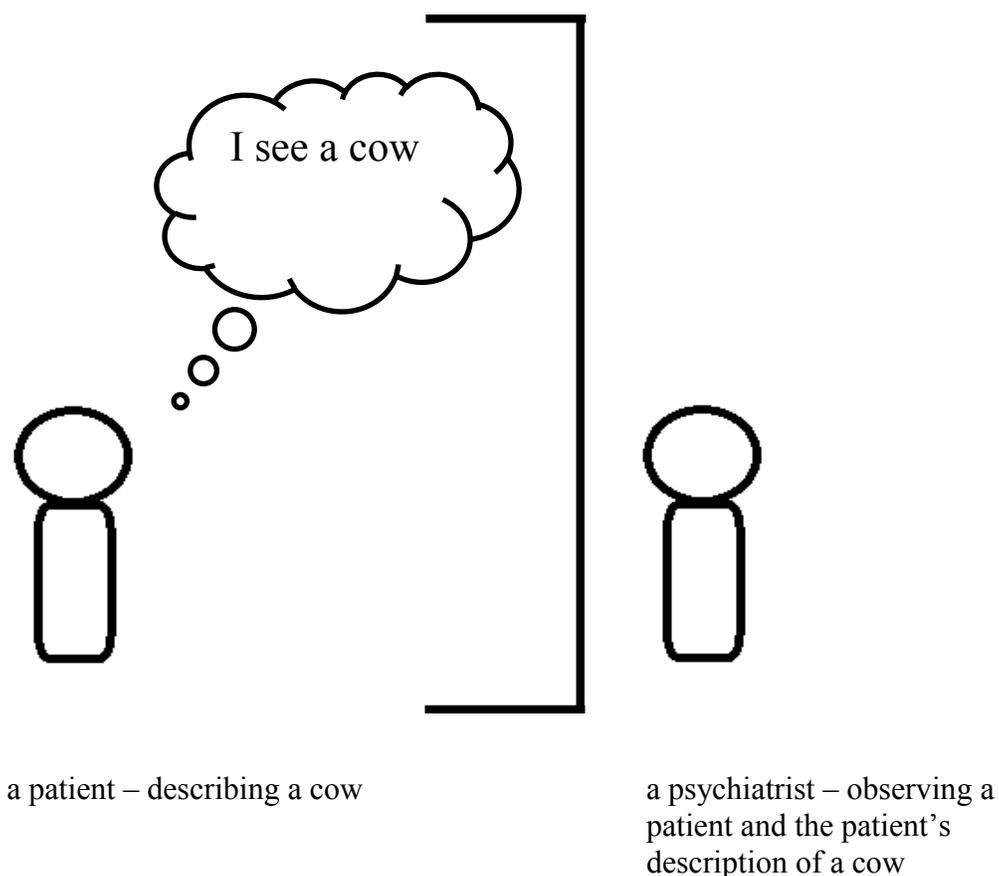
Figure 6: The Patient's Perspective:



Diagnostic terms (such as "hallucination") remove the descriptive element of patients' statements, which might focus on an object, such as a cow. The psychiatrist is not concerned with explaining the patients' surroundings. Rather the psychiatrist looks at information that *should not be present*. The psychiatrist's observation centres on the patient and their description, which is recognized as a subjective interpretation by a particular individual. The psychiatrist's assessment therefore highlights the

relationship between the individual and what the individual thinks. In other words, the psychiatrist is observing the patient observing the cow. Figure 7 depicts a patient describing a cow, as well as a psychiatrist observing the patient and the patient's description of the cow. The individual is central to defining the symptom.

Figure 7: The Psychiatrist's Assessment



Diagnostic terms (such as “hallucination”) not only establish a “standard way of being human”⁹³ but they also privilege the observational power of the psychiatrist while marginalizing the experience of the patient. The observational nature of these terms connect thought, emotion, and behaviour to the individual. Rather than

⁹³ Laing, *The Divided Self*, 27.

examining thought, emotion, and even behaviour as experiences *for* the individual, psychiatry emphasized the individual's role in thinking and behaving in order to define "dementia praecox." Another way of putting this would be to say that the disorder was *not* being defined by the presence of the cow, but rather by the individual *thinking* about the cow. This definition emphasizes consequences of the disorder and impairment of the individual. Disability theorists criticize the medical model of disability for locating disability within the individual, as opposed to the social model which attributes disability to social barriers.

To what extent did this way of thinking about dementia praecox permeate psychiatry? Despite the *Compendium's* emphasis on conditions resulting from the disorder, there was continued interest in causation, a category used by psychiatrist Alexander Leighton, as mentioned in chapter one. Discussion of causation dated back to the seventeenth century and included voices such as the aforementioned Thomas Willis.⁹⁴ But these discussions seem to have encompassed a wide variety of mental disorders. As mental disorders were differentiated and named, these discussions became more precise. Benedict Morel wrote specifically about the causes of dementia praecox. His admiration for Charles Darwin's theory of evolution led him to attribute dementia praecox to heredity in his early work, though he later gave consideration to external factors, such as alcohol.⁹⁵ Even Kraepelin speculated about the causes of this particular disorder, which he attributed to defective sex glands.⁹⁶

⁹⁴ Millon, *Masters of the Mind*, 73.

⁹⁵ "Benedict Augustin Morel," *Encyclopaedia Britannica*.

⁹⁶ Millon, *Masters of the Mind*, 181.

As in the case of diagnostic terminology that remarked on symptoms of dementia praecox, identifying causation also entailed observation of the individual. The brain development of an individual, for example, was placed under scrutiny by Morel. In this sense, disability was similarly located within the individual. Yet causation, which may refer to an individual's external environment or internal body, is not as inextricably linked to identity as is what the person is thinking, doing, or feeling.

While discussion of causation continued, the *Compendium of Psychiatry*, with its focus on symptoms such as "hallucinations and bizarre behaviour," was revised, expanded, and reprinted, and gained a dominant position within psychiatry. By 1915, the *Compendium of Psychiatry* appeared in its eighth edition and encompassed four volumes.⁹⁷ The text was credited with reducing "diagnostic confusion"⁹⁸ and standardized and informed the diagnosis of individuals affected by dementia praecox. It demonstrates one way in which practising psychiatrists conceptualized "dementia praecox," which was renamed "schizophrenia" by 1911. This way of conceptualizing mental disability was not without its problems. But how did these conceptions of the disorder affect Canadian psychiatry? What networks existed for the dispersal of knowledge among Canadian psychiatrists? These questions will be explored in the next section.

2.1.3 Conceptions of Dementia Praecox in Canada after Kraepelin, 1918-1949

The Canadian Psychiatric Association was founded in 1951. Prior to its development, Canadian psychiatrists had actively participated in the Royal

⁹⁷ Ibid., 179.

⁹⁸ Ibid., 181.

Psychopathological Association or the American Psychiatric Association, which was founded in 1844.⁹⁹ It was not until 1918 that a National Committee for Mental Hygiene (NCMH) was founded in Canada. The records of the NCMH, including the records of the Executive, Board of Directors, and Scientific Advisory Committee,¹⁰⁰ offer insight into the way in which “dementia praecox” or “schizophrenia”¹⁰¹ was conceptualized by Canadian mental health professionals as well as others before 1951.

The National Committee for Mental Hygiene, founded by Clifford Beers and Dr. Clarence M. Hincks, was an organization for professionals in the field of mental health, including Canadian psychiatrists.¹⁰² Hincks, according to the Canadian Mental Health Association, “was interested in the field because he had experienced bouts of mental illness.”¹⁰³ Support for the organization came from eminent psychiatrists including Dr. C. K. Clarke, Dean of Medicine and Professor of Psychiatry at the University of Toronto.¹⁰⁴ Dr. Clarke served as the organization’s first Medical

⁹⁹ Canadian Psychiatric Association, *Psychiatry in Canada: 50 Years*, 30. American Psychiatric Association, Homepage, Accessed November 26, 2013, <http://www.psychiatry.org/about-apa--psychiatry>.

¹⁰⁰ I focused my search of the records of the NCMH, from 1918-1950, at the beginning and ending of this time period, and sampling in the middle.

¹⁰¹ I will explain the usage of this word at a later point.

¹⁰² Canadian Mental Health Association, “History of CMHA,” Accessed November 26, 2013, <http://www.cmha.ca/about-cmha/history-of-cmha/>.

¹⁰³ Ibid.

¹⁰⁴ I have not found literature that explains the creation of this organization at this particular time. The organization was following its American counterpart and there was a general shift towards professionalization during this period. Additionally, the war generated a demand for psychiatric services and the management of immigration. Although I did not find prominent references to eugenics in their papers, their terminology, including terms like “defective” and “mental hygiene” borrows from the eugenics movement, which gained popularity in the 1920s and 1930s. Ian Dowbiggin, author of *Keeping America Sane*, suggests that the Canadian NCMH “was more aggressive than the NCMH in promoting sterilization as a mental hygiene measure.” Dr. Hincks and the CNCMH compiled the Mental Hygiene Survey of the Province of Alberta in 1921, which arguably lay the foundation for the passage of Alberta’s Sexual Sterilization Act in 1928. The creation of the Canadian NCMH was likely due to a variety of factors. Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (New York: Cornell UP, 2003).

Director.¹⁰⁵ Dr. Hincks assumed the position of Associated Medical Director and Secretary while Dr. C. F. Martin, a Professor of Medicine at McGill University, served as the organization's first President.¹⁰⁶ According to the resolutions passed in 1919, one third of the organization's membership had to be physicians¹⁰⁷ while another third had to be "persons other than physicians."¹⁰⁸

Despite the formation of an organization led by Canadian leaders, mental health professionals continued to reference their American counterparts. In the early stages of the organization, members studied the work of the American National Committee of Mental Hygiene¹⁰⁹ and appealed to American philanthropic organizations such as the Rockefeller Foundation for funding.¹¹⁰ This American connection continued into the middle of the century, and included changes to diagnostic practices, as will be seen. Nevertheless, the Canadian NCMH developed its own mandate. In its history of its predecessor, the NCMH, the Canadian Mental Health Association identifies the following as central tenants of the organization:

1. War Work
 - (a.) Psychiatric examination of recruits
 - (b.) Adequate care of returned soldiers suffering from mental disabilities
2. Mental examination of immigrants (post-war) to ensure a better selection of newcomers
3. Adequate facilities for the diagnosis and treatment of cases of mental disease

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ I have not found any information pertaining to the training undergone by its members. This would be an interesting point of research. Were they trained in the same Kraepelian methods?

¹⁰⁸ Library and Archives Canada, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, "Minutes of the Fourth Executive Meeting of the Canadian National Committee for Mental Hygiene – Toronto 26 May 1919," volume 1, file 10, page 26.

¹⁰⁹ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, "Minutes of the First Executive Meeting of the Canadian National Committee for Mental Hygiene – Hamilton 29 May 1918," volume 1, file 10, page 2, 4.

¹¹⁰ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, "Minutes of the First Meeting (Second Year) of the Finance Committee, Canadian National Committee for Mental Hygiene – Toronto 15 October 1919," volume 1, file 10, page 31.

4. Adequate care of the mentally deficient
5. Prevention of mental disease and deficiency¹¹¹

The organization's approach to war work was pragmatic. They sought to identify mental disabilities among recruits and to care for returning soldiers. These objectives were aimed at individuals with existing mental disabilities. This pragmatism may be explained by the conditions brought about by the war. Yet similar objectives were articulated with respect to immigrants and the general population. The organization was concerned with identifying cases of mental disability among potential immigrants and it demanded adequate facilities for affected individuals, in the tradition of Morel and Kraepelin.

Although a majority of the policies articulated by the NCMH were based on the existence of mental disability, the organization was not concerned with how the disorder would be identified. *How* would recruits and immigrants be examined? Did they use the diagnostic categories compiled by Emil Kraepelin? On this, there is silence in the historical record, despite the detail of the organization's accounts. This silence may be explained in part by the inexperience of the NCMH. Early on, the NCMH identified the need for an "investigation" into the "most suitable diagnostic methods."¹¹² Yet the NCMH may also be said to have focused more on the conditions of care for individuals, particularly the facilities, and less on the mental condition of individuals.

The "prevention of mental disease and deficiency" appears last in the list of goals compiled by the CMHA, but it came to dominate the attention of the

¹¹¹ Canadian Mental Health Association, "History of CMHA," Accessed November 26, 2013.

¹¹² LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, "Minutes of the First Executive Meeting (Second Year) of the Canadian National Committee for Mental Hygiene – Montreal 17 October 1919," volume 1, file 10, page 35.

organization. Lynn Gamwell and Nancy Tomes suggest that its American equivalent “focused its attention almost exclusively on the prevention of mental illness.”¹¹³ Very early on, the Canadian NCMH began to target the “primary school” as “the best vantage ground for applying the principles of prevention in connection with the problem of mental abnormality.”¹¹⁴ Later on, they developed programs for education. Unlike other initiatives, these programs were intended for individuals *without* mental disabilities.

Which mental disorders did the NCMH seek to prevent? In general, the organization did not specify or name the disorders it sought to prevent.¹¹⁵ The organization sought to prevent mental disability in all of its various guises. Their language was similarly vague when discussing individuals affected by mental disorder, despite the appearance of medical terminology differentiating various disorders. When discussing their mandate, the organization stated that they were concerned with the welfare of “the insane.”¹¹⁶

The mandate of the NCMH therefore focused on preventing but also caring for individuals affected by mental disorder. As in the case of rehabilitation, both of these efforts centred solely on the individual. Whereas individuals who were deemed at risk of developing a mental disability were not identified by their condition, individuals

¹¹³ Gamwell and Tomes, *Madness in America*, 171.

¹¹⁴ LAC, “Minutes of the First Executive Meeting (Second Year) of the Canadian National Committee for Mental Hygiene – Montreal 17 October 1919,” volume 1, file 10, page 35. The NCMH does not seem to explain this focus on children until the middle of the century, when they began talking about programs that would serve the nation.

¹¹⁵ Members debated the connection between venereal disease and “feeble-mindedness” and whether the disease warranted attention by the organization. This debate was unique. LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Minutes of the Second Executive Meeting of the Canadian National Committee for Mental Hygiene – Ottawa 17 September 1918,” volume 1, file 10, page 12.

¹¹⁶ *Ibid.*, page 10.

affected by mental disability were identified as “the insane” by the NCMH, a problematic term that interwove identity and mental disorder by identifying disability as the predominant and exclusive characteristic of the person. The increasing use of diagnostic terminology and changing definitions of “dementia praecox” or “schizophrenia” by the NCMH would further reinforce the connection between identity and mental disability.

The term “dementia praecox” appeared in the Executive Committee records of the NCMH in 1919. A year after their foundation, they started collecting statistics. The organization was attempting to track cases of mental disorder. From March 12, 1919 to October 1, 1919, it recorded only two cases of “dementia praecox.”¹¹⁷ Despite its limited scope, this survey shows that the organization was beginning to distinguish between different forms of mental disorder. They recorded the existence of mental disorders.¹¹⁸ Though the NCMH began to document the types of tests used among children,¹¹⁹ they did not detail the way in which these labels were assigned to individuals. The NCMH did not identify symptoms outlined by Kraepelin, which involved the observation of how individuals thought, felt, and behaved. That being said, the NCMH’s statistics, which listed cases of “dementia praecox” without any accompanying information, masked other markers of individuals’ identity. In other words, the disorder had greater importance to the NCMH than did other pieces of information concerning affected individuals.

¹¹⁷ LAC, “Minutes of the First Executive Meeting (Second Year) of the Canadian National Committee for Mental Hygiene – Montreal 17 October 1919,” volume 1, file 10, pages 42-45.

¹¹⁸ Ibid.

¹¹⁹ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Report of the Proceedings of the Second Annual Meeting of the Canadian National Committee for Mental Hygiene – 22 June 1920,” volume 1, file 10, page 8.

In the minutes of the NCMH, “dementia praecox” received little attention for several decades, though this silence may have resulted from discrepancies in diagnostic practices. A 1922 report by the NCMH noted that the Royal Victoria Hospital cited “different types of psychoses” that had been referred to their Psychiatric Clinic, specifically a condition in which individuals were “suffering from ideas of persecution.”¹²⁰ An individual in this condition was referred to as “the paranoid.”¹²¹ This description of symptoms offers some insight into the diagnostic guidelines used by Canadian psychiatrists. It also highlights the extent to which Canadian psychiatry operated separately from international medicine. Kraepelin’s *Compendium of Psychiatry* had incorporated catatonia, hebephrenia, and paranoia into the diagnostic category of dementia praecox. Yet Canadian mental health professionals used the more specific category of paranoia to describe an individual, rather than the broader category of dementia praecox. The NCMH did not always use the term “dementia praecox,” yet this discussion about paranoia was also an exception.

This case, though it was unusual, foreshadowed later reports that listed an array of symptoms, which served to locate disability within the individual. In this case, the individual was said to be “suffering from ideas of persecution.” This way of framing disability corresponded with the assessment of the violence of “these individuals.” “Not only [are they] hard to handle,” suggested the report, “but if not committed to a hospital, [they] are very dangerous to the public.”¹²² The stigmatization of associating

¹²⁰ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Minutes of the Combined Meeting of the Executive and Finance Committees of the Canadian National Committee for Mental Hygiene – Montreal 17 February 1922,” volume 1, file 10, pages 1-2.

¹²¹ Ibid.

¹²² Ibid.

“these individuals” with violence, corresponded with locating disability within the individual. Both made people the object of observation and assessment.

The term “dementia praecox” appeared again in the records of the NCMH in 1938. In 1919, dementia praecox had been one of many disorders recorded by the NCMH. By 1938 dementia praecox had gained notoriety in the records of the NCMH Board of Directors. A file recording the activities of the NCMH in 1938 listed four topics, each of which was accompanied by a brief description. In first place was “Dementia Praecox and Medical Education Program.”¹²³ A brief description referenced “newer forms of treatment for Dementia Praecox,”¹²⁴ including insulin shock and metrazol convulsive therapy.¹²⁵ The administration of insulin was intended to induce a coma while the administration of metrazol was intended to induce seizures.¹²⁶ This report was based on the existence of a specific mental disorder. But unlike the statistics recorded by the NCMH in 1919, this report went beyond identifying cases of the disorder to discuss the treatment of the disorder, which coincided with the development of several “surgical, electrical, and chemical remedies for mental illness,” including insulin shock therapy, a version of electrotherapy, and the lobotomy in the 1930s and 1940s.¹²⁷

¹²³ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “National Committee for Mental Hygiene (Canada) Meeting of Board Directors – Montreal 6 March 1939,” volume 1, file 7, page 10.

¹²⁴ Ibid.

¹²⁵ In the same year, the *American Journal of Psychiatry* published an article comparing the effectiveness of insulin and metrazol. The article recorded the benefits of insulin, but noted that “metrazol, besides being not especially effective, also produces serious complications, notably fractured spines.” John Ross and Jonathan Malzberg, “A Review of the Results of the Pharmacological Shock Therapy and the Metrazol Convulsive Therapy in New York State,” *American Journal of Psychiatry* 96, no. 2 (1939), Accessed April 2014, <http://ajp.psychiatryonline.org/article.aspx?articleid=141761>.

¹²⁶ “Shock Therapy,” Encyclopaedia Britannica, Accessed November 26, 2013, <http://www.britannica.com/EBchecked/topic/541334/shock-therapy?anchor=ref145472>.

¹²⁷ Gamwell and Tomes, *Madness in America*, 171.

The NCMH focused more on the effect of these treatment methods than on the symptoms they sought to treat. Although insulin shock and metrazol continued to “prove their value,” the NCMH was hopeful for the “development of a therapy for dementia praecox that is as effective as insulin shock or metrazol but less disturbing to the patients involved.”¹²⁸ Though the report exemplifies the medical mode of disability, which focuses on the rehabilitation of the patient, it goes further in noting patients’ experience of two treatment methods. This report did not discuss the personal circumstances of individuals with the disorder, yet it was concerned with the “disturbing” experience of patients receiving insulin shock or metrazol therapy. This report did not, however, deal with patient experiences of “dementia praecox.” Nor did it provide any information about the disorder or the symptoms it sought to treat, a type of information that became more prevalent in later minutes of the NCMH meetings. Research on dementia praecox was identified as a primary objective of the NCMH for the following year.¹²⁹ This file does not offer any description of the type of research it sought to conduct. The minutes do not list its initiatives. Also in 1939, the NCMH noted that it had prepared a bulletin on “newer forms of treatment for Dementia Praecox.”¹³⁰ Treatment of individuals affected by mental disorder remained a prominent topic of discussion, owing perhaps to the novelty of newer forms of treatment, and even formed a part of the organization’s educational initiatives.

The NCMH also noted the preparation of publications, including “Mental Hygiene,” and various lectures for teachers and nurses on the “importance of

¹²⁸ LAC, “National Committee for Mental Hygiene (Canada) Meeting of Board Directors – Montreal 6 March 1939,” volume 1, file 7, page 10.

¹²⁹ Ibid., page 6.

¹³⁰ Ibid., page 2.

preventative work.”¹³¹ The NCMH provided more detailed discussion of its preventative efforts. Prevention, a different form of treatment, focused on individuals not affected by a mental disorder and remained a prominent topic of discussion by the NCMH. In an address delivered to the Board of Directors of the NCMH in 1938, a physician complained that the “causes [of mental disorders] are so diverse and so varied, and often so difficult to get at.”¹³² But despite this challenge, he emphasized “prevention” as the “important problem.”¹³³ While the NCMH did not identify the symptoms of mental disorders it sought to *treat*, it listed “personality deficiencies in children,” including shyness, recessiveness, and seclusiveness, which it believed could *lead* to a mental disorder.¹³⁴ Unlike Kraepelin’s text, the NCMH focused more on causation than the symptoms that resulted from “dementia praecox.” While prevention involved the observation of children for “personality deficiencies” and was exceedingly personal, this observation did not locate disability in these individuals because they were only identified as being at risk of mental disability, not as being disabled.

The General Director addressed the Board of Directors in 1940 and once again raised the issue of treatment for dementia praecox. The organization, according to the General Director, “granted encouragement in every province for the utilization of the insulin and metrazol treatments.”¹³⁵ This address differed from previous discussions

¹³¹ Ibid.

¹³² Ibid.

¹³³ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Canadian National Committee for Mental Hygiene Annual Meeting – 21 March 1938,” volume 1, file 7, page 4.

¹³⁴ LAC, “National Committee for Mental Hygiene (Canada) Meeting of Board of Directors – Montreal 6 March 1939,” volume 1, file 7, page 2.

¹³⁵ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “National Committee for Mental Hygiene (Canada) Report of the General Director to the Board of Directors – Montreal 16 December 1940, page 2,” volume 1, file 7, page 2.

of dementia praecox. Perhaps the General Director sought to justify the initiatives of the NCMH in describing dementia praecox as “one of the most prevalent and crippling forms of mental disease.”¹³⁶ Like Kraepelin’s text, the General Director defined the disorder as a disabling impairment and stressed the “crippling” impact of the disorder on the individual.

The General Director did not neglect prevention in his address to the Board of Directors. The “education and health of shy children” also warranted attention because this demographic, according to the General Director, contributed to “later disability.”¹³⁷ Although the members of the NCMH began to stress the impact of dementia praecox on the individual, the NCMH continued to provide more information on the causes of mental disorder, though it did not identify a specific condition.

In 1940, the NCMH took this interest in causation one step further as it continued to develop educational programs for schoolchildren during this period. “This activity,” according to the NCMH, had “significance from the angle of prevention because shy children...contribute to dementia praecox and other mental disabilities.”¹³⁸ Whereas earlier discussions of prevention had not targeted particular disorders, this statement connected their goals to a specific mental disorder, dementia praecox. This discussion of prevention / causation did not locate disability within the individual, though it did look to the individual to predict later disability.

Interest in the “newer forms of treatment” for dementia praecox, which had occupied the attention of the NCMH from 1938 to 1940, was accompanied by

¹³⁶ Ibid.

¹³⁷ Ibid., page 3.

¹³⁸ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Twenty-Second Annual Report of the National Committee for Mental Hygiene (Canada) – Montreal 16 December 1940,” volume 1, file 7, page 4.

concerns over prevention. In 1942, the NCMH recommended “extensive work” to educate children on “how their mental health...[could] be preserved.”¹³⁹ This initiative was similar to earlier initiatives in that it focused on positive measures. Yet it differed from earlier initiatives which had focused on specific demographics of children who exhibited qualities that the NCMH considered problematic. Causation was not prominent in this discussion, although “this activity” was designed “to contribute to the prevention of dementia praecox and other mental disorders.”¹⁴⁰ By 1947, the NCMH had changed its focus and stated that the “emphasis should be on the normal range of children’s problems.”¹⁴¹ The NCMH moved away from identifying characteristics it believed contributed to dementia praecox, and potentially putting less emphasis on prevention, a shift that Peter Conrad suggests occurred in the 1970s.¹⁴²

The NCMH continued to use the term “dementia praecox” up to 1947, despite the appearance of the term “schizophrenia” by 1911. Eugen Bleuler objected to Kraepelin’s term, “dementia praecox,” which referred to and singled out mental deterioration as the identifying characteristic of the condition he sought to describe.¹⁴³ For Bleuler, “disturbances in the associative link among thoughts, a breach between affect and intellect, ambivalence towards the same objects, and an autistic detachment

¹³⁹ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Dr. Hincks General Director Report to Board of Directors – Montreal 26 June 1942,” volume 1, file 7, page 3.

¹⁴⁰ Ibid.

¹⁴¹ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Minutes of the Meeting of the Scientific Advisory Committee of the National Committee for Mental Hygiene (Canada) – Toronto 29-30 December 1947,” volume 1, file 11, page 5.

¹⁴² Conrad and Schneider, *Deviance and Medicalization*, 70.

¹⁴³ Millon, *Masters of the Mind*, 187.

from reality” more accurately described the condition.¹⁴⁴ He substituted the term “schizophrenia,” which suggests a “splitting between segments of the mind.”¹⁴⁵

“Dementia praecox” and “schizophrenia” would be used interchangeably by American psychiatrists,¹⁴⁶ at least until the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I). Yet this interchangeability was not present in the minutes of the NCMH, which continued to use the term “dementia praecox” up until 1947. By 1950, the term “schizophrenia” had replaced “dementia praecox” among Canadian health care professionals in the National Committee for Mental Hygiene. What provoked this change?

In 1918, the NCMH had remarked on “some confusion of terminology” and called for a “standard classification of disabilities.”¹⁴⁷ The use of the term “dementia praecox” up to 1950 suggests the isolation of the NCMH from its European counterparts. But what about its American counterparts? The NCMH increasingly employed nationalistic rhetoric to describe its mandate. Yet the organization continued to rely on funding from American philanthropic corporations into the late 1930s and promoted professional relations with the American Psychiatric Association in the 1950s. How did this relationship affect psychiatric practices?

2.1.4 Later American Diagnostic Texts, 1933-1943

Most historiography attributes Canadian diagnostic practices to systems of classification developed by the American military, specifically the US War Office’s

¹⁴⁴ Ibid.

¹⁴⁵ Ibid., 185.

¹⁴⁶ Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Harvard UP: 2011), 233.

¹⁴⁷ LAC, “Minutes of the Second Executive Meeting of the Canadian National Committee for Mental Hygiene – Ottawa 17 September 1918,” volume 1, file 10, page 10.

Technical Bulletin, Medical 203 which was published in 1943.¹⁴⁸ *Medical 203* was preceded, however, by the *Standard Classified Nomenclature of Disease*, published in New York in 1933, which was a collaborative effort of various American organizations, including the Public Health Service, military medical departments, the American Hospital Association, and various hospital and medical associations,¹⁴⁹ to standardize classifications of disease. Though it was compiled and published in the United States, it received attention in Canada.

The *Standard Classified Nomenclature of Disease*, according to an editorial published in the Canadian Medical Association Journal (CMAJ) in 1933, stated that the document “goes far to fill a long-felt want.”¹⁵⁰ Despite Emil Kraepelin’s attempt to standardize psychiatry in the 1890s, the Canadian NCMH called for a standard system of classifying mental disability. A similar concern could be found among other Canadian medical professionals, who bewailed the absence of a standardized system of nomenclature. The editorial in the CMAJ commented:

Hitherto hospitals, health organizations, and insurance companies have been devising their own nomenclatures, or, if they have adopted an existing one have proceeded to modify it beyond recognition. All this indicates the inherent difficulties in the problem and that there has been need of a central guiding influence.¹⁵¹

The *Standard Classified Nomenclature of Disease*, according to the CMAJ, fulfilled this need. The journal argued that the “central authority, for the United States, at least,

¹⁴⁸ Allan Tasman and Wanda K. Mohr, *Fundamentals of Psychiatry* (Chichester: John Wiley & Sons, 2011).

¹⁴⁹ Canadian Medical Association Journal, “A Standard Classified Nomenclature of Disease” August 29, no. 2: 193-194, Accessed February 6, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC402979/?page=1>.

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

has now been provided.”¹⁵² Yet the CMAJ traced the development of the *Standard Classified Nomenclature of Disease* to the 1929 Conference of Expert Statisticians in Berlin, sponsored by the League of Nations, and the 1931 Second International Hospital Conference in Vienna. The Canadian medical journal regarded the document as the result of international initiatives and furthermore argued that the “work of the National Conference on Nomenclature of Disease in the United States may therefore be regarded as a preliminary part of an international effort to simplify and facilitate the exchange between nations of information upon disease and its prevention.”¹⁵³

The importance of medical statistics was equally significant within the American context. George H. Van Burn, writing in the *American Journal of Public Health and the Nations Health* in 1933, hailed the *Standard Classified Nomenclature of Disease* for its “classification of diseases on a dual basis, that is etiological and anatomical.”¹⁵⁴ He suggested that this approach “makes it possible for hospitals to make statistical accountings of all the diseases affecting any organ of the body; and for the first time, hospital statistics showing both the site...and cause...of disease will become available.”¹⁵⁵ Though he mentions that it has “spread to other countries,”¹⁵⁶ Burn does not reflect on the international significance of the document.

The reception of the *Standard Classified Nomenclature of Disease* by Canadian medical professionals suggests the receptiveness of the profession to international bodies of literature as well as an interest in standardizing the profession. The *Standard*

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ George H. Van Buren, “A Standard Classified Nomenclature of Disease,” *American Journal of Public Health and the Nations Health* 23, no. 10 (October): 1104-1105, Accessed February 6, 2014, <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.23.10.1104>.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

Classified Nomenclature of Disease reflected previous efforts within psychiatry to standardize nomenclature concerning psychiatric disability but was viewed, at least in Canada, as having international significance. Though the *Standard Classified Nomenclature of Disease* was concerned with disease more broadly, and though the CMAJ did not reference the impact of the text on Canadian psychiatry, the *American Journal of Psychiatry* noted the involvement of the American Psychiatric Association in the development of the *Standard Classified Nomenclature of Disease* and published an article on its subsequent use within psychiatric hospitals in 1935.¹⁵⁷ Given the close relationship between Canadian and American psychiatry, it is reasonable to assume its impact within Canada.

The reception of the *Standard Classified Nomenclature of Disease* by Canadian medical professionals foreshadowed the receptiveness of Canadian psychiatry to other diagnostic developments originating in the United States, including *Medical 203*. The *Standard Classified Nomenclature of Disease* was followed by the US War Office's *Technical Bulletin, Medical 203* in 1943. As in the case of the Canadian NCMH which had devoted part of its mandate to the screening recruits and caring for returned soldiers, *Medical 203* was a pragmatic response to the conditions of war. Unlike the collaborative effort by various medical groups to produce the *Standard Classified Nomenclature of Disease*, *Medical 203* is attributed to the American military. Yet *Medical 203* reflects a continued attempt to standardize medical nomenclature within a particular branch of medicine.

¹⁵⁷ Neil A. Dayton, "The First Year of the New Standard Nomenclature of Diseases in Massachusetts [sic] Mental Hospitals," *American Journal of Psychiatry*, 92 (1935), Accessed February 6, 2014, <http://ajp.psychiatryonline.org/article.aspx?articleID=14103>.

While the document may have focused on conditions specific to the military,¹⁵⁸ *Medical 203* sought to describe the schizophrenic disorders. Though Emil Kraepelin had grouped various conditions that had been considered disparate, including catatonia, hebephrenia, and paranoia, into the broader category of “dementia praecox,” *Medical 203* divided schizophrenia into subcategories. Hallucinations and “inappropriate” behaviour were listed within specific subcategories.¹⁵⁹ However, *Medical 203* sought to define the disorder more broadly. A definition preceded the subcategories of schizophrenia and stated that the disorder was characterized by “personality disintegration and failure to test and evaluate correctly external reality in various spheres.”¹⁶⁰ It went further than Kraepelin’s text, which focused on the way in which individuals thought and felt, and suggested that individuals “fail in their ability to relate themselves effectively or happily to other people or to their own work.”¹⁶¹

Like Kraepelin’s *Compendium of Psychiatry*, published sixty years earlier, this text marginalized the perspectives of the patient and privileged the observations of the psychiatrist. Marking behaviour as “inappropriate” similarly locates disability within the individual. “Behaviour” refers to an observation that encompasses an individual and their actions. Making the diagnosis of schizophrenia therefore involved identifying disability in the individual’s actions. Assessing behaviour as “inappropriate” further marginalized the individual by establishing a dichotomy between “appropriate” and “inappropriate” behaviour and individuals that displayed

¹⁵⁸ Arthur C. Houts, “Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203,” *Journal of Psychology* July 56, no. 7: 945.

¹⁵⁹ Office of the Surgeon General, Army Service Forces, “Nomenclature of Psychiatric Disorders and Reactions,” *War Department Technical Bulletin, Medical 203*, republished by the *Journal of Clinical Psychology* 56, no. 7 (July 2000), 932.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

one type of behaviour instead of another. That the (moral) distinction between what was “appropriate” and “inappropriate” appeared in discussions of behaviour perhaps speaks to the place of behaviour in the social realm, as opposed to the individuals’ thoughts and feelings.

Medical 203 also scrutinized the ability of the individual to “test and evaluate correctly external reality.” Like Kraepelin’s discussion of “hallucinations,” the absence of “external reality” was not framed as an experience for the individual. Rather, “external reality” was something that was unattainable based on the abilities of the individual. Like its predecessor, *Medical 203* emphasized the effect of the disorder on the individual’s ability to function.

There was limited discussion of causation, or that is to say factors that preceded the onset of mental disability. *Medical 203* noted the impact of “concept formation” in relation to “consequent affective and intellectual disturbances.” Yet “affective and intellectual disturbances” were said to be the result of “concept formation.” *Medical 203* consequently focused on symptoms following the onset of the disorder, as opposed to the causes, of “schizophrenia.”

2.1.5 Conceptions of Dementia Praecox in Canada after Medical 203, 1950

Although *Medical 203* was a text produced in the United States, it raised the issue of nomenclature among Canadian professionals. “Standardization of Nomenclature” became a topic of discussion by the NCMH three years after the publication of *Medical 203*, though they did not reference the text. It preceded changes in nomenclature used by the NCMH, notably the use of “schizophrenia”

instead of “dementia praecox.” It also coincided with changes to the way in which the disorder was conceptualized.

By 1950, the NCMH refocused its attention from the prevention of mental disability to the impact of “schizophrenia” on the individual. This shift was precipitated by debates over the place of psychiatry in the general hospital, which unfolded in the minutes of the Scientific Advisory Committee of the NCMH in 1950.¹⁶² Although this committee generally supported the practice of psychiatry in the general hospital, it was advised that the general hospital “should not include chronic epileptics, defectives and chronic schizophrenics.”¹⁶³ This report differentiated patients affected by “schizophrenia” as suffering from a disorder that was “purely psychological.”¹⁶⁴ This discussion focused on individuals affected by schizophrenia, rather than individuals targeted for preventative measures. It continued to intertwine identity and disability by identifying individuals as “schizophrenics.” But what kind of relationship between schizophrenia and the individual was the committee assuming? Was schizophrenia caused by psychological factors or was it expressed through psychological symptoms?

Further discussion suggested that the general hospital was “inadequate” to care for individuals affected by schizophrenia because of the “noise, violence, and disciplinary problems of the unco-operative schizophrene [sic].”¹⁶⁵ Whereas earlier discussions of mental disorder and dementia praecox had been accompanied by lists of characteristics that were considered predisposing factors, this passage was different in

¹⁶² LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Minutes of the Meeting of Scientific Advisory Committee of the National Committee for Mental Hygiene (Canada),” volume 1, file 11, page 13.

¹⁶³ Ibid.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid.

that it listed behaviours that followed the onset of the disorder. This description of schizophrenia focused on symptoms, such as behaviour, which suggests the disorder is located in the individual because of the individual's role in making noise and being "unco-operative."

This conceptual shift, which focused on the consequences, as opposed to the causes, of the disorder, coincided with changes in medical terminology and marked a turning point in the way in which the disorder was conceptualized by Canadian mental health professionals, which continued into the 1950s, as will be seen in the next chapter. But how did changes to medical conceptions of "dementia praecox" / "schizophrenia" affect public conceptions of this disorder? How did public conceptions compare to medical conceptions of "dementia praecox?" The next section will examine public conceptions of "insanity" from 1889 to 1950.

2.2 PUBLIC CONCEPTIONS OF "INSANITY" IN THE *OTTAWA CITIZEN*, 1889-1950

On December 21, 1895, Walter Scott and Miss. Clara Dawson were married following her release from an asylum at Mount Pleasant.¹⁶⁶ The couple had met two years previously and the "friendship had ripened into love."¹⁶⁷ Yet her father disapproved and forbade a relationship. "But as they persisted, he took the girl before the Insanity Commissioners and gave testimony on the strength of which she was found insane and sent to an asylum."¹⁶⁸ In the end, her love "succeeded in proving

¹⁶⁶ "Killed for His Love," *Ottawa Citizen*, December 25, 1895, 2.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

that she was sane” and she left the asylum, whereupon Walter Scott was “Killed for His Love” by her father.¹⁶⁹

This story was recounted in the *Ottawa Citizen* several days after the marriage took place. Perhaps the sensational nature of the case explains its popularity within the press. The story originated in Des Moines, Iowa, but was picked up by the *New York Times* and even recounted in the *New Zealand Herald*. Yet despite a detailed account of events leading up to their wedding day, there is silence surrounding the rationale for her internment in an asylum and her subsequent release. This silence reflects a lack of curiosity on the part of the journalist, and the public for whom the journalist was writing. Absent was a definition of insanity, which was present in later articles. What testimony did her father give to the commissioners? Was her love of Walter Scott considered a sign of “insanity?” What “steps” did Scott take to “secure her release?”¹⁷⁰ And why is Dawson’s voice absent from the historical record?

Perhaps the answers to these questions would have been apparent to a nineteenth-century audience. The testimony by Clara Dawson’s father and her lover, however, are lost. Yet it is clear that particular voices dominated this narrative. There was a privileged authority in that the voices were male. But Miss. Dawson was also a patient. The case of Clara Dawson reflects the marginalization of the female voice as well as the patient’s voice. Gender and the construction of disability, as other scholars have suggested, frequently intersected in this period as well as in the present. Hysteria, for example, was and continues to be characterized as a female disorder.¹⁷¹

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ See for example Richard Warner, “The Diagnosis of Antisocial and Hysterical Personality Disorders: An Example of Sex Bias,” *Journal of Nervous and Mental Disease* 166, no. 12 (1978),

The story of Clara Dawson, one of many stories recounted in the *Ottawa Citizen*, furthermore highlights the way in which insanity is a social construct, which can be conferred upon an individual or taken away. This chapter will examine social conceptions of insanity in the late nineteenth century and early twentieth century.

The *Ottawa Citizen* continued to use the term “insanity” exclusively despite the appearance of the term “dementia praecox” within the medical community.¹⁷² Other newspapers, such as the *Globe and Mail*, began using the term “dementia praecox” in the 1930s and 1940s. As discussed in chapter one, this work is not necessarily intended to examine “informed” public dialogue. Whereas the medical community was beginning to differentiate between different mental disorders, this newspaper’s use of the term “insanity” was a more inclusive, and consequently more vague, point of reference. In the nineteenth century, the term “insanity” denoted “false action of conception or judgement.”¹⁷³ Its usage resembled Emil Kraepelin’s work on “dementia praecox,” which similarly emphasized impairment. “Insanity,” according to contemporary sources, indicated some form of “mental derangement or disorder,”¹⁷⁴ including what would later be known as schizophrenia.

This ambiguity could make tracing the history of a particular mental disorder difficult. But this ambiguity is also important to the history of public conceptions of

Accessed February 6, 2014,

http://journals.lww.com/jonmd/Abstract/1978/12000/THE_DIAGNOSIS_OF_ANTISOCIAL_AND_HYSTERICAL.2.aspx, and Carroll Smith-Rosenberg “The Hysterical Woman: Sex Roles and Role Conflict in 19th Century America,” *Social Research* 39, no. 4 (Winter 1972), Accessed February 6, 2014,

<http://www.jstor.org/discover/10.2307/40970115?uid=3739448&uid=2134&uid=2&uid=70&uid=3737720&uid=4&sid=21103469795243>.

¹⁷² Lynn Gamwell and Nancy Tomes, *Madness in America* (New York: Cornell UP, 1995), 119.

¹⁷³ “Insanity,” *Oxford English Dictionary Online*, Accessed April 15, 2014,

<http://www.oed.com.proxy.library.carleton.ca/view/Entry/96612?redirectedFrom=insanity#eid>.

¹⁷⁴ “Insanity,” *The Free Dictionary*, <http://medical-dictionary.thefreedictionary.com/insanity>.

schizophrenia. The use of the term “insanity” rather than “dementia praecox” or “schizophrenia” suggests the isolation of the public from medical influences. Were public conceptions of “insanity” as isolated? Who had the authority and the clout to inform public conceptions of this disorder? This section will examine public conceptions of “insanity” in the absence of specific references to “dementia praecox” or “schizophrenia” by the *Ottawa Citizen* before 1950. It will focus on articles that contained a substantial discussion of “insanity.”

There was limited discussion of “insanity” in the late nineteenth-century press. The term was employed in the sensational case of Mr. Walter Scott and Miss. Clara Dawson. In this case, Clara Dawson’s behaviour, which challenged parental authority, may have provoked the diagnosis of insanity. As will be seen, the term “insanity” was often connected with behaviour that contradicted social norms in the late nineteenth and early twentieth century. The term was therefore used to *explain* existing behaviour. With the rise of the medical profession, however, “insanity” would become a concept that required definition and the attribution of the condition to someone would increasingly require an assessment of the individual in order to identify particular symptoms associated with mental disability.

Advertisements were the primary forum in which the term appeared. Between 1889 and 1897, advertisements for Paine’s Celery Compound put the issue of insanity before the Canadian public.¹⁷⁵ Milton K. Paine, a pharmacist in Vermont, developed

¹⁷⁵ “Canadians Work Too Hard!” *Ottawa Citizen*, October 23, 1889.
 “At Last!” *Ottawa Citizen*, October 30, 1889, 4.
 “Canadians Work Too Hard!” *Ottawa Citizen*, November 15, 1889.
 “Canadians Work Too Hard!” *Ottawa Citizen*, November 25, 1889.
 “Canadians Work Too Hard!” *Ottawa Citizen*, February 5, 1890.
 “Canadians Work Too Hard!” *Ottawa Citizen*, January 11, 1890, 6.
 “Paine’s Celery Compound,” *Ottawa Citizen*, April 3, 1897, 2.

his concoction consisting of: “celery seed, red cinchona, orange peel, coriander seed, lemon peel, hydrochloric acid, glycerin’s simple syrup, water, and alcohol,” which was made available on the market by Wells, Richardson and Co. of Vermont.¹⁷⁶ By 1889 advertisements for Paine’s Celery Compound appeared in the *Ottawa Citizen*. How did these advertisements conceptualize insanity? Unlike the ambiguous use of the term in the case of Scott and Dawson, these advertisements offered a more substantial description of “insanity.” They assumed a similar format as other nineteenth-century advertisements. Although they were outside contributions, they were stylized to imitate a formal newspaper article and perhaps were intended to be taken as an objective presentation of information. A title and subtitle would precede a column of text, which included an introduction. In the case of advertisements for Paine’s Celery Compound, the introduction also outlined a problem. The conclusion then introduced the product that would solve the problem.

“Pains in the back, poor and unrefreshing sleep, lack of appetite, dyspepsia, and lost energy and strength, are the first symptoms of more serious trouble,” one advertisement read.¹⁷⁷ “This is the way Paralysis, Paresis and Insanity begin.”¹⁷⁸ Paine’s Celery Compound was advertised as a solution for existing symptoms and as a preventative measure against ensuing conditions, including insanity.

This advertisement consequently focused on the causes of the condition, including “pains in the back, poor and unrefreshing sleep, lack of appetite dyspepsia, and lost energy and strength,” which it identifies in a rather lengthy list. This way of

¹⁷⁶ Cortland Contrarian, “Paine’s Celery Compound,” Accessed February 5, 2014, <http://jeffpaine.blogspot.ca/2013/03/paines-celery-compound.html>.

¹⁷⁷ “At Last!” 4.

¹⁷⁸ Ibid.

conceptualizing insanity depends partially on the advertisement's preventative approach. It does purports to prevent, not to treat, insanity. Yet it could have listed the consequences of the condition that it seeks to prevent. Instead it concludes with testimonials of good health, which gave authority as well as voice to individuals who used their product and had something positive to say about it. The advertisement included female as well as male voices. But its preventative approach gave voice to individuals who were considered to be in good health and excluded the voice of individuals affected by "insanity."

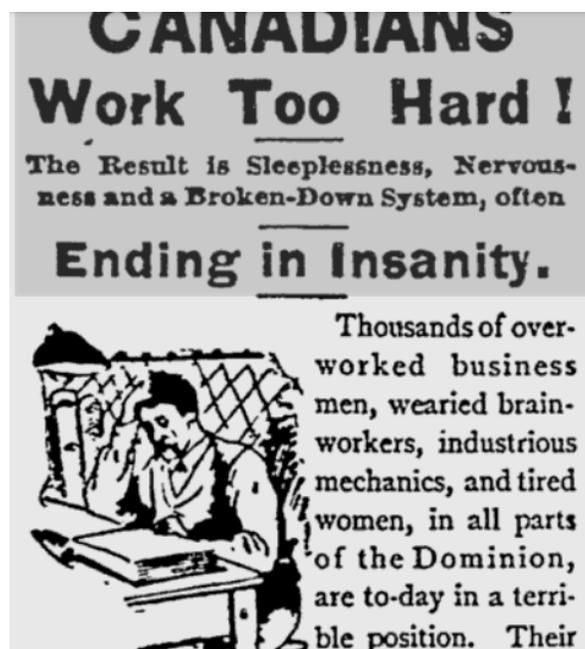
A series of advertisements, titled "Canadians Work Too Hard," followed. These advertisements similarly identified a problem. In this case, it was Canadians' work habits. "The Result," the subtitle continued, "is Sleeplessness, Nervousness and a Broken-Down System Ending in Insanity."¹⁷⁹

These advertisements profited by extolling the short and long-term consequences of working hard and not taking Paine's Celery Compound. This advertisement reinforced its message with a picture of a man, seemingly at work who is supporting his head with his hand, as seen in Figure 8. This illustration foreshadowed later advertisements, which similarly depicted individuals with their hands on their heads, as seen in Figure 9. Yet the last three words of the subtitle, "Ending in Insanity," more than doubled in size.¹⁸⁰ So health consequences were featured prominently in the public sphere. Yet insanity was not defined according to its consequences – insanity itself was listed as a long-term consequence. Insanity was defined according to a list of suspected causes. This use of the term insanity resembles

¹⁷⁹ "Canadians Work Too Hard!" 4.

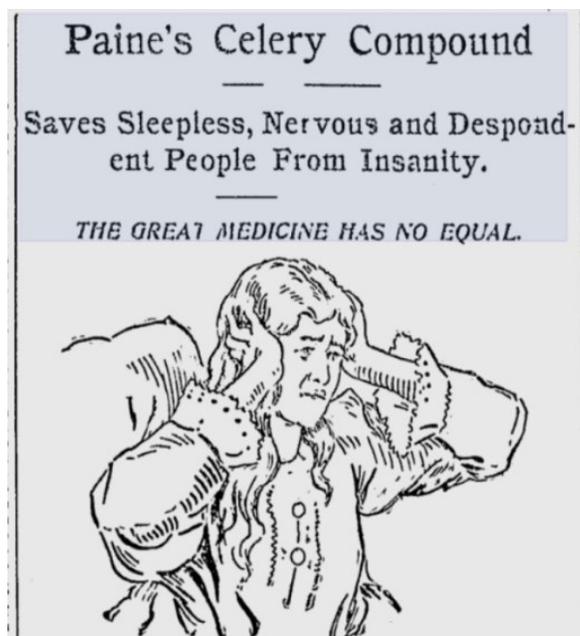
¹⁸⁰ Ibid.

the case of Clara Dawson, where insanity seems to have been predicated on behaviour that contradicted parental authority. All of these articles connected undesirable behaviour with insanity. In this case, insanity was predicated on what was deemed poor work habits, in a similar way that *Medical 203* later identified individuals' inability "to relate themselves effectively or happily to other people or to their work" as a symptom of schizophrenia. Work, or the ability to work, is a reoccurring theme in the history of disability, which is related to the notion of moral reform and the incorporation of work in rehabilitation. The ability to work has also been central to defining who is impaired.



Source: *Ottawa Citizen*, November 23, 1889.

Figure 8: Advertisement for Paine's Celery Compound depicting a man, apparently at work, who must support his head, giving the appearance of tiredness.



Source: *Ottawa Citizen*, April 3, 1897, 2.

Figure 9: Advertisement for Paine's Celery Compound which depicts a woman clutching her head. Her nightgown suggests that she is "sleepless," a condition that the advertisement warns will lead to "insanity."

What is also striking are the gender and class dimensions at play. In the case of Clara Dawson, her gender gave her father authority and may have influenced her committal. The advertisements, which seem targeted towards working-class Canadians, display class biases. Therefore the insanity ascribed to Clara Dawson and working-class Canadians was constructed within a wider social context of gender and class relations.

Was this how the public conceptualized insanity? These advertisements were outside contributions to the public press, developed by an advertising company and the doctor that developed the compound. They showcase the company's perception of

public attitudes. Given the company's mandate to sell their product to the public, the company catered to the public's fear of insanity, especially through their discussion of causes. But even if these advertisements do not reflect conceptions of insanity *by* the public, they demonstrate the definition of insanity *before* the public. Their stylization as formal newspaper articles and their medical references gave them authority.

Advertisements for Paine's Celery Compound appeared more sporadically after 1890. The last advertisement appeared in 1897. In what context did the term "insanity" appear in the public press in the twentieth century? Though we often think of "insanity" in connection with institutionalization in the late nineteenth and early twentieth century, references to the asylum were not prominent in the records of the *Ottawa Citizen*. The report of Clara Dawson briefly referenced her committal in an asylum, but subsequent articles did not reference these institutions, perhaps because the institutionalized were indeed "hidden," especially from residents of Ottawa. The Lady Grey Hospital, which specialized in the treatment of tuberculosis until 1970 and was renamed the Royal Ottawa Hospital in 1969, did not begin its conversion into a health centre for individuals living with mental disability until 1961.¹⁸¹ Prior to this period, individuals living with mental disability would have been sent to the provincial psychiatric hospital in Brockville, which was founded in 1894 and called the Eastern Hospital for the Insane.¹⁸² Nevertheless, a majority of the references to "insanity" in the *Ottawa Citizen* came from elsewhere in Canada or abroad. These articles did not reference the infrastructure designed to care for individuals with mental disability, but

¹⁸¹ The Royal Ottawa Hospital, "About the Royal: Our History," Accessed February 6, 2014 <<http://www.theroyal.ca/about-the-royal/our-history/>>.

¹⁸² Ibid.

perhaps this silence speaks to the focus on crime and “insanity” in the early twentieth century.

The turn of the century ushered in a series of high profile criminal cases, including the trial of Harry K. Thaw. Thaw was accused of murder. But his conviction was not straightforward. He pleaded not guilty on the account of insanity.¹⁸³ The very public nature of his actions contrasted with the domestic context in which the term had appeared in the late nineteenth century. The case of Scott and Dawson had centred around family relations while advertisements for Paine’s Celery Compound were intended for individual consumption and demonized the public sphere for its negative health consequences for Canadian workers. The trial of Harry K. Thaw, in contrast, played out as a very public affair.

Criminal trials showcase debates over the meaning of insanity and its manifestation. Was Thaw in fact insane? He had a jury to convince. In this case, “insanity” was being used to reduce culpability and explain Thaw’s actions. Yet this case required definition and a way of assessing “insanity.” Thaw’s defence, according to the *Ottawa Citizen*, was based on his “family history.”¹⁸⁴ The defence was accepted. He was subsequently found “not guilty on the account of insanity.”¹⁸⁵

Though the article did not explain what was meant by his “family history,” it was likely referring to the predisposition of his family to be impaired as opposed to the impact of his family on his well-being given the influence of eugenicist thought during this period which traced impairment through families. He made “family history” his defence despite the existence of profound symptoms. In one of several articles

¹⁸³ “Thaw Trial Nearing End,” *Ottawa Citizen*, April 3, 1897, 2.

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

covering the trial, the *Ottawa Citizen* remarked on his “alleged” experience of “hallucinations.”¹⁸⁶ Perhaps the contestation over whether Thaw experienced hallucinations explains his defence. Yet Thaw’s defence should not be seen as a reflection of the way in which he conceptualized “insanity.” It was only in 1984 that the Insanity Defense Reform Act established the “insanity plea” as the responsibility of the defendant in the United States and it was only in the last few decades that Canada changed its legislation so that an “insanity plea” can only be entered by the defendant.¹⁸⁷ In the late nineteenth and early twentieth centuries, however, “insanity” could be ascribed to an individual regardless of whether he or she agreed with it.

His defence reflects his lawyer’s perception of public conceptions of “insanity” and underscores the historical relevance of causation in defining insanity. As in the case of the advertisements, the press focused primarily on causation in order to define “insanity” while consequences such as hallucinations were considered less significant. Absent from his defence, however, were assumptions of gender or class.

Thaw or his lawyer referenced his “family history” in order to identify “insanity.” Whereas the NCMH was later concerned with causation in order to prevent mental disorder, or more specifically dementia praecox, in individuals without the disorder, this case concerned an individual affected by mental disorder. This reference to causation did not, however, conflate the individual’s identity with the disorder. The article did not offer a definition of “insanity” against which the individual’s thinking, feeling, or actions could be assessed. Indeed, referencing his “family history” shifted observation away from Thaw. Whereas the NCMH listed

¹⁸⁶ “Thaw Scores on States Attorney,” *Ottawa Citizen*, July 26, 1909, 36.

¹⁸⁷ Ralph Slovenko, *Psychiatry in Law / Law in Psychiatry* (Routledge, 2002): 242.

traits, such as reclusiveness, which it believed could lead to mental disability and which would have been identified through an examination of the individual, this article referenced a cause that involved the examination of his family. The minutes of the NCMH therefore reflect a shift to a more individual-centred model of treatment even though their attempts at prevention did not identify at-risk individuals as disabled.

The trial of Thaw marked a turning point in social conceptions of insanity in the *Ottawa Citizen*. Although causation formed the basis of Thaw's defence and although the press was hesitant to report on Thaw's "alleged" hallucinations, the press increasingly commented on consequences attributed to insanity in the early twentieth century. However, press coverage generally ignored less visible symptoms, such as hallucinations, and instead began to focus on the observable actions of individuals, such as suicide. This trend may have directed more attention to the individual. Yet the press used "insanity" to *explain* these behaviours, particularly suicide.

In 1927, the press described the case of a "railway executive" who "plunged four storeys to his death from a hospital window."¹⁸⁸ The man had committed suicide, according to the press, "after having been seized with what apparently was a fit of temporary insanity."¹⁸⁹ In this case, the man could not speak for himself. But the press was interested in giving reasons for the man's actions, which conflicted with social norms as well as Canadian laws. His actions were explained through "temporary insanity."

¹⁸⁸ "Railway Executive in Plunge to His Death," *Ottawa Citizen*, February 11, 1927, 2.

¹⁸⁹ *Ibid.*

The elastic relationship between insanity and suicide was showcased in another article, published the same year. Russell Scott, convicted of murder and imprisoned in a county jail in Chicago, committed suicide, which ended a “long desperate fight to escape [the] gallows.”¹⁹⁰ His family had long maintained his insanity. This article does not explain the basis for this defence or whether it was sanctioned by Scott. But Scott’s suicide, his family declared, “only proved their last plea – that he was insane.”¹⁹¹ In this case, suicide was used to explain insanity.

Yet for the most part, “insanity” was used to explain behaviour. This way of viewing “insanity” also applied in the colloquial use of the term. There was limited use of the term colloquially in the *Ottawa Citizen*, with the exception of an article published in 1916. This article related outbreaks of violence in Ireland, which it attributed to the “insanity of a small section of her people.”¹⁹² The transnational origins of this article may explain the isolated, colloquial use of the term. Yet the usage of this term conforms to the general usage of the term in the early nineteenth century. Like subsequent articles correlating “insanity” and suicide, this article was concerned with the activities of individuals arising from a real or imagined state of “insanity.” The press sought to explain this behaviour, which conflicted with social norms. Yet again, insanity was identified as the cause. As in the case of the advertisements, this article incorporated a class dimension, which may have influenced the use of this term.

¹⁹⁰ “Long Desperate Fight to Escape Gallows Closed,” *Ottawa Citizen*, October 10, 1927, 6.

¹⁹¹ *Ibid.*

¹⁹² “John Redmond Denounces the Outbreaks in Ireland Grave Danger to Home Rule,” *Ottawa Citizen*, April 29, 1916, 3.

This chapter's focus on conceptions of "insanity" in the late nineteenth and early twentieth century obscures articles that do not contain qualitative descriptions of insanity. What about cases in which there is little evidence about how the term "insanity" was being defined? Which articles contain qualitative descriptions of "insanity?" Early descriptions of "insanity" in the *Ottawa Citizen* came from medical advertisements speaking about individuals' health concerns, but "insanity" was increasingly described in cases in which the term was being attributed to specific individuals or groups of people. The term was not described within articles dealing with political subjects. Changes to legal principles dealing with "insanity" in other countries received coverage by the *Ottawa Citizen*.¹⁹³ Here was a meeting place between experts and the public.¹⁹⁴ Yet despite the importance of definitions in legal situations, the press did not define the term. Description of the term "insanity" appeared in articles involving specific individuals or groups of individuals as in the case of Clara Dawson, Harry K. Thaw, Russell Scott, and the Irish protesters. The term was frequently being used to *explain* particular behaviours. In contrast, there was substantially more discussion of "schizophrenia" in the second half of the twentieth century that sought to *define* the condition. This shift coincided with the introduction of medical testimony in the press.

Emphasis on explaining observable behaviour through "insanity" continued into the 1930s. Tracing "insanity" through the *Ottawa Citizen* shows that the relationship between "insanity" and suicide became engrained within literary circles.

¹⁹³ "Hickman Pleads Not Guilty – Goes on Trial Jan. 25," *Ottawa Citizen*, December 31, 1927, 35. "Third Reading for Divorce Bill Monday," *Ottawa Citizen*, July 16, 1937, 3.

¹⁹⁴ This project's choice of newspaper articles that provide descriptive discussions of "insanity" does not permit for a more in-depth examination of other forms of expert "knowledge" within the press. Whereas the press gave considerable attention to medical testimony, especially in cases of violence, the press did not define "insanity" in legal situations.

“Out of the Night,” a short story published in the *Ottawa Citizen* in 1937, dealt with the suspected suicide of a young woman.¹⁹⁵ The sergeant in charge of the case attempted to explain the situation to her disbelieving friend. “We come up against these suicides every day,” he said, “and in most cases we never know why they have to be. Melancholia of a sort. I guess. Or insanity.”¹⁹⁶ Again, the press sought to explain the woman’s behaviour and “insanity” operated as a form of explanation. Although gender and the construction of disability often intersect, in this case, there was no difference because she was a women. The suicide of the fictional female character was explained in the same manner as the suicide of the railway executive

Conceptions of “insanity” underwent further change in the 1940s. Behaviour continued to be explained through “insanity.” However, “insanity” became a medical category that required its own explanation and criteria, involved examination of the individual, and resulted in the classification of an individual as “insane.” Symptoms of “insanity” also became more diverse.¹⁹⁷

Emphasis on invisible symptoms of “insanity” entered the legal realm in Canada in the late 1940s. At the turn of the century, Harry K. Thaw was said to have based his defence on his “family history” of insanity rather than his “alleged” hallucinations.¹⁹⁸ Exactly forty years later, Thomas Gibbons likewise pleaded not guilty to murder on the account of insanity. His defence, according to the *Ottawa Citizen*, stated that he was “suffering from delusions and hallucinations, that he was

¹⁹⁵ Marion White, “Out of the Night,” *Ottawa Citizen*, September 20, 1937, 8.

¹⁹⁶ Ibid.

¹⁹⁷ “Defence Pleads Insanity,” *Ottawa Citizen*, April 10, 1947, 1.

¹⁹⁸ “Thaw Scores on States Attorney,” 36.

mentally ill...and that he was not capable of sifting right and wrong.”¹⁹⁹ In this case, “insanity” was not just being used to *explain* behaviour, though it was used to reduce culpability. His defence spoke to the criteria established by Canada’s *Criminal Code*, enacted in 1892, which “disallowed conviction of any accused who, because of a ‘natural imbecility, or disease of the mind,’ was ‘incapable of appreciating the nature and quality of the act or omission’ and of knowing that it was wrong.”²⁰⁰

Yet Gibbons’ defence also attempted to *show* “insanity” and defined “insanity” through various symptoms, including “hallucinations and delusions.” Whereas suicide was a very visible behaviour associated with “insanity,” the “delusions and hallucinations” ascribed to Gibbons were less visible. Yet this attempt to show “insanity” put more focus on the individual. Whereas previous articles used “insanity” to explain visible behaviour that conflicted with social norms, such as suicide or protest, Gibbons’ defence centred on symptoms that did not directly conflict with social norms. The symptoms did, however, establish impairment. They required a more intrusive examination of the individual on the part of professionals. As noted earlier in this chapter, terms such as “delusion” or “hallucination” involve a comparison of information that *should* be present versus information that *should not* be present, marginalizing the experience of the individual as subjective. These symptoms therefore showed impairment, rather than culpability, of the individual. At the same time, these symptoms located disability within the individual.

Gibbons’ defence does not necessarily reflect the way in which he conceptualized “insanity.” His defence was intended for a jury and could have been

¹⁹⁹ “Defence Pleads Insanity,” 1.

²⁰⁰ Marilyn Pilon, “Mental Disorder and Canadian Criminal Law,” Law and Government Division, Accessed February 7, 2014, <http://publications.gc.ca/Collection-R/LoPBdP/BP/prb9922-e.htm>.

crafted by law or medical professionals. Yet this statement gave Gibbons a voice, when the press overwhelmingly controlled his representation in the public sphere. The trial of Thomas Gibbons occurred in a county adjacent to Ottawa and received more coverage than earlier trials.²⁰¹

Joe Finn, a writer for the *Ottawa Citizen*, “interviewed” Gibbons.²⁰² Perhaps the location of the crime made interviewing the defendant possible. The *Ottawa Citizen* did not interview Harry K. Thaw, but neither did it print any interviews, if any interviews were conducted, by other journalists. The “interview” says something about the treatment of Gibbons. The article appeared on the front page of the evening edition of the newspaper, but did not read like a traditional interview. It began with an overview of the charges against Gibbons and ended with a narrative about the night of the murder, as told by the reporter.²⁰³ The voice of Gibbons was suppressed by the reporter. Rather than printing Gibbons’ conversation, the reporter dismissed it as “rambling.”²⁰⁴ Gibbons’ brief reflection on the murder charge and the night of the murder serves as a segue in the narrative told by the reporter.

In addition to remarking on his conversational abilities, the reporter described Gibbons’ behaviour during the ‘interview,’ including his request for a “cigarette.”²⁰⁵ The reporter also questioned Gibbons’ ability to “comprehend the enormity of the charge against him.”²⁰⁶ Just as the attribution of symptoms to Gibbons was based on observation, Gibbons was treated as a subject of examination by the reporter.

Moreover, the reporter constructed impairment by dismissing Gibbons’ conversation

²⁰¹ “Charge ‘Tom’ Gibbons with Double Slaying,” *Ottawa Citizen*, February 2, 1946, 1.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ Ibid.

²⁰⁶ Ibid.

as “rambling” and questioning his comprehension. The “interview” did not give agency to Gibbons.

Though Gibbons’ “mental state” was also a subject of discussion within the courtroom, the press did not print “psychiatric testimony,” which was information presented by medical professionals about the mental condition of the defendant.²⁰⁷ The press only noted the existence of discrepancies between “psychiatric testimony introduced by the Crown and the defence.”²⁰⁸ The press printed Gibbons’ defence, which included medical terminology, yet the press did not engage with what the medical professionals had to say. Yet the press mentioned the “psychiatric testimony” introduced within the court. In contrast, the *Ottawa Citizen* did not reference the medical testimony at the trial of Harry K. Thaw, despite the involvement of Thaw’s psychiatrist, Dr. C. C. Wiley.²⁰⁹

The press continued to examine Gibbons, including his impassive response to the jury’s verdict, which “removed Gibbons from the shadow of the gallows.”²¹⁰ The jury found him “not guilty by reason of insanity” after forty minutes of deliberation.²¹¹ The jury may have been guided by the authoritative opinion of the medical professionals who testified on Gibbons’ behalf. Or the jury may have accepted Gibbons’ description of imperceptible symptoms. But this case indicates the appearance of a different set of symptoms within the public sphere and more personal examination of the individual.

²⁰⁷ “Defence Pleads Insanity,” 1.

²⁰⁸ Ibid.

²⁰⁹ Douglas Linder, “The Trials of Harry Thaw for the Murder of Stanford White,” 2009, Accessed February 7, 2014, <http://law2.umkc.edu/faculty/projects/ftrials/thaw/Thawaccount.html>.

²¹⁰ “Will Confine Gibbons to Mental Institution,” *Ottawa Citizen*, April 11, 1947, 12.

²¹¹ Ibid.

The voice of medical professionals superseded the voice of the patient. Perhaps it was the sensational and morbid nature of the case, but considerable medical testimony accompanied the English murder trial of John George Haigh, also known by the public press as the “Vampire,” two years following the trial of Thomas Gibbons.²¹² Like a majority of articles that dealt with “insanity” in the late nineteenth and early twentieth centuries, this article also covered transnational events. Dr. Henry Yellowlees testified on behalf of the defendant. According to the press, he affirmed that Haigh was “suffering from paranoiac insanity.”²¹³

What was “paranoiac insanity?” The answer depends on the article. One article published in the *Ottawa Citizen* references an unnamed “mental specialist,” who suggested that Haigh “was driven insane by dreams of blood.”²¹⁴ Yet another article cited Dr. Yellowlees, who “explained that Haigh’s condition was caused by a combination of hereditary influences and childhood environment.”²¹⁵ Causation was used by medical professionals to describe “paranoiac insanity.”

Yet the latter article, which made front page news, also references Dr. Yellowlees’ description of a “paranoiac as a mentally ill person whose ‘system of mystical ideas are ever less related to the morals of ordinary society...associated with references to some vague force or principle under whose guidance he is acting.’”²¹⁶ Again, “paranoiac insanity” was not just being used to explain murder, but to reduce culpability. The focus of this article, however, was defining “paranoiac insanity.” For this, less visible symptoms were identified. Haigh’s “mystical ideas” were used to

²¹² “Vampire Haigh to be Hanged,” *Ottawa Citizen*, July 19, 1949, 1.

²¹³ Ibid.

²¹⁴ “‘Vampire’ is Hanged,” *Ottawa Citizen*, August 8, 1949, 47.

²¹⁵ “Vampire Haigh to be Hanged,” 1.

²¹⁶ Ibid.

define “paranoiac insanity.” Dr. Yellowlees’ testimony therefore emphasized a consequence of his condition.

As in the case of Gibbons, this definition identifies a symptom that is less visible than behaviour and Dr. Yellowlee’s testimony centred on information that *should not* be present, which located impairment in the individual. However, this article did not only compare information that *should* be present against information that *should not* be present. Dr. Yellowlees’ testimony went further than the defences of Thaw and Gibbons. Haigh’s thought processes and “mystical ideas” were compared and contrasted against the “morals of ordinary society” by Dr. Yellowlees.²¹⁷ As in the case of visible behaviour, which had been explained through “insanity,” Haigh’s “mystical ideas,” which were used to explain “paranoiac insanity,” were pitted against social norms. Whereas it is difficult to identify the influence of legal or medical professionals in the defences of Thaw and Gibbons, this definition originated from a medical source.

Despite the personal nature of this definition, Haigh’s voice was silent on the topic of “paranoiac insanity.” Haigh’s defence, as reported by the public press, rested on Dr. Yellowlees’ testimony, which made Haigh a subject of examination. Yet coverage of the trial was as personal as coverage of Gibbons’ trial, though the trial took place in England. The press reported on the details of his crimes. But the press also quoted Haigh on his impending execution and speculated about his emotional state on the day of his execution.²¹⁸ Just as medical professionals made the individual a subject of examination, the press likewise made Haigh a subject of examination.

²¹⁷ “Vampire Haigh to be Hanged,” 1.

²¹⁸ “‘Vampire’ is Hanged,” 47.

The jury did not accept Dr. Yellowlees' testimony. Haigh was hanged on August 8, 1949, after the jury "rejected a defence plea of insanity" that closed an expedient, two day trial. The jury's rejection of Dr. Yellowlees' testimony reflects public conceptions of "insanity" in England in the mid-twentieth century. Yet the transnational coverage of this case had the potential to affect public conceptions of the disorder within Canada.

In conclusion, a gradual shift began to occur in the twentieth century. Whereas the press had used insanity to explain behaviour that conflicted with social norms, the press increasingly sought to define insanity in legal and medical cases. Insanity increasingly became identified by less visible consequences that were identified in legal defences or by medical professionals.

This shift in conceptualizing "insanity" highlighted the unique challenges faced by certain individuals. Press coverage began to emphasize the effect of "insanity" on specific individuals. Yet this way of defining schizophrenia involved observation of the individual, which emphasized impairment and located disability within the individual.

The medicalization of "insanity" presaged the public's use of the medical term "schizophrenia" in the latter twentieth century. "Schizophrenia," from the beginning, required explanation. But what *type* of information would be used to define the disorder? Despite press coverage on the causes of "schizophrenia," the *Ottawa Citizen* increasingly discussed symptoms of the disorder identified by the medical community that interwove disability and identity.

CHAPTER 3: PSYCHIATRY AND THE PUBLIC AFTER 1950

3.1 PSYCHIATRIC CONCEPTIONS OF “SCHIZOPHRENIA”

Two major developments occurred almost simultaneously within Canadian psychiatry. The first was the establishment of the Canadian Psychiatric Association (CPA) in 1951. This organization, according to its early institutional records, sought to become “the voice of psychiatry in this country.”²¹⁹ As mentioned previously, Canadian psychiatrists were affiliated with the American Psychiatric Association (APA) prior to the establishment of the Canadian organization.²²⁰ But just as the National Committee for Mental Hygiene (NCMH) had developed its own mandate separate from its American counterpart, the CPA replaced the APA in Canada. Quentin Rae-Grant, author of a commemorative history of the CPA and past president of the organization, explains that the creation of the CPA was a nationalistic endeavor, spurred by the failure of the APA to be able to engage in political advocacy in Canada.²²¹

The second major development came a year following the establishment of the Canadian Psychiatric Association. In 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published by the American Psychiatric Association. In the preface of the first edition, the authors included a history of psychiatric diagnosis, which served to validate the use of their diagnostic text. Beginning their history in the 1920s, when “each large teaching centre employed a system of its own origination, no

²¹⁹ Library and Archives Canada, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Board of Directors Minutes 1953-1958.”

²²⁰ Quentin Rae-Grant, “Psychiatry in Canada: 50 Years,” Accessed February 1, 2014 <<http://publications.cpa-apc.org/browse/documents/13>>.

²²¹ Ibid.

one of which met more than the immediate needs of the local institution,” the authors highlight diagnostic discrepancies and confusion.²²² According to the authors of the DSM, the resulting “polygot of diagnostic labels and systems” impeded “communication and the collection of medical statistics,”²²³ which led to the development of the *Standard Classified Nomenclature of Disease*. While the authors of the DSM acknowledged earlier concerns with statistics, they made it clear that their primary goal was to standardize psychiatric diagnosis. The authors of the DSM remarked on the different systems of nomenclature brought about by the Second World War. They justified the involvement of the military, commenting that “American psychiatry, civilian and military, was utilizing a system of naming developed primarily for the needs and case loads of public mental hospitals.”²²⁴ Yet they bewailed “the situation in psychiatric nomenclature” by 1948 which they contended “had deteriorated to the point of confusion.”²²⁵ In proposing their standardized diagnostic text, they proposed a text “drawn from the experience of the Armed Forces and Veterans Administration.”²²⁶ Yet the text also, according to the authors, “constitutes the section on Diseases of the Psychobiologic Unit from the Fourth Edition of the Standard Nomenclature of Diseases” published in 1952.²²⁷ In standardizing the nomenclature, the authors of the DSM thus sought to incorporate military and non-military texts, as

²²² The Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington: APA, 1952): v.

²²³ Ibid.

²²⁴ Ibid., vi.

²²⁵ Ibid., vii.

²²⁶ Ibid., viii.

²²⁷ Ibid. vi.

well as the opinions of practising American psychiatrists. In the preface to the DSM, the authors outline how they solicited their opinions by sending them questionnaires.²²⁸

Despite the formation of a Canadian professional psychiatric organization, the DSM was adopted by Canadian psychiatry and continues to inform psychiatric diagnosis in Canada. Several years before its publication, the Canadian NCMH had noted efforts at standardizing nomenclature. In terms of clinical practice, the publication of the DSM was a culmination of efforts to standardize the diagnosis of mental disorders within psychiatry. Yet the publication of the DSM was also an exercise in the construction of ‘knowledge’ and determines what constitutes mental disability in Canada. Both the development of the Canadian Psychiatric Association and the publication of the DSM reflect the standardization of the profession after 1950.

The records of the Canadian Psychiatric Association and various editions of DSM provide an entry point to examine conceptions of “schizophrenia” by Canadian psychiatry after 1950. The National Committee for Mental Hygiene, which was studied in the previous chapter, was renamed the Canadian Mental Health Association (CMHA) and continues its affiliation with mental health professionals. This section of the chapter, however, will examine the records of the Canadian Psychiatric Association because of its role as a strictly professional organization for psychiatrists. It will cover the diagnostic texts used by Canadian psychiatry, published in 1952 (DSM-1) and revised in 1968 (DSM-II), 1980 (DSM-III), and 1994 (DSM-IV), in addition to the records of the Board of Directors of the Canadian Psychiatric Association, from 1953 to 1978 as well as their current website.

²²⁸ Ibid., ix.

3.1.1 Diagnostic Texts: DSM-I, II, III, and IV

There were technical differences between DSM and its predecessors, including Emil Kraepelin's *Compendium of Psychiatry* and the U.S. War Office's *Technical Bulletin, Medical 203*. Personality disintegration, for example, was no longer associated with schizophrenia.²²⁹ However, these works continued to identify many of the same symptoms. In his comparison of *Medical 203* and the various editions of the DSM, Arthur C. Houts links these texts with broader conceptual changes within psychiatry and emphasizes their differences while dismissively commenting that the only continuity between the texts was their basic attention to the symptoms of mental disorders. Yet from a disability studies perspective, this continuity is significant to broader conceptions of mental disability and the relationship between mental disability and individual identity. Rather than shifting attention away from the individual, these diagnostic texts continued to identify disability through an assessment of the individual and thus located disability in the individual.

Like *Medical 203*, both DSM-I and DSM-II introduced the section on schizophrenia with a short description of the disorder. DSM-I began by noting that “schizophrenia” was “synonymous with the formerly used term dementia praecox.”²³⁰ It went on to describe the disorder:

It represents a group of psychotic reactions characterized by fundamental disturbances in reality relationships and concept formations, with affective behavioral, and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality, by emotional

²²⁹ The Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington: American Psychiatric Association, 1968): 33.

²³⁰ The Committee on Nomenclature, *Diagnostic and Statistical Manual (I)*, 26.

disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, by a tendency to ‘deterioration.’ The pre-dominant symptomology will be the determining factor in classifying such patients into types.²³¹

DSM II offered a more succinct definition of schizophrenia, identifying the disorder by “characteristic disturbances of thinking, mood and behavior.”²³² Beneath these general descriptions were the “types” of schizophrenia. DSM-I listed eight categories, including: “simple, hebephrenic, catatonic, paranoid, acute undifferentiated, chronic undifferentiated, schizo-affective, childhood, and residual type.”²³³ Within their respective categories, DSM-I and DSM-II then listed more specific symptoms of schizophrenia, including delusions and hallucinations, “ambivalent, constricted and inappropriate emotional responsiveness” and behaviour that was “withdrawn, regressive and bizarre.”²³⁴

Whereas *Medical 203* had listed “inappropriate” behaviour within specific subcategories of schizophrenia, DSM-I and DSM-II expanded their general definitions of schizophrenia to incorporate behaviour as well as thinking and mood. Like its predecessors, the various editions of DSM put a great deal of emphasis on symptoms, such as delusions and hallucinations, resulting from the disorder. There was limited discussion, in contrast, of causation, or predisposing factors. *Medical 203* discussed the impact of “concept formation” in relation to “consequent affective and intellectual disturbances.”²³⁵ DSM II similarly raised “concept formation,” which it argued “may

²³¹ Ibid.

²³² Ibid.

²³³ The Committee on Nomenclature, *Diagnostic and Statistical Manual (I)*, 26-27.

²³⁴ Ibid.

²³⁵ Office of the Surgeon General, Army Service Forces, “Nomenclature of Psychiatric Disorders and Reactions,” *War Department Technical Bulletin, Medical 203*, republished by the *Journal of Clinical Psychology* 56, no. 7 (July 2000): 932.

lead to misinterpretation of reality and sometimes to delusions and hallucinations.”²³⁶ But it was not until DSM III that sections were specifically devoted to “predisposing factors,” “premorbid personality,” and “prevalence.”²³⁷ These additions can be attributed to the space offered by subsequent editions. Whereas DSM-I and DSM-II were less than a centimetre in thickness, DSM-III more than quadrupled in size. Arthur Houts remarks on the addition of new diagnostic categories, which had an impact on the size of subsequent editions, but the section on schizophrenia, though present in earlier editions, also expanded. Though causation was documented in these voluminous editions, the structure and organization of subsequent texts highlighted the consequences of schizophrenia.

DSM-III and IV went further than DSM-I and II in emphasizing symptoms of the disorder by listing criteria required for a diagnosis of schizophrenia, as seen in appendix 4. These lists followed the textual description of schizophrenia and provided a simplified reference section for psychiatrists. In the case of schizophrenia, diagnosis required the presence of “bizarre delusions,” “prominent hallucinations,” or two of the following: “delusions, prominent hallucinations, incoherence or marked loosening of associations, catatonic behavior, or flat or grossly inappropriate affect.” Diagnosis was therefore predicated on an array of symptoms resulting from an underlying condition, which were expressed through the thought, mood, and behaviour of the individual.

DSM-III and IV made an effort to distinguish between the disorder and the individual. The introduction of DSM IV notes changes to the way in which

²³⁶ American Psychiatric Association, *DSM-II*, 33.

²³⁷ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised* (Cambridge: American Psychiatric Association, 1987): 191-192.

individuals affected by mental disorders are identified by the text. DSM-IV, for example, no longer referred to people by their illness by calling individuals “alcoholics.” This term, intertwined mental disability and individual identity, was replaced by phrases which separated the individual and the disorders. Rather than referring to individuals as “alcoholics,” DSM-III and DSM-IV discussed individuals *affected* by alcoholism. The introduction did not challenge the description of a person as “schizophrenic,” yet the broader principle could be inferred and expanded to individuals affected by schizophrenia. This attempt at sensitivity was not unique to the American Psychiatric Association, but rather reflected challenges by the disabled community. But this attempt did not go far enough. Although this way of describing individuals with disabilities separated individual identity and mental disorder, these texts continue to locate impairment in the individual.

These texts continue to *assess* individuals’ thought, behaviour, and feeling by marking thought as “bizarre,” behaviour as “catatonic,” or feeling as “inappropriate.” The observational nature of these assessments emphasizes the subjective nature of individuals’ thought, behaviour, and emotion and also frames thought, behaviour, and emotion as inextricably linked to the individual. By examining the thought, behaviour, and emotion of the individual, these assessments diminish the extent to which thought, behaviour, and emotion are experienced *by* the individual. A part of the social construction of disability, they locate disability in the individual.

3.1.2 Conceptions of Schizophrenia in Canada after DSM, 1952-2013

Though DSM was intended to standardize the diagnosis of schizophrenia across psychiatry, did DSM standardize conceptions of schizophrenia among Canadian psychiatrists? The records of the Canadian Psychiatric Association offer insight into the way in which schizophrenia was conceptualized within a professional, rather than a clinical, environment. How did members of the Canadian Psychiatric Association conceptualize schizophrenia? In what context did psychiatrists discuss schizophrenia?

The evolving mandate of the CPA corresponded with discussions of schizophrenia and other mental disorders. In its formative years, the CPA focused on professional issues. Of particular concern was the relationship between psychiatrists and other professionals. In 1953, the CPA established a “Committee on Relations of Psychiatrists and Clinical Psychologists.”²³⁸ In 1954, the CPA became concerned by a shortage of occupational therapists and decided “that the Board would keep a watching brief on the situation.”²³⁹ Yet the organization was also concerned with standards within the profession and established the “Committee on Professional Standards” in 1954, which spoke on issues such as the Royal College Examinations for Certification and Fellowship in psychiatry.²⁴⁰

The relationships cultivated by the CPA reflect the professional orientation of this organization during a period of professionalization. Whereas the NCMH relied on

²³⁸ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Executive Meeting – Ottawa 23 September 1953” page 3.

²³⁹ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of Meeting of Board of Directors – Montreal 5 November 1954” page 1.

²⁴⁰ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Meeting of the Executive of the Canadian Psychiatric Association – Montreal 18 February 1954” page 1.

patronage by prominent Canadian individuals, the CPA cultivated more affiliations with other organizations, including the Canadian Medical Association (CMA), the APA (American Psychiatric Association), and smaller Canadian psychiatric associations.²⁴¹ By February 1956, the CPA recorded their correspondence with the CMA and their appointment of a delegate to the General Council of the Canadian Medical Association.²⁴² Though the CPA encouraged strong affiliations with the CMA, the delegate was required to be a “member of C.P.A. who is fully informed of C.P.A. activities and interests.”²⁴³ The CPA continued to gain credence within the medical community and by June 1956, the Canadian Medical Association requested the CPA to “act as its official body for consultation on mental health matters.”²⁴⁴

The CPA nevertheless maintained a strong relationship with the American Psychiatric Association (APA), which had been established in 1844 and had developed a reputation for innovation. Whereas the NCMH had used the APA as a model for their organization, the CPA sought contact and even incorporation with the APA, though this goal was abandoned due to “antagonism towards APA in many parts of Canada” and incorporation was decided to be “not possible constitutionally.”²⁴⁵ The CPA nevertheless continued to recognize the importance of the APA for its members,

²⁴¹ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Executive Meeting – Winnipeg 16 June 1953) page 1.

²⁴² LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Meeting of Board of Directors – Toronto 23 February, 1956” page 1.

²⁴³ Ibid.

²⁴⁴ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Meeting of the Board of Directors – Quebec 14 June 1956” page 1.

²⁴⁵ Ibid.

attempting to plan meetings to coincide with meetings of the APA “so that those attending would not have to travel twice during the Spring.”²⁴⁶

In its early years, the CPA engaged in less activism than the NCMH. Whereas the NCMH had conducted reviews of hospitals and care for individuals with mental disorders, the CPA considered accreditation for “mental hospitals” to be a “dangerous field for the C.P.A.” though it attributed its hesitance to the CPA’s “present stage of organization” rather than its mandate.²⁴⁷ In 1956, the Canadian Medical Association raised the issue of the “improvement of psychiatric facilities in Canada.”²⁴⁸ Yet the CPA followed the lead of the Canadian Mental Health Association (which had replaced the NCMH), and debated their findings.²⁴⁹

At this stage of its development, the CPA put less emphasis on mental disorders and clinical matters. In 1955, the CPA noted the ineffectual nature of their Committee on Child Psychiatry, which was described as “the only clinical committee.”²⁵⁰ It was subsequently moved that this committee would “cease to exist.”²⁵¹ Explicit reference to mental disorders did not appear in the early records of the CPA. A general discussion of professional knowledge and responsibilities, however, shed some light on the way in which psychiatrists conceptualized the disorders affecting their patients.

²⁴⁶ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Board of Directors – Edmonton 20 June 1957” page 2.

²⁴⁷ “Board of Directors Minutes – Ottawa 23 September 1953” page 3.

²⁴⁸ “Meeting of the Board of Directors – Quebec 14 June 1956” page 1.

²⁴⁹ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Meeting of Board of Directors and Committee Chairs – Ottawa 20 November 1956” page 1.

²⁵⁰ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of Meeting of the Board of Directors – Toronto 17 June 1955” page 1.

²⁵¹ Ibid.

In 1956, the CPA deliberated on “what the general practitioner need[s] to know.”²⁵² This discussion fit with the professional mandate of the organization, as it defined the role of the psychiatrist against the role of other medical practitioners and positioned psychiatry as a medical specialty. But how did the CPA describe its specialized knowledge? Psychiatrists, according to the CPA, were concerned with “the management of human behaviour.”²⁵³ This way of thinking about the role of psychiatrists put emphasis on the control of the individual. As in the case of DSM, mental disorders were viewed through the expressions, in this case the behaviour, of an individual. Making the individual’s behaviour synonymous with the disorder similarly located disability in the individual.

As it developed, the CPA assumed a more activist role. In 1958, the records of the CPA noted efforts in four provinces “to cover general hospital care.”²⁵⁴ The CPA bewailed the fact that “Mental hospitals have too long been isolated and excluded from the health programs.”²⁵⁵ The organization was concerned by the effect on the “quality of service, the individual patients, the staff and public attitudes.”²⁵⁶ Not only was the CPA concerned with the care of patients, but with the place of their patients within society. This role was important as it defined psychiatry’s relationship with their patients beyond diagnostic practices which located impairment in the individual.

²⁵² “Meeting of Board of Directors and Committee Chairs – Ottawa 20 November 1956” page 2.

²⁵³ Ibid.

²⁵⁴ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Meeting of the Board of Directors of the Canadian Psychiatric Association – Halifax 19 June 1958” page 3.

²⁵⁵ Ibid.

²⁵⁶ Ibid.

The increased activism of the CPA in matters concerning the profession and disability advocacy corresponded with increased discussion of patient care, clinical practices and specific references to mental disorders. In 1958, the CPA established a Committee on Mental Deficiency, which was renamed the Committee on Mental Retardation in 1959.²⁵⁷ This committee, which focused on patient care, referenced a particular type of mental disorder. Further differentiation came within a discussion of ineffectual treatment, which psychiatry attributed to “deficient motivation.”²⁵⁸ “Deficient motivation” was considered “a reflection of a chronic neurosis or character disorder.”²⁵⁹ In this case, the CPA committee referenced specific disorders identified by DSM. Moreover, it defined “chronic neurosis” and “character disorder” (disorders) based on “deficient motivation” (a symptom). This way of thinking about particular mental disorders reflects DSM’s focus on symptoms. Remarkably, motivation as “deficient” also reflected psychiatry’s practice of assessing individuals’ behaviour, which connected the individual and the disorder. It is important to note, however, the appearance of these references to mental disorders within a discussion of patient care. While psychiatric forms of assessment located impairment in the individual so that disability informed the individual’s identity, the psychiatrist’s affiliation with the individual was defined through a therapeutic relationship.

²⁵⁷ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “CPA Board of Directors Meeting – Banff 15 June 1960.” Library and Archives Canada, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Canadian Psychiatric Association Board of Directors Meeting – Ottawa 4 June 1959” page 5.

²⁵⁸ “Canadian Psychiatric Association Board of Directors Meeting – Ottawa 4 June 1959” Appendix 8 page 3.

²⁵⁹ Ibid.

The CPA continued its activist role into the 1960s. Already concerned with the stigmatization of mental disorders, the CPA began to develop the idea of reaching out to the public.²⁶⁰ A committee on “Public Relations and Information” was subsequently formed, with the “main purpose of communicating subject matter to the public.”²⁶¹

1. to give the public understanding of the meaning of psychiatry in order to eliminate popular misconceptions and prejudices
2. to indicate the needs of psychiatry in clear and precise terms
3. to describe the kind of support psychiatry needed in order to carry out its work²⁶²

The mandate of this committee centred on professional objectives, though ostensibly their patients would have also benefited.

The CPA also expanded its activism into the political sphere. The CPA was a vocal critic of changes to health care in the 1960s and voiced what it deemed to be omissions. The CPA wrote to the Honourable J. Waldo Monteith, Minister of National Health and Welfare in 1960 “requesting the inclusion of mental hospitals in the federal-provincial hospital insurance program.”²⁶³ While this change would ostensibly benefit patients, it would also have given credibility to a profession which sought to be recognized within medicine.

This was not the only letter sent to the Minister of National Health and Welfare by the CPA. The organization also wrote to Monteith regarding the Immigration Act to petition that words such as “‘insanity’” and “‘imbecile’ be dropped and more suitable terms introduced.” The CPA did not elaborate on the type of terminology they

²⁶⁰ “Canadian Psychiatric Association Board of Directors Meeting – Banff 15 June 1960.”

²⁶¹ Ibid., appendix 9, page 2.

²⁶² Ibid.

²⁶³ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Canadian Psychiatric Association Board of Directors Meeting – Ottawa 21 April 1960” page 2.

would have preferred. But within the letter, the CPA refers to their patients as “the mentally ill.” This medicalized terminology may have been seen as more respectful by the CPA, but it still intertwined individual identity with mental disability. For a profession concerned with treating individuals, it also gave psychiatry more control. This case does, however, show that the CPA was not only concerned with the care of their patients, but they also were concerned with their representation within society.

The terms “psychosis” and “schizophrenia” appeared in the records of the CPA in 1962 in an Interim Report of the Nucleus Committee on Research of the Canadian Psychiatric Association. The CPA did not purport to understand these disorders. Rather, the CPA sought “basic research into the reinforcement parameters associated with psychosis” and “basic and clinical research into hallucinatory phenomena.”²⁶⁴

Furthermore, the organization recommended:

that research be made into therapy, drugs, follow-up studies, alcoholism, effect of disability pensions, the contribution of social factors to mental breakdown or their influence on the return of the mentally ill to the community, learning difficulties of children, the educability of mentally defective patients, and lastly, the ‘biology of schizophrenia.’²⁶⁵

This list comprised causation, treatment methods, and the conditions they sought to treat. As in the case of its patients, the CPA approached schizophrenia as an entity that could be studied.

The CPA continued to define the role of its members within the medical community, but it also sought to defend the practice of psychiatry, which gives further insight into the way in which mental disorders were conceptualized by the CPA. In

²⁶⁴ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Canadian Psychiatric Association Minutes of Meeting of the Board of Directors – Winnipeg 21 June 1962” appendix 7 page 5.

²⁶⁵ Ibid., appendix 7 page 10.

1963, the CPA contended that “a psychiatric illness is an illness which should be treated by physicians, whether recognized as a psychiatrist or not, who have sufficient training in the field of psychiatry to deal with psychiatric problems.”²⁶⁶ Not only did the CPA define the specialized knowledge of the practitioner, but also distinguished between mental disorders and other medical conditions.

The CPA also began to discuss procedures which it felt defined the practice of psychiatry. Particular attention was paid to psychotherapy, which the CPA thought “differentiates a psychiatrist from a nonpsychiatrist medical practitioner who is also interested in psychiatric disorders.”²⁶⁷ In 1963, the CPA defined psychotherapy: “a medical act by which a physician treating a patient explores the forms, mechanisms used and the origins, both conscious and unconscious, of conflicts in the life of, and the human relationships of his patient.”²⁶⁸

At a subsequent meeting, the wording of this definition was revised, though the meaning was not changed. The following year, the CPA sought a new definition of psychotherapy. In 1964, it was “moved and seconded THAT the Canadian Psychiatric Association’s definition of psychotherapy”²⁶⁹ should read that: “Psychotherapy is a

²⁶⁶ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Canadian Psychiatric Association Minutes of the Board of Directors – Toronto 3 March 1963” Appendix 2 page 2.

²⁶⁷ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “CPA Minutes Meeting of the Board of Directors – Toronto 12 June 1963” Appendix 1 page 2.

²⁶⁸ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “CPA Minutes of the Board of Directors – Toronto 3 March 1963” Appendix 2 page 1.

²⁶⁹ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Meeting of the Board of Directors – Ottawa 22 March 1964” page 1.

medical act by which a physician...explores and attempts to influence the behaviour of a psychiatrically disordered patient with the objective of reducing his disability.”²⁷⁰

This renewed interest in psychotherapy perhaps resulted from the development of cognitive-behavioural therapy (CBT) in the 1960s, which emphasized the connection between an individual’s feelings and their behaviour.²⁷¹ CBT was applied to psychotherapy²⁷² and the influence of CBT can be seen in the definition offered by the CPA, which focused on behaviour.

This definition offers insight into the way in which disability was defined by the CPA. Rather than focusing on the individual’s experience or the social barriers faced by the individual, the CPA continued to focus on the behaviour of the individual and used the behaviour of the individual to identify a disability. This approach is problematic because it locates disability solely within the individual and it does not recognize the inter-relationship between the individual and the individual’s environment, as noted in Michel Oliver’s work.²⁷³ Moreover, it is problematic because it assumes psychiatry *should* have the authority to “influence the behaviour of a psychiatrically disordered patient.” Yet again, it is important to note that this view of disability appeared in a discussion of patient care.

There are gaps in the records of the CPA. Their records for 1968 to 1971 and 1973 to 1974 are not available through Library and Archives Canada. Yet the records that are available continue to show schizophrenia referenced within discussions of

²⁷⁰ Ibid.

²⁷¹ Beck Institute for Cognitive Behavior Therapy, “Cognitive Therapy,” Accessed February 1, 2014, <http://www.beckinstitute.org/history-of-cbt/>.

²⁷² Kendra Cherry, “What is Psychotherapy?” Accessed February 1, 2014, <http://psychology.about.com/od/psychotherapy/a/what-is-psychotherapy.htm>.

²⁷³ Oliver, *Politics of Disablement*, 2.

patient care. In 1967, the CPA reported on psychiatric research being conducted in Canada. The CPA reported:

There is very little definitive good work progressing in the study of the psychoses across the whole country. Pharmacological studies must be excluded from this appraisal. Seven schools are paying some attention to the study particularly of schizophrenia...²⁷⁴

Schizophrenia gained prominence as an area of research within Canadian psychiatry. Yet this research was not divorced from the practice of psychiatry. Research was expected to have practical implications. The authors of the report on psychiatric research were critical of research that had “no relevance for clinical psychiatry.”²⁷⁵

Reference to schizophrenia continued to appear within discussions of research,²⁷⁶ yet reference to schizophrenia increasingly appeared specifically within discussions of treatment in the 1970s. Two papers debating the effectiveness of electroconvulsive therapy (ECT) and psychosurgery commented on the condition of “schizophrenic patients.”²⁷⁷ Both papers noted some improvement in the condition of their patients. The paper on psychosurgery, for example, reported that “aggression associated with schizophrenia was not influenced by amygdalotomy but was effectively treated by posterior hypothalamotomy.”²⁷⁸ This paper gives insight into the way in which schizophrenia was conceptualized by Canadian psychiatrists.

Schizophrenia continued to be identified through assessments of behaviour, such as

²⁷⁴ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “CPA Minutes of the Meeting of the Board of Directors – Beauport 14 June 1967” Appendix 4 page 3.

²⁷⁵ Ibid., page 2.

²⁷⁶ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Meeting of the Board of Directors – Montreal 6 and 7 June 1972” Appendix 3 page 1.

²⁷⁷ LAC, Canadian Psychiatric Association fonds, MG28 I165, “Board of Directors Minutes 1953-1958” series, volume 1, file “Minutes of the Meeting of the Board of Directors – Ottawa 3 June 1978” Appendix D page 5 and Appendix C page 11.

²⁷⁸ Ibid., Appendix C page 11.

aggression, which located disability within the individual. Moreover, individuals who experienced schizophrenia continued to be labelled “schizophrenic,” a term which made disability the predominant characteristic of an individual’s identity.

Psychiatry may be criticized for this approach, for the morality of these methods of treatment, and for their focus on the “symptoms” of schizophrenia. In another paper published the same year, the CPA noted the effectiveness of tranquilizers to “obtain dramatic symptomatic improvement the large number of our patients who suffer from schizophrenia.”²⁷⁹ Yet again, it is important to note the appearance of these references to schizophrenia within a discussion of patient care.

Even in attempting to justify the intrusive therapy of psychosurgery, which they acknowledged could be seen as the treatment of “personal suffering” *OR* the control of “deviant or violent behaviour,” the CPA framed the debate “in terms of the quality of the person’s own life.”²⁸⁰ The CPA expressed their concern with the care of their patients. In an address to the CPA, one physician discussed their relationship with their patients:

Medicine is the healing profession. Medicine is the treating profession. Medicine has earned its honored position not only by appearing to take the patient’s side, but by taking the patient’s side in point of fact. We have become trusted because we deserve to be trusted.²⁸¹

Though Canadian psychiatry continued to focus on symptoms of mental disorders and located disability in the individual, the relationship between psychiatrist and patient continued to be based on therapeutic grounds.

²⁷⁹ Ibid., Appendix A page 5.

²⁸⁰ Ibid., Appendix C page 10.

²⁸¹ Ibid., Appendix A page 3.

The records of the CPA are not available past 1978, yet the organization maintains a website where it posts its position on various topics, from education and training to ethical and legal issues. Additionally, the CPA posts papers related to clinical practice, reflecting the evolving interest of the organization in clinical as well as professional issues.

How does the CPA define schizophrenia in the present? How does the organization view treatment? In 2005, members of the CPA produced “clinical practice guidelines” for the “treatment of schizophrenia.”²⁸² Their diagnostic guidelines mirror the Diagnostic and Statistical Manual (DSM) and identify five major categories of assessment: “psychopathology, level of function, substance use or abuse, cognitive function, genetic.”²⁸³ The guide suggests looking for the following positive, negative, and affective symptoms:

- positive symptoms such as hallucinations and delusions
- negative symptoms such as flat or blunted affect, poverty of thought or thought content, and avolition
- disorganization such as thought disorder, inappropriate affect, and disorganized behaviour
- affective symptoms such as anxiety or depression, particularly in relation to the psychotic symptoms²⁸⁴

These symptoms assess the patient’s experience by commenting on whether information should be perceived by the patient, or the quality of information perceived by the patient, as well as the behaviour and emotion of the patient. Canadian psychiatry continues to assess the experiences of the patient and frames their experiences in terms of impairment. Yet Canadian psychiatry seeks to alleviate this

²⁸² Canadian Psychiatric Association, “Clinical Practice Guidelines – Treatment of Schizophrenia.” *The Canadian Journal of Psychiatry*. 50, no. 1 (2005): 1.

²⁸³ *Ibid.*, 12.

²⁸⁴ *Ibid.*

impairment. A part of their “clinical practice guidelines” relates to diagnosis. The rest of their guidelines are dedicated to treatment.

The CPA continues to attempt to define the term “psychotherapy.” The result was a four page paper outlining the position of the CPA, approved in 2003, defining the term as “a treatment interaction (usually verbal) between patient and psychiatrist whereby the psychiatrist works with the patient to effect change in the thought processes, mood, or behaviours of the patient.”²⁸⁵

This statement resembles the definition of psychotherapy established by the CPA in 1964, though it identifies change in thought processes and mood in addition to behaviour. Like the earlier definition, this definition also makes thinking, mood, and behaviour areas of assessment as well as areas to be modified. This definition highlights the role of the individual in thinking, behaving, and feeling and therefore frames schizophrenia in terms of impairment.

Should schizophrenia be framed in terms of impairment? Ronald David Laing cautions psychiatrists to pay attention to the experiences of their patients, rather than attempting to categorize thought, mood, and behaviour. Psychiatrists should also be wary of the way in which their assessments of thought, mood, and behaviour obscure the patients’ experiences and makes the individual synonymous with the disorder. The way in which psychiatrists conceptualize schizophrenia should fulfill their professional needs as well as the needs of their patients. Psychiatrists and patients should, as

²⁸⁵ Canadian Psychiatric Association, “CPA Position Statement – Psychotherapy in Psychiatry,” *The Canadian Journal of Psychiatry* 49, no. 2 (2003): 2.

suggested by the CPA's clinical guidelines for schizophrenia, develop "a collaborative understanding of the nature of illness."²⁸⁶

Yet psychiatrists have primary contact with individuals affected by schizophrenia. Though psychiatric forms of assessment locate disability in the individual, the relationship between psychiatrist and patient is dependent on therapeutic care. Psychiatrists are concerned with the care of their patients within a clinical setting and more broadly. The CPA has a long history of being concerned with the stigmatization of their patients. The primary purpose of this study is to trace, not to criticize, psychiatric conceptions of schizophrenia.

The question remains whether psychiatric conceptions of schizophrenia fuel stigmatization within the public sphere. The CPA continues to identify stigma as a barrier for individuals living with schizophrenia.²⁸⁷ To what extent do psychiatric forms of assessment appear within the public domain? And what place do these forms of assessment have within the public domain?

3.2 PUBLIC CONCEPTIONS OF SCHIZOPHRENIA, 1950-1985

On January 13, 1950, the *Ottawa Citizen* ran an article entitled "Claim Patient Admits Setting Hospital Fire." The article described the case of a "twenty-three-year-old woman patient" who had confessed to "setting a fire in a mental ward" of the Mercy Hospital five days earlier in Davenport, Iowa.²⁸⁸ This article is worth mentioning because it was the first time that the term "schizophrenia" appeared in the *Ottawa Citizen*. What did this term mean to readers? And what would it come to mean in the ensuing years? How was "schizophrenia" conceptualized?

²⁸⁶ "Clinical Practice Guidelines – Treatment of Schizophrenia" (2005): 30.

²⁸⁷ *Ibid.*, 33.

²⁸⁸ "Claim Patient Admits Setting Hospital Fire," *Ottawa Citizen*, January 13, 1950, 35.

The publication of this article preceded a period of deinstitutionalization that occurred in Canada and the United States in the 1960s. In 1964, the Royal Commission on Health Services argued that ““Any distinction in the care of physically and mentally ill individuals should be eschewed as unscientific for all time.””²⁸⁹ Unlike the discussion which played out in the records of the National Committee for Mental Hygiene in 1950, which had suggested that the general hospital was “inadequate” to care for individuals affected by schizophrenia because of the “noise, violence, and disciplinary problems of the unco-operative schizophrene [sic],”²⁹⁰ the Hall Commission recommended that individuals living with mental disability be incorporated and cared for in psychiatric wards of general hospitals during acute episodes and live in the community the rest of the time.²⁹¹

Yet despite the nineteenth-century public practice of visiting institutions such as prisons and asylums described by Janet Miron, there was no prominent discussion of care for individuals affected by mental disability in the articles examined in the previous chapter, with the exception of Clara Dawson, the woman institutionalized in 1895. The case of Mrs. Elnora Eperly, situated within the hospital, foreshadowed later articles which placed greater emphasis on places of psychiatric care, coinciding with greater references to medical professionals. Psychiatric institutions and the institutionalized became prominent subjects of discourse in the twentieth century, as will be seen, and so did the place of psychiatric terminology in the public domain.

²⁸⁹ Parliament of Canada, “Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada,” Accessed February 2, 2014, <http://www.parl.gc.ca/content/sen/committee/381/soci/rep/report1/repintnov04vol1part3-e.htm>.

²⁹⁰ LAC, Canadian National Committee for Mental Hygiene fonds, MG28 I 391, “Minutes of the Meeting of Scientific Advisory Committee of the National Committee for Mental Hygiene (Canada),” volume 1, file 11, page 13.

²⁹¹ Parliament of Canada, “Mental Health, Mental Illness and Addiction.”

As a primary source, this article can give insight into how individuals and the public at large may have *interpreted* and *conceptualized* schizophrenia and the patient (Elnora Eperly). This article has the potential to address a variety of questions relating to the framing of mental disorders. For example, how did the newspaper portray Mrs. Eperly, an individual with a mental disorder? How did the newspaper conceptualize the mental disorder affecting Mrs. Eperly? How did the newspaper treat a criminal act committed by this individual?

The article, “Claim Patient Admits Setting Hospital Fire,” focused on the criminal case against Mrs. Elnora Eperly. The article reported on the casualties of the fire, but none of the forty-one women who perished were mentioned.²⁹² Only the accused is named. The complete charge of “murder committed in the perpetration of arson” as well as the activities of authorities were reported in the article.²⁹³ But subtle details are added to the discussion of the case. The article identified Mrs. Eperly as the “small and attractive brunette” patient being questioned by authorities and furthermore described her behaviour, in addition to her physical appearance, while in custody.²⁹⁴ The article noted that “she smiled frequently during questioning, and calmly smoked cigarets.”²⁹⁵ Perhaps the press’ description of Mrs. Eperly was intended to add to the horror of the story by contrasting the crime and the unassuming appearance of Mrs. Eperly. The question then becomes why she committed the act of arson, and the answer rests on her mental disability. This description of Mrs. Eperly constructs the social image of the ‘psychiatric patient.’ More importantly, however, it says

²⁹² Ibid.

²⁹³ Ibid.

²⁹⁴ Ibid.

²⁹⁵ Ibid.

something about the press' treatment of the individual. Like Gibbons and Haigh, mentioned in the previous chapter, Elnora Eperly was made an object of examination and discussion by the press.

The second half of the article moves beyond the depiction of Elnora Eperly as the “small and attractive brunette” and becomes a public dissection of the accused and her mental disability. The article cited hospital records, which included the date of her hospitalization, the date of her discharge, and the name of her psychiatrist. Mrs. Eperly was not given a voice. This article drew attention to the mental illness of Mrs. Eperly. At times it appears that the mental disorder was used to describe the ‘total’ individual. The behaviour of Mrs. Eperly, for example, was described as “typical” for “her type of patient.”²⁹⁶ However, there was also significant description of the mental disorder, which is identified as “schizophrenia.” A definition appeared in brackets at the bottom of the article. Schizophrenia, according to the article, “is a form of mental derangement resulting in inaction or the stimulating of qualities which one does not possess.”²⁹⁷

The definition of “schizophrenia” offered by the *Ottawa Citizen* did not replicate the definition printed in *Medical 203*, published in 1943, nor the first edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which was published two years after the arson (as seen in appendix 3). The newspaper's reference to “inaction” somewhat resembled the prelude to the “psychotic disorders” in *Medical 203* which suggested that “individuals with such disorders fail in the ability to relate themselves effectively or happily to other people or to their own work,” as can be seen in the

²⁹⁶ Ibid.

²⁹⁷ Ibid.

appendix. But the newspaper's reference to "inaction" was vague in comparison to the definition printed in *Medical 203*, as was the newspaper's reference to the "stimulating of qualities which one does not possess." What qualities did they mean, precisely?

Perhaps the newspaper included this definition in an attempt to explain what may have been an unfamiliar term for the public. This was the first time that the term "schizophrenia" appeared in the *Ottawa Citizen*. While this definition differed from the medical texts of the time, the inclusion of this definition at the bottom of the article continued the trend of defining medical disorders by legal and medical professionals that began at the middle of the twentieth century, as seen in the previous chapter. This article differed from early twentieth-century articles because schizophrenia was not (only) being used to explain the charges of arson or reduce culpability. Rather, the press was actively attempting to define "schizophrenia." The press did not directly cite a medical professional, though it did cite her psychiatrist in other parts of the article to certify that she was a patient. The press did not quote the psychiatrist in order to define "schizophrenia," perhaps because the definition of "schizophrenia" remained contested within the medical profession. DSM had not yet been published and there was no standardized definition of the disorder.

Though mental disability remained highly stigmatized, the newspaper's definition of schizophrenia did not explicitly suggest social deviance. In contrast, Dr. Yellowlees' testimony a few years earlier had contrasted Haigh's "mystical ideas" with the "morals of ordinary society." Nevertheless, the definition printed at the bottom of the article about Elnora Eperly did locate disability within the individual. It assessed, for example, Mrs. Eperly's activities as indicative of "inaction." Her

“inaction” implicitly contrasted with her *potential* action. Rather than society acting as a point of comparison, as in the case of John George Haigh, difference was determined through an assessment of the individual – her impairment versus her potential ability. Locating disability in the individual is problematic, as noted earlier, because it makes disability the dominant characteristic of an individual’s identity.

Though the newspaper’s definition of “schizophrenia” differed from the medical texts of the time, the newspaper’s use of the term “schizophrenia” in 1950 reflected the rising influence of the medical profession in the field of diagnosis and treatment which in turn corresponded with the development of the *Diagnostic and Statistical Manual* and the standardization of mental disorders within the medical community. This document would appear to show the effect of the standardization of terminology and classification systems within the public domain, and helped to establish psychiatry’s dominance and influence over diagnosis and treatment of the ‘disease.’ This passage set a precedent. Descriptions of schizophrenia became less overt as the term became a part of the public’s vocabulary. But the term continues to be defined within the public domain. These definitions are increasingly based on medical conceptions of disability.

Despite the established parameters of diagnosis, classification, and treatment, not all members of the medical community accepted psychiatry’s dominance over the treatment of schizophrenia and there appears to have been notable public debate during the early 1950s. Interest in the causes of schizophrenia did not disappear from public discussion. Five years after the case of the arson in Davenport, Iowa, the

Ottawa Citizen, for example, cited Dr. Jean Morin of the Ottawa General Hospital: “psychiatrists do not know what schizophrenia is or what causes it.”²⁹⁸ Yet the newspaper printed their speculation. The same article cited his colleague, Dr. C. C. Bracken of the Ottawa Civic Hospital, who “traced” schizophrenia to the “infant days” of affected individuals.²⁹⁹ According to Dr. Bracken, the “mother’s pre-natal fear” was used to explain the “infant’s antagonistic attitude toward the mother and to society.”³⁰⁰ This article was a very early example of the influence of the medical profession within the public domain after 1950, and one in which the press turned to local medical professionals.

The explanation of schizophrenia offered by Dr. C. C. Bracken resembles the case of Clara Dawson who challenged the parental authority of her father and was interned in an asylum in the late nineteenth century. According to the social values of the era it is likely that Clara Dawson was viewed as a woman who had transgressed gender roles as well as parental authority. In the case of Dr. Bracken’s explanation of schizophrenia, gender was also significant in dictating the mother’s responsibility when it came to raising her infant. As in the case of Clara Dawson’s transgression of marrying a man whom her father did not approve was associated with “insanity,” the mother’s “pre-natal fear” was used to explain the “infant’s antagonistic attitude.” Though the “infant’s antagonistic attitude” was the culminating characteristic ascribed to schizophrenia, schizophrenia was defined according to Dr. Bracken’s explanation of causation (the mother’s pre-natal fear) that preceded the onset of the disorder.

²⁹⁸ “Study Helps Detection of Disease,” *Ottawa Citizen*, May 4, 1955, 14.

²⁹⁹ Ibid.

³⁰⁰ Ibid.

Causation remained a prominent topic of discourse within both the private (medical community) and the public (press), though the medical community (and consequently the press) would increasingly identify impairment that was not explicitly dependent on gender, class, or race.

A series of articles found in the *Ottawa Citizen* from the mid-1950s entitled “Mirror of your Mind” provided information on subjects related to mental processes, particularly emotions and behaviour, in a question and answer format. The publication of these articles suggests a growing interest in mental health. During the six years that this column was in print, only two articles dealt with schizophrenia and both articles discussed causes of the disorder.

The first article was published on May 30, 1955 and sought to reassure parents of “shy, withdrawn children” that there was no evidence that their children would “grow up to be schizophrenics.”³⁰¹ Although the article questioned the relevance of personality as a predisposing indicator or factor of schizophrenia, it was part of a broader debate over causation which Dr. C.C. Bracken of the Ottawa Civic Hospital had raised in 1955. The image that accompanied this article showed a group of boys in the background, and a single boy in the foreground, symbolizing his isolation from the group (see Figure 10). The second article, published three months later, discussed the causes of schizophrenia in greater detail. It attempted to answer the question: “Can you inherit schizophrenia?”³⁰² Citing Dr. Seymour Katy of the National Institute

³⁰¹ Joseph Witney, “Mirror of Your Mind,” *Ottawa Citizen*, May 30, 1955, 48.

³⁰² Joseph Witney, “Mirror of Your Mind,” *Ottawa Citizen*, August 14, 1959, 15.

of Health, the article attributed schizophrenia to a “combination of hereditary and environmental factors.”



Source: *Ottawa Citizen*, May 30, 1955, 48.

Figure 10: Illustration accompanying article from the *Ottawa Citizen*, published on May 30, 1955, showing the isolation of the boy, supposedly an “introvert.”

Both of these articles dealt with hypothetical scenarios which could lead to the onset of schizophrenia in later life. The “shy, withdrawn children” did not actually have schizophrenia. The article looked to the future to predict whether the child would develop the disorder, though the article illustrated, and therefore made tangible, a boy’s isolation from his peers. The second article similarly dealt with individuals who did not have schizophrenia. And like its predecessor, the article attempted to identify the factors that would lead to schizophrenia. Despite the hypothetical nature of these

articles, the questions that they posed demonstrated continued interest in causation. Gender, class, and race, however, were not significant to the factors (heredity and the environment) which were identified. The above examples show that the press continued to identify causes leading to schizophrenia.

While the press adopted the medical terminology of DSM, newspaper descriptions of schizophrenia did not consistently replicate the medical classifications of the disorder. The press defined schizophrenia according to the literal translation of the term, which had been developed by Eugen Bleuler in 1911, despite the publication of *Medical 203* in the United States in 1943 and the publication of DSM-I in 1952, neither of which emphasized this interpretation of the disorder. The newspaper continued to use an outdated point of reference.

So “schizophrenia” was replaced by “split personality” in articles published by the *Ottawa Citizen* in 1950, 1955, and 1957.³⁰³ This translation stood in contrast to the definition of schizophrenia published in DSM-I, which remarked on “emotional disharmony” but not personality. Unlike some of the theories concerning causation, such as a “mother’s pre-natal fear,” this definition of schizophrenia was not predicated on class, gender, or race and did not stress deviance from social norms, though as Jonathon Metzl and others have pointed out, their application to particular individuals can be based on racial or gender prejudices. But regardless of the inaccuracy which resulted from the press adopting medical terminology, the literal translation of “schizophrenia” also located impairment within the individual. The assessment of an

³⁰³ “The Case of Klaus Fuchs,” *Ottawa Citizen*, March 1, 1950, 85.
“Clue to Schizophrenia in ‘Silliness’ Chemical,” *Ottawa Citizen*, December 28, 1955, 17.
“Tranquillizers Wrong for Neurotics – Expert,” *Ottawa Citizen*, July 18, 1957, 15.

individual's personality as "split" implicitly contrasted with a whole personality. Again, the individual's impairment contrasted against the individual's potential. This assessment served to locate disability within the individual.

By the mid-1950s the medical term "schizophrenia" had been usurped by the press to describe issues in the social domain and was often used in political analysis of the period. In the United States, for example, both the American Republican Party and the Democratic Party were accused, at different times, of suffering from "political schizophrenia."³⁰⁴ It was not apparent what the press meant by "political schizophrenia." Another article published on August 14, 1957, relating the "basic schizophrenia" of Britain, helped to contextualize the term.³⁰⁵ This article contrasted the "tacit acceptance of the fact that Britain cannot afford to go on acting as a really great power" with the country's "determination to be more than ever independent of the United States."³⁰⁶ In this case, the term was used to signify a division or dichotomy within the political sphere of Britain. Its usage reflected the literal translation established by the press. Yet it also emphasized the inability of the government to function, or the impairment of the government.

Newspaper references pertaining to causes of schizophrenia became increasingly limited in the 1960s. Only one article that was found identified schizophrenia as one of the "hereditary diseases."³⁰⁷ This single article contrasted with the assortment of political-based articles which emphasized the consequences of

³⁰⁴ "Testing Times for Ike," *Ottawa Citizen*, November 4, 1954, 45.

J.R. Walker, "Labor in American Politics," *Ottawa Citizen*, November 28, 1958, 6.

³⁰⁵ Joseph Alsop, "Breaks in the Western Alliance," *Ottawa Citizen*, August 14, 1957, 48.

³⁰⁶ *Ibid.*

³⁰⁷ W. Gifford Jones, "Legalized Abortion in Japan," *Ottawa Citizen*, September 21, 1963, 58.

the disorder. The Canadian press similarly used the term “schizophrenia” in political discussions. In an article published on February 15, 1967 in the *Ottawa Citizen*, journalist Roger Appleton borrowed the term to describe the condition of the state, which he alleged was “suffering an epidemic of overlapping government.”³⁰⁸ This depiction of schizophrenia, though it reflects the literal translation of the term, likewise emphasized impairment of the government by describing the way the government should *not* operate and contrasting it against the way in which the government *should* operate.

In the 1960s, the *Ottawa Citizen* continued to refer to the literal translation of “schizophrenia,” which it used to identify the disorder. The “Split Personality” of the United Nations captured headlines in the *Ottawa Citizen* in 1962 when the newspaper reported on the “pros and cons” of the organization.³⁰⁹ “It is precisely because of this split personality,” the newspaper commented, “that serious politicians in the United States, and perhaps millions of reasonably intelligent citizens, are exhibiting unmistakable signs of schizophrenia about it.”³¹⁰

But during this period, symptoms identified by DSM began to appear within popular culture and in stories reported by the press. A couple of years following the article on the UN, in October of 1964, Canadian Prime Minister Lester B. Pearson remarked on an episode of “national schizophrenia.”³¹¹ The *Ottawa Citizen* offered commentary. “What Prime Minister Pearson was referring to,” according to the press,

³⁰⁸ Roger Appleton, “Queen’s Park is the Villain,” *Ottawa Citizen*, February 14, 1967, 22.

³⁰⁹ Rowland Evans, Jr., “UN’s ‘Split Personality’ Shows Like Falling Hem,” *Ottawa Citizen*, April 9, 1962, 7.

³¹⁰ *Ibid.*

³¹¹ Maurice Huot, “Problem of National Unity,” *Ottawa Citizen*, October 2, 1964, 4.

was the “sort of internal insecurity and incoherence which makes us lose touch with living reality.”³¹² While the press’ explanation, which touched on “incoherence,” reflected the literal translation of the term, it also described disconnect with reality, a consequence of schizophrenia identified by the first edition of DSM, as seen in the appendix. In many ways, this article shows the manner in which terms went far beyond their intended purpose from the medical sphere to the public sphere and especially how such terms became a part of the dialogue concerning Canadian politics, yet at the same time began to mirror medical definitions of schizophrenia.

Unlike references to “insanity” during the late nineteenth and early twentieth centuries, which identified specific individuals, this reference to “schizophrenia” was applied more broadly to the *nation*. As in the case of Elnora Eperly, however, the press’ interpretation of Pearson’s remark emphasized the impairment of a group of individuals. Loss of “touch with living reality” was a consequence attributed to schizophrenia that was based on the assessment of a group of people.

The use of “schizophrenia” as a politically charged point of reference which appeared during the mid-1960s was followed by national awareness campaigns about mental health. In addition to the remarks made by Canada’s prime minister, considerable attention was paid to mental health to coincide with Mental Health Week. Not unlike the present day, there were public awareness campaigns about various disabilities and by 1960, Canada was hosting a Mental Health Week. News reports from the era suggest that notices about Mental Health Week were widely disseminated. A special correspondent to the *Ottawa Citizen* wrote a series of articles dealing with

³¹² Ibid.

“the problem,” a term which the journalist does not elaborate on but presumably refers to the hospitalization of one out of ten Canadians, the topic of the article.³¹³ While the series by Ernest E. Barr discussed a number of issues pertaining to mental health, only one article referred to “paranoid schizophrenia.”³¹⁴ It was the only disorder referenced by name. Schizophrenia was described as the disorder “where the person thinks he is Napoleon or some other great individual.”³¹⁵ While this notation does over-simplify the complexities of schizophrenia, it does at least indicate the thought of the individual, rather than a broader category that assessed their way of thinking. The public’s use of the medical term “schizophrenia” was still in a period of transition.

As far as the press was concerned, “schizophrenia” or “schizophrenic” could be applied to any number of issues to make a point in an article. Popular use of these terms peaked in the 1970s and 1980s and they were commonly used by reporters to describe any number of difficulties.³¹⁶ The literal translation remained dominant outside of a medical context. The press continued to use the term to describe political, economic, or even social discord.³¹⁷ For example, the “ambiguity” faced by adolescent girls with conflicting social messages was equated to “schizophrenia.”³¹⁸

³¹³ Ernest E. Barr, “Gloomy Forecast,” *Ottawa Citizen*, May 1, 1967, 4.

³¹⁴ Ibid.

³¹⁵ Ibid.

³¹⁶ John Gray, “Jerome, Macdonald Wise to Go,” *Ottawa Citizen*, January 2, 1980, 12 and Larry Black, “The Summit: Why Have High Hopes Suddenly Come Crashing to Earth?” *Ottawa Citizen*, November 14, 1985, 2 and Don McGillivray, “Regulation Reform,” *Ottawa Citizen*, February 14, 1986, 8.

³¹⁷ Richard Gwyn, “Business Group Realistic on Deficit,” *Ottawa Citizen*, October 4, 1984, 10. McGillivray, “Regulation Reform Not a New Idea,” 8.

Black, “The Summit,” 2.

Patrick Nagle, “Nagging Questions Cloud Opening of Robert Mugabe’s New Government in Zimbabwe,” *Ottawa Citizen*, August 6, 1985, 12.

Nicholas Hills, “U.K.’s Devolution Try Ends in Disaster,” *Ottawa Citizen*, March 21, 1979, 12. “Schizophrenia in Economics,” *Ottawa Citizen*, July 6, 1976, 8.

But use of the term also expanded. Politicians, in addition to political policies, could “display...symptoms of political schizophrenia” if they were faced by contradictory messages.³¹⁹ This was the plight, according to *Citizen* staff writer John Gray, for James Jerome, the Speaker of the House of Commons. While Jerome had to remain non-partisan while presiding over the House of Commons, he also had to continue his partisan work as a Liberal MP.³²⁰ The journalist continues the parody of equating schizophrenia with a dual role and comments: “Poor man. They’ve talked about finding a cure, but nobody has yet come up with a solution.”³²¹

By the late 1970s, newspapers began to apply the term “schizophrenic” to behaviours displayed by a broad range of individuals. Both lawyers and strippers were described as schizophrenic if their words or values appeared inconsistent.³²² In 1978, *Citizen* staff writer Rick Laiken interviewed “exotic dancer-cum-evangelist” Kelly Evert.³²³ At the core of this article was the assumption that exotic dancing and evangelism were contradictory and led the journalist to question whether she felt a “sense of schizophrenia.”³²⁴ Again, the literal translation of the term remained dominant in popular culture. By 1986, the term had even been used in the reporting of fashion.³²⁵ Frank DeCaro of the *Night Ridder* remarked on the dubious pairing of “a curve-hugging wool knit dress by Azzedine Alaia...next to jodhpurs and a Laura

³¹⁸ Mary Schmiech, “Adolescent Girls Continue to Suffer Low Self-Esteem,” *Ottawa Citizen*, November 6, 1984, 69.

³¹⁹ Gray, “Jerome Faces ‘Unspeakable’ Election Fuss,” 21.

³²⁰ Ibid.

³²¹ Ibid.

³²² “A Paeon to Secrecy,” *Ottawa Citizen*, September 6, 1977, 310.

Rick Laiken, “Stripper Bares Soul for Unity,” *Ottawa Citizen*, August 1, 1978, 18.

³²³ Laiken, “Stripper,” 18.

³²⁴ Ibid.

³²⁵ Frank DeCaro, “Magazines out to Prove Fashion a Weighty Topic,” *Ottawa Citizen*, September 4, 1986, 73.

Ashley jacket” as “a bit of fashion schizophrenia.”³²⁶ This article was re-printed by the *Ottawa Citizen*.

Using the term “schizophrenia” or “schizophrenic” to describe politics, political policy, the actions and words of lawyers or strippers, or even fashion trivializes a medical condition. This distinction is particularly important when this medical condition may be connected to an individual’s diagnosis and possible identity. The use of this term is also problematic because it has the potential to associate the medical condition with particular characteristics that are no longer associated with schizophrenia, perpetuating a false representation of the disorder. While “split personality” was, at one time, considered a characteristic of schizophrenia, this interpretation has fallen from medical discourse.

Although the literal translation continued to dominate popular culture, the *Ottawa Citizen* increasingly defined the term according to DSM in other situations, including the murder trial of Shawn Stuart Durward, an outpatient of the Royal Ottawa Hospital, in 1979. Considerable medical testimony accompanied this trial. As in the case of Thomas Gibbons and the earlier twentieth-century trials, this case was a local affair. The trial sought to determine whether Durward was accountable for his actions – the murder of his two younger sisters. Three psychiatrists testified on behalf of the Crown and several others testified on behalf of the defence. Dr. John Bradford, a world-renowned forensic psychiatrist, and Dr. Selwyn Smith, Chief of Psychiatry at the Royal Ottawa Hospital, testified that Durward was a “psychopath incapable of remorse and without any feeling for others” and that “there was no mental disturbance

³²⁶ Ibid.

or major psychotic illness” at the time of the murder.³²⁷ Yet Dr. Bradford acknowledged that “there were some signs of schizophrenia in the youth.”³²⁸ Dr. Elliott Barker further contended that “Durward was becoming increasingly schizophrenic.”³²⁹

What did “schizophrenia” mean to the readers of the *Ottawa Citizen*? What effect did medical testimony have on public conceptions of schizophrenia? The news reports did not directly explain the “signs of schizophrenia” referenced by Dr. Bradford. Yet it did reiterate testimony that Durward had “heard voices” in the past.³³⁰ And the article went on to note that Durward “believed that killing his sisters would help him escape to another world where he wouldn’t have any problems.”³³¹ The article does not give the origins of this testimony, but this information, though relevant to a DSM diagnosis of schizophrenia, was not framed in terms of DSM terminology. The article could have suggested that Durward had “delusions,” but instead it described what he was thinking. This information was not framed as characteristic of the disorder, which was contested. This article differs from the explicit definition of “paranoiac insanity” offered by Dr. Yellowlees at the trial of John George Haigh in 1949 or the definition of “schizophrenia” in the article concerning Elnora Eperly.

In another article on the case of Durward, also written by Dave Rogers, the reporter sought to explain schizophrenia. The journalist referenced Dr. Selwyn Smith,

³²⁷ Dave Rogers, “Psychiatric Treatment Did Accused Murderer No Good,” *Ottawa Citizen*, February 7, 1979, 4.

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid.

³³¹ Ibid.

who “said that schizophrenia meant disturbed, illogical thinking and delusions.”³³²

This description mirrored the first definition of schizophrenia, published twenty-nine years before in the case of Elnora Eperly, though the list of symptoms differed. Rather than remarking on “inaction” or the “stimulating of qualities which one does not possess,” this article focused on processes of thought, which it assessed as “disturbed” or “illogical” or even delusional. In this case, the definition was produced by a psychiatrist, as opposed to the journalist, and directly references symptoms identified by DSM-II, as seen in appendix 3.

Although popularized use of the term “schizophrenia” continued into the 1980s, the voice of psychiatry remained prominent within the public sphere, while the voice of the patient remained marginalized. Definitions of “schizophrenia” were increasingly medicalized. Discrepancies between lists of symptoms, like discrepancies between the medical profession and popular culture, all occurred *within* a broader conceptual framework. Whereas “insanity” had operated as a form of explanation for visible behaviours before 1950, the *way* in which schizophrenia was conceptualized increasingly depended on a list of symptoms that followed the onset of the disorder, such as “disturbed, illogical thinking and delusions.” These symptoms, which assessed an individual’s thinking, located impairment in the individual.

The use of medicalized definitions of schizophrenia continued in the 1980s. Reference to causation appeared in two articles published between 1980 and 1985 in

³³² Dave Rogers, “Durward Realized Nature of Actions, Murder Trial Told,” *Ottawa Citizen*, February 2, 1979, 78.

the *Ottawa Citizen*. In both of these articles, causation appeared alongside a long list of consequences, which became the standard format of defining the disorder.

The first of these articles, published in 1980, provided a brief overview of programs for individuals affected by schizophrenia.³³³ Beside this article, written by the same journalist, was an article devoted to describing one specific program developed by the Causeway Work Centre.³³⁴ These articles reflected the development of community services for individuals living with disability following the period of de-institutionalization. These articles were also unique in that they provided readers with insight into the everyday lives of individuals affected by schizophrenia. They also heard the voice of individuals affected by schizophrenia. That being said, these narratives were organized around comments made by family members and staff at Causeway. Take the case of “Andrew,” for example. “Andrew” was given space for a very personal self-reflection.³³⁵ His agency should not be denied. Yet “Andrew” was introduced to readers of the *Ottawa Citizen* by counsellors at Causeway, who commented on and assessed his progress at Causeway.³³⁶ Moreover, the comments made by “Andrew” that were selected by the press for publication related only to his involvement in the program and endorsed Causeway as “the best program.”³³⁷ Andrew was not given a voice in describing the medical condition of schizophrenia.

A description of schizophrenia was provided by the journalist in the first article, which provided a brief overview of the programs. Schizophrenia, the article

³³³ Louise Crosby, “Schizophrenia Shunned,” *Ottawa Citizen*, January 16, 1980, 177.

³³⁴ Louise Crosby, “Causeway Helps Mentally Ill Cross Troubled Waters of Past,” *Ottawa Citizen* January 16, 1980, 177.

³³⁵ Ibid.

³³⁶ Ibid.

³³⁷ Ibid.

began, was a “chemical imbalance”³³⁸ and the disorder, the article continued, “causes its victims to lose touch with reality, hear voices, become paranoid and afraid, incoherent, depressed, suspicious and withdrawn. Some hallucinate.”³³⁹ After listing these symptoms, the article then returned to causation and suggested that the disorder is “hereditary” and that “environment” is a “factor.”³⁴⁰ In addition to identifying environment and heredity as causes, the article adopted the more contemporary explanation that schizophrenia is caused by a “chemical imbalance.” But the article’s description of schizophrenia also involved information following the onset of the disorder. The symptoms of schizophrenia described in this article involved the assessment of individuals’ emotion (described as “afraid”), actions (described as “withdrawn”), and thinking (described as “incoherent”).

Which set of information had a greater impact on public conceptions of schizophrenia? Both definitions were present in the article. But one set of information informed the discussion of these programs. The programs were “extremely important for all schizophrenics,” according to the journalist, because this group of individuals “lack the initiative and the resources to structure their own day.”³⁴¹ The relevance of these programs was attributed to the assessment of individual’s ability – what individuals could *not* do – as a result of the disorder (“lack the initiative and the resources...”). Disability and identity were thus intertwined.

Both cause and consequence were referenced in another international case of an individual with schizophrenia, published by the *Ottawa Citizen* in the mid-1980s.

³³⁸ Crosby, “Schizophrenia Shunned,” 177.

³³⁹ Ibid.

³⁴⁰ Ibid.

³⁴¹ Ibid.

In 1982, John W. Hinckley Jr. was tried for the attempted assassination of American President Ronald Reagan. As in the trial of Shawn Stuart Durward, the mental condition of Hinckley was contested by both the defence and the prosecution. In the case of Hinckley, however, the types of evidence that could be admitted in court were also contested.³⁴² One important area of contention was whether or not to allow into evidence the brain scans of John Hinckley. As in the case of the “Vampire” Haigh and later in the case of Shawn Stuart Durward, considerable medical testimony appeared in this article, which cited Dr. Marjorie LeMay, a neuroradiologist at the Massachusetts General Hospital. The news report indicates that Dr. LeMay testified that Hinckley’s brain scans showed “‘less tissue than one generally sees,’ that the ventricles which hold fluid in his brain were enlarged, and that the folds on the brain’s surface, called sulci, were ‘very prominent.’”³⁴³ The judge had ruled that this evidence was permissible, reflecting a greater reliance on technology in the diagnosis of mental disorders, but what was its relevance?

The prosecutor asked Dr. LeMay “whether the scan results could be linked to Hinckley’s behavior on the day of the shooting.”³⁴⁴ This question showed continued interest by the press in explaining criminal acts. Yet the connection between the physiology of Hinckley’s brain and schizophrenia was made by Dr. Daniel Weinberger of the National Institutes of Mental Health. The voice of medical professionals remained prominent, while the voice of the patient was absent. Yet the press gave Dr.

³⁴² “Hinckley’s Brain Scans Admitted as Evidence,” *Ottawa Citizen*, June 2, 1982, 36.

³⁴³ *Ibid.*

³⁴⁴ *Ibid.*

Weinberger, the “world’s leading expert on CAT scans,” the final word.³⁴⁵ According to Dr. Weinberger, the results of the brain scans “increase the likelihood” that Hinckley was “schizophrenic.”³⁴⁶ Though the physiology of the brain was not listed in DSM’s “criteria” for diagnosing schizophrenia, the physiology of Hinckley’s brain was nevertheless used to help identify the illness, and the illness was used to identify Hinckley. Yet Dr. Weinberger downplayed the significance of the brain scans. A “CAT scan,” the press cited Dr. Weinberger, “is not an accepted psychiatric tool for diagnosing the disease.”³⁴⁷ This medical testimony, which appeared within the public domain, placed less importance on causation, such as brain physiology.

It was the press that discussed the consequences of schizophrenia. As in previous cases, the press offered a definition of schizophrenia. Unlike many of the previous articles, this article did not cite a medical source. Schizophrenia, according to this article, was “a disease in which a person suffers delusions, lacks emotional expression and falls victim to his impulses.”³⁴⁸ Though the article did not directly cite a medical source, this definition clearly shows the influence of the medical profession on public conceptions of schizophrenia. The article listed symptoms of schizophrenia identified by DSM that followed the onset of the disorder, though there were discrepancies. While the newspaper article, DSM-II, and DSM-III all referenced “delusions” as characteristic of schizophrenia, DSM-III, published two years before the trial of Hinckley, did not discuss emotional response in its general definition of schizophrenia. The article’s reference to the absence of “emotional responsiveness”

³⁴⁵ Ibid.

³⁴⁶ Ibid.

³⁴⁷ Ibid.

³⁴⁸ Ibid.

more closely resembles DSM-II's reference to "constricted and inappropriate emotional responsiveness."³⁴⁹ While the newspaper did incorporate aspects of the medical classification system, its definition was outdated and did not exactly mirror DSM. The newspaper article's definition of schizophrenia also suggests a certain amount of invention. Suggesting that a person with schizophrenia "falls victim to his impulses" does not mirror any of the definitions offered by DSM, though it does mirror the definition offered in the case of Elnora Eperly in 1950.

The newspaper's attempt to define schizophrenia was therefore a conglomeration of medical as well as colloquial views of schizophrenia. This definition of schizophrenia was not shaped by issues of gender, class, or race. Rather, it was based on the ability of the individual. Regardless of its diverse medical and colloquial origins, the newspaper commented on the *presence* of delusions, the *absence* of emotional expression, and *yielding* to impulses which marked the individual's ability as different from their *potential* ability. This assessment mirrored the medical model of disability which locates impairment within the individual.

On March 24, 1983, the *Ottawa Citizen* ran another article which centred on schizophrenia. Unlike the majority of articles published in the twentieth century, which had focused on cases in which specific individuals were affected by the disorder, the subject of this article discredited kidney dialysis as treatment and reported on a study involving fifteen unidentified patients.³⁵⁰ This article was more closely connected to the medical advertisements for Paine's Celery Compound, which

³⁴⁹ DSM-II.

³⁵⁰ "Dialysis No Cure for Schizophrenia," *Ottawa Citizen*, March 24, 1983, 87.

appeared in the late nineteenth century. Yet again, there were differences. The medical advertisements dealt with treatment, yet they offered treatment for individuals unaffected by the disorder. Patients who had something positive to say about the medicine were given a voice. This article, in contrast, dealt with treatment of individuals affected by the disorder. Their voice was absent from the article, which focused on the results of the study.

Who was selected for the study? The article cited the *New England Journal of Medicine*. The patients, according to the article, “displayed a broad range of symptoms including paranoia, delusions, hallucinations, disordered thinking and bizarre behavior.”³⁵¹ The use of DSM criteria in this medical study is not surprising. What is surprising is the extent to which medical conceptions of schizophrenia, which focused on the consequences of the disorder, appeared in the public domain, as well as the format in which this information appeared. The article *could* have referenced DSM criteria without listing the specific symptoms of the disorder. Instead, its discussion of schizophrenia identified specific symptoms of the disorder.

In conclusion, public conceptions of schizophrenia evolved over the latter part of the twentieth century and the newspaper’s reporting of schizophrenia indicated a greater understanding of the disease over time. But, at the same time, there was greater medicalization of the concept and greater professional dominance, but not necessarily less stigmatization of people with schizophrenia. Whereas “insanity” had often been used by the press to *explain* behaviour that violated social norms or Canadian laws, the press increasingly focused on *defining* the term “schizophrenia.”

³⁵¹ Ibid.

The term appeared in articles concerning particular individuals, but the term was used more broadly than “insanity” to denote issues or behaviours in the public sphere. Although public interest in causation continued, or at least the reporting of causation continued over the years, the press cited medical testimony and increasingly identified schizophrenia according to symptoms identified by the medical community. The press increasingly relied on the reporting of professional opinions, including local as well as international psychiatrists, a trend which began around the middle of the twentieth century. This trend of offering a definition of schizophrenia first appeared in an article relating the case of Mrs. Eperly but continued into the 1960s and was evident in political and popular articles. By the 1970s and 1980s, medical symptoms identified by DSM appeared in the public domain. Causation no longer formed the basis for understanding schizophrenia. The disorder was defined according to consequences identified by the medical community, which were based on assessment and located impairment in the individual, often by contrasting their ability with their *potential* ability.

What did these articles mean for individuals affected by the disorder?

Medicalization of the disorder reduced dimensions of class, gender, and race that were prevalent in descriptions of “insanity” in the late nineteenth and early twentieth century. Moreover, “schizophrenia” was not used to *explain* behaviour which conflicted with social norms or Canadian laws. In other words, “schizophrenia” did not operate as a way of being ostracized. Yet the emphasis on *defining* schizophrenia, however, increasingly publicized medical symptoms that were identified through assessment of the individual. In many cases, psychiatric knowledge was being cited

by the press and digested by readers *not involved in the care of the individual*. Medical symptoms implicitly contrasted individual ability with *potential* ability, thereby locating impairment in the individual. “Schizophrenia” was increasingly being described as a “debilitating” condition, which “leaves most patients unable to work or function socially.”³⁵² These statements likewise locate impairment within the individual.

3.3 DOMINANT PUBLIC CONCEPTIONS OF SCHIZOPHRENIA AFTER 1985

Identity and impairment continued to be intertwined after 1985. “Schizophrenic patients sometimes suffer the delusion their faces are puffed, elongated or misshapen. This is a hallucination typical of the disease, but researchers have found schizophrenics may indeed have a different head size than other people,” read an article republished by the *Ottawa Citizen* on September 16, 1985.³⁵³ The article came from Washington and was attributed to the United Press International.

The study referenced in this article was conducted at the University of Iowa³⁵⁴ and was typical of news reports reprinted by the *Ottawa Citizen* which focused on the reporting of medical studies, which were aimed at uncovering the “key to schizophrenia.”³⁵⁵ Also typical of these post-1985 articles was the reporting of medically scientific studies which emphasized symptoms, as well as causes, of schizophrenia. Symptoms, according to the article from Iowa, included “loss of will or

³⁵² Ibid.

³⁵³ Jan Ziegler, “Schizophrenics May Have Different Head Sizes: Research,” *Ottawa Citizen*, September 16, 1985, D4.

³⁵⁴ Ibid.

³⁵⁵ “Winnipeg Doctor May Have Found Key to Schizophrenia,” *Ottawa Citizen*, February 6, 1986, D10.

drive, disconnected thinking, loss of emotional response, and inability to experience pleasure or pay attention.”³⁵⁶ This list appeared towards the end of the article and contrasted with the article’s opening statement. Both sections discussed consequences of the disorder. Yet the opening statement discussed experiences of the individual; the latter part of the article assessed the individual’s abilities. The article, however, went further. Schizophrenia was constructed as a frightening disease wherein patients were said to “suffer” from particular symptoms.³⁵⁷

Locating mental disability through the individual had begun with the medicalized definitions of “schizophrenia” after 1950 wherein cause and consequence became prominent ways of conceptualizing schizophrenia. The *Ottawa Citizen* continues to define schizophrenia as a “biological brain disease that can cause hallucinations and delusions.”³⁵⁸ Yet schizophrenia is increasingly identified for its cumulative effect on the individual, a trend which became entrenched after 1985. The disorder is often simply referred to as “the debilitating mental illness,” a phrase which similarly focuses attention on the abilities of the individual.³⁵⁹

To what extent did this way of thinking about schizophrenia dominate other Canadian newspapers? It appears that the *Ottawa Citizen* was not the only large newspaper wherein schizophrenia was labelled a “debilitating mental illness” or a “confusing and disabling illness.”³⁶⁰ The *Ottawa Citizen* published several articles

³⁵⁶ Ziegler, “Schizophrenics May Have Different Head Sizes,” D4.

³⁵⁷ Ibid.

³⁵⁸ Sharon Kirkey, “Mentally Ill Make Up 15% of Hospital Admissions,” *Ottawa Citizen*, October 13, 2005, A3.

³⁵⁹ Bruce Culp, “A Beautiful Mind,” *Ottawa Citizen*, March 7, 2004, C3.

³⁶⁰ Peter Giffiths, “Woman Suffering Depression Fears Schizophrenia,” *Ottawa Citizen*, January 20, 1987, D9.

acquired from the *Canadian Press*, which framed schizophrenia in terms of its ‘damaging’ effect *on* the individual.

Schizophrenia was identified as the “debilitating mental illness” by an article published in 1987.³⁶¹ Another article, published on April 22, 1988, was more subtle, but similarly framed the disorder in terms of impairment. Individuals with schizophrenia, according to the article, “suffer from a dissociation between thoughts and emotions.”³⁶² The newspaper identified symptoms of the disorder, locating disability through an assessment of individuals’ ways of thinking, feeling, and acting. Yet this article differed from many previous articles in that it emphasized the impact of the disorder on the individual, through its explanation of symptoms, as well as through a description of its effect on individuals. This article goes on to contrast the behaviour and activities of individuals before and after the onset of the disorder: “Schizophrenia seems to hit the brightest and best. Honor students suddenly lose interest, usually in high school. They tend to drop out. They become lethargic and can’t hold a job.”³⁶³ Schizophrenia is thus said to be affecting the individual.³⁶⁴

Framing schizophrenia as the “debilitating mental illness” and suggesting that individuals “suffer” from symptoms acknowledges the gravity of mental disability and even suggests a degree of empathy. Yet, as in the case of medicalized definitions of schizophrenia which assess an individual’s thought, feeling, and actions, these

³⁶¹ “Schizophrenia Link Possible,” *Ottawa Citizen*, November 13, 1987, D15.

³⁶² Dave Brown, “Schizophrenia: Nightmare Emerges,” *Ottawa Citizen*, April 22, 1988, B1.

³⁶³ *Ibid.*

³⁶⁴ Throughout the first three chapters, I have adopted the dominant discourse concerning schizophrenia, referring to individuals “affected” by schizophrenia. Please note a change in discourse in the fourth chapter.

statements tend to intertwine individual identity and mental disability and the disease of schizophrenia is often presented as the dominating characteristic of the person. Regardless of their role in life, the individual is defined by the disease. References to individuals “suffering” from schizophrenia suggest a top-down hierarchy between the individual and the disorder.

These statements are also problematic because of their negative connotations, which reinforces popular conceptions of mental disabilities as overwhelmingly negative. This portrayal, disability theorists such as Adrienne Asch argue, does not capture the multi-faceted experience of disability nor do they capture the multi-faceted experiences of people living with schizophrenia and their day-to-day lives, which cannot be reduced to such a negative portrait.³⁶⁵ Do individuals “suffer” from disability, as the press suggests, or do individuals “live” with disability, as an acquaintance of this author, who lives with a disability, has suggested? Disability, according to Sam Haigh, is “a ‘normal’ – as in ordinary – facet of human experience, and one that, like all forms of human experience, can be simultaneously negative and positive; painful and pleasurable; desirable and non-desirable.”³⁶⁶ The notion of “living” with a disability gets at a different way of conceptualizing schizophrenia, as will be seen later in this chapter.

The appearance of empathetic statements did not coincide with destigmatization of schizophrenia. Though the press suggests that individuals “suffer”

³⁶⁵ Adrienne Asch, “Prenatal Diagnosis and Selective Abortion: A Challenge to Practice and Policy,” *American Journal of Public Health* 89, no. 11 (1999): 1.

³⁶⁶ Sam Haigh, “Beyond the ‘Narrative of Overcoming:’ Representations of Disability in Contemporary French Culture,” Accessed April 15, 2014, <http://backdoorbroadcasting.net/2013/03/sam-haigh-beyond-the-narrative-of-overcoming-representations-of-disability-in-contemporary-french-culture/>.

from symptoms, which might suggest some degree of empathy for those living with schizophrenia, the press also list symptoms that engender a response of fear. The same article that might suggest empathy for the individual also remarks that schizophrenia is characterized by the presence of “voices,” which “can give orders that are bizarre and dangerous” and suggests that individuals’ personalities “may change quickly – sometimes from being virtually catatonic to bizarre and violent.”³⁶⁷ Not only did this article report on potential consequences for the public, it also included accounts of violence against family members.³⁶⁸ Newspaper articles such as this tend to promote and reinforce the popular stigmatization of schizophrenia.

While these examples highlight the manner in which newspapers report on the negative elements of schizophrenia, there are exceptions which should be noted. Janice Kennedy, a long-time journalist and columnist for the *Ottawa Citizen*, has written fourteen articles which reference schizophrenia, which says something about the growing public interest in discussing mental disability. One of her articles, published in 2010, bears mention. It seeks to guide public opinion of Kevin Gregson, charged in the murder of an Ottawa police officer. The “behaviours of mental illness,” writes the journalist, “are something different from moral choice.”³⁶⁹ She suggests the public “think about [Kevin Gregson] seriously, openly and maybe (if we can manage it) sympathetically.”³⁷⁰

Other journalists, however, continue to connect schizophrenia with violence.

An article written by Grant Duwe for the *Ottawa Citizen* in 2012 suggests individuals

³⁶⁷ Ibid.

³⁶⁸ Ibid.

³⁶⁹ Janice Kennedy, “Anger, Grief and the Bigger Picture,” *Ottawa Citizen*, January 17, 2010, A11.

³⁷⁰ Ibid.

who commit societal acts of violence “feel persecuted and are frequently plagued by mental illness such as depression or schizophrenia.”³⁷¹ Though the journalist decries the impact of the disorder on the individual, suggesting empathy, the journalist also emphasizes the impact of the individual on society, reinforcing the stigmatization of mental disability and individuals affected by mental disability.

The medicalization of mental disorders has affected the way in which schizophrenia is conceptualized by the public. But this *conceptual* shift has the potential to affect public *attitudes* towards individuals living with the disorder. Public attitudes can be considered a different sort of ‘social barrier’ for individuals living with the disorder.

Stigmatization is an important topic within the medical community and among health care providers. Medical journals have published a wide range of articles on the subject. Some of these articles document cases of stigmatization and review its ramifications.³⁷² However, there has also been considerable discussion about how to deal with stigmatization. Some of these measures involve helping people with mental disorders “cope” with stigmatization.³⁷³ But there is also discussion about how to put an end to stigmatization.

³⁷¹ Grant Duwe, “Horrible, But Rare,” *Ottawa Citizen*, July 21, 2012, B7.

³⁷² Otto F. Wahl, “Mental Health Consumers’ Experience of Stigma,” *Schizophrenia Bulletin* 25, no. 3 (1999): 467 and Patrick Corrigan, “How Stigma Interferes with Mental Health Care,” *American Psychologist* 59, no. 7 (October 2004): 614.

³⁷³ Faith B. Dickerson et al., “Experiences of Stigma Among Outpatients with Schizophrenia,” *Schizophrenia Bulletin* 28, no. 1 (2002): 143.

Overwhelmingly, these articles recommend providing more information about schizophrenia.³⁷⁴ However, one seminal article, titled “Dispelling the Stigma of Schizophrenia: What Sort of Information is Best?” questions the *type* of information that should be provided.³⁷⁵ This article correlates a knowledge of the most acute symptoms of schizophrenia with stigmatization.

Only conceptualizing schizophrenia according to its symptoms, and not according to the way it is experienced by individuals, is therefore problematic for the individual and the public. Consequences are expressed *through* individuals, whether it is how they are interpreting the world (ie. hallucinations) or whether it is how they are interacting with it (ie. behaviour). Moreover, assessments between individual ability and *potential* ability locate impairment in the individual. More recently, the press associates individual identity with mental disability by highlighting the effect of the disorder *on* the individual. This way of conceptualizing schizophrenia constructs difference between individuals affected by schizophrenia and those unaffected by the disorder. Are there better ways of conceptualizing schizophrenia? To answer this question, one important step is to ask: how do medical and social conceptions of schizophrenia compare to the way in which patients conceptualize the disorder?

At the same time as the newspaper began overtly identifying schizophrenia as “debilitating,” the newspaper also began to show interest in the perspective of individuals affected by schizophrenia. As early as 1986, the newspaper featured

³⁷⁴ Patrick Corrigan and David Penn, “Lessons from Social Psychology on Discrediting Psychiatric Stigma,” *American Psychologist* 54, no. 9 (September 1999), Accessed April 15, 2014, <http://www.ncbi.nlm.nih.gov/pubmed/10510666>.

³⁷⁵ David Penn et al., “Dispelling the Stigma of Schizophrenia: What Sort of Information is Best?” *Schizophrenia Bulletin* 20, no. 3 (1994): 437.

Atalanta Bachischin.³⁷⁶ Like the interview of Elnora Eperly in 1950 or the interview of Thomas Gibbons in 1946 or the interview of “Andrew” in 1980, this interview profiled an individual affected by the disorder. It differed from previous interviews, however, because it was positive, incorporated her point of view, and centred on her experiences.

The article begins by describing her social work in the Ottawa community. It then backtracks twelve years to her time as a “straight-A student” studying at the University of Western Ontario.³⁷⁷ The article highlights her academic successes. “Her gifted mind,” according to the article, “had earned her a place on the Dean’s honor roll.”³⁷⁸

By January 1975, the “gifted mind had grown haunted.”³⁷⁹ The article describes her sleeping habits, her ability to concentrate, her mood, and the appearance of voices. This part of the article stands in stark contrast to the introduction. But why does the article emphasize change? Why does it contrast Bachischin’s “gifted” and “haunted” mind? Framing schizophrenia in this way continues the trend that began around the mid-twentieth century wherein conceptions of schizophrenia increasingly focused on consequences of the disorder. Then journalists began to remark on the way in which individuals ‘suffered.’³⁸⁰ Contrasting Bachischin’s “gifted” and “haunted” mind took this trend one step further by highlighting the effect of the disorder on the individual, and not just locating disability within the individual.

³⁷⁶ “A Schizophrenic’s Transition to a ‘Much Happier Person,’” *Ottawa Citizen*, March 17, 1986, D1.

³⁷⁷ Ibid.

³⁷⁸ Ibid.

³⁷⁹ Ibid.

³⁸⁰ This theme informed the selection of articles in this section.

The appearance of articles that emphasized the cumulative effect of schizophrenia on the individual coincided with articles which gave greater attention to the individual. Not only did the article featuring Atalanta Bachischin profile a member of the Ottawa community. It gave her a voice in describing her experiences, as compared to Elnora Eperly or Thomas Gibbons, who were made objects of observation by the press, or even ‘Andrew.’ While Andrew was given a voice to describe how the Causeway programs benefited him, he was not given space to talk about living with schizophrenia. The definition of schizophrenia in this article was provided by the journalist. The journalist of this later article noted, in a similar manner as the articles that preceded it, that Bachischin became “virtually paralyzed by her own paranoia.”³⁸¹ This statement assesses Bachischin and locates disability within the individual. But what did it mean to Bachischin? The journalist quotes her:

‘I isolated myself,’ she said. ‘I’d stay in my room all day, afraid of the other people in the house. I’d look into the hall to make sure no one was there before going to the bathroom. I was even afraid to go out to buy a quart of milk.’³⁸²

Bachischin’s voice recalls what she felt and her consequent actions.

Bachischin’s recollections are not necessarily pleasant. At one point, she remarks that she wants to show other patients that there is “light at the end of the tunnel.”³⁸³ Yet her comments are not passive and do not assess her experiences in terms of impairment. They are more descriptive than the journalist’s voice and are framed as an experience that explains how, during a specific period, she interpreted the world around her.

³⁸¹ Ibid.

³⁸² Ibid.

³⁸³ Ibid.

In 1998, the newspaper interviewed Mac Hardie, an individual affected by the disorder.³⁸⁴ The journalist noted that he was not only “tortured by voices, a characteristic of schizophrenia, but he had hallucinations.”³⁸⁵ This information can be traced back to the medicalization of the topic in the second half of the twentieth century, which corresponded with increased attention given to the symptoms of mental disability. But what did these voices and hallucinations mean to the individual? The journalist quotes Hardie: “I felt everything was directed at me. I felt I was the centre of the universe and that people were throwing knives in my direction.”³⁸⁶

This description suggests a different way of conceptualizing schizophrenia. It is more descriptive than medical conceptions of the disorder, which would summarize this information into medical terms such as ‘hallucination’ or ‘delusion.’ But it is also expressed in terms of experience. It focuses on the way in which information presented to Hardie. Although he claims ownership of the experience, it is not presented in objective, analytical terms, such as “delusion” or “hallucination.” Do patient conceptions of schizophrenia differ from medical and social conceptualizations of the disorder? The next chapter will examine conceptions of schizophrenia from the perspective of individuals living with the disorder.

³⁸⁴ Jeff Bartkiewicz, “Chess Expert Refuses to be Pawn in Battle Against Schizophrenia,” *Ottawa Citizen*, July 15, 1998, D3.

³⁸⁵ *Ibid.*

³⁸⁶ *Ibid.*

Chapter 4: Patient Conceptions of “Schizophrenia,” 1885-2013

1.1 INTRODUCTION

What about other ways of thinking about schizophrenia? Do individuals who experience schizophrenia conceptualize this disorder differently than members of the public who do not experience the disorder? Do patients adopt medical ways of thinking about schizophrenia? Or do individuals conceptualize schizophrenia differently, based on their personal relationship to the disorder? How do individuals who actually experience schizophrenia conceptualize the disorder?

An anonymous story posted on a website called the “Schizophrenic Diaries” and written by a sixteen-year old individual who identifies himself / herself as a “schizo,”³⁸⁷ contrasts public perceptions with his / her perception of schizophrenia: “People think us schizophrenics are just crazy. We’re not crazy. We just dee [see] things differently than them. We are suffering. Suffering.”³⁸⁸ This individual seems to think there is a difference. This individual objects to being dismissed as “just crazy” and instead emphasizes his / her senses and distress. In other words, the individual is describing his / her experiences and seeking to legitimize them beyond the language of sickness or abnormality. This way of thinking about disability, which gives the individual’s perspective, contrasts with diagnostic practices and terminology which, as seen in previous chapters, locate disability in the individual through observation and assessment.

³⁸⁷ “Delusional: Schizophrenia – Its a Nightmare,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

³⁸⁸ Ibid.

As stated in previous chapters, this work is not directly intended to challenge medical practices so much as it is to challenge the public's use of medical ways of thinking about mental disability. Identifying impairment is important from a clinical perspective. In my experience of disability, identifying impairments has also given me agency. Recognizing that I have difficulty integrating information, for example, gives me agency in attempting to orientate myself, interpret my surroundings, and put information together. Yet from my perspective, it is not the inability to make connections between pieces of information that I experience on a daily basis. Rather, it is the incongruity between objects, words, and sounds that is central to my experience of the "confusion." From my point of view, it is the experience, that is to say the "actual observation of or practical acquaintance with facts or events,"³⁸⁹ as expressed through thought, feeling, or action, that is my disability. This process involves me and the world around me. It is not solely located within me.

Examining the experience of individuals is a contentious topic. Some theorists will note that an experience is a representation or interpretation of reality, which is further represented or interpreted by a scholar. Moreover, some theorists, such as Michael Oliver, privilege the social model of disability over the experiences of individuals.³⁹⁰ Their focus, they argue, is on social change. So they view experience as a private matter not worthy of discussion. Feminist scholars such as Carol Thomas reject their argument, charging that it reinforces a dichotomy, rather than the

³⁸⁹ "Experience," *Canadian Oxford Dictionary* (New York: Oxford UP, 2004).

³⁹⁰ Carol Thomas, *Female Forms: Experiencing and Understanding Disability* (Buckingham: Open University Press, 1999): 72.

intersectionality, between the public and the private.³⁹¹ Social barriers, for example, inform personal experience.³⁹² They argue that to study individual experience does show the social construction of disability.³⁹³

Examining personal experience rather than constructing disability solely in terms of impairment offers a different model for thinking about disability. It acknowledges impairment as suggested by Carol Thomas, but it does not locate disability in the individual. Rather, looking at disability as an experience takes into account the individual's "actual observation of or practical acquaintance."³⁹⁴ Thus the power of observation is given to the individual with a disability, rather than a medical professional or society whose observation and assessment of an individual locates disability in the individual. Describing disability as an experience does not necessarily entail labelling the individual's thoughts, emotions, or actions using diagnostic terminology such as "hallucinations" or "delusions" or "catatonic behaviour" or "grossly inappropriate affect." Examining personal experience is therefore about giving agency to individuals and questioning the place of impairment outside a clinical setting? To whose voice does the public give agency? This chapter will give voice to individuals who experience schizophrenia.

This chapter is also intended to get around notions of 'normalcy.' Identifying schizophrenia according to symptoms that are located in the individual may lead to stigmatization. Challenging notions of 'normalcy' may be one way of resolving difference. Another is to locate disability outside the individual, through the

³⁹¹ Ibid., 73.

³⁹² Ibid., 74.

³⁹³ Ibid.

³⁹⁴ "Experience," *Canadian Oxford Dictionary*

observations made by the individual who experiences schizophrenia. Finally, viewing disability as an experience also gives us the opportunity to think about the multifaceted nature of schizophrenia. While some experiences associated with disability may be bad, others may be good, as suggested by Adrienne Asch and Sam Haigh. Many of the personal accounts represented in this chapter emphasize “suffering” and difficulty. Yet life experiences, even ones that may be very difficult, can be viewed as a positive thing. Disability should, activists argue, be no different.

4.2 HISTORIOGRAPHY

Canadian historian Geoffrey Reaume is particularly concerned with telling the story of the patient. He attributes this preoccupation to his personal experiences. According to him, the six months he “spent as a psychiatric in-patient and the periods right after these hospitalizations were the most influential times” of his life and “led directly to the existence” of his book, *Remembrance of Patients Past*, published in 2009.³⁹⁵ Reaume himself was diagnosed with schizophrenia.³⁹⁶

Though Reaume’s work is situated within an institution, it goes beyond traditional narratives in which the individual is defined by their environment. Reaume emphasizes the difference between recognizing patients as “individual human beings” and disparaging of them as “a collection of labels and anonymous numbers.”³⁹⁷ This distinction is central to his work, which he describes as a personal history of 167 patients at the Toronto Hospital for the Insane. Though he relates the diagnoses of

³⁹⁵ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2009).

³⁹⁶ Ibid.

³⁹⁷ Ibid.

various patients, he focuses on significant aspects of their lives, including leisure activities and personal relationships, albeit within the space of the institution.

His approach is not unique. His scholarly attempt to “present inmates in mental institutions as individual human beings who deserve to be understood on their own terms as *people*”³⁹⁸ follows psychology’s humanistic therapy, which promotes respect for the individual. Reaume’s work, however, is a practical application of this therapy. He not only directs his reader to think of a patient as a person but actively shapes this process throughout his narrative by interpreting descriptions of individuals produced by medical staff. Meaning is derived mainly from considering the patient’s perspective. For example, hospital staff frequently commented on patients’ smoking habits in their reports. But what did smoking mean to these patients? Reaume suggests it was one of many leisure activities on the ward.³⁹⁹

Reaume’s work is intended to reach a wider audience. Reaume expands upon a therapy intended for a clinical setting and repackages it for public education in order to forward a particular agenda. He is concerned with stigmatization at several points, from both historical and contemporary perspectives.⁴⁰⁰ Reaume’s work attempts to dispel stigma by focusing on commonality between ‘ill’ and ‘healthy’ people. His social mandate sets his work apart from traditional historiography. When historiography critiques the coerciveness of historical institutions, it rarely addresses contemporary social perceptions of mental disorders and rarely documents the lives of individuals who experience mental disorders. Once such commonalities are

³⁹⁸ Ibid.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

established, however, what about also appreciating difference? What about respect for the entire individual, of which disability may be a part? Reaume's work does not suggest ways of thinking about difference.

Gail Hornstein, a psychologist and the author of the 2009 book, *Agnes Jacket: A Psychologist's Search for the Meanings of Madness*, allows us to go further than Reaume's humanism. Hornstein advocates the reading of patient accounts and denounces their dismissal by the psychiatric community as "irrational and meaningless."⁴⁰¹ Going as far as to suggest that "many patients regard their physicians less as healers than as police,"⁴⁰² Hornstein depicts an impasse between the psychiatric and patient communities.

Hornstein criticizes the "medical model" of understanding mental disorder and hopes to give patients agency where she thinks that they have been denied it.⁴⁰³ Moreover, she highlights the under-valued aspect of reading patients' accounts, arguing that patients "weren't just writing about their own personal experiences; they were proposing alternative ways of understanding madness and coping with it."⁴⁰⁴ Her work therefore goes beyond Reaume's work, which focuses on finding commonality between people, by studying madness as a distinct phenomenon. She contrasts the tropes of medical and patient accounts:

Most firsthand accounts of emotional distress contradict doctors' triumphant stories of 'conquering mental illness.' For patients, madness isn't about

⁴⁰¹ Gail Hornstein, *Agnes Jacket: A Psychologist's Search for the Meanings of Madness* (Routledge Books, 2009): xvi.

⁴⁰² Gail Hornstein, xvi

⁴⁰³ Ibid., xx.

⁴⁰⁴ Ibid., xvi

‘scrambled electrical signals’ or ‘new breakthroughs in the exciting world of brain research.’ They write of captivity, insight, and resilience.⁴⁰⁵

While Hornstein establishes the significance of reading patient accounts, her motivations remain professional. She argues that “first-person experience is crucial to understanding madness and its treatment.”⁴⁰⁶ She views patient accounts as a contribution to the study of mental disorders and focuses on their practical implications for the treatment of individuals, particularly the development of coping mechanisms. Yet what about their potential role in informing social thought about mental disorders or patients’ experiences? “What if the mad are trying to tell us [the public, not the professional] something?”⁴⁰⁷ And in so doing, maybe changing the very definition of what it means to be disabled?

My work also differs from Hornstein’s work in another way. Whereas she privileges patient conceptions of mental disorders and seeks to replace medical definitions of mental disability, I do not seek to challenge psychiatric models. Psychiatry has developed a particular discourse surrounding mental disorders in the efforts of practitioners to care for their patients in ways that might be helpful. More problematic is the use of psychiatric forms of assessment within the public domain. This chapter juxtaposes the way in which psychiatry and patients have conceptualized schizophrenia since 1883 in an international context with the intention of challenging the tendency of the public to use psychiatric models that emphasize impairment and locate disability within the individual.

⁴⁰⁵ Ibid., xvii.

⁴⁰⁶ Ibid., xxii.

⁴⁰⁷ Ibid., xiii.

Danielle Cooke is a registered nurse in acute care psychiatry and for her master's degree in nursing likewise sought to understand the "experience" of individuals living with schizophrenia.⁴⁰⁸ Like Gail Hornstein, she sought to challenge the dominant position of the biomedical model and to question whether, to use her words, there is anything else.⁴⁰⁹

Despite expectations about the importance of relapse to individuals living with schizophrenia based on her medical knowledge of schizophrenia, she found that relapse was "not all that visible or important" to the people she interviewed.⁴¹⁰ Yet she remarks on the dominance of the "biomedical discourse"⁴¹¹ in several interviews conducted with individuals living with schizophrenia:

Even when a narrator denied having the diagnosis of schizophrenia, he still used the language of the discourse to describe and understand his experience. For example, although Doug does not believe he is a person with schizophrenia, he used the biomedical language to describe his 'altered reality.' ... Most of the narrators spoke of the process of socialization or education they had gone through in an attempt to learn how to articulate their experience based on the biomedical discourse. Prior to being socialized to the illness, the narrators had their own way of describing and understanding their experience.⁴¹²

Cooke contrasts the patient and medical ways of describing disability. She goes on to remark on "aspects of experience the biomedical discourse did not seem to have space for," notably emotion.⁴¹³ She also remarks on "signs of resistance," where the individuals she interviewed "questioned or challenged the dominant discourse."⁴¹⁴

⁴⁰⁸ Danielle Cooke, "Understanding Schizophrenia and Relapse from Persons Who Experience It: An Oral History," MA Thesis University of Calgary (July 2004).

⁴⁰⁹ *Ibid.*, iii.

⁴¹⁰ *Ibid.*, 73.

⁴¹¹ *Ibid.*, 74.

⁴¹² *Ibid.*, 74-75.

⁴¹³ *Ibid.*, 75, 78.

⁴¹⁴ *Ibid.*, 77.

Treatment meant something different to them. “Medication,” she wrote, “was not only a way of preventing relapse.”⁴¹⁵ Rather “medication was viewed as a way to live life and do activities such as writing and working.”⁴¹⁶

Cooke’s work is limited when she interprets other ways of conceptualizing schizophrenia as “resistance,” rather than as an alternative way of thinking about schizophrenia. Moreover, she does not interrogate individuals’ original experience of the disorder, which she suggests they had before the process of socialization occurred. She writes that “the narrators described the experience of having their own way of understanding their experience when they first got ill but were not able to articulate this understanding.”⁴¹⁷

While Cooke explores the “experience” of schizophrenia that exists outside the biomedical model, my work compares, more broadly, ways of conceptualizing schizophrenia by individuals who experience the disorder and by medical professionals and examines the relationship between individual identity and disability. The very notion that schizophrenia is experienced by an individual contrasts with the objective assessments offered by medical professionals which locate impairment within the individual. Though they use the objective language of psychiatry in many cases, individuals with lived experience of mental disability articulate a different way of understanding schizophrenia just by describing their thoughts, feelings, and actions in the first-person. Rather than designating a thought as a “hallucination,” for example, the description of *what* is thought conveys the individual’s perspective, rather than an

⁴¹⁵ Ibid.

⁴¹⁶ Ibid.

⁴¹⁷ Ibid., 77.

objective assessment. Overriding these different narratives, schizophrenia is presented by patients as experiences for individuals, and only sometimes as the impairment of an individual.

This chapter will examine “patient” accounts published within the public domain in order to respect the privacy of individuals who have written accounts for primarily therapeutic or personal reasons. Many of these texts are therefore prominent sources that have been studied before, particularly their medical aspects.⁴¹⁸ My work will adopt a disability studies approach in examining these texts over time. Though these accounts have been selected based on a diagnosis of a mental disorder, this chapter will not privilege the authority of medical professionals. Medical diagnosis is not always accepted by the individual, as will be seen later in this chapter. For the purpose of examining patient conceptions of schizophrenia, this chapter will focus on accounts by individuals who identify themselves as experiencing or having experienced a mental disorder. The individuals are therefore connected by their experiences, rather than through their clinical identity as “patients.” It will focus on texts published within Canada, yet it will also examine texts published internationally as the experiences of patients go beyond the categories established by national psychiatric organizations (or time periods).

⁴¹⁸ Robert Rogers, *Metaphor: A Psychoanalytic View* (University of California Press, 1978), 97.

4.3 PATIENT CONCEPTIONS OF “SCHIZOPHRENIA,” 1885-2013

4.3.1 *Diary Written in the Provincial Lunatic Asylum, 1885*

In 1885, two years after the publication of the *Compendium of Psychiatry*, Mary Huestis Pengilly published the diary in which she had recorded five months of her residence as a patient in the Provincial Lunatic Asylum in Saint John, New Brunswick. The author, writing in her “sixty-second year,” addresses her work to the people of New Brunswick and Massachusetts, as well as to the people of “every State of the Union, as well as throughout the Dominion of Canada.”⁴¹⁹ She wrote as: “one who has had so sad an experience in this, the sixty-second year of her age, that she feels it to be her imperative duty to lay it before the public in such a manner as shall reach the hearts of the people.”⁴²⁰

Her work focuses on conditions within the asylum. The beginning of her work describes the female patients around her and the staff, including Dr. Steeves and Mrs. Hays, the assistant nurse. Though she is critical of the staff, she is not critical of her fellow residents. Yet her work offers more than a critique of the institution. How did Pengilly conceptualize insanity?

In critiquing the management of the asylum, Pengilly pays significant attention to her surroundings and her fellow residents. How does the author, who experienced “insanity,” describe the condition of her fellow residents? She assesses these women and locates disability within the individual. She describes a woman from

⁴¹⁹ Mary Huestis Pengilly, *Diary Written in the Provincial Lunatic Asylum* (Project Gutenberg: 2006), <http://www.gutenberg.org/files/18398/18398-h/18398-h.htm>.

⁴²⁰ Ibid.

Westmoreland as “crazy” and Miss. Short as “much out of order.”⁴²¹ She bases her assessment of these individuals on their behaviour:

Poor Miss Short! Last week I saw her lying on the floor nearly under the bed, her dress torn, her hair disheveled. How can her friends leave her so long! Some ladies came to see her a short time ago, and as they left the hall I heard her call them to take her with them. If they knew all as I do, they would not leave her here another day.⁴²²

The first time I spoke to her she struck me, lightly, and I walked away; I knew she was crazy. After I had met her a few times and found she was not dangerous, I ventured to sit down beside her. She was lying on her couch in a room off the dining-room; she lay on her back knitting, talking in a rambling way: ‘Do you know what kind of a place this is? Aren't you afraid I'll kill you? I wish I was like you.’ I smoothed her hair with my hand as I would a child.⁴²³

Though she assesses their condition, calling one woman “crazy” based on her violent behaviour, she does not contrast specific behaviour with social norms, nor does she use terms of impairment to describe their thoughts, feelings and behaviour. Instead, she offered a descriptive account of her interaction with the women. Medical literature was only just beginning to standardize categories of impairment, such as “delusion” or “hallucination,” and this period preceded the medicalization of discourse within the public domain.

Yet the author focused more on the conditions of care for the residents than their behaviour. She frames her discussion of the residents’ behaviour more broadly in terms of the care they did or did not receive, either by their friends or Pengilly herself. These observations fit with the overall intent of the document, which was to challenge the conditions of the asylum. Although Pengilly identified the women as “crazy,” and

⁴²¹ Ibid.

⁴²² Ibid.

⁴²³ Ibid.

thus conflated identity and disability, she expressed an overwhelming concern with their welfare.

And what about her own condition? Throughout her work, Pengilly denies “being a lunatic,” which she suspects that “Dr. Steeves tells them [her sons].”⁴²⁴ Pengilly would have had reason to refute this claim, both in order to be able to leave the asylum and to increase the credibility of her critique of the asylum. This work will not, however, privilege the diagnosis of medical professionals and will therefore not examine Pengilly’s experience of mental disability, excepting her account of the period before her sons brought her to the asylum. Though she refutes being a “lunatic” at the time in which she wrote this diary, she accepted the diagnosis in describing her past experiences:

I was very much alone, engaged in writing a book on the laws of health. My desire to write increased; I became so absorbed with my work I forgot to eat, and, after a day or two, I seemed to think I had done some wrong. The angel voices whispered me that I must fast and pray; I know I had plenty of food in my closet, but I don't remember eating any more. I fasted eight days, and felt comfortable and happy most of the time. I sang to myself, ‘O death, where is thy sting, where is thy victory, boasting grave.’ I wept for my own sins, and wished to die, the world to save. I was trying to perform some ancient right or vow, one day, and my sons came in.⁴²⁵

This account provides descriptive detail about the time leading up to her hospitalization. The line between cultural practice and madness depends on what is considered standard within a particular culture. In this case, Pengilly attributes her religious fervour and these events to the medical condition for which she was hospitalized. She does not deny the existence of disability. Relating her conversation with another doctor before her hospitalization, she explains: "I know you are a good

⁴²⁴ Ibid.

⁴²⁵ Ibid.

man, Dr. Hunter, but you need not come to see me again; I will be all right in time; God and His angels will keep me always." These were my words to him; I know not what prompted me; I suppose it was my insanity."⁴²⁶

She attributes her response to the disorder and she claims insanity by using the possessive "my" to describe her condition. That being said, the disorder, for the most part, remains in the background. At the forefront of her detailed description are her activities (fasting and praying), thoughts (about wrongdoing), what she heard (angel voices), emotions (happy), and what she verbalized (singing). While Pengilly claims insanity based on these activities, the descriptive quality of her recollections also frames the disorder in terms of experiences for herself, rather than impairment of herself. She does not speak in terms of what she cannot do or in terms of abnormality.

Pengilly therefore offers two views of insanity. Though she is sympathetic to the other women she identifies as "crazy," she assesses their well-being and behaviour. This depiction contrasts with her portrayal of insanity, which centres on elements of experience. No doubt it is easier to recall her own perspective than to identify what other people are experiencing. Yet Pengilly's diary highlights two ways of thinking about mental disability. One centres on observation and entails assessment, while the other centres on experience. Observation and experience are not necessarily incompatible. It is possible to observe that an individual is experiencing disability. But viewing mental disability as an experience differs from the assessment of an individual's thoughts, feelings, and actions, which locate impairment in the individual.

⁴²⁶ Ibid.

Viewing disability as an experience focuses attention on the perspective of the individual and their experience of *what* is thought, *what* is felt, and *what* is done.

4.3.2 *A Mind that Found Itself, 1908*

Clifford Beers is often recognized as “the founder of the American mental hygiene movement” for his efforts in founding the American National Committee for Mental Hygiene (NCMH) in 1909, the American predecessor of the Canadian National Committee for Mental Hygiene which was founded in 1918.⁴²⁷ Even before his work for the NCMH, Beers was a vocal critic of the treatment of individuals living with mental disabilities. He was the author of *A Mind That Found Itself*, published a year prior to the development of the NCMH, and based on his personal experiences in mental institutions less than a decade earlier. His work is often acclaimed for raising awareness about the abuse of individuals in mental institutions.⁴²⁸ “I am not telling the story of my life just to write a book,” noted Beers.⁴²⁹ “I tell it because it seems my plain duty...”⁴³⁰ Throughout his work, Beers advocates for compassion to be given to individuals who experience insanity. He draws on his own experiences in a mental institution, noting that the staff thought that he was “stubborn.”⁴³¹ He challenges this notion, suggesting:

In the strict sense of the word there is no such thing as a stubborn insane person. ... When one possess of the power of recognizing his own errors continues to hold an unreasonable belief – that is stubbornness. But for a man

⁴²⁷ “Clifford Beers,” Wikipedia, Accessed 20 November 2012
http://en.wikipedia.org/wiki/Clifford_Whittingham_Beers.

⁴²⁸ Ibid.

⁴²⁹ Clifford Beers, *A Mind That Found Itself* (Project Gutenberg: 2004),
<http://www.gutenberg.org/files/11962/11962-h/11962-h.htm>.

⁴³⁰ Ibid.

⁴³¹ Ibid.

bereft of reason to adhere to an idea which to him seems absolutely correct and true because he has been deprived of the means of detecting his error – that is not stubbornness. It is a symptom of his disease, and merits the indulgence of forbearance, if not genuine sympathy.⁴³²

There is tension throughout Beers' work that revolves around his conception of 'insanity.' For Beers, disability resides both within and without the individual.

Though Beers takes the side of the patient, arguing that patients should not be held accountable for their “stubbornness,” he still describes the disorder in terms of impairment, unlike Mary Huestis Pengilly. He treats disability as a static phenomenon located only within the individual when he notes that the individual “has been deprived of the means of detecting his error.”⁴³³ Throughout his work, Beers often remarks on impairment, describing himself in one case as a “sick man.”⁴³⁴ On several occasions, he makes his mind an active participant in his distress: “My mind was in a delusional state, ready and eager to seize upon any external stimulus as a pretext for its wild inventions.”⁴³⁵ At other times, however, Beers seems to conceive of the disorder as an external entity:

An Army of Unreason, composed of the cunning and treacherous thoughts of an unfair foe, attacked my bewildered consciousness with cruel persistency, and would have destroyed me, had not a triumphant Reason finally interposed a superior strategy...⁴³⁶

Rather than emphasizing impairment, this personification of “Unreason” and “Reason” gives the impression that Beers was under attack from without rather than from within.

⁴³² Ibid.

⁴³³ Ibid.

⁴³⁴ Ibid.

⁴³⁵ Ibid.

⁴³⁶ Ibid.

This depiction of the disorder corresponds with his description of his surroundings, which are also framed in terms of assessment / experience. Beers often remarks on the presence of “delusions” and to a lesser extent “hallucinations of hearing” which “added to [his] torture.”⁴³⁷ He uses clinical terms to describe impairment that are based on an assessment of the individual’s way of thinking. Unlike Pengilly’s use of colloquial terms such as “crazy,” Beer’s association with the medical profession is also evident in the terms he uses, which correspond with his view of disability as impairment of himself. Despite his medical approach, Beers, like Pengilly, offers a descriptive explanation of the clinical terms that he employs: “I remember distinctly my delusion of the following day. ... I seemed to be no longer in the hospital. In some mysterious way I had been spirited aboard a huge ocean liner.”⁴³⁸ Rather than assessing *how* he thought, using terms such as “hallucination” or “delusion,” Beers described the content of *what* he thought.

The dichotomy between assessment and experience is present throughout his work. Beers will relate a conversation or an activity, such as a one-sided conversation with his brother, which assumedly expressed his concern for Beers’ welfare: “ ‘You are looking better and getting stronger We shall straighten you out yet.’ ”⁴³⁹ Beers then follows-up, noting his impressions, which relate to his “delusions” about persecution: “To be ‘straightened out’ was an ambiguous phrase which might refer to the end of the hangman’s rope or to a fatal electric shock.”⁴⁴⁰ The juxtaposition between these interpretations – the care of Beers by hospital staff or the persecution of

⁴³⁷ Ibid.

⁴³⁸ Ibid.

⁴³⁹ Ibid.

⁴⁴⁰ Ibid.

Beers by “detectives” – is central to his work.⁴⁴¹ Though Beers describes particular sets of information as “delusions” or “false beliefs” and generally uses the language of medical objectivity, Beer also frames his disability in terms of an experience. By contrasting different sets of information, rather than just categorizing the information he perceived as a “hallucination” or “delusion,” Beers calls attention to his perspective and how he experienced his surroundings. Again, mental disability is not only a medical assessment, but an experience.

4.3.3 *Autobiography of a Schizophrenic Girl, 1951*

The English translation of *Autobiography of a Schizophrenic Girl* preceded the publication of the Diagnostic and Statistical Manual (DSM-1), which was published in 1952. This transnational account further highlights the dichotomy between psychiatric and patient conceptions of schizophrenia. The author is identified as Renée but there is speculation about her identity. Clearly identified is her psychoanalyst, Marguerite Sechehaye, who introduces and concludes the book. This text provides a comparative opportunity – *Autobiography of a Schizophrenic Girl* incorporates both the patient’s and professional’s perspective. This text also provides insight into the way in which a patient with a close relationship to the medical community writes about the disorder.

Renée does not comment on her reasons for writing this book. The foreword belongs to the translator and Sechehaye, who speaks on the significance of the text. The translator focuses on Renée's recovery and suggests the text will "prove useful and

⁴⁴¹ Ibid.

engaging to anyone engaged in therapy.”⁴⁴² Sechehaye similarly ascribes a practical purpose to the text. She notes the presence of literature "scarcely penetrating the patient's inner life.”⁴⁴³ *Autobiography of a Schizophrenic Girl*, on the other hand, "shows what lies behind schizophrenic signs and symptoms.”⁴⁴⁴ Comparing the patient's perspective with professional observations “furnishes information preventing a false estimation of the patient and the degree of his indisposition.”⁴⁴⁵ Therefore, the patient's perspective is relevant to Sechehaye, but only so far as it is relevant to the professional's assessment of the individual. She ascribes less importance to the validity of Renée's perspective and what it might garner. In addition to recording her experiences, Renée's work shows how she thinks about schizophrenia.

Like Canadian psychiatrists of the same period, Sechehaye's interpretation of Renée's condition focuses on the effect of schizophrenia. Renée's recollections, she argues, result from a "loss of contact with life" and "an intelligence remaining intact and acting as a motion picture camera to record whatever comes within range of the lens.”⁴⁴⁶ Though Sechehaye emphasizes the importance of Renée's recollections, she contextualizes her experiences by assessing Renée's ability to connect with "life," suggesting impairment of the individual. In comparing Renée's observations to a motion picture camera, which captures but does not interpret, Sechehaye furthermore makes Renée a passive observer and diminishes the importance of the information she relays, which seems to be a central part of her experience of schizophrenia.

⁴⁴² Grace Rubin-Rabson, "Translator's Preface," *Autobiography of a Schizophrenic Girl*, translated by Grace Rubin-Rabson (New York: Grune and Stratton, 1951): vi.

⁴⁴³ Marguerite Sechehaye, "Introduction," *Autobiography of a Schizophrenic Girl*, translated by Grace Rubin-Rabson (New York: Grune and Stratton, 1951): ix.

⁴⁴⁴ *Ibid.*, x.

⁴⁴⁵ *Ibid.* x-xi.

⁴⁴⁶ *Ibid.*, xi.

Renée's narrative emphasizes the information she perceives. This information appears central to her experience of the disorder. Her narrative is arranged chronologically, from her first experiences of the disorder to her recovery, and intertwines events experienced by herself and other individuals (such as the birth of her brother) and events experienced only by herself (her "rebirth" with the arrival of her brother). Renée reflects on these topics, assessing her experiences and contrasting them with her schoolmates' experiences. She describes her thoughts as "my unreal perceptions."⁴⁴⁷ In a similar manner as psychiatry and Clifford Beers, she observes her thoughts and makes them objective. Yet she combines this objectivity with a first-hand narrative of how her schoolmates "looked to [her] like ants under a bright light" or that "[she] fancied that people watching us...were prisoners."⁴⁴⁸ Like Mary Huestis Pengilly and Clifford Beers, Renée emphasizes *what* she thought, as opposed to *how* she thought.

Though Renée categorizes her experiences as subjective, to what extent did this subjectivity affect her impressions of the disorder? While Sechehaye describes Renée's experiences in clinical terms as a "loss of contact with life," Renée characterizes her experiences in terms of feelings and places. Remarking on her first impressions of the disorder, she noted "a strange feeling came over me...a disturbing sense of unreality."⁴⁴⁹ She commented: "It seemed to me that I no longer recognized the school, it had become as large as a barracks; the singing children were prisoners, compelled to sing. It was as though the school and the children's song were set apart

⁴⁴⁷ Renée, *Autobiography of a Schizophrenic Girl*, translated by Grace Rubin-Rabson (New York: Grune and Stratton, 1951), 5.

⁴⁴⁸ *Ibid.*, 6.

⁴⁴⁹ *Ibid.*, 3.

from the rest of the world.”⁴⁵⁰ In this case, "unreality" was not connected with the individual's ability to discern information, but rather an experience comprising the school and the children's song. These pieces of information formed her surroundings, a place that was unconnected to “the rest of the world.”

And the opposite of unreality? How did Renée conceptualize information shared by other individuals? She remarks on several occasions throughout her work that she "wanted to return to real life" or "to return to reality.”⁴⁵¹ Renée does not hope for the ability to distinguish reality. Rather, "real life" and "reality" appear to be ways of experiencing her surroundings. Schizophrenia is contextualized in terms of experience, rather than abilities.

This does not mean that Renée does not discuss impairment. However, impairment appears to be the result of an experience, rather than a disorder acting upon the individual, and is similarly framed in terms of experiences, as opposed to assessment. In describing her transition to secondary school, for example, she notes:

From the point of view of scholarship, my last year at the elementary school was good enough. . . . I seemed to have, then, everything necessary for success in the secondary school. Unfortunately, this was not the case, and the cause lay in the ‘unreality.’⁴⁵²

Renée continues to separate “the ‘unreality’” from herself, making it an experience rather than a disability. Yet she acknowledges her difficulty in secondary school, which she attributes to “the ‘unreality.’” She therefore distinguishes between (1) her experience and (2) impairment resulting from her experience. This separation

⁴⁵⁰ Ibid., 3.

⁴⁵¹ Ibid., 6, 4.

⁴⁵² Ibid., 9.

acknowledges disability while connecting it to the experiences of the individual rather than to the abilities of the individual. Renée subsequently frames disability in terms of its effect on her experiences, rather than on her ability to function: “So I passed a year, suffering the fear and the unreality. ... the ‘Fear’...robbed me of all joy in living.”⁴⁵³ While Renée does not locate disability in the individual, Renée still acknowledges the difficult experience that is schizophrenia.

4.3.4 The Schizophrenia Diaries, 2012

The “Schizophrenic Diaries” is a collaborative web-based effort. The founders based their site on the work of James Caldwell, who they identify as a “real life Schizophrenic.”⁴⁵⁴ The founders transcribed and posted Caldwell’s “True Diary of Psychological Episodes” on their website, which they identify as “Our Founding Story.”⁴⁵⁵ Unlike many other publications, such as *Autobiography of a Schizophrenic Girl*, this website was produced outside the realm of psychiatry and the medical community. However, it has created a community of individuals living with schizophrenia that feel comfortable enough to share their experiences. The site was created “for the purpose of helping others” with schizophrenia and its interactive nature allows individuals to post their own story.⁴⁵⁶

How does this community describe schizophrenia? The founders include an

⁴⁵³ Ibid., 15.

⁴⁵⁴ *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture* (2009), Accessed 2012, <http://schizophreniadiaries.com/>. I accessed this site between 2012 and 2013 but it has since disappeared. This site originates from Albany, New York and should not expire until April 6, 2015 according to this website: <http://cqcounter.com/site/schizophreniadiaries.com.html>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid.

informational page “About Schizophrenia.”⁴⁵⁷ Most of the page relates statistics about onset and progression. There is some description about its onset: “During onset, the person often withdraws from others, gets depressed and anxious and develops extreme fears or obsessions.”⁴⁵⁸ This description mirrors more clinical definitions, though they do not use the word “hallucination” or “delusion.” Yet in noting the significance of James Caldwell’s work, they focus on different features of the disorder: “His diaries of psychosis talk about everything he was hearing, tasting, smelling, and seeing during these encounters at the time, Hallucinating [sic]. He will take you through his fears, thoughts, and feelings.”⁴⁵⁹

Though the word “hallucinating” appears, this explanation focuses on Caldwell’s senses (hearing, taste, smell, and vision) and his experience of his surroundings. While they frame schizophrenia as an experience, rather than in terms of assessment, the founders by no means present a glorified depiction of schizophrenia. “Nobody,” they charge, “but other Schizophrenics can understand the severity of psychotic torture that we endure.”⁴⁶⁰

The stories are organized by category, including various states of the disorder, such as “Coping,” “Diagnosed,” “Recovery,” “Suicide,” or by emotions in dealing with the disorder, including “Afraid” and “Scared.”⁴⁶¹ Other categories do not relate directly to the disorder: “Family Members,” “Relationship,” and “Upbringing.”⁴⁶² The founders’ categories combine diagnostic labels, such as “Delusional,” and terms

⁴⁵⁷ Ibid.

⁴⁵⁸ Ibid.

⁴⁵⁹ Ibid.

⁴⁶⁰ Ibid.

⁴⁶¹ Ibid.

⁴⁶² Ibid.

that reflect sensory experiences, such as "Hearing Things."⁴⁶³ This dichotomy is reflected in the stories themselves.

There is a tension between assessment and experience in these stories. Many of the authors characterize schizophrenia as an entity, including the author of "The Beginning," who notes "I never thought that I would be 1 of 100 people that would ever get it."⁴⁶⁴ Yet schizophrenia remains a *separate* entity. The author of "Haunted by a Voice" notes "I knew something was wrong when the voice I was talking to for about two weeks straight turned on me."⁴⁶⁵ This individual notes the agency of the disorder, yet they emphasize "something" was different; they do not comment on changes in personal abilities. Rather than locating impairment in the individual, they locate disability outside the individual. In conceptualizing schizophrenia, individuals focus less on impairment than experience.

The authors of the Schizophrenic Diaries have or have had some interaction with psychiatry since their diagnosis is predicated on an assessment by a medical professional. Bev, for example, cites the opinion, assumedly of medical professionals: "I have been told it is not me but my mind is ill," though she resists their opinion, noting "but I cannot believe and never will."⁴⁶⁶ Whether or not these individuals accept their diagnosis, they have some knowledge of psychiatric labels and clinical terminology. Frank Catrelli demonstrates the most knowledge, using psychiatric

⁴⁶³ Ibid.

⁴⁶⁴ "Delusional: Schizophrenia – Its a Nightmare," *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

⁴⁶⁵ "Delusional: Haunted by a Voice," *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

⁴⁶⁶ "Diagnosed: Story from Bev," *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/diagnosed/>.

symptoms to define the disorder: “I finally began to understand the bizarre world of hallucinations, delusions, paranoia, and psychotic episodes that is called schizophrenia.”⁴⁶⁷ Frank has a stronger connection with the psychiatric community than most. He notes that he belongs to the National Alliance for the Mentally Ill (NAMI) and Pennsylvania Mental Health Consumers’ Association (PMHCA).

Disability may also be constructed, as Danielle Cooke suggests. Disability may be learned yet individuals’ experience of disability precedes the diagnosis of “disability” by medical professionals. Though these individuals use psychiatric terminology, they also rely heavily on the senses. In part, this may be because the use of psychiatric terminology requires the ability to assess what is happening and the ability to make the experience subjective. One author notes: “... I took a few moments to calm myself down and collect what I had seen. I later went home and realized I was hallucinating in a very bad way.”⁴⁶⁸ This individual describes what he saw and heard and only later “realized” that he was “hallucinating.” Experience has to precede the categorization of experience and the use of terms such as “hallucination.” Yet this individual takes this one step further and notes the difficulty of categorizing their experiences.

This difficulty seems common. Another individual, for example, notes:

I was beginning to experience visual hallucinations. There were people and things that apparently only I saw, and a nearly continuous whispering in my head. The first time I heard a voice, it was telling me nasty things. This voice

⁴⁶⁷ “My Story: Frank Catrelli’s Story,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/my-story/>.

⁴⁶⁸ “Delusional: Dealing with Schizophrenia without Medication,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

has developed into a character called Francis, who tries his hardest [sic] to make me miserable.⁴⁶⁹

This author acknowledges that information should not have been there, an assessment that corresponds with psychiatric assessment. Yet he qualifies this statement, noting that the “people and things” were “apparently” only seen by himself, suggesting that this information was not immediately known to him or that it was explained to him by other individuals. As in the previous story, this individual suggests the difficulty that comes with categorizing his experiences.

This story also differs from the previous story. Whereas the author of the first story uses the term “hallucinating,” the author of the second story describes his “experience” of “visual hallucinations.”⁴⁷⁰ The use of the term “hallucinating” is unusual in this collection of stories. Most of the stories do not connect the state with the individual, unlike psychiatry. Rather, they note the *presence* of “hallucinations.” Though “hallucination” categorizes experience and emphasizes impairment, it is less direct in connecting the disorder to the individual. In noting their “experience” of “visual hallucinations,” the author uses terminology that corresponds with other ways of conceptualizing the disorder that puts less emphasis on impairment.

The authors of these stories emphasize experience to a much greater extent than other discourses on schizophrenia, even though time has elapsed between their experience and the process of writing. They do not simply categorize their experiences, using terms such as “delusion” or “hallucination.” Many of the authors focus on their senses: “Hello, This is what I’ve experienced. When I was a little kid, I

⁴⁶⁹ “Hearing Things: No One Knows,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/hearing-things/>.

⁴⁷⁰ Ibid.

always heard [sic] stuff, somehow I just tend to know things. I also saw things.”⁴⁷¹

Another author comments: “I’m 17 years old and since the age of 7 or so I have seen things and heard things on a regular basis.”⁴⁷² Like the author in the introduction, these individuals describe the presence of sensory information, without assessing the information that should not be present. In many of these stories, individuals explicitly describe their experiences.

Several individuals have posted stories under “Delusional,” including the author of “Delusional Disorder.” This individual begins their story by introducing their diagnosis as “Delusional Disorder—a relatively new classification subsumed under the general classification of Paranoid Schizophrenia.”⁴⁷³ The author uses clinical terms in their introduction, noting they are “afflicted by delusions and hallucinations.” As their narrative progresses, however, they elaborate:

I believe that some kind of a device or power opens up my thoughts to the public so that everyone can know what I’m thinking or feeling. This is particularly problematic in crowds, when everyone is staring at me and whispering about me. Frustratingly, while the crowd all know what I’m thinking, I have no idea what they are thinking or saying.⁴⁷⁴

This individual goes beyond categorizing their experience as an impairment. Rather than assessing the validity of his thoughts, the individual writes about his interaction with the crowd. The author also explains why this information is “problematic,” not in terms of its effect on the individual, but rather in terms of how he experiences crowds.

⁴⁷¹ “Hearing Things: LSD Fun,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/hearing-things/>.

⁴⁷² “Personal Stories: Manifested Visions,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/schizophrenic-stories/>.

⁴⁷³ “Delusional: Delusional Disorder,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

⁴⁷⁴ Ibid.

Another story, posted by an individual who identifies himself as a nurse, uses clinical terms, such as “visual hallucinations,”⁴⁷⁵ to a larger extent. However, this individual also expands on this category and describes his surroundings:

It wasn't until the evening that the visual hallucinations started. Hearing repetitively [sic] and loud ‘They’re coming to get you,’ ‘They will kill you,’ and ‘They are after you,’ I also had to contend with seeing dark shadows roaming around my room with knives weaving in and out of my doors and windows and around my bed.⁴⁷⁶

The author makes the “dark shadows” subjective, yet the information he provides about his thoughts and the appearance of the room also frames the disorder an experience. What was its significance? The author does not emphasize impairment, but rather describes “seeing dark shadows” as a source of contention. The author therefore frames schizophrenia as a (difficult) experience for the individual, rather than as an impairment *of* the individual.

In conclusion, psychiatry has influenced the way in which individuals categorize their experiences, using terms such as “delusion” or “hallucination.” Yet individuals who experience schizophrenia continue to describe the disorder in terms of their experience. They continue to focus on the appearance of their surroundings through the senses – taste, vision, smell, and hearing. These individuals do not downplay the severity of schizophrenia. However, they conceptualize schizophrenia as a (difficult) experience *for* the individual, rather than as an impairment *of* the individual. This way of conceptualizing schizophrenia focuses less attention on the individuals’ abilities and locates disability outside the individual.

⁴⁷⁵ “Delusional: Things Started to Go Wrong on Saturday the 13th of June,” *Schizophrenia Diaries: True Stories and Diaries of Psychological Torture*, <http://schizophreniadiaries.com/category/delusional/>.

⁴⁷⁶ Ibid.

CONCLUSION

As in the case of the elephant and two blind men, there are many different ways to think about schizophrenia. Moreover, the way in which we conceptualize “schizophrenia” has changed over time. This work has approached schizophrenia as a historical concept. It has gone further than previous historiography by examining at once historical conceptions of schizophrenia in one place, and over time, coming from three perspectives – that of psychiatry, the public, and patients. This comparative approach allowed for a more critical examination of public conceptions of schizophrenia. This thesis has traced the intersection between psychiatric and public conceptions of “insanity” or “dementia praecox” or “schizophrenia” and examined the evolving relationship between individual identity and disability. Public conceptions of schizophrenia have increasingly referred to medicalized definitions of the disorder since the mid-twentieth century.

As we have seen, standardization within psychiatry began with the publication of Emil Kraepelin’s *Compendium of Psychiatry*. Critics of Kraepelin and the psychiatric profession, including Ronald David Laing, denounced diagnostic practices that did not pay attention to the perspective of the patient. Recent critics have further charged that psychiatric practices and diagnostic categories, such as “schizophrenic,” equate identity and disability. Taking this one step further, diagnostic terms such as “hallucination” or “delusion” are based on the observation and assessment of an individual’s thoughts, feelings, or actions and similarly locate disability exclusively in the individual.

In Canada, the National Committee for Mental Hygiene (NCMH), later the Canadian Mental Health Association, was founded in 1918. Despite Kraepelin's efforts to standardize psychiatry in the late nineteenth century, Canadian mental health professionals did not write about the symptoms of "dementia praecox" he identified. Rather, the focus of the NCMH up to the mid-twentieth century was prevention. The organization discussed ways of identifying traits, such as shyness, that it believed could lead to dementia praecox. Although this examination involved personal markers of identity, the organization's emphasis on prevention, and thus on causation, meant that the individuals they examined were not living with mental disability at that time. So the relationship between identity and disability was tenuous.

Canadian psychiatrists devoted less attention to the treatment of dementia praecox, though they did mention the development of metrazol therapy and insulin shock. In these rare discussions of treatment, the NCMH did not seek to define either the causes or symptoms of the disorder. By 1950, however, the NCMH began noting efforts in the United States to standardize psychiatric diagnosis, which Kraepelin had begun a half century earlier, and at this time turned its attention to the symptomatic behaviour of dementia praecox, which located impairment in the individual.

Locating impairment in the individual became standard practice after the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1952 and subsequently revised. The Canadian Psychiatric Association, a strictly professional organization, was founded in 1951 and focused less on prevention than on the treatment of mental disorders. In the minutes of their meetings and in their clinical guidelines, schizophrenia was increasingly defined according to symptoms identified

through the assessment of an individual's thought, emotion, and actions and for the effect of these symptoms on the individual.

What did this conceptual shift mean for public conceptions of "schizophrenia?" My project focused on the *Ottawa Citizen*, a newspaper whose coverage was national as well as international, since 1895. Neither the term "schizophrenia" nor the term "dementia praecox" appeared in the *Ottawa Citizen* before 1950 and so I traced the use of the term "insanity" up to 1950. As in the case of the meeting minutes of the NCMH up to the mid-twentieth century, there was an emphasis on causation, that is to say factors that could lead to insanity, such as heredity or working too hard. Yet "insanity" generally operated as a form of explanation to describe visible behaviours, such as suicide. "Insanity" was not being defined through an assessment of an individual.

The public press increasingly sought to define "schizophrenia" and referenced medicalized definitions of the disorder after the development of the *Diagnostic and Statistical Manual of Mental Disorders*. It became standard practice within the press to provide a definition of schizophrenia that mentioned symptoms identified by the profession of psychiatry. For example, schizophrenia to this day is often defined by "paranoia, delusions, hallucinations, disordered thinking and bizarre behavior."⁴⁷⁷ This conceptual shift put greater emphasis on impairment and tightly interwove identity and disability. It is not the point of this project to criticize medical diagnostic practices, which revolve around observation and assessment, but to problematize the use of this post-1950 medical model within the public domain.

⁴⁷⁷ "Dialysis No Cure for Schizophrenia," *Ottawa Citizen*, March 24, 1983, 87.

The purpose of this project was also to consider different ways of thinking about mental disability. The perspective of patients living with psychiatric disability offers an important way of thinking about schizophrenia. This study has looked at a number of personal accounts of such individuals written over the past century. Though individuals may use psychiatric labels and have knowledge of the ways in which psychiatrists explain the disorder, their experiences generally preceded their exposure to psychiatry and the mental health community. Many of these individuals tended to conceptualize schizophrenia differently. As in the case of Atalanta Bachischin and Mac Hardie, Mary Huestis Pengilly, Clifford Beers or Renée, or the authors of “The Schizophrenic Diaries,” they paid significant attention to the way in which the world appeared around them. In their writings, schizophrenia is therefore as much an experience as impairment. This way of thinking about mental disability, in contrast to the medical model, locates disability outside the individual.

This project has been critical of public conceptions of schizophrenia which locate disability within the individual, particularly conceptions of schizophrenia that make disability the sole marker of an individual’s identity. It has consequently turned to the accounts of individuals living with schizophrenia to find an alternative way of thinking about the disorder. Yet it is important to note the importance of disability in identity. Many individuals claim disability as a part of their identity. The difference is dependent on whether schizophrenia is being imposed as the defining characteristic of a person’s identity or whether disability is being claimed by an individual as a part of his or her identity.

Appendix 1 – Table of *Ottawa Citizen* articles with substantial discussion of “insanity” in chronological order (1895-1949)

Date	Author	Title	Newspaper	Source	Page Number
December 25, 1895	--	“Killed for His Love”	<i>Ottawa Citizen</i>	Des Moines, Iowa	2
October 23, 1889	--	“Canadians Work Too Hard!”	<i>Ottawa Citizen</i>	--	
October 30, 1889	--	“At Last!”	<i>Ottawa Citizen</i>	--	4
November 15, 1889	--	“Canadians Work Too Hard!”	<i>Ottawa Citizen</i>	--	
November 25, 1889	--	“Canadians Work Too Hard!”	<i>Ottawa Citizen</i>	--	
February 5, 1890	--	“Canadians Work Too Hard!”	<i>Ottawa Citizen</i>	--	
January 11, 1890	--	“Canadians Work Too Hard!”	<i>Ottawa Citizen</i>	--	6
April 3, 1897	--	“Paine’s Celery Compound”	<i>Ottawa Citizen</i>	--	3
*	*	“Thaw Trial Nearing End”	<i>Ottawa Citizen</i>	*	*
July 26, 1909	--	“Thaw Scores on States Attorney”	<i>Ottawa Citizen</i>	White Plains, New York – Associated Press Despatch	36
April 29, 1916	--	“John Redmond Denounces the Outbreaks in Ireland Grave Danger to Home Rule”	<i>Ottawa Citizen</i>	London	3
February 11, 1927	--	“Railway Executive in Plunge to His Death”	<i>Ottawa Citizen</i>	San Francisco – Associated Press Despatch	2
October 10, 1927	--	“Long Desperate Fight to Escape Gallows Closed”	<i>Ottawa Citizen</i>	Chicago, Illinois – Associated Press	6
December 31, 1927	--	“Hickman Pleads Not Guilty – Goes on Trial Jan. 25”	<i>Ottawa Citizen</i>	Los Angeles, California – Associated Press	35

July 16, 1937	--	"Third Reading for Divorce Bill Monday"	<i>Ottawa Citizen</i>		3
September 20, 1937	Marion White	"Out of the Night"	<i>Ottawa Citizen</i>	London – Canadian Press Cable	8
February 2, 1946	Eric Watt	"Charge 'Tom' Gibbons with Double Slaying"	<i>Ottawa Citizen</i>	Evening <i>Citizen</i> Staff Writer	1
April 10, 1947	--	"Defence Pleads Insanity"	<i>Ottawa Citizen</i>	Pembroke – Staff	1
April 11, 1947	--	"Will Confine Gibbons to Mental Institution"	<i>Ottawa Citizen</i>	Pembroke – Staff Writer	12
July 19, 1949	--	"Vampire Haigh to be Hanged"	<i>Ottawa Citizen</i>	Lewes, London – Associated Press	1
August 8, 1949	--	"'Vampire' is Hanged"	<i>Ottawa Citizen</i>	London – Associated Press	47

* This article was accessed in 2011, at which time it was possible to search Google News Archive's database for specific words. Since Google News Archive changed their format, I have not been able to find this article again.

Appendix 2 – Table of *Ottawa Citizen* articles with substantial discussion of “schizophrenia” in chronological order (1950-2010)

Date	Author	Title	Newspaper	Source	Page Number
January 13, 1950	--	“Claim Patient Admits Setting Hospital Fire”	<i>Ottawa Citizen</i>	Davenport, Iowa	35
March 1, 1950	--	“The Case of Klaus Fuchs”	<i>Ottawa Citizen</i>	--	85
May 4, 1955	--	“Study Helps Detection of Disease”	<i>Ottawa Citizen</i>	--	14
May 30, 1955	Joseph Witney	“Mirror of Your Mind”	<i>Ottawa Citizen</i>	--	48
August 14, 1959	Joseph Witney	“Mirror of Your Mind”	<i>Ottawa Citizen</i>	--	15
December 28, 1955	--	“Clue to Schizophrenia in ‘Silliness’ Chemical”	<i>Ottawa Citizen</i>	Atlanta, Ga. – AP	17
July 18, 1957	--	“Tranquillizers Wrong for Neurotics – Expert”	<i>Ottawa Citizen</i>	Newcastle-on-Tyne, England – <i>Reuters</i>	15
November 4, 1958	*	“Testing Times for Ike”	<i>Ottawa Citizen</i>	*	45
November 28, 1958	J. R. Walker	“Labor in American Politics”	<i>Ottawa Citizen</i>	Southam News Service**	6
August 14, 1957	Joseph Alsop	“Breaks in the Western Alliance”	<i>Ottawa Citizen</i>	Paris – Copyright <i>New York Tribune Herald Inc.</i>	48
April 9, 1962	Rowland Evans Jr.	“UN’s ‘Split Personality’ Shows Like Falling Hem”	<i>Ottawa Citizen</i>	Washington – <i>New York Tribune Herald</i>	7
September 21, 1963	W. Gifford Jones	“Legalized Abortion in Japan”	<i>Ottawa Citizen</i>	Ontario medical doctor	58
October 2, 1964	Maurice Huot	“Problem of National Unity”	<i>Ottawa Citizen</i>	Quebec – <i>Le Soleil</i>	4
February 14, 1967	Roger Appleton	“Queen’s Park is the Villain”	<i>Ottawa Citizen</i>	<i>Citizen City Hall</i> reporter	22
May 1, 1967	Ernest E. Barr	“Gloomy Forecast”	<i>Ottawa Citizen</i>	<i>Citizen Special Correspondent</i>	4
July 6, 1976	--	“Schizophrenia in Economics”	<i>Ottawa Citizen</i>	<i>Citizen Editorial</i>	8

September 6, 1977	--	"A Paeon to Secrecy"	<i>Ottawa Citizen</i>	Citizen Editorial	310
May 3, 1978	John Gray	"Jerome Faces 'Unspeakable' Election Fuss"	<i>Ottawa Citizen</i>	Citizen Staff Writer	21
August 1, 1978	Rick Laiken	"Stripper Bares Soul for Unity"	<i>Ottawa Citizen</i>	Citizen Staff Writer	18
February 2, 1979	Dave Rogers	"Durward Realized Nature of Actions, Murder Trial Told"	<i>Ottawa Citizen</i>	Citizen Staff Writer	78
February 7, 1979	Dave Rogers	"Psychiatric Treatment Did Accused Murderer No Good"	<i>Ottawa Citizen</i>	Citizen Staff Writer	4
March 21, 1979	Nicholas Hills	"U.K.'s Devolution Try Ends in Disaster"	<i>Ottawa Citizen</i>	Southam News Service	12
January 2, 1980	--	"Jerome, Macdonald Wise to Go"	<i>Ottawa Citizen</i>	<i>Citizen</i> Editorial??	12
January 16, 1980	Louise Crosby	"Schizophrenia Shunned"	<i>Ottawa Citizen</i>	Citizen Staff Writer	177
January 16, 1980	Louise Crosby	"Causeway Helps Mentally Ill Cross Troubled Waters of Past"	<i>Ottawa Citizen</i>	Citizen Staff Writer	177
June 2, 1982	--	"Hinckley's Brain Scans Admitted as Evidence"	<i>Ottawa Citizen</i>	Washington – UPI	36
March 24, 1983	--	"Dialysis No Cure for Schizophrenia"	<i>Ottawa Citizen</i>	Boston – UPI	87
October 4, 1984	Richard Gwyn	"Business Group Realistic on Deficit"	<i>Ottawa Citizen</i>	--	10
November 6, 1984	Mary Schmich	"Adolescent Girls Continue to Suffer Low Self-Esteem"	<i>Ottawa Citizen</i>	Orlando Sentinel	69
August 6, 1985	Patrick Nagle	"Nagging Questions Cloud Opening of Robert Mugabe's New Government in Zimbabwe"	<i>Ottawa Citizen</i>	Harare – [Undecipherable] <i>News</i>	12
September 16, 1985	Jan Ziegler	"Schizophrenics May Have Different Head Sizes: Research"	<i>Ottawa Citizen</i>	Washington United Press International	D4
November 14, 1985	Larry Black	"The Summit: Why Have High Hopes"	<i>Ottawa Citizen</i>	<i>The Canadian Press</i>	2

		Suddenly Come Crashing to Earth?"			
February 6, 1986	--	"Winnipeg Doctor May Have Found Key to Schizophrenia"	<i>Ottawa Citizen</i>	Winnipeg – CP	D10
February 14, 1986	Don McGillivray	"Regulation Reform"	<i>Ottawa Citizen</i>	Southam News	8
March 17, 1986	--	"A Schizophrenic's Transition to a 'Much Happier Person'"	<i>Ottawa Citizen</i>	--	D1
September 4, 1986	Frank DeCaro	"Magazines Out to Prove Fashion a Weighty Topic"	<i>Ottawa Citizen</i>	Night Ridder	73
January 20, 1987	Peter Griffiths	"Woman Suffering Depression Fears Schizophrenia"	<i>Ottawa Citizen</i>	*	D9
November 13, 1987	*	"Schizophrenia Link Possible"	<i>Ottawa Citizen</i>	*	D15
April 22, 1988	Dave Brown	"Schizophrenia: Nightmare Emerges"	<i>Ottawa Citizen</i>	*	B1
July 15, 1988	Jeff Bartkiewicz	"Chess Expert Refuses to be Pawn in Battle Against Schizophrenia"	<i>Ottawa Citizen</i>	*	D3
March 7, 2004	Bruce Culp	"A Beautiful Mind"	<i>Ottawa Citizen</i>	*	C3
October 13, 2005	Sharon Kirkey	"Mentally Ill Make Up 15 % of Hospital Admissions"	<i>Ottawa Citizen</i>	*	A3
January 17, 2010	Janice Kennedy	"Anger, Grief and the Bigger Picture"	<i>Ottawa Citizen</i>	*	A11
January 17, 2010	Grant Duwe	"Horrorifying, But Rare"	<i>Ottawa Citizen</i>	*	B7

* Due to changes in the formatting of Google News Archive, these articles were not found upon a second search.

** The *Ottawa Citizen* was published by the proprietor, Southam Press Limited, at this time.

*** References to "schizophrenia" increased significantly after 1985. The selection of articles after this time period focused on conceptions of schizophrenia that emphasized "suffering."

Appendix 3 – Definitions of “Schizophrenia” in three editions of the Diagnostic and Statistical Manual of Mental Disorders (1952-1980)

The following definitions precede the “types” of schizophrenia outlined in the various editions of the *Diagnostic and Statistical Manual of Mental Disorders*.

Diagnostic and Statistical Manual of Mental Disorders, First Edition (DSM-I), 1952

It represents a group of psychotic reactions characterized by fundamental disturbances in reality relationships and concept formations, with affective behavioral, and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, by a tendency to ‘deterioration.’ The pre-dominant symptomology will be the determining factor in classifying such patients into types.⁴⁷⁸

Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II), 1967

This large category includes a group of disorders manifested by characteristic disturbances of thinking, mood, and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre. The schizophrenias, in which the mental status is attributable primarily to a *thought* disorder, are to be distinguished from the *Major affective illnesses* (q.v.) which are dominated by a *mood* disorder. The *Paranoid states* (q.v.) are distinguished from schizophrenia by the narrowness of their distortions of reality and by the absence of other psychotic symptoms.⁴⁷⁹

Diagnostic and Statistical manual of Mental Disorders, Third Edition (DSM-III), 1980

The essential features of this group of disorders* are: the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months. The disturbance is not due to an Affective Disorder or Organic Mental Disorder. At some phase of the illness Schizophrenia always involves delusions, hallucinations, or certain disturbances in the form of thought.

The limits of the concept of Schizophrenia are unclear. Some approaches to defining the concept have emphasized the tendency toward a deteriorating course (Kraepelin), underlying disturbances in certain psychological processes (Bleuler), or pathognomonic symptoms

⁴⁷⁸ The Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington: American Psychiatric Association, 1968), 33.

⁴⁷⁹ Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (Washington: American Psychiatric Association, 1968), 33.

(Schneider). In this manual the concept is not limited to illnesses with a deteriorating course, although a minimal duration of illness is required since the accumulated evidence suggests that illness of briefer duration (here called Schizophreniform Disorder) are likely to have different external correlates, such as family history and likelihood of recurrence. The approach taken here excludes illnesses without overt psychotic features, which have been referred to as Latent, Borderline, or Simple Schizophrenia. Such cases are likely to be diagnosed in this manual as having a personality disorder such as Schizotypal Personality Disorder. Illnesses with onset after mid-adult life are also excluded, and may be classified as Atypical Psychosis. Furthermore, individuals who develop a depressive or manic syndrome for an extended period relative to the duration of certain psychotic features or before the psychotic features appear, are not classified as having Schizophrenia but rather as having either an Affective or Schizoaffective Disorder. Thus, this manual utilizes clinical criteria that include both a minimum duration and a characteristic symptom picture to identify a group of conditions that has validity in terms of differential response to somatic therapy; presence of a familial pattern; and a tendency toward onset in early adult life, recurrence and deterioration in social and occupational functioning.⁴⁸⁰

⁴⁸⁰ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (Washington: APA, 1980), 181.

Appendix 4 – Diagnostic criteria set forth in DSM-III, DSM-III-R and DSM-IV (1980-1994)

Diagnostic and Statistical manual of Mental Disorders, Third Edition (DSM-III), 1980

Diagnostic Criteria for a Schizophrenic Disorder

A. At least one of the following during a phase of the illness:

- (1) bizarre delusions (content is patently absurd and has no possible basis in fact), such as delusions of being controlled, thought broadcasting, thought insertion, or thought withdrawal
- (2) somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content
- (3) delusions with persecutory or jealous content if accompanied by hallucinations of any type
- (4) auditory hallucinations in which either a voice keeps up a running commentary on the individual's behavior or thoughts, or two or more voices converse with each other
- (5) auditory hallucinations on several occasions with content of more than one or two words, having no apparent relation to depression or elation
- (6) incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech if associated with at least one of the following:
 - (a) blunted, flat, or inappropriate affect
 - (b) delusions or hallucinations
 - (c) catatonic or other grossly disorganized behavior

B. Deterioration from a previous level of functioning in such areas as work, social relations, and self-care.

C. Duration: Continuous signs of the illness for at least six months at some time during the person's life, with some signs of the illness at present. The six-month period must include an active phase during which there were symptoms from A, with or without a prodromal or residual phase, as defined below.

D. The full depressive or manic syndrome (criteria A and B of major depressive or manic episode), if present, developed after any psychotic symptoms, or was brief in duration relative to the duration of the psychotic symptoms in A.

E. Onset of prodromal or active phase of the illness before age 45.

F. Not due to any Organic Mental Disorder or Mental Retardation.⁴⁸¹

Diagnostic and Statistical manual of Mental Disorders, Third Edition (DSM-III-R), 1987

Diagnostic criteria for Schizophrenia

A. Presence of characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):

(1) two of the following:

(a) delusions

(b) prominent hallucinations (throughout the day for several days or several times a week for several weeks, each hallucinatory experience not being limited to a few brief moments)

(c) incoherence or marked loosening of associations

(d) catatonic behavior

(e) flat or grossly inappropriate affect

(2) bizarre delusions (i.e., involving a phenomenon that the person's culture would regard as totally implausible, e.g., thought broadcasting, being controlled by a dead person)

(3) prominent hallucinations [as defined in (1)(b) above] or a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other⁴⁸²

Diagnostic and Statistical manual of Mental Disorders, Fourth Edition (DSM-IV), 1994

Diagnostic criteria for Schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (ore less if successfully treated):

(1) delusions

(2) hallucinations

(3) disorganized speech (e.g., frequent derailment or incoherence)

(4) grossly disorganized or catatonic behavior

(5) negative symptoms, i.e., affective flattening, alogia, or avolition

⁴⁸¹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (Washington: APA, 1980), 188-190.

⁴⁸² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition – Revised (Washington: APA, 1987), 194.

Note: only one Criterion A symptoms is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social / occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration*: continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criteria A present in attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion*: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance / general medical condition exclusion*: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug abuse, a medication) or general medical condition.

F. *Relationship to a Pervasive Developmental Disorder*: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least one month (or less if successfully treated).⁴⁸³

⁴⁸³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (Washington: APA, 1994), 285-286.

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