CHAPTER 1

Introduction: Definitional and Historical Considerations, and Canada's Mental Health System

LEARNING OBJECTIVES

1. Understand what constitutes abnormal behaviour.
2. Compare the history of psychopathology across centuries.
3. Describe current attitudes toward people with psychological disorders, including how stigma and self-stigma are potential barriers to help-seeking.
4. Describe mental health problems and their treatment in Canada.
5. Describe the issues and challenges in the delivery of psychotherapy.

Every day of our lives we try to understand other people. Acquiring insight into what we consider normal, expected behaviour is difficult. It is even more difficult to understand human behaviour that is beyond the normal range.

This book deals with abnormality as it applies to psychological disorders, including their description, causes, and treatment. As you will see, we know with certainty much less about our field than we would like. As we approach the study of **psychopathology**—the field concerned with the nature and development of abnormal behaviour, thoughts, and feelings—we do well to keep in mind that the subject offers few hard and fast answers.

Another challenge we face in studying abnormal psychology is the need to remain objective. Our subject matter is personal and it is powerfully affecting, making objectivity difficult but no less necessary. The disturbing effects of abnormal behaviour intrude on our own lives. Who has not experienced irrational thoughts, fantasies, and feelings? Who has not felt profound sadness that is more extreme than circumstances can explain? Most of you will have known someone whose behaviour was upsetting and impossible to fathom, and realize how frustrating and frightening it is to try to help a person suffering psychological difficulties.

This feeling of familiarity with the subject matter adds to its intrinsic fascination—undergraduate courses in abnormal psychology are among the most popular in psychology departments and indeed in the entire university or college curriculum. But it has one distinct disadvantage. All of us bring to our study preconceived notions of what the subject matter is. We have developed certain ways of thinking and talking about behaviour, certain words and concepts that somehow seem to fit.

As scientists, we have to grapple with the difference between what we may feel is the appropriate way to talk about human behaviour and experience and what may be a more productive way of defining it in order to study and learn about it. The concepts and labels we use in the scientific study of abnormal behaviour must be free of the subjective feelings of appropriateness ordinarily attached to certain human phenomena. As you read this book and try to understand the mental disorders it discusses, you may be asked to adopt frames of reference different from those to which you are accustomed.

We will now turn to a discussion of what we mean by the term "abnormal behaviour." Then we will look briefly at how our view of abnormality has evolved through history to the more scientific perspectives of today. We then continue with a discussion of current attitudes toward people with psychological

problems and with an introduction to the system of mental health care in Canada. Chapter 1 concludes with a discussion of the issues and challenges in the delivery of psychotherapy.

Before we embark on this journey, it is important to note that this is an exceptionally good time to be a student learning about abnormal psychology, especially in Canada. Important research discoveries continue to emerge, in part fuelled by developments in neuroscience. The field is also under great scrutiny as a result of the introduction in May 2013 of the next edition of the diagnostic system, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5;* see www.dsm5.org). Moreover, mental health issues are very much at the forefront of the public consciousness at present, and this is partly due to the efforts of heroic famous Canadians such as Clara Hughes (see photo) and the many individuals and corporations who are determined to make a difference. Arguably, there has been no time in our past when public interest and determination to make positive changes in mental health has been higher. Another important development is that due to the exceptional efforts of the Mental Health Commission of Canada and individuals across our nation, Canada finally has its first comprehensive Mental Health Strategy (see http://strategy.mentalhealthcommission.ca/). And even politicians seemed poised to do their part. For instance, Canada is now seriously considering a national suicide prevention strategy as a result of public support for a nonpartisan motion put forth in October 2011 by then-federal Liberal leader Bob Rae.

These efforts and initiatives are important because the challenges still facing us are very significant ones. Some challenges require filling key gaps in knowledge, but more importantly, the remaining challenges are the sheer prevalence of psychological problems among people of various ages in Canada and elsewhere. We will see that the number of people who require treatment and other services for mental health issues far outweighs the services that are available. Ideally, we will get to the point that, collectively, we will have all of the resources needed to put timely preventions in place and thereby substantially decrease the suffering that accompanies mental illness.

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Clara Hughes, Olympic champion, also champions awareness of mental health issues and has been open about her own bouts with depression. She is shown here in October 2012 speaking to graduates when receiving an honorary Doctor of Laws degree from York University for her tireless efforts. Among other things, in 2014 her "Big Ride" had her go across Canada by bike to heighten awareness of mental health issues. Her new 2015 autobiography *Open Heart Open Mind* details the challenges she has faced.

1.1 What Is Abnormal Behaviour?

One of the more difficult issues facing us is how to define abnormal behaviour. Several characteristics have been proposed as components. No single one is adequate, although each has merit and captures some part of what might be a full definition. Consequently, abnormality is usually determined by the presence of several characteristics at one time. Our best definition of **abnormal behaviour** includes such characteristics as statistical infrequency, violation of norms, personal distress, disability or dysfunction, and unexpectedness.

Statistical Infrequency

One aspect of abnormal behaviour is that it is *infrequent* in the general population. The **normal curve**, or bell-shaped curve, places the majority of people in the middle as far as any particular characteristic is concerned; very few people fall at either extreme. An assertion that a person is normal implies that he or she does not deviate much from the average in a particular trait or behaviour pattern.

Statistical infrequency is used explicitly in diagnosing mental retardation. Figure 1.1 shows the normal distribution of intelligence quotient (IQ) measures in the population. Though a number of criteria are used to diagnose mental retardation, low intelligence is a principal one. When an individual's IQ is below 70, his or her intellectual functioning is considered sufficiently subnormal to be designated as mental retardation.

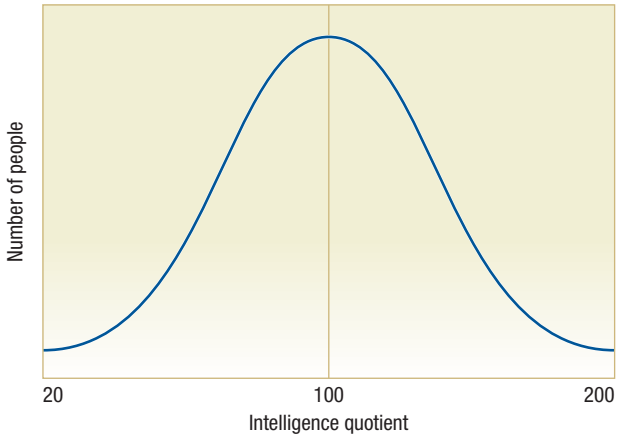


FIGURE 1.1 The distribution of intelligence among adults, illustrating a normal, or bell-shaped, curve.

Although some infrequent behaviours or characteristics of people do strike us as abnormal, in some instances, the relationship breaks down. Having great athletic ability is infrequent (see photo), but few would regard it as part of the field of abnormal psychology. Only certain infrequent behaviours, such as experiencing hallucinations or deep depression, fall into the domain considered in this book. Unfortunately, the statistical component gives us little guidance in determining which infrequent behaviours psychopathologists should study.

Violation of Norms

Another characteristic to consider is whether the behaviour *violates social norms* or threatens or makes anxious those observing it. Violation of norms explicitly makes abnormality a relative concept; various forms of unusual behaviour can be tolerated, depending on the prevailing cultural norms. Yet violation of norms is at once too broad and too narrow. Criminals and prostitutes, for example, violate social norms but are not usually studied within the domain of abnormal psychology, and the highly anxious person, who is generally regarded as a central character in the field of abnormal psychology, typically does not violate social norms and would not be bothersome to many lay observers.

In addition, cultural diversity can affect how people view social norms. What is the norm in one culture may be abnormal in another. This subtle issue is addressed throughout the book (see especially Chapters 2 and 3).

Personal Suffering

Another characteristic is *personal suffering;* that is, behaviour is abnormal if it creates great distress and torment in the person experiencing it. Personal distress clearly fits many of the forms of abnormality considered in this book—people experiencing anxiety disorders and depression truly suffer greatly—but some disorders do not necessarily involve distress. The psychopath, for example, treats others cold-heartedly and may continually violate the law without experiencing any guilt, remorse, or anxiety whatsoever. And not all forms of distress—for example, hunger or the pain of childbirth—belong to the field.

Disability or Dysfunction

Disability—that is, impairment in some important area of life (e.g., work or personal relationships) because of an abnormality—can also be a component of abnormal behaviour. Substance-use disorders are defined in part by the social or occupational disability (e.g., poor work performance, serious arguments with one's spouse) created by substance abuse and addiction. Similarly, a phobia can produce both distress and disability; for example, a severe fear of flying may prevent someone from taking a job promotion. Like suffering, disability applies to some, but not all, disorders. Transvestism (cross-dressing for sexual pleasure), for example, which is currently diagnosed as a mental disorder if it distresses the person, is not necessarily a disability. Most transvestites are married, lead conventional lives, and usually cross-dress in private. Other characteristics that might in some circumstances be considered disabilities—such as being short if you want to be a professional basketball player—do not fall within the domain of abnormal psychology. We do not have a rule that tells us which disabilities belong and which do not.

Unexpectedness

We have just described how not all distress or disability falls into the domain of abnormal psychology. Distress and disability are considered abnormal when they are *unexpected* responses to environmental stressors (Wakefield, 1992). For example, an anxiety disorder is diagnosed when the anxiety is unexpected and out of proportion to the situation, as when a person who is well off worries constantly about his or her financial situation.

We have considered here several key characteristics of a definition of abnormal behaviour. Again, none by itself yields a fully satisfactory definition, but together they offer a useful framework for beginning to define abnormality. In this volume we will study a list of human problems that are currently considered abnormal. The disorders on the list will undoubtedly change with time, for the field is continually evolving, and it is not possible to offer a simple definition of abnormality that captures it in its entirety. The characteristics presented constitute a partial definition, but they do not equally apply to every diagnosis.

Focus on Discovery 1.1 describes the education and training of professionals who study and treat mental disorders. Goering, Wasylenki, and Durbin (2000) estimated that approximately 3,600 practising psychiatrists, about 13,000 psychologists and psychological associates, and about 11,000 nurses specialize in the mental health area in Canada. Thousands of

John Berry/Getty Images

Although abnormal behaviour is infrequent, so, too, is great athletic talent, such as that of the proud members of the Canadian multiple gold medal-winning Olympic women's hockey team. Therefore, infrequency is not a sufficient definition of abnormal behaviour.

Focus on Discovery 1.1

The Mental Health Professions

The training of **clinicians,** the various professionals authorized to provide psychological services, takes different forms. Here, we discuss several types of clinicians, the training they receive, and a few related issues.

To be a **clinical psychologist** typically requires a Ph.D. or Psy.D. degree, which entails four to seven years of graduate study. However, in Canada, professional regulation of the psychology profession is within the jurisdiction of the provinces and territories and, depending upon regulatory statutes, a psychologist may have either a doctoral- or a master's-level degree (Hunsley & Johnston, 2000). In some jurisdictions the title "psychologist" is reserved for doctoral-level registrants, whereas master's-level registrants are referred to as "psychological associates." Specific curriculum requirements vary across jurisdictions. Gauthier (2002) concluded that there was effectively no consensus among the provinces on the minimal academic requirements, the required length of supervised practice, and the timing of such practice (i.e., before or after the degree is achieved).

The 1995 Agreement on Internal Trade stipulated that a framework for mobility had to be developed so that the credentials of professional psychologists from one part of Canada would be recognized in other parts of Canada. A Mutual Recognition Agreement was signed in June 2001. According to Gauthier (2002), this requires a person to obtain five core competencies in order to become a registered psychologist: (1) interpersonal relationships, (2) assessment and evaluation (including diagnosis), (3) intervention and consultation, (4) research, and (5) ethics and standards.

Training for a Ph.D. in clinical psychology requires a heavy emphasis on laboratory work, research design, statistics, and the empirically based study of human and animal behaviour. The Ph.D. is basically a research degree, and candidates are required to research and write a dissertation on a specialized topic. But candidates in clinical psychology learn skills in two additional areas, which distinguishes them from other Ph.D. candidates in psychology. First, they learn techniques of **assessment** and **diagnosis** of mental disorders. Second, they learn how to practise **psychotherapy**, a primarily verbal means of helping troubled individuals change their thoughts, feelings, and behaviour to reduce distress and to achieve greater life satisfaction. Students take courses in which they master specific techniques under close professional supervision; then, during an intensive internship or post-doctoral training, they gradually assume increasing responsibility for the care of clients.

Other clinical graduate programs are more focused on practice. These programs offer the relatively new degree of Psy.D. (doctor of psychology). The curriculum is similar to that required of Ph.D. students, with less emphasis on research and more on clinical training. The Ph.D. approach is based on a scientist-practitioner model, while the Psy.D. approach is based on a scholar-practitioner model, which is described below. Note that a survey of clinical psychology students in Ph.D. programs in Canada found that most students enrolled in current programs were satisfied with their level of science training, and as was the case in the United States, students felt that the training received was slightly more weighted toward research than toward clinical practice (Peluso, Carleton, & Asmundson, 2010).

The Canadian Psychological Association (CPA) Psy.D. Task Force (1998) described a scholar-practitioner as a "flexible, socially responsible, thinking practitioner who derives his/her skills from core knowledge in scientific psychology. This comprehensively trained professional is capable of performing in a number of roles, and would not be trained simply to be a technician in specific areas" (p. 13). As of 2007 there were two Psy.D. programs in Canada, at the Université du Quebec and Université Laval, both offered in French. Later, Memorial University initiated a Psy.D. program in 2009 and in 2013, a Psy.D. program was introduced in Vancouver at a campus of the Adler School of Professional Psychology.

According to the CPA, psychologists are Canada's single largest group of licensed and specialized mental health care providers. Further, psychologists are the primary researchers and providers of evidence-based psychological treatments.

A **psychiatrist** holds an MD degree and has had postgraduate training, called a residency, in which he or she has received supervision in the practice of diagnosis and psychotherapy. By virtue of the medical degree, and in contrast with psychologists, psychiatrists can also continue functioning as physicians—giving physical examinations, diagnosing medical problems, and the like. Most often, however, the primary aspect of medical practice in which psychiatrists engage is prescribing **psychoactive drugs**, chemical compounds that can influence how people feel and think. Nonetheless, a study (Hadjipavlou & Ogrodniczuk, 2007) concluded that current psychiatry residents in Canada have a strong interest in psychotherapy training.

A **psychoanalyst** has received specialized training at a psychoanalytic institute. The program usually involves several years of clinical training as well as the in-depth psychoanalysis of the trainee. It can take up to 10 years of graduate work to become a psychoanalyst and there are proportionally fewer psychoanalysts in modern times.

A **social worker** obtains an M.S.W. (master of social work) degree. Programs for **counselling psychologists** are somewhat similar to graduate training in clinical psychology but usually have less emphasis on research and the more severe forms of psychopathology. How does counselling psychology differ from clinical psychology in Canada? First, they differ in number. A survey reported in 2012 compared 22 accredited clinical psychology programs and 4 counselling psychology programs in Canada (see Bedi, Klubben, & Barker, 2012). While there are many similarities, there also key differences. Another key difference is that counselling programs tend to be terminal, meaning that students earn a master's degree and there is no doctoral progress that follows. Also, clinical psychology programs tend to have a large proportion of their faculty members registered as clinical psychologists (see Bedi et al., 2012).

social workers also work in the mental health field. Goering et al. (2000) also noted that, "The major proportion of primary mental health care in Canada is delivered by general practitioners (GPs)" (p. 350). Psychiatrists (who are medical doctors) have a great deal of clinical autonomy. The majority are self-employed professionals whose clinical income is usually based on billing their provincial health plan. As noted by Latimer (2005), "Psychiatrists are essentially free to choose the patient population they wish to care for, and how" (p. 566).

Analyses of the results of the National Population Health Survey (NPHS; Statistics Canada, 1995) indicated that approximately 2% of respondents had consulted with a psychologist one or more times in the preceding 12 months (Hunsley, Lee, & Aubry, 1999)—equivalent to almost 515,000 people in the Canadian population aged 12 and older. Hunsley and colleagues concluded, however, that psychological services are vastly underused. They also determined that psychological services are more available in urban areas than in rural areas and that psychiatrists tend to practise in major urban centres. Thus, many areas of Canada are underserved by two important mental health professions.

There has been a lively and sometimes acrimonious debate concerning the merits of allowing clinical psychologists with suitable training to prescribe psychoactive drugs (see Westra, Eastwood, Bouffard, & Gerritsen, 2006). Predictably, granting **prescriptive authority** to psychologists is opposed by psychiatrists for various reasons (see McGrath, 2010). It is also opposed by many psychologists, who view it as an ill-advised dilution of the behavioural science focus of psychology. Is it possible for a non-MD to learn enough about biochemistry and physiology to monitor the effects of drugs and protect clients from adverse side effects and drug interactions? This debate will undoubtedly continue for some time; at present, prescriptive authority has been granted to psychologists in three U.S. jurisdictions (New Mexico, Louisiana, and the U.S. territory of Guam) (see McGrath, 2010).

1.2 History of Psychopathology

> *"Those who cannot remember the past are condemned to repeat it."*
>
> —*George Santayana,* The Life of Reason

The search for the causes of deviant behaviour has gone on for a long time. Before the age of scientific inquiry, all good and bad manifestations of power beyond the control of humankind—eclipses, earthquakes, storms, fire, serious and disabling diseases, the passing of the seasons—were regarded as supernatural. Behaviour seemingly outside individual control was subject to similar interpretation. Many early philosophers, theologians, and physicians who studied the troubled mind believed that deviancy reflected the displeasure of the gods or possession by demons.

Early Demonology

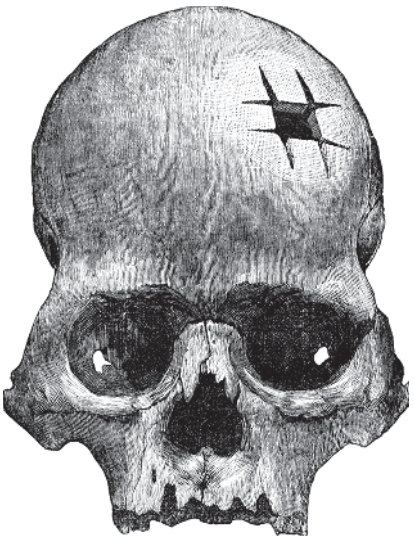
The doctrine that an evil being, such as the devil, may dwell within a person and control his or her mind and body is called **demonology**. Examples of demonological thinking are found in the records of the early Chinese, Egyptians, Babylonians, and Greeks. Among the Hebrews, deviancy was attributed to possession of the person by bad spirits, after God in his wrath had withdrawn protection. Christ is reported to have cured a man with an unclean spirit by casting out the devils from within him and hurling them into a herd of swine (Mark 5:8–13).

Following from the belief that abnormal behaviour was caused by possession, its treatment often involved **exorcism**, the casting out of evil spirits by ritualistic chanting or torture. Exorcism typically took the form of elaborate rites of prayer, noisemaking, forcing the afflicted to drink terrible-tasting brews, and on occasion more extreme measures, such as flogging and starvation, to render the body uninhabitable to devils.

Trepanning of skulls (the making of a surgical opening in a living skull by some instrument) by Stone Age or neolithic cave dwellers was quite widespread. One popular theory is that it was a way of treating conditions such as epilepsy, headaches, and psychological disorders attributed to demons within the cranium. It was presumed that the individual would return to a normal state by creating an opening through which evil spirits could escape. Trepanning was presumably introduced into the Americas from Siberia. Although the practice was most common in Peru and Bolivia, three Aboriginal specimens have been found in Canada, all on the Pacific coast in British Columbia (see illustration). One skull is that of a young male believed to be of high rank, since he received a "copper burial" (his forehead and chest were covered by thin sheets of copper). Despite the extensive focus in Aboriginal cultures on possession by spirits, the widely accepted interpretation of the historical data has been disputed. Kidd (1946) suggested that the trepannings "were done to relieve pressure resulting from depressed fractures caused by war clubs" (p. 515).

Somatogenesis

In the fifth century B.C., Hippocrates (ca. 460–377 B.C.), often regarded as the father of modern medicine, separated medicine from religion, magic, and superstition. He rejected the prevailing Greek belief that the gods sent serious physical diseases and mental disturbances as punishment and insisted instead that such illnesses had natural causes and hence should be treated like other, more common maladies, such as colds and constipation. Hippocrates regarded the brain as the organ of consciousness, of intellectual life and emotion; thus, he thought that deviant thinking and behaviour were indications of some kind of brain pathology. Hippocrates is often considered one of the very earliest proponents of **somatogenesis**—the notion that something wrong with the soma, or physical body, disturbs thought and action (see photo). **Psychogenesis**, in contrast, is the belief that a disturbance has psychological origins.



The Auger Photo Archive

Was trepanning by the Aboriginals of British Columbia performed to allow evil spirits to escape the body?

Jeremy Horner/Corbis/VCG/Getty Images

The Greek physician Hippocrates held a somatogenic view of abnormal behaviour, considering psychopathology a disease of the brain.

Hippocrates classified mental disorders into three categories: mania, melancholia, and phrenitis (or brain fever). Through his teachings, the phenomena of abnormal behaviour became more clearly the province of physicians than of priests.

Hippocrates's physiology was rather crude, however, for he conceived of normal brain functioning, and therefore of mental health, as dependent on a delicate balance among four humours, or fluids, of the body: blood, black bile, yellow bile, and phlegm. An imbalance produced disorders and an associated temperament or personality style. If a person was sluggish and dull, for example, the body supposedly contained a preponderance of phlegm and a phlegmatic temperament. A preponderance of black bile was the explanation for melancholia; too much yellow bile explained irritability and anxiousness; and too much blood, changeable temperament.

Hippocrates's humoral physiology did not withstand later scientific scrutiny. However, his basic premise—that human behaviour is markedly affected by bodily structures or substances and that abnormal behaviour is produced by some kind of physical imbalance or even damage—did foreshadow aspects of contemporary thought.

The Dark Ages and Demonology

Historians have often suggested that the death of Galen (130–200 A.D.), the second-century Greek who is regarded as the last major physician of the classical era, marked the beginning of the Dark Ages for Western European medicine and for the treatment and investigation of abnormal behaviour. Over several centuries of decay, Greek and Roman civilization ceased to exist. The churches gained in influence, and the papacy was declared independent of the state. Christian monasteries, through their missionary and educational work, replaced physicians as healers and as authorities on mental disorder. The monks cared for and nursed the sick. A few monasteries were repositories for the classic Greek medical manuscripts, even though the monks may not have made use of the knowledge within these works. When monks cared for the mentally disordered, they prayed over them and touched them with relics or they concocted fantastic potions for them to drink in the waning phase of the moon. The families of the deranged might take them to shrines. Many of the mentally ill roamed the countryside, becoming more and more disturbed.

The Persecution of Witches

During the thirteenth and the following few centuries, a populace that was already suffering from social unrest and recurrent famines and plagues again turned to demonology to explain these disasters. People in Europe became obsessed with the devil. Witchcraft, viewed as instigated by Satan, was seen as a heresy and a denial of God. Faced with inexplicable and frightening occurrences, people tended to seize on whatever explanation was available. The times conspired to heap enormous blame on those regarded as witches, and these unfortunates were persecuted with great zeal.

In 1484 Pope Innocent VIII exhorted the clergy of Europe to leave no stone unturned in the search for witches. He sent two Dominican monks to northern Germany as inquisitors. Two years later they issued a comprehensive and explicit manual, *Malleus Maleficarum* ("the witches' hammer"), to guide the witch hunts. This legal and theological document came to be regarded by Catholics and Protestants alike as a textbook on witchcraft. Those accused of witchcraft were to be tortured if they did not confess (see artwork); those convicted and penitent were to be imprisoned for life; and those convicted and

Illumination from a 15th-century manuscript showing Christ exorcising a demon from a possessed youth.

unrepentant were to be handed over to the law for execution. The manual specified that a person's loss of reason was a symptom of demonic possession and that burning was the usual method of driving out the supposed demon. Although records of the period are not reliable, it is thought that over the next several centuries, hundreds of thousands of women, men, and children were accused, tortured, and put to death.

Witchcraft and Mental Illness The prevailing interpretation for some time in the later Middle Ages was that the mentally ill were generally considered witches (Zilboorg & Henry, 1941). Detailed examination of this historical period, however, indicates that many of the accused were not mentally ill. Careful analyses of the witch hunts reveal that many more sane than insane people were tried. The delusion-like confessions were typically obtained during brutal torture; words were put on the tongues of the tortured by their accusers and by the beliefs of the times. Indeed, in England, where torture was not allowed, the confessions did not usually contain descriptions indicative of delusions or hallucinations (Schoeneman, 1977).

In the dunking test, if the woman did not drown, she was thought to be in league with the devil, the ultimate no-win situation.

Other information, moreover, indicates that witchcraft was not the primary interpretation of mental illness. From the thirteenth century on, as the cities of Europe grew larger, hospitals began to come under secular jurisdiction. Municipal authorities, gaining in power, tended to supplement or take over some of the activities of the church, one of these being the care of the ill. English laws during this period allowed both the dangerously insane and the incompetent to be confined in a hospital. Notably, the people who were confined were not described as being possessed (Allderidge, 1979).

Beginning in the thirteenth century, "lunacy" trials to determine a person's sanity were held in England. The trials were conducted under the Crown's right to protect the mentally impaired, and a judgement of insanity allowed the Crown to become guardian of the lunatic's estate (Neugebauer, 1979). The defendant's orientation, memory, intellect, daily life, and habits were at issue in the trial. Strange behaviour was typically linked to physical illness or injury or to some emotional shock. In all the cases that Neugebauer examined, only one referred to demonological possession. The preponderance of evidence thus indicates that this explanation of mental disturbance was not as dominant during the Middle Ages as was once thought.

While our focus is on what took place centuries ago, it is important to realize that there are some places in the world where this practice continues today. For instance, northern Ghana has six witch camps over 100 years old that hold 800 women. These camps were finally slated to close in 2012. Ghana has acknowledged the need for greater public education, in part due to incidents such as what took place in 2010 when Madam AmaHemmah, a 78-year-old woman, was accused of being a witch and was burned alive (see Dixon, 2012).

Development of Asylums

Until the end of the Crusades in the fifteenth century, there were very few mental hospitals in Europe, although there were thousands of hospitals for lepers. In the twelfth century, England and Scotland had 220 leprosy hospitals for a population of 1.5 million. After the principal Crusades had been waged,

Charles Phelps Cushing/ClassicStock/Getty Images

A tour of St. Mary of Bethlehem (Bedlam) provides amusement for two upper-class women in Hogarth's 18th-century painting.

leprosy gradually disappeared from Europe, probably because with the end of the wars came a break with the eastern sources of the infection. With leprosy no longer of such great social concern, attention seems to have turned to the mad.

Confinement of the mentally ill began in earnest in the fifteenth and sixteenth centuries. Leprosariums were converted to **asylums**, refuges established for the confinement and care of the mentally ill. Many of these asylums took in a mixed lot of disturbed people and beggars. Beggars were regarded as a great social problem at the time; in sixteenth-century Paris the population of fewer than 100,000 included 30,000 beggars (Foucault, 1965). These asylums had no specific regimen for their inmates other than to get them to work, but during the same period, hospitals geared more specifically for the confinement of the mentally ill also emerged.

Bethlehem and Other Early Asylums

The Priory of St. Mary of Bethlehem was founded in 1243. In 1547 Henry VIII handed it over to the City of London, thereafter to be a hospital devoted solely to the confinement of the mentally ill. The conditions in Bethlehem were deplorable. Over the years the word **bedlam**, a contraction and popular name for this hospital, became a descriptive term for a place or scene of wild uproar and confusion. Bethlehem eventually became one of London's great tourist attractions, by the eighteenth century rivalling both Westminster Abbey and the Tower of London. Even as late as the nineteenth century, viewing the violent patients and their antics was considered entertainment, and tickets of admission to Bedlam were sold (see artwork). Similarly, in the Lunatics' Tower constructed in Vienna in 1784, patients were confined in the spaces between inner square rooms and the outer walls, where they could be viewed by passersby.

It should not be assumed that the inclusion of abnormal behaviour within the domain of hospitals and medicine necessarily led to more humane and effective treatment. Medical treatments were often crude and painful. Benjamin Rush (1745–1813), who began practising medicine in Philadelphia in 1769, is considered the father of American psychiatry. He believed that mental disorder was caused by an excess of blood in the brain. Consequently, his favoured treatment was to draw great quantities of blood (Farina, 1976)! Further, he believed that many "lunatics" could be cured by being frightened. A New England doctor of the nineteenth century implemented this prescription in an ingenious manner: "On his premises stood a tank of water, into which a patient, packed into a coffin-like box pierced with holes, was lowered. He was kept under water until the bubbles of air ceased to rise, after which he was taken out, rubbed, and revived—if he had not already passed beyond reviving!" (Deutsch, 1949, p. 82).

Moral Treatment

Philippe Pinel (1745–1826) is considered a primary figure in the movement for humanitarian treatment of the mentally ill in asylums. According to Cohen, Patel, and Minas (2014), it was in 1838 that France created a state-run asylum system. But individual asylums existed before then, and in 1793, while the French Revolution raged, Pinel was put in charge of a large asylum in Paris known as La Bicetre (see artwork). It has long been asserted that Pinel removed the chains of the people imprisoned there. Although Pinel actually adopted the practice, it appears that it was a former patient orderly, Jean-Baptiste Pussin, who first removed the chains (Weiner, 1994). Pinel also began to treat the patients as sick human beings rather than as beasts. Many who had been completely unmanageable became calm and much easier to handle. They strolled through the hospital and grounds with no inclination to create disturbances or harm anyone. Light and airy rooms replaced dungeons. Some patients who had been incarcerated for years were eventually discharged.

Pinel also believed that the patients in his care were essentially normal people who should be approached with compassion and understanding, and treated with dignity as individual human beings. According to Charland (2010), a scholar from the University of Western Ontario, Pinel was a pioneer in promoting a view of mental illness as affective disorder and a form of mental alienation. Psychopathology stems from "affections moral" or passions. Specific passions include anger, hate, wounded pride, seeking vengeance, disgust with life, and irresistible tendencies toward suicide.

Pinel also surmised that if patients' reason had left them because of severe personal and social problems and the presence of these passions, it might be restored to them through comforting counsel and purposeful activity. However, for all the good Pinel did for people with mental illness, he was not a complete paragon of enlightenment and egalitarianism. The more humanitarian treatment he reserved for the upper classes; patients of the lower classes were still subjected to terror and coercion as a means of control.

In the wake of Pinel's revolutionary work in La Bicetre, the hospitals established in Europe and the United States were for a time relatively small and privately supported. A prominent merchant and Quaker, William Tuke (1732–1822), shocked by the conditions at York Asylum in England, proposed to the Society of Friends that it found its own institution. In 1796 the York Retreat was established on a country estate, providing

mentally ill people with a quiet and religious atmosphere in which to live, work, and rest. Patients discussed their difficulties with attendants, worked in the garden, and took walks through the countryside. Charland (2007) described the moral treatment offered at the York Retreat as a form of affective conditioning informed by "benevolent theory" steeped in religious ethics.

In the United States the Friends' Asylum, founded in 1817 in Pennsylvania, and the Hartford Retreat, established in 1824 in Connecticut, were patterned after the York Retreat. Other U.S. hospitals were influenced by the sympathetic and attentive treatment provided by Pinel and Tuke. In accordance with this approach, which became known as **moral treatment**, patients had close contact with the attendants, who talked and read to them and encouraged them to engage in purposeful activity; residents led as normal lives as possible and in general took responsibility for themselves within the constraints of their disorders. According to Charland (2007), Pinel believed that a central aspect of moral treatment was restoring a patient's sense of self-esteem by letting her or him demonstrate self-restraint.

Despite the emphasis on moral treatment in the early nineteenth century, drugs were also used frequently in mental hospitals. Two findings emerged from a review of detailed case records of the York Retreat from 1880 to 1884 (Renvoise & Beveridge, 1989). First, drugs were the most common treatment and included alcohol, cannabis, opium, and chloral hydrate (knockout drops). Second, the outcomes were not very favourable; fewer than one-third of the patients were discharged as improved or recovered.

Moral treatment was abandoned in the latter part of the nineteenth century. Ironically, the efforts of Dorothea Dix (1802–77), a crusader for improved conditions for people with mental illness, helped effect this change (see illustration). Dix, a Boston schoolteacher, taught a Sunday-school class at the local prison and was shocked at the deplorable conditions in which the inmates lived. Her interest spread to the conditions of patients in private mental hospitals and to the mentally ill people of the time who had nowhere to go for treatment. Dix campaigned vigorously to improve the lot of people with mental illness; she personally helped see that 32 state hospitals were built to take in the many patients whom the private ones could not accommodate. Unfortunately, state hospital staff members were unable to provide the individual attention that was a hallmark of moral treatment (Bockhoven, 1963). Moreover, the hospitals came to be administered by physicians who were interested in the biological aspects of illness and in the physical, rather than the psychological, well-being of mental patients. The money that once paid the salaries of personal attendants now paid for equipment and laboratories. Nonetheless, on March 2, 2009, as part of National Women's History Month and its 100th anniversary celebration, Mental Health America honoured the significant contributions of Dorothea Dix to the field.

Encyclopaedia Britannica/UIG/Getty Images

In the 19th century, Dorothea Dix was a tireless social reformer who lobbied for improvement of the deplorable treatment of mentally ill people.

Historical Picture Services/Stock Montage

Pinel's freeing of the patients at La Bicetre is often considered to mark the beginning of more humanitarian treatment of people with mental illness.

For a limited time, there were attempts to apply moral treatment in certain regions of Canada, but these were undermined by the political and economic decisions of those in power. LaJeunesse (2002) documented how attempts at moral treatment in Alberta in the early twentieth century were undercut by Premier Arthur Sifton's decision to focus on larger institutions, where patients were crowded into buildings with inadequate space. Dr. Henry Hunt Stabb made heroic efforts to institute moral treatment and non-restraint at the Lunatic Asylum in St. John's, Newfoundland (see O' Brien, 1989). He presided at this site until his death in 1892, but his efforts were hindered by inadequate financial resources and more patients than the hospital could reasonably accommodate. Also, beginning in the late 1870s, the hospital often played a custodial role, as Stabb was made to take in low-functioning patients deemed untreatable.

Asylums in Canada

> *"This, you must remember, that patients here within, Are here, because we all were born into a world of sin. . . . Now come inside the building, and enter into the halls, You will see many patients, whose sorrows for pity calls. But pay no attention, to what might be said of you, Some of them had fine intellects 'fore trouble their minds o'erthrew. . . ."*
>
> *—Graeme L., 1907, patient at the Toronto Hospital for the Insane (Rheaume, 2000)*

A network of asylums was eventually established in Canada. According to Cohen et al. (2014), mentally ill people were admitted to hospital in Quebec as early as 1714, but psychiatric asylums emerged in the decades following 1840, and eventually there was a network of asylums. The history of the development of this network is a history of the institutionalization of people with serious psychological disorders. However, as pointed out by Sussman (1998), the process "began with humane intentions as part of a progressive and reformist movement, which attempted to overcome neglect and suffering in the community, jails, penitentiaries, almshouses, poorhouses, and hospitals" (p. 260). Dorothea Dix described poignant and shameful examples of this neglectful community care and human suffering in her eloquent 1850 memorial prayer to the Nova Scotia Legislative Assembly (see Canadian Perspectives 1.1).

Canadian Perspectives 1.1

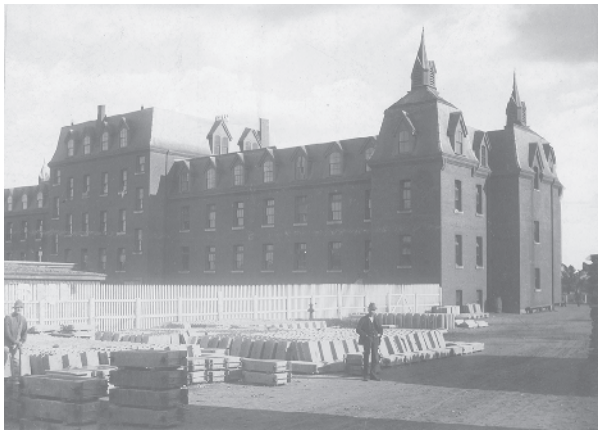
Dorothea Dix and the Development of the Asylums in Canada: Light into the Darkness?

> *"One lost mind whose star is quenched Has lessons for mankind."*
>
> *—Dorothea Dix, 1850 (Hurd, 1916, Volume I, p. 492)*

When Dorothea Dix visited "the Canadas" in 1843 and 1844, she discovered appalling conditions suffered by the "insane" incarcerated in the Toronto jail and the Quebec Lunatic Asylum (Hurd, 1916, Volume I).

On January 21, 1850, Dix presented a compelling "memorial prayer" on behalf of the mentally ill to the Nova Scotia legislature and requested construction of a public mental hospital (see photo). She stated that "[t]hroughout the province, in short, I found cases incurable through long neglect, doomed to a life-long burden to themselves through suffering, and a life-long charge either upon their friends or the public for care and maintenance" (Hurd, 1916, Volume I, p. 485). Dix also discussed moral treatment and the consequences of failure to obtain help at an early point. Her emphasis on early detection and treatment over 150 years ago is consistent with current views (e.g., see the discussion of early risk detection and intervention for schizophrenia in Chapter 11). Dix appealed to the members to consider what it was like to be mentally ill in Canada:

> *"In imagination, for a short hour, place yourselves in their stead; enter the horrid, noisome cell, invest yourselves with the foul, tattered garments which scantily serve the purposes of decent protection; cast yourselves upon the loathsome pile of filthy straw; find companionship in your own cries and groans, . . . then, if self-possession is not overwhelmed under the imaginary miseries of what are the actual distresses of the insane, return to the consciousness of your sound intellectual health, and answer if you will longer refuse or delay to make adequate appropriations for the establishment of a provincial hospital for those who are deprived of reason, and thereby of all that gladdens life or makes existence a blessing."*
>
> *(Hurd, 1916, Volume I, p. 493)*



NSA, J.M. Margeson, photographer – the Halifax Poor Asylum, 1899

The Halifax Poor House being rebuilt in 1899 following a fire in 1882.

This appears to be Dorothea Dix's only *public* appeal to a Canadian province. She did take an active role in selecting the site for the Nova Scotia hospital and helped Henry Hunt Stabb raise funds for the St. John's, Newfoundland, asylum (see O'Brien, 1989).

Thinking Critically

1. Imagine yourself back in 1850 Nova Scotia. You're suffering with a major psychiatric disorder such as schizophrenia, living under conditions similar to those described by Dorothea Dix. What would it be like for you? What could realistically be done to help you?
2. Given the establishment of a public "asylum," what model of care would you propose? How should the "inmates" be "treated"?
3. Assuming that people in the community treated you with humanity and compassion, cared for you, and supported you, do you think that it would be possible for you to live among them?

Around this time, J. F. Lehman (1840) wrote the first textbook published in Canada with a focus on the care and control of mentally ill people. Unfortunately, Lehman recommended stringent discipline and harsh treatments, including flogging. Although his views failed to stimulate much popular or medical support, as we will see, many strategies employed in Canada during the twentieth century were just as harsh and a few were much more severe and had tragic consequences.

Sussman (1998) argued that the development of services for the mentally ill in Canada and British North America was largely ad hoc, with little cross-fertilization of ideas from province to province. During the 1840s through to the 1880s, when most of the formal asylums were first established, all of the jurisdictions could be characterized as having a need to develop separate facilities with better conditions for the mentally ill. As noted by Sussman (1998), "This segregated form of care, the psychiatric institution known as the asylum, was the very beginning of state provisions for mentally ill people in a vast and sparsely populated country" (p. 261).

The earliest precursor to the nineteenth-century asylums was the Hotel-Dieu, established in Quebec City in 1714 by the Duchess d'Aiguillon, niece of Cardinal Richelieu, the effective ruler of New France. The facility cared for indigents and crippled people in addition to "idiots." Similar "hospitals" were built in other parts of Quebec, using a contracting-out system whereby the King of France paid religious orders of the French Roman Catholic Church to care for the mentally ill. However, following the 1763 Treaty of Paris, the English assumed power over the area and the British influence on care practices prevailed.

Asylums in Canada were built during the institution-building period prior to the First World War. Alberta was the last province to open an asylum for the insane, which meant that mentally ill people no longer had to be transported from Alberta to Manitoba by the Royal North West Mounted Police. Typically, asylum superintendents were British-trained physicians who modelled the asylums after British forms of structure, treatment, and administration, although Bartlett (2000), in a comparative analysis of structures in Ontario and England, concluded that they functioned differently and reflected very different norms of social governance.

In Upper Canada, power rested with the asylum doctor. A few years before Confederation, the Annual Report of the Board of Inspectors of Asylums, Prisons, & c., for the Year 1864 (1865) included a memorandum "on the necessity of providing additional accommodation for lunatics in Upper and Lower Canada" (p. iii). The inspectors gave a glowing report on behalf of the medical superintendent of the Provincial Lunatic Asylum in Toronto, the principal asylum in Upper Canada. However, the superintendent reported that both the Chief Asylum and the University Branch (a smaller asylum near the University of Toronto) were "dangerously overcrowded" and lamented the fact that this overcrowding was responsible for a striking increase in the death list (composed mostly of females) and for the impaired general health of the inmates. The average cost of caring for each patient to the province in 1864 was $152.88! Over the years since the asylum was opened in 1841, the superintendent calculated the discharge rate to be 52%. Almost 20% of the inmates died while in the institution, a large number due to "general paresis of the insane" and to a condition called "phthisis."

Concerns exist today that Canada has developed a two-tier medical system in which the wealthy have more opportunity for, and quick access to, superior quality care (e.g., Adams & Laghi, 2000). Such a system had the force of law in the era of institution building, at least in Upper Canada (present-day Ontario). In 1853 the legislature passed the Private Lunatic Asylums Act to accommodate the wealthy in alternatives to the public asylums. As a consequence of the preferential legislation, the Homewood Retreat, a profit-oriented, independent, private asylum, was established in 1883 at Guelph, Ontario. Dr. Lett, the first medical superintendent, believed in the humane care of patients. Despite his resistance to the "cult of curability" ascribed to by practitioners of moral therapy, he encouraged his staff to employ the principles of moral therapy in order to provide symptomatic relief to his wealthy charges (Warsh, 1989).

The history of the development of institutions for the mentally disordered in Canada can be characterized in terms of two distinctive trends: (1) with the advent of the asylums, provisions for the mentally ill were separate from provisions for the physically ill, indigents, and criminals; and (2) the process was segregated from the wider community—"The institution and the community were two separate and distinct solitudes" (Sussman, 1998, p. 262).

Canadian Perspectives 1.2 examines mental institutions in Canada in the latter part of the twentieth century versus mental health services at present.

The Beginning of Contemporary Thought

Recall that in the West, the death of Galen and the decline of Greco-Roman civilization temporarily ended inquiries into the nature of both physical and mental illness. Not until the late Middle Ages did any new facts begin to appear, discovered thanks to an emerging empirical approach to medical science that gathered knowledge by direct observation. One development that fostered progress was the discovery by the Flemish anatomist and physician Vesalius (1514–64) that Galen's presentation of human anatomy was incorrect. Galen had presumed that human physiology mirrored that of the apes he studied. It took more than a thousand years for autopsy studies of humans—not allowed during Galen's time—to begin to prove that he was wrong. Further progress came from the efforts of the English physician Thomas Sydenham (1624–89). He was particularly successful in advocating an empirical approach to classification and diagnosis, one that subsequently influenced those interested in mental disorders.

Canadian Perspectives 1.2

The Mental Hospital in Canada: The Twentieth Century Versus Today

Despite the humane motives that stimulated the institution-building period in Canada, the results during much of the twentieth century were not very positive, especially from a patient's perspective. Provincial mental hospitals became extremely overcrowded, and in too many instances individual treatment was unavailable, with the exception of some radical treatments (such as lobotomy) and whatever psychoactive drugs were available in different eras. Drugs became the central means of treatment, especially after the introduction of the antipsychotic phenothiazines in the 1950s. As Sussman (1998) noted, "Eventually, institutionalization in Canada became a synonym for an inhumane response to mentally ill people, often because of a scarcity of resources" (p. 262).

Provinces varied in their responsiveness to mental illness. Mills (1997) applauded the province of Saskatchewan for being highly progressive and having a number of Canadian "firsts." Most notably, with changes implemented under the leadership of Premier Tommy Douglas, Saskatchewan was the first province to use more humane treatment and it implemented Canada's first provincially funded psychiatric research program in the 1950s. Overcrowded conditions were also found there but steps were taken to improve institutional environments. Saskatchewan is also where the initial research took place on attitudes toward mentally ill people. This research sought to learn how people would respond to the deinstitutionalization of patients placed in the community (see Cumming & Cumming, 1957).

According to Sealy (2012), the process of deinstitutionalization has been going on for more than 40 years in Canada. The goal of deinstitutionalization is to shift care from psychiatric hospitals into the community. The process of rapid deinstitutionalization occurred in five provinces (Alberta, British Columbia, Ontario, Nova Scotia, and Saskatchewan). Dramatic reductions in places for psychiatric patients took place when this change in policy was first implemented. According to Wasylenki, Goering, and MacNaughton (1994), the capacity of Canadian mental hospitals went from about 50,000 beds to about 15,000 beds between 1960 and 1976. At the same time, beds in general hospital psychiatric units increased from fewer than 1,000 to almost 6,000. Budget cuts in the 1980s and 1990s caused the trend of deinstitutionalization to continue. However, the enthusiasm for deinstitutionalization was tempered by evidence that many discharged people led lives of poverty in the community, with a significant number included among the homeless and the prison population.

A process of **transinstitutionalization** has also taken place. That is, while the number of beds has declined in various institutions, a shift has occurred and more care is now provided in psychiatric units of general hospitals rather than in psychiatric hospitals. Sealy (2012) reported that across Canada, the average days of care provided in psychiatric hospitals went from 418 days per 1,000 Canadians in 1994–95 to 215 days in 1998–99 and 99 days in 2002–03. Meanwhile, the average days of care in psychiatric units in general hospitals went from 176 days per 1,000 people in the population in 1994–95 to 127 days in 1998–99 and 118 days in 2002–03. The amount of care provided over this time frame decreased by an estimated 77% in psychiatric hospitals versus about 34% in hospital units.

Photo by R. Essex. Courtesy of Archives of the Centre for Addiction and Mental Health (CAMH), Toronto.

East Wing of the 1868 addition to the Provincial Asylum in Toronto (opened 1850), as seen in 1971.

A somewhat specialized mental hospital, sometimes called a prison or forensic hospital, is reserved for people who have been arrested and judged unable to stand trial and for those who have been acquitted of a crime because they are "not criminally responsible on account of mental disorder." Although these patients have not been sent to prison, their lives are controlled by guards and tight security. Treatment of some kind is supposed to take place during their incarceration. In Canada there are three maximum-security forensic hospitals, in Ontario, Quebec, and British Columbia. Also, in Ontario, forensic services are provided through small, medium-security regional forensic units based in the provincial psychiatric hospitals (e.g., METFORS—Metropolitan Toronto Forensic Service).

A recent assessment of the forensic mental health hospital in British Columbia indicated that substantial improvements have taken place over the years. This study found that both the patients and service providers held favourable views of the social climate in the hospital (see Livingston, Nijdam-Jones, & Brink, 2012). Overall, the study concluded that forensic mental health hospitals are not necessarily inhospitable environments for patient-centred care. There are issues, however, involving safety; some staff members in the Livingston et al. (2012) study expressed concerns about their own well-being. Similar concerns have been expressed by workers elsewhere. For instance, in Hamilton, Ontario, workers demanded safer conditions in May 2012 after one mental health patient used his bare hands to beat another patient to death. Here it is important to not make the inferential leap that most mental patients are violent or potentially violent; in fact, as we see later in this chapter, just the opposite is true.

At present, the role of the remaining **provincial psychiatric hospitals** is "tertiary"; that is, they "provide specialized treatment and rehabilitation services for individuals whose needs for care are too complex to be managed in the community" (Goering et al., 2000, p. 349). As provincial governments continue to develop portable and community-based tertiary care and "delink" delivery from particular settings (Goering et al., 2000), the provincial psychiatric hospitals' role will be increasingly minimized.

The trend toward community care has fuelled a debate on the value of **community treatment orders** (CTOs), a legal tool issued by a medical practitioner that establishes the conditions under which a mentally ill person may live in the community, including requirements for compliance with treatment (O'Reilly, 2004). The consequence for a patient of failing to follow the CTO is being returned to a psychiatric facility for assessment. We examine this emotionally charged, contentious issue in detail in Chapter 18.

One thing is certain. The "asylums" as we have known them over the past 150 years are a thing of the past as the trend toward societal integration continues.

Thinking Critically

1. Current institutions such as the Centre for Addiction and Mental Health (CAMH) in Toronto refer to people with psychological problems or psychiatric disorders—historically and traditionally called "patients"—as "clients." This term has also been used commonly in the past by many practising psychologists, particularly by those who adopt a less biological, medically oriented approach. The authors of this textbook also prefer the term "client" and will use it throughout the remainder of the book whenever appropriate. Do you agree with this decision? Why or why not?
2. How should chronic patients (now referred to as clients) be managed and treated so that their dignity is respected but society is protected?
3. In 1988 the federal government published *Mental Health for Canadians: Striking a Balance* (Epp, 1988). It claimed that closure of psychiatric hospitals was not offset by "strengthening community resources" and that psychiatric patients (clients) "face a life of deprivation, danger and neglect." Is there still a huge gap between deinstitutionalization, outpatient care, and community care? If so, how would you close it? Does society have a responsibility for the treatment of the vulnerable mentally ill?

An Early System of Classification

One of those impressed by Sydenham's approach was the German physician Wilhelm Griesinger, who insisted that any diagnosis of mental disorder specify a biological cause—a clear return to the somatogenic views first espoused by Hippocrates. A textbook of psychiatry, written by Griesinger's well-known follower Emil Kraepelin (1856–1926) and first published in 1883, furnished a classification system in order to establish the biological nature of mental illnesses.

Kraepelin discerned among mental disorders a tendency for a certain group of symptoms, called a **syndrome**, to appear together regularly enough to be regarded as having an underlying physical cause, much as a particular medical disease and its syndrome may be attributed to a biological dysfunction. He regarded each mental illness as distinct from all others, having its own genesis, symptoms, course, and outcome. Even though cures had not been worked out, at least the course of the disease could be predicted.

Kraepelin proposed two major groups of severe mental diseases: dementia praecox, an early term for schizophrenia, and manic-depressive psychosis (now called bipolar disorder). He postulated a chemical imbalance as the cause of schizophrenia and an irregularity in metabolism as the explanation of manic-depressive psychosis. Kraepelin's scheme for classifying these and other mental illnesses became the basis for the present diagnostic categories, described in Chapter 3.

General Paresis and Syphilis

Although the workings of the nervous system were understood somewhat by the mid-1800s, not enough was known to reveal all the expected abnormalities in structure that might underlie various mental disorders. Degenerative changes in the brain cells associated with senile and presenile psychoses and some structural pathologies that accompany mental retardation were identified, however. Perhaps the most striking medical success was the discovery of the full nature and origin of syphilis, a venereal disease that had been recognized for several centuries.

The story of this discovery provides a wonderful picture of the empirical approach, the basis for contemporary science. Since 1798 it was known that a number of mental patients manifested a syndrome characterized by a steady deterioration of both physical and mental abilities and that these patients suffered multiple impairments, including delusions of grandeur and progressive paralysis. Soon after these symptoms were recognized, it was observed that these patients never recovered. In 1825 this deterioration in mental and physical health was designated a disease, **general paresis**. Although it was established in 1857 that some patients with paresis had earlier had syphilis, there were many competing theories for the origin of paresis. For example, in attempting to account for the high rate of the disorder among sailors, some supposed that seawater might be the cause. And Griesinger, in trying to explain the higher incidence among men, speculated that liquor, tobacco, and coffee might be implicated.

In the 1860s and 1870s, Louis Pasteur established the **germ theory of disease**, which set forth the view that disease is caused by infection of the body by minute organisms. This theory laid the groundwork for demonstrating the relation between syphilis and general paresis. In 1905, the specific micro-organism that causes syphilis was discovered. A causal link had been established between infection, destruction of certain areas of the brain, and a form of psychopathology. If one type of psychopathology had a biological cause, so could others. Somatogenesis gained credibility, and the search for more biological causes was off and running.

Psychogenesis

The search for somatogenic causes dominated the field of abnormal psychology until well into the twentieth century, no doubt partly because of the stunning discoveries made about general paresis. But in the late eighteenth

and throughout the nineteenth century, some investigators considered mental illnesses to have an entirely different origin. Various psychogenic points of view, which attributed mental disorders to psychological malfunctions, were fashionable in France and Austria.

Mesmer and Charcot Many people in Western Europe were at that time subject to hysterical states; they suffered from physical incapacities, such as blindness or paralysis, for which no physical cause could be found. Franz Anton Mesmer (1734–1815), an Austrian physician practising in Vienna and Paris in the late eighteenth century, believed that hysterical disorders were caused by a particular distribution of a universal magnetic fluid in the body. Moreover, he felt that one person could influence the fluid of another to bring about a change in the other's behaviour. Mesmer conducted meetings cloaked in mystery and mysticism at which afflicted patients sat around a covered *baquet*, or tub. Iron rods protruded through the cover of the baquet from bottles underneath that contained various chemicals. Mesmer would enter a room, take various rods from the tub, and touch afflicted parts of his patients' bodies. The rods were believed to transmit animal magnetism and adjust the distribution of the universal magnetic fluid, thereby removing the hysterical disorder. Whatever we may think of what seems today to be a questionable theoretical explanation and procedure, Mesmer apparently helped many people overcome their hysterical problems.

You may wonder about our discussing Mesmer's work under the rubric of psychogenic causes, since Mesmer regarded hysterical disorders as strictly physical. Because of the setting in which Mesmer worked with his patients, however, he is generally considered one of the earlier practitioners of modern-day hypnosis (see artwork). The word "mesmerize" is an older term for "hypnotize." (The phenomenon itself, however, was known to the ancients of probably every culture and was part of the sorcery and magic of conjurers, fakirs, and faith healers.)

Mesmer was regarded as a quack by his contemporaries, but the study of hypnosis gradually became respectable. A great Parisian neurologist, Jean Martin Charcot (1825–93), also studied hysterical states, including anaesthesia (loss of sensation), paralysis, blindness, deafness, convulsive attacks, and gaps in memory. Charcot initially espoused a somatogenic point of view. One day, however, some of his enterprising students hypnotized a normal woman and prompted her to display certain hysterical symptoms. Charcot was deceived into believing that she was an actual hysterical patient. When the students showed him how readily they could remove the woman's symptoms by waking her, Charcot changed his mind about hysteria and became interested in non-physiological interpretations of these very puzzling phenomena (see artwork).

Jean Loup Charmet/Science Source

Mesmer's procedure for transmitting animal magnetism was generally considered a form of hypnosis.

Bettmann/Getty Images

The French psychiatrist Jean Charcot lectures on hysteria in this famous painting. Charcot was an important figure in reviving interest in psychogenesis.

Breuer and the cathartic method At about this time, in Vienna, a physician named Josef Breuer (1842–1925) treated a young woman who had become bedridden with a number of hysterical symptoms. Her legs and right arm and side were paralyzed, her sight and hearing were impaired, and she often had difficulty speaking. She also sometimes went into a dreamlike state, or "absence," during which she mumbled to herself, seemingly preoccupied with troubling thoughts. During one treatment session, Breuer hypnotized Anna O. and repeated some of her mumbled words. He succeeded in getting her to talk more freely—ultimately, with considerable emotion—about some very upsetting past events. Frequently, on awakening from these hypnotic sessions, she felt much better. With Anna O. and other hysterical patients, Breuer found that the relief and cure of symptoms seemed to last longer if, under hypnosis, they were able to recall the precipitating event for the symptom and if their original emotion was expressed. The experience of reliving an earlier emotional catastrophe and releasing the emotional tension caused by suppressed thoughts about the event was called *catharsis*. Breuer's method became known as the **cathartic method**. In 1895 one of his colleagues joined him in the publication of *Studies in Hysteria*, a book considered a milestone in abnormal psychology. In the next chapter we examine the thinking of Breuer's collaborator, Sigmund Freud.

Many people go about the study of abnormal psychology without considering the nature of the perspective, conceptual framework, or paradigm (see Chapter 2) they have adopted. The choice of a paradigm, however, has important consequences for the way in which abnormal behaviour is defined, investigated, and treated. Canadian Perspectives 1.3 examines, from a historical perspective, some of the treatment strategies that developed as a result of adopting a particular paradigm, and leads us to consider the lesson of history. It raises ethical issues and concerns that we will address in detail in Chapter 18.

Canadian Perspectives 1.3

The Lesson of History: A View from the Twenty-First Century

"CIA brainwash settlement 'a flea': Spy agency escaped lightly in lawsuit, Winnipegger says"

—The Canadian Press, October 6, 1988

"Brainwash 'guinea pig' seeks more damages: Canadian victim of CIA experiment in late 1950s tries to launch class-action suit against Ottawa"

—The Canadian Press, January 8, 2007 to Moore, January 8, 2007

These Canadian Press reports describe the settlement of a lawsuit resulting from what is probably the greatest abuse of psychiatric power in Canadian history. Similar abuses occurred in the United States and elsewhere during the same era and, tragically, are common in some parts of the world even today. However, before proceeding to tell the CIA story, we should point out that a majority of psychiatric patients in Canada were treated with decency and humanity within the constraints of scientific knowledge and accepted clinical practice at the time.

Dr. Ewen Cameron, a world-renowned Montreal psychiatrist, was head of the Allan Memorial Institute at McGill University in the 1950s and early 1960s (see photo). At one point, he was president of the Quebec, Canadian, American, and World Psychiatric Associations. In 1955 he initiated a nine-year series of experiments on unsuspecting psychiatric patients, apparently in a misguided attempt to discover breakthrough treatments or a "cure" for mental illness. None of his patients or their families was asked for consent, nor were they informed of the experimental treatments involved that went far beyond the limits of acceptable treatments. Dr. Cameron's quest led to a bizarre theory of "beneficial brainwashing" that had tragic consequences for hundreds of Canadians. Many years later, it was determined that his shocking mind-control experiments were funded secretly by the U.S. Central Intelligence Agency and the federal government of Canada. The CIA believed that these brainwashing strategies might be used on "enemies" during the Cold War (Gillmor, 1987).

McGill News/McGill University Archives, PR019175

What did Dr. Cameron—and his staff—do that was of such great interest to the CIA? He administered massive doses of hallucinogenic drugs, such as LSD. He administered intensive, repeated courses of electroconvulsive therapy (ECT), or "shock treatment," often three times each day, while patients were kept in a drug-induced coma for as long as three months. He also administered so-called psychic driving, in which subliminal messages, such as "You killed your mother," were repeated over and over while the patient was in the drug-induced state (Collins, 1988). The alleged purpose of these "treatments" was to "wipe away" the troubled past of his patients. It succeeded. Linda Macdonald, who initiated a lawsuit against the federal government, claimed that the experiments erased her memory for the first 26 years of her life. She received over 100 electroshock treatments and was kept in a drug-induced sleep for 86 days. Theoretically, Dr. Cameron would bestow a "new," healthy personality on her. Macdonald claimed, however, that there was no subsequent care directed at the psychological difficulties that brought her to the institute in the first place, or for the effects of Dr. Cameron's experiments on her. Victims claimed that they suffered permanent damage. Those still alive (several committed suicide) remain in psychiatric hospitals or attempt to live in the community but require extensive support.

The role of the CIA was not discovered until 1977. In 1988 the U.S. government settled out of court for a total of $750,000 with a group of nine former patients who had initiated a lawsuit in 1980. At the time, Val Orlikow, a former patient and the wife of a then Winnipeg Member of Parliament, stated that with the settlement, the CIA had merely "flicked a flea off the sleeve of their jacket" (The Canadian Press, 1988). She told CBC's investigative news program *the fifth estate* that Dr. Cameron had let her down. "It was an awful thing to realize, when I found this out, that the man whom I had thought cared about what happened to me didn't give a damn. I was a fly, just a fly." Her granddaughter Sarah Anne Johnson later told the Globe and Mail that her grandmother had been an avid reader but after her treatment, she lost her ability to read. It would take her a week to read a simple note or a month to read a newspaper (Milroy, 2009).

In 1992 the Canadian government finally agreed to a settlement of up to $100,000 per person. Neither the CIA nor the Canadian government apologized to the surviving patients who lost their identities and their dignity, or to the families of approximately 150 former patients who died. In 1998, following an exposé on *the fifth estate,* CBC Television aired a miniseries dramatizing the work of Dr. Cameron and the occurrences in his "Sleep Room." In early

(*Continued*)

2007 another victim sought approval to launch a class-action lawsuit against the federal government of Canada. She and more than 250 others had been denied compensation by the government because they had not suffered "total depatterning" and were not rendered to a child-like state (The Canadian Press, 2007).

Several radical approaches for the treatment of serious mental disorders were introduced during the twentieth century. Lobotomy or psychosurgery is particularly controversial. In this surgical procedure, the tracts connecting the frontal lobes to lower centres of the brain are destroyed. Egas Moniz of Lisbon introduced prefrontal lobotomy into psychiatry in 1935. The first lobotomies in Canada were performed in Ontario in 1944 on 19 female patients from various mental hospitals. Simmons (1987) demonstrated that psychosurgery was used in Ontario for several reasons, including out of curiosity, to observe the consequences to patients.

Three operations conducted in 1981 were the last lobotomies performed in Ontario (Simmons, 1987). Lobotomies were effectively banned in all public psychiatric hospitals.

What is the lesson of history with respect to society's "treatment" of the mentally ill? The examples presented here, together with examples from the more distant past and knowledge of circumstances surrounding events, point to two main conclusions:

1. Periods in which people exhibiting psychologically disordered behaviour were persecuted and treated cruelly (e.g., witch hunts, bloodletting, asylums) have often alternated with periods of humanitarian reform and care for suffering people (e.g., Hippocrates's humanitarian treatments, Pinel's reform of the asylums).
2. Cycles of persecution, neglect, and humanitarianism in the treatment of the mentally ill have occurred irrespective of the helping agency, whether religious, medical, or psychological.

Thinking Critically

1. Are you aware of any "treatment" of people with psychological disorders that illustrates the wisdom of paying attention to Santayana's famous dictum about the need to remember the past? Is continued progress in Canada inevitable? What economic, political, and social circumstances could potentially contribute to a lack of progress?
2. What steps would you take to ensure that tragic incidents, such as the "treatments" employed by Dr. Cameron, never occur again in Canada?
3. Do you think that lobotomy was ever justified? (After you think critically about this issue, refer to the discussion of ethical dilemmas of research and therapy in Chapter 18.)

1.3 Current Attitudes toward People with Psychological Disorders

> *"Changing attitudes to mental illness continues to be our biggest challenge. Discrimination, ignorance and fear remain the enemies that we have to conquer."*
>
> *—Bill Gaudette, National President, Canadian Mental Health Association, May 2001*

Many Canadians are suspicious of people with psychological disorders. Their concerns have been reinforced by incidents involving threats, violence, and other examples of frightening behaviour on the part of seriously mentally ill people, many of whom had refused to take or were no longer taking their prescribed medications. We will likely never forget the media reports of the tragic, horrific, brutal case of 40-year-old Vince Li, who killed and then mutilated the body of a young passenger named Tim McLean, whom he didn't even know, on a bus in Manitoba in 2008. At Li's trial, it was revealed that he told a psychiatrist that he was commanded by God to kill the young man because he was a force of evil:

> *"Suddenly the sunshine came in the bus and the voice said, 'Quick. Hurry up. Kill him and then you'll be safe.' It was so quick, such an angry voice, and I had to do what it said. I was told that if I didn't listen to the voice, I would die immediately."*
>
> *(Puxley, 2009, March 6, p. A2)*

The judge, with the agreement of both the Crown and the defence, declared Li not criminally responsible on account of mental disorder. Psychiatrists testified that Li was suffering from untreated **schizophrenia**. Li spent seven years at Selkirk Mental Health Centre and it was announced in early 2016 that Li would soon be moving to independent living in the community. As we will see, cases such as this one, and numerous others that you can probably recall, are actually extremely rare. Unfortunately, they can leave an indelible impression on people and impact negatively on our attitudes toward people with mental health issues or psychological problems.

Consistent with other minority groups in Canada, people with psychological disorders often face negative **stereotyping** and **stigmatization**. For example, according to the Centre for Addiction and Mental Health in Toronto (CAMH, 2000), the social stigma surrounding depression is the primary reason why only one-third of the estimated three million people in Canada who suffer from depression seek help. According to a report on the 2002 Mental Health and Well-being Survey (Government of Canada, 2006), over 50% of Canadians who suffered from mood, anxiety, or substance dependence disorders in the previous year felt embarrassed about their problems and reported facing discrimination. One Canadian

study (Bahm & Forchuk, 2009) found that people with both a psychiatric and a physical disability faced more perceived stigma and discrimination than those with a psychiatric disability alone.

A much publicized example of the issue of stereotyping and stigmatizing of the mentally ill was the 2000 movie *Me, Myself & Irene* starring Canadian actor Jim Carrey. The character played by Carrey develops a "split personality" and fights against himself. A coalition of Canadian health organizations and advocacy groups, including the Canadian Mental Health Association, demanded that disclaimers be attached to the film, arguing it reinforces negative stereotypes of people suffering from psychiatric disorders, in particular the schizophrenias. Carrey's character is misidentified as having schizophrenia rather than **dissociative identity disorder** (see Chapters 7 and 11). One unfortunate and particularly ironic aspect of this example is Carrey's own struggles with depression (see Canadian Contributions 1.1).

Mental illness can occur regardless of fame, fortune, or power, and there are many examples of well-known Canadians, or their loved ones, who have experienced a diagnosable psychological disorder (see Nunes & Simmie, 2002). Canadian Contributions 1.1 identifies some of these celebrities, all of whom have acknowledged their adjustment problems despite the possible stigma associated with admitting a mental health problem.

Canadian Contributions 1.1

The Advocacy of Well-Known Canadians with Mental Health Problems

Clara Hughes is not alone. A growing number of Canadian celebrities have been open about their history of mental health problems and they have advocated for more treatment resources and greater awareness of the impact that mental illness has on our citizens. As noted above, actor Jim Carrey suffered from depression, which he discussed during a 2009 interview on *60 Minutes.* Carrey revealed that he spent years on Prozac but now relies on spiritual forms of coping. Another example is Margot Kidder, the actress from Yellowknife who is famous for her role as Superman's girlfriend in the *Superman* movies starring the late Christopher Reeve. Kidder's problems with bipolar disorder led to her temporary retention in a psychiatric facility. She has campaigned against the drug treatments she received.

Another celebrity from the same era is Margaret Trudeau, who married then-Prime Minister Pierre Trudeau in 1971 when she was only 22 years old. Of course, she is now the mother of Prime Minister Justin Trudeau. Margaret Trudeau has been open about her long history of battles with bipolar depression, including her symptoms while being the Prime Minister's wife. In 2006, she recalled, "It was never talked about in those days, and barely recognized, no matter what sector of society you lived in. And so, in the public eye and under public scrutiny, I tried to manage as best I could" (Berthiaume, 2006, p. A6).

Margaret Trudeau is the mother-in-law of another notable Canadian with a history of mental health problems. Sophie Grégoire, wife of Prime Minister Justin Trudeau, admitted her history with an eating disorder in 2006. Grégoire has worked extensively in recent years on behalf of the Montreal-based BACA Eating Disorders Clinic.

Canadian entertainers have been particularly open about the mental health challenges they have faced. Perhaps the most well-known is comedian Howie Mandel. Mandel suffers from obsessive-compulsive disorder and it is his fear of contamination that made him uneasy about shaking the hands of contestants on the show *Deal or No Deal* (and he shaves his head so that germs will not get in his hair!). Meanwhile, actor Keanu Reeves, who is known primarily for his role in the *Matrix* movies, acknowledged that he was plunged into depression when he turned 40 years old.

Mary Walsh (formerly of *This Hour Has 22 Minutes* and co-star in several films) is another celebrity with a history of mental health issues. Walsh had a difficult upbringing in St. John's, Newfoundland. She took her first drink at the age of 13 and eventually came to abuse alcohol. In 2005, she was given the Centre for Addiction and Mental Health's Courage to Come Back Award. In 2015–2016, in recognition of her advocacy work, Walsh was the Honorary Canadian Psychological Association President. She addressed the annual convention in June 2016 in Victoria and urged for national reform to improve access to mental health care.

Singer Alanis Morissette revealed her battles with anorexia and bulimia in 2005. She acknowledged that as a teenage prodigy, she struggled with the symptoms when she was between the ages of 14 and 18, and much of it was due to the need to meet high expectations. She stated, "The pressure was hardcore. For four to six months at a time, I would barely eat, so I constantly felt dizzy. I lived on a lot of Melba toast, carrots and black coffee" (*Vancouver Sun,* 2005, p. C3). Morissette has fought against the unrealistic body image pressures prescribed for females. More recently, in 2012, Morissette revealed her struggles with postpartum depression.

Other Canadians in the music industry have similarly revealed their difficulties. Steven Page, former frontman for the Barenaked Ladies, acknowledged his struggles with bipolar depression in 2011. Canadian rocker Matthew Good revealed that he has struggled with anxiety and depression for years and he dealt with it by becoming a seemingly tireless worker. Good was eventually hospitalized after ingesting 50 Ativan pills. He has since recovered (Patch, 2009, D4).

Some scholars have suggested that the professional performers who are vulnerable often experience psychological distress because of the heightened self-consciousness and self-focused attention that comes from being in the public spotlight. Given the potential stigma associated with admitting a mental health problem, it is particularly impressive when these celebrities acknowledge their issues and instead shine that same spotlight on the significant psychological disorders that afflict people in Canada and around the world. Congratulations to all of them!

The Public Perception

Many common misconceptions or myths of mental illness can be dispelled. For example, as noted above, it is a common belief that people with psychological disorders are unstable and dangerous. We will revisit this issue in subsequent chapters but at this point we can state that recent research does not provide confirmation of this widespread idea, although there is a small but significant relation between schizophrenia and violent acts (see Taylor, 2008, for review). A major American epidemiological study (Elbogen & Johnson, 2009) found that the incidence of violence was higher for people with severe mental illness; however, the effect was significant only for those with co-occurring substance abuse or dependence. As suggested earlier, the majority of mentally ill people never perpetrate violent acts; in fact, they are more likely to be victims (Taylor, 2008).

Another insidious myth is the belief that people with psychological disorders can never be "cured" and can never contribute meaningfully to society again. As you read the research findings presented in this text, you will readily conclude that such a belief is a major misconception. Further, you will no doubt be able to cite examples of people who, though never "cured" of their psychological problems, nevertheless went on to make significant contributions to humanity. One such individual was Clarence Hincks. He suffered from serious, chronic psychological problems but was able to devote his life to helping the mentally ill and to trying to change the public's attitudes toward them. Hincks was a founder and long-term medical director of the **Canadian Mental Health Association** (CMHA).

A survey released for the 50th anniversary of Mental Health Week in Canada, in May 2001 (CMHA, 2001), found that the majority of Canadians believe that maintaining mental health is "very important" (95% of women and 88% of men). However, relative to a 1997 survey, fewer Canadians were willing to tell their bosses (only 42%) or friends (only 50%) if they were receiving help for depression. Women were more willing to admit to receiving treatment than men.

A 2008 national Ipsos Reid online survey, commissioned by the Canadian Medical Association (see Kirkey, 2008), indicated the extent of current negative attitudes and discrimination. The following were some of the findings.

- Almost 50% of Canadians (46%) believe "we call some things mental illness because it gives some people an excuse for poor behaviour and personal failings."
- About 50% indicated they would avoid socializing with (42%) or marrying (55%) someone who is mentally ill.
- Twenty-seven percent are afraid to even be around someone with a serious mental illness.
- About 50% would decline to tell friends or co-workers about a family member suffering from a mental illness (but 72% would share a cancer diagnosis).
- Most wouldn't hire a doctor, a lawyer, a financial adviser, someone to care for or teach their child, or even a landscaper who has a mental illness!

Dr. David Goldbloom, who has served as the chair of the Mental Health Commission of Canada, summarized the message from this survey about Canadians' attitudes toward mental illness: "They're not going to talk about it. They're not going to disclose. And they're not going to disclose as long as there is a culture of shame, secrecy and stigma" (Kirkey, 2008, p. A1). However, on the bright side, 72% of survey respondents agreed that funding to treat mental illness should be comparable to funding for physical illnesses such as cancer (see Zon, 2009).

Anti-Stigma Campaigns

Over the past decade, there have been numerous widely publicized campaigns in Canada and throughout the world to try to destigmatize mental illness. Michael Wilson, a prominent former federal minister of finance, lost a young son, who suffered from depression, to suicide. Wilson has been a tireless crusader to help reduce the stigma associated with depression. Wilson encourages people to seek help for themselves or for loved ones and friends. He served as chair of a multi-year campaign launched by CAMH and various partners to remove barriers that impede people from seeking treatment for mental health and addiction problems.

Kevin Bieksa, formerly of the Vancouver Canucks NHL team, is actively engaged in fighting schema. Bieksa became involved with and filmed a video appeal for the site Mindcheck.ca following the death of his friend and former teammate Rick Rypien, who took his own life in 2011 after struggling for years with depression. It is important for athletes to continue the fight against mental health stigma in light of recent research with student athletes indicating that the culture and values of highly competitive sport can create an atmosphere that promotes and maintains stigma (Delenardo & Terrion, 2014).

Another crusader is actress Glenn Close, who was in Ottawa in June 2012 to attend an international anti-stigma conference hosted by the Mental Health Commission of Canada (see photo). Close was accompanied by two family members who have suffered from mental illness. Close is striving to influence public awareness through her non-profit organization BringChange2Mind. She has also indicated that in retrospect, she should have refused the role of Alex Forrest in the movie *Fatal Attraction* due to the extreme way that the movie depicted mental illness (see Anderssen, 2012).

The reduction of the stigma of schizophrenia is the continuing focus of a global campaign by the World Psychiatric Association. Meanwhile, in Canada, Heather Stuart from Queen's University is the national leader in fighting stigma (see photo). Stuart was named in 2012 as the Bell Mental Health and Anti-Stigma Research Chair, which is the first research chair created in the world that is focused on assessing and remediating mental health stigma. An intriguing aspect of Stuart's personal story is that she grew up next to the Homewood Sanitorium in Guelph, Ontario, where her mother worked as an administrator. Stuart recounted that "I would meet the patients every day when I went to see my mother . . . They were pleasant and kind people and I made friends with them. It never occurred to me that there was a social division between us" (Curtis, 2012; www.universityaffairs.ca. Indeed, contact with

Joe Lofaro/Metro News

Actress Glenn Close with her sister, Jessie Close, and her nephew, Calen Pick, at an international conference on eliminating mental health stigma in Ottawa.

people who have psychological problems is a factor that mitigates against stigma.

A preventive intervention developed by Stuart (2006a) sought to reduce stigma in high school students through a video-based active learning program (The Schizophrenia Society of Canada's Reaching Out program) that chronicled the challenges of actual people with schizophrenia. Exposure to the program resulted in increased knowledge of schizophrenia and its treatment and less social distancing (and presumably less stigma). Female students showed greater gains in understanding than males. Although it is not known whether a lasting improvement in knowledge resulted, this study illustrates the potential of such programs with young people. Indeed, programs that send speakers to talk in public about mental health have been used worldwide and effectively improve knowledge and attitudes of students toward the mentally ill (see Sartorius & Schultze, 2005).

The opportunity to hear from a mental health consumer was part of a program that was used effectively in a recent intervention conducted in schools in Hamilton, Ontario. In this instance, high school students heard in person the autobiographical account of a married woman in her forties who was diagnosed with schizophrenia in her late teens (see Hartman et al., 2013). She described her experiences and challenges with mental illness, including the initial onset of symptoms, such as auditory hallucinations, and the problems she faced throughout the process of arriving at her diagnosis. She was also very forthcoming about times when her mental illness led to suicide attempts and hospitalizations. Her story concludes with an account of her recovery. She is happily married and she works as a full-time health care worker. She is doing quite well and the psychotic symptoms remain under control as long as she takes her medication.

Two aspects of this autobiographical first-hand account are particularly compelling. First, this brave woman described what happened when she started to experience her symptoms while at university. She recounted, "In my final year of university I was trying to study for final exams and write my thesis. But the voices in my head were so horrible and the visions so great I had to tell someone. I phoned my parents. I came home that weekend and was in a doctor's office by Monday" (Hartman, 2012, p. 93). Most students can easily imagine how distressing this would be if it happened to them.

Courtesy of Heather Stuart

Heather Stuart, who holds the Bell Mental Health and Anti-Stigma Research Chair, is a crusader for the rights of mentally ill people. Stuart met many such people as a child as a result of visiting her mother, who worked at the Homewood Sanitorium.

Second, she discussed at length the upset associated with continuing exposure to stigma. Specifically, she recounted the following:

> *"I hear the comments all the time, both at work and when I am with friends. Things like 'psycho', 'crazy', 'one side of the brain isn't listening to the other side', 'schizo's shouldn't be driving'. These words and ideas hurt me immensely, I'm stuck here taking pills and going to counselling for the rest of my life and to top it off I can't tell anyone about my problem because people think I'm going to attack them! I can't say anything because of fear that I will be alienated from all my friends and coworkers, not to mention the chance of getting some sort of promotion in the organization is probably out the window! So please as health care workers and as people please stop this vicious style of talk and understand that I am a productive person in society and should be treated as such. Thank you!"*
>
> *(Hartman, 2012, p. 94).*

Once again, you can easily imagine how you would feel if this happened to you.

The research component of the Hartman et al. (2013) study showed that students who took part in this prevention did have improved knowledge and less social distancing from people with mental illness, indicating decreased stigma. Conclusions are restricted somewhat due to the lack of a no-intervention control group in this study. A control group that does not receive the intervention is needed for comparison purposes. A control group was not included because it was deemed that all students should have this learning opportunity. One of the most unique elements of this study is that it also assessed **self-stigma**, which is the tendency to internalize mental health stigma and see oneself in more negative terms as a result of experiencing a psychological problem. Hartman et al. (2013) found the intervention also yielded substantial reductions in self-stigma, suggesting that exposure to these programs can result in more self-compassion. Research is now beginning to identify factors that seem to protect against self-stigma such as being securely attached to significant others instead of having insecure anxious attachments to others (Zhao et al., 2015).

Media images of mental illness with a focus on dangerousness, criminality, and unpredictability, and that model negative reactions to people with psychological problems such as fear, rejection, and ridicule, can inhibit help-seeking behaviours, medication adherence, and recovery (see Stuart, 2006b). However, "The media have produced some of the most sensitive, educational and award-winning material on mental illness and the mentally ill" (Stuart, 2006b, p. 99). Thus, the media can play a strong role as allies in anti-stigma activities and can challenge prejudice and discrimination, project positive human-interest stories that promote understanding and compassion, and encourage help-seeking and self-esteem in the mentally ill.

Anti-stigma campaigns in Canada are escalating. Heather Stuart and other advocates have joined with the Mental Health Commission of Canada to spread the Opening Minds (OM) Anti-Stigma Initiative (see Stuart et al., 2014). OM is working with more than 100 community partners and their affiliates. Extensive research is also underway in order to further our understanding of stigma and how to combat it. A recent review paper by one of the world leaders in this area (Patrick Corrigan) and his colleagues reminds us that there are both individual and system factors that promote stigma and concerns about stigma and it is essential to view stigma as involving complex phenomena (see Corrigan, Druss, & Perlick, 2014). Because it is such an important topic, the American Psychological Association has recently introduced a new journal called *Stigma and Health* and Patrick Corrigan was selected as editor of this important new journal.

So, do you believe that the Canadian public's perception of people with psychological problems has become more positive and supportive in the past 15 years? Attitudes only change when they are challenged! It is our hope and expectation that you will treat all people, including those with psychiatric disorders, whether real or imagined, with decency and dignity. We further hope that many of you will take an active role in advocating for, or helping, people with psychological problems.

Mental Health Literacy

How much do people actually know about mental health and related issues? The term **mental health literacy** has been created to refer to the accurate knowledge that a person develops about mental illness and its causes and treatment. What do we know about mental health literacy in general? A review concluded that more positive and informed attitudes are found among younger people, more educated people, people with training, and those with personal experience, perhaps due to having a family member with some form of illness. This review also concluded that there is a reasonably high level of knowledge about depression, but surprising ignorance of disorders such as schizophrenia and social anxiety. Finally, the prevailing view is that mental health is a reflection of biological and genetic causes, but a substantial proportion of people attribute mental health problems to early family experience (see Furnham & Telford, 2011).

What about Canadians? In 2008, the Canadian Alliance on Mental Illness and Mental Health presented its report on Mental Health Literacy in Canada. Funded by Health Canada, the report is the culmination of approximately four years of research, planning, and consultation across Canada. While this study was supposed to assess mental health literacy, the focus was more on beliefs rather than the accuracy of the beliefs. Among the conclusions were the following:

- Most Canadians see mental health as a medical problem (66% recommend medical intervention for schizophrenia, 61% for depression, and 46% for anxiety).

- Many Canadians are cautious about the use of psychiatric medications (e.g., while 60% believe that antidepressants can be helpful, 51% agree that they can be harmful).
- Canadians prefer a holistic treatment approach but are largely unaware of the range of available treatment options.
- About 90% of Canadians believe that anyone can suffer from a mental disorder.
- Common mental problems, such as anxiety or depression, are viewed as more likely caused by psychosocial factors whereas mental illnesses such as schizophrenia are viewed as more serious and more likely caused by biomedical factors.

As of 2008, Canada has a national integrated strategy, but how much do people actually know about mental health issues? Useful information was provided by a team of York University researchers who conducted the first national study of mental health literacy that compared younger people (18–24 years old) and older people (25–64 years old) (see Marcus, Westra, Eastwood, & the Mobilizing Minds Research Group, 2012). Overall, while few age differences were found, it seems that Canadians have a good understanding of depression; the recognition of depression was substantially better than the recognition of anxiety or schizophrenia. In general, the respondents correctly identified major mental health problems at moderate rates and about two-thirds of the participants were accurate at estimating mental health disorders in Canada. Thus, while there is considerable mental health literacy in Canada, there is also considerable room for improvement.

How will such improvements actually occur? One way is to develop and deliver mental health education programs in elementary schools and high schools. A recent study conducted with the assistance of four Ontario school boards indicates that this approach has substantial promise. The delivery of a mental health literacy program called The Guide resulted in lasting improvements in students' knowledge of and attitudes toward mental health problems (McLuckie, Kutcher, Wei, & Weaver, 2014).

1.4 Mental Health Problems and Their Treatment in Canada

The Extent of Mental Health Problems in Canada

> *"Conservatively, we estimate that 7.5 million Canadians suffer from depression, anxiety, substance abuse or another mental health disorder."*
>
> —*Phil Upshall, National Executive Director of the Mood Disorders Society of Canada, and chair of Mental Illness Awareness Week* (Canadian Psychiatry Aujourd'hui,October 2008)

Canada as a Whole So just how many people in Canada have mental health problems? An initial broad look at Canada as a whole came from the Canadian Community Health Survey (CCHS) (Cycle 1.2), which was the first comprehensive Canadian *national* study to use a full current version of the Composite International Diagnostic Interview (developed by the World Health Organization). For this reason and because of the large sample size (nearly 37,000 community-dwelling respondents), the CCHS 1.2 provided the best available description of selected disorders in Canada for many years (see Gravel & Beland, 2005, for a description).

However, another study was conducted in 2012 by Statistics Canada. The 2012 Canadian Community Health Survey—Mental Health (CCHS-MH) collected information from Canadians aged 15 and older on the prevalence of six mental disorders (within the 12 months prior to the interview as well as overall lifetime): depression, bipolar disorder, generalized anxiety disorder, alcohol abuse or dependence, cannabis abuse or dependence, and other drug abuse or dependence (excluding cannabis). Disorders assessed in 2002 but not this time included panic disorder, social phobia, and agoraphobia, as well as eating attitude problems, and problem gambling or moderate risk for problem gambling.

The results are summarized in Table 1.1. Some major findings were as follows (see Pearson, Janz, & Ali, 2013):

- About 1 out of every 10 Canadians aged 15 and over (about 2.8 million people) reported *symptoms* consistent with one of the disorders during the previous 12 months.

TABLE 1.1 Rates of Selected Mental or Substance Use Disorders, Lifetime and 12 Month, Canada, Household Population 15 and Older, 2012

	Lifetime (%)	12-Month (%)
Mental or substance use disorders[1]	**33.1**	**10.1**
Substance use disorder[2]	21.6	4.4
Alcohol abuse or dependence	18.1	3.2
Cannabis abuse or dependence	6.8	1.3
Other drug abuse or dependence (excluding cannabis)	4.0	0.7
Mood disorder[3]	12.6	5.4
Major depressive episode	11.3	4.7
Bipolar disorder	2.6	1.5
Generalized anxiety disorder	8.7	2.6

[1]**Mental or substance use disorders** is comprised of: substance use disorders, mood disorders, and generalized anxiety disorder. However, these three disorders cannot be added to create this rate because these three categories are not mutually exclusive, meaning that people may have a profile consistent with one or more of these disorders.

[2]**Substance use disorder** includes alcohol abuse or dependence, cannabis abuse or dependence, and other drug abuse or dependence.

[3]**Mood disorder** includes depression (major depressive episode) and bipolar disorder.

Source: Statistics Canada, Canadian Community Health Survey—Mental Health, 2012.

- 1 in 3 Canadians met criteria for a disorder at some point in their lifetimes.
- About 1 in 5 Canadians met lifetime criteria for a substance use disorder. This amounts to approximately 6 million Canadians.
- About 1 in 7 Canadians met lifetime criteria for a major depressive episode or a bipolar disorder.
- Females, relative to males, had higher rates of mood disorders and generalized anxiety disorder. Males had higher rates of substance abuse.
- About 1 in 3 Canadians had a need for treatment that was unmet, either in whole or in part.

Clearly, mental health and addiction problems are widespread in Canada and point to the need for a dramatic escalation of prevention and intervention efforts. The number of people with unmet needs is equally alarming. Comparable levels of unmet need were identified in another study conducted with 571 Canadians (see Fleury et al., 2016). About 3 out of 10 reported an unmet need for counselling. However, higher levels of unmet need were found among younger people, and people with an addiction.

Regional Differences Does the mental health of the population differ from one region of Canada to another? Do the provinces and territories differ from one another in terms of mental health? These questions are difficult to answer. There are, of course, some obvious differences in certain parts of Canada. In Chapter 2, for example, we will discuss the high level of mental health problems among some of Canada's Aboriginal people. However, Stephens, Dulberg, and Joubert (1999) did not find any major independent association between mental health and a respondent's province of residence.

There are, however, a few consistent differences. One of these is the good mental health in both Newfoundland and Labrador and Prince Edward Island. People in these two provinces reported the most happiness and the least distress. Quebec is noteworthy because it reported very high levels of self-esteem and mastery but the least happiness and most distress. The initial results of an intriguing new study suggest that mental health problems may be more prevalent in Quebec but the results could be influenced by an oversampling of people with lower socio-economic status (SES). Caron et al. (2012) reported the initial results of the first Epidemiological Catchment Area Study of mental health in Canada. This study is being conducted with a randomly selected sample of 2,433 people from the southwest sector of Montreal. Overall, Caron et al. (2012) found that the rate of psychological distress was 38%, which was almost double the rate found in the earlier Canadian Community Health Survey—Mental Health. The rate of diagnosable mental disorder was 17% (versus 11% in the general population). The study found that SES mattered. When compared with people with an annual income of $70,000 or more, people with less than $19,000 per year were 4.3 times more at risk of having a diagnosable mental disorder. The risk inherent among people who live in poverty is explored in more detail both later in this chapter and in Chapter 2.

Cost of Mental Health Problems

> *"A newly coined term, 'presenteeism,' describes those who currently work but are depressed and non-productive."*
>
> *—Patrick J. White, President of the Canadian Psychiatric Association, February 2008*

What is the cost of mental health problems in Canada? The cost in misery and human suffering among both the people who experience psychological problems and those they touch—their family, friends, and even strangers—is *incalculable*. An Ontario Ministry of Health study (1994) reported that disability costs to society, which often go unrecognized owing to the stigma attached to symptoms of mental disorders and their treatment, include (1) personal misery, (2) disruption of family life, (3) lower quality of life, and (4) loss of productivity. Regarding the last point, in Ontario the monthly total number of work days lost by people with mental disorders was estimated at more than 1.8 million in 1990.

Cost can also be expressed in terms of the disease burden for people: how it impacts life expectancy and the quality of life. A study from Ontario estimated that the burden of mental illness and addictions is 1.5 times greater than the combined burden of all cancers (see Ratnasingham et al., 2012). The five disorders with the highest amount of burden were depression, bipolar disorder, alcohol use disorders, social phobia, and schizophrenia. Depression by itself was deemed to have a higher level of burden than the combined burden of four types of cancer.

How does mental illness compare with other difficulties? Ormel et al. (2008) reported on the administration of epidemiological surveys in 15 countries through the World Health Organization Mental Health Survey initiative. It was found that respondents in both high-income and low- and middle-income countries attributed higher disability to mental disorders than to commonly occurring physical disorders. Further, this higher disability was limited to disability in social and personal role functioning. Productive role functioning was generally comparable for mental and physical disorders. Despite higher disability, mental disorders were generally under-treated in all countries.

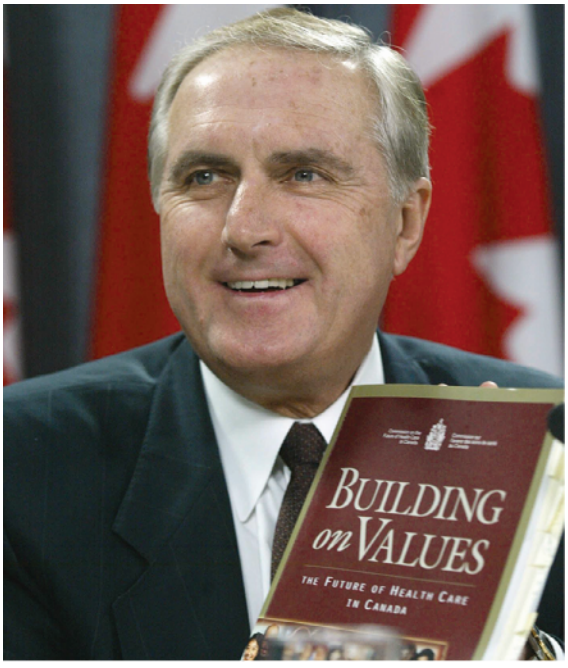
The situation begs an answer to an urgent question: How can we ensure that care for Canadians with psychological disorders is both cost-efficient and effective? We must also ask ourselves: How much should we invest in finding and disseminating better treatments in order to reduce these costs, and how much should we invest in the prevention of disorders in the first place? These issues will be examined further in a later segment of this chapter.

Transformations in Canada's Mental Health System

The Romanow Report The Government of Canada established the Commission on the Future of Health Care in

Canada in 2001 and appointed the former premier of Saskatchewan, Roy Romanow, as commissioner (see photo). The mandate was to engage Canadians in a national dialogue and to assess options for a long-term, sustainable, universally accessible, publicly funded health care system. Although the commission intended to examine mental health issues, various stakeholders formed an alliance (the Canadian Alliance on Mental Illness and Mental Health or CAMIMH) to address what they saw as two key policy weaknesses in the mental health area in Canada (see Canadian Psychiatric Association, 2002): (1) a fragmented constituency, and (2) the lack of a comprehensive national plan. CAMIMH is an alliance of five national organizations representing major consumer, family, community, and medical constituencies: the Canadian Mental Health Association, the Mood Disorders Association of Canada, the Schizophrenia Society of Canada, the National Network of Mental Health, and the Canadian Psychiatric Association. The accord reached meant that for the first time, these diverse interests could speak in a unified way about policies in Canada that affect the mentally ill. Among other things, the organization called for a national, coordinated action plan on mental illness and mental health. Other stakeholders in the mental health field, such as the Canadian Psychological Association, as well as private citizens, made presentations and submissions to Romanow at public hearings as he criss-crossed the country.

Romanow released his final report on November 28, 2002 (Romanow, 2002). A comprehensive template for the development of health care in Canada, it reaffirmed and expanded upon the five principles of the Canada Health Act. It also proposed sweeping changes to **medicare** and made 47 specific recommendations. Perhaps the central element of the report was the proposal to expand medicare coverage beyond just physicians and hospitals. We focus here on the mental health implications. Calling mental health the "orphan child of medicare," Romanow recommended that it be made a priority within the system. Of particular relevance, he recommended broadening medicare to include a limited number of home care services and, eventually, some drug treatments and a national drug agency.



Fred Chartrand /The Canadian Press

Health care commissioner Roy Romanow recommended crucial changes to Canada's system.

The report's proposed expansion of the Canada Health Act would specifically include home care coverage for mental health case management and intervention services (over $500 million of new funding) as part of a $1-billion home care transfer. Romanow also proposed the establishment of a new program to provide direct support to informal caregivers (e.g., family and friends) to allow them to be away from work to provide necessary home care assistance at critical times. Although he stopped short of full pharmacare, he recommended a $1-billion "catastrophic drug transfer" to cover 50% of the cost of drug insurance plans in excess of $1,500 per person a year, a strategy that would improve access to necessary medications for people with severe, chronic psychiatric disorders such as schizophrenia and bipolar disorder. The report also called for an improvement in services to rural and remote communities, including Aboriginal communities. Consistent with our previous discussion of best practice models and evidence-based treatment, the report stated that the principle of **accountability** must be added to the Canada Health Act.

Numerous mental health professional and advocacy groups (e.g., CAMIMH) endorsed these and other key recommendations and urged the Minister of Health to include them in any proposed implementation plans, in order to offer hope to people with serious mental illnesses (see Canadian Psychological Association, 2003). Further, the proposed transformation strategies (such as for primary care and services to remote areas) were presumed to offer a chance to improve integration of primary care and mental health reforms. However, Romanow subsequently expressed frustration because his recommendations had not been implemented (Romanow, 2006; Walkom, 2003).

The Senate Committee Final Report

On May 9, 2006, the Senate Committee on Social Affairs, Science and Technology released its final report relating to mental health, mental illness, and addiction in Canada. Michael Kirby was chair (see photo) and Wilbert Keon deputy chair of the three-year study that culminated in the most comprehensive report on mental health in Canada ever completed. The committee held public hearings in every province and territory, offered two online questionnaires, received briefs (including from CMHA, CAMIMH, and CPA), conducted literature searches, and explored international innovations before preparing the report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada,* also known as the Kirby Report (Kirby & Keon, 2006). In a subsequent interview, Kirby stated:

> *"We managed to ignore the issue of mental health for a very long time. If you look at the services on the ground, they are hugely fragmented. There is no cohesive, patient-oriented system. Mental health*

THE CANADIAN PRESS/Sean Kilpatrick

Michael Kirby chaired the Senate study that resulted in a 2006 comprehensive report on mental health in Canada. After retiring from the Senate, he was subsequently appointed chair of the Mental Health Commission of Canada. Most recently, he was promoted to officer of the Order of Canada, which recognizes a lifetime of achievement and merit of a high degree, especially in service to Canada or to humanity at large.

> *has not been at the top of the political agenda. The overwhelming reason for that is the stigma of mental health, which is the reason it has never had the kind of public support that other health issues, such as cancer, have had. The second reason is that services for the mentally ill do not fall under a single department—some aspects address health, others relate to housing or training."*
>
> *(Andresen, 2006, p. 39)*

The Senate committee put forward 118 specific recommendations for transforming Canada's mental health system. Two recommendations were key—the creation of the Mental Health Commission of Canada and the Mental Health Transition Fund.

1. Mental Health Commission of Canada: The commission would pave the way for a national action plan. It would complement work being done by people and existing structures at all government levels and be designed according to two key principles: an independent not-for-profit organization at arm's length from governments and existing stakeholder organizations, and one with a central focus on those living with mental illness and their families. The committee recommended that the commission be composed of 19 members (one-third from governments and two-thirds without any government connection), independent of narrowly focused interest groups.

   The mission of the commission would be to:

   - Act as facilitator, enabler, and supporter of a national approach to mental health issues.
   - Be a catalyst for reform of mental health policies and improvements in service delivery.
   - Educate all Canadians about mental health and increase mental health literacy.
   - Diminish the stigma and discrimination faced by mentally ill Canadians and their families.

   The commission was agreed to by all the provinces and territories, except Quebec (for constitutional reasons). Its important work has been mentioned in several places in this chapter.

2. Mental Health Transition Fund: The Mental Health Transition Fund was created to allow the federal government to make a time-limited investment to cover transition costs and to speed the process of developing a community-based system of mental health service delivery. The provinces and territories would decide how to allocate the funds.

1.5 Delivery of Psychotherapy: Issues and Challenges

> *"The best practice will continue to be based on the best science."*
>
> *—Alan E. Kazdin on evidence-based treatment and practice (2008, p. 157)*

Restructuring health care services has implications for people treated with psychotherapy or a combination of psychological and biological interventions. Evaluation of the effectiveness of psychotherapy has become a significant issue because of the increasing demands placed on psychotherapists by both the universal health care system and third-party insurance companies (Hunsley & Johnston, 2000). Psychotherapists are being asked to restrict themselves to the most effective and efficient treatments. Professional organizations are becoming involved as well. For example, the Section on Clinical Psychology of the Canadian Psychological Association has been spearheading efforts to reach consensus on which treatments are supported by enough controlled data to be regarded as an **evidence-based treatment** or psychological practice (Hunsley, Dobson, Johnston, & Mikail, 1999; also see Epp & Dobson, 2010; Hunsley & Lee, 2007).

Since time-limited psychotherapy is available as an alternative to classic psychodynamic treatment, which sometimes requires many years, provincial governments concerned about cost-effectiveness are limiting or attempting to limit the use of classical analysis and other forms of long-term psychotherapy within the medicare system. Medication-based treatments benefit from the major marketing efforts of huge pharmaceutical companies. In contrast, evidence-based psychological and psychosocial interventions rarely reach the average client in a timely fashion and when they do, research on the quality of care for various disorders sometimes shows gaps between treatments shown to be efficacious in clinical research trials and the care provided people with these problems "in the real

world," leading Unutzer (2008) to question if "this tremendous activity in clinical research is having an impact on the millions of patients living with depression and anxiety disorders or if this important work is 'getting lost in translation'" (p. 726).

What do the data indicate? Hunsley and Lee (2007) examined 35 "effectiveness" studies on a variety of disorders and concluded that improvement rates as a result of cognitive behavioural therapy were comparable in actual clinical practice to the improvement rates or outcomes ("efficacy") obtained in randomized, tightly controlled clinical trials within an experimental setting. (Cognitive behavioural therapy, which seeks to change people's thought patterns to help overcome some disorders, is discussed in later chapters.) The issues are complex. As noted by Kazdin (2008), "Researchers and clinicians alike see dangers in prescriptive and inflexible treatments" (p. 146). In fact, most psychological treatments are implemented in a flexible way (see Murphy et al., 2009). We will revisit these issues in Chapter 17.

Wait Times for Treatment

One of the most vexing problems for those who require mental health services is the problem of wait times. The Fraser Institute provides an annual report each year (see *Waiting Your Turn: Wait Times for Health Care in Canada,* see Barua & The Fraser Institute, 2015) and it includes an emphasis on access to psychiatric services. The national median wait time for those seeking psychiatric treatment (i.e., the time to begin a treatment program after being referred by a general practitioner to a psychiatric specialist) in 2015 was 19.8 weeks, which far exceeds what specialists believe is appropriate. More specific findings included the following:

- The shortest wait times were in Ontario, British Columbia, and Manitoba (15.8, 18.5, and 19.5 weeks, respectively).
- The longest wait times were in Newfoundland and Labrador (59.0 weeks) followed by New Brunswick (51.0 weeks). Data were not available for Prince Edward Island, which tends to historically have one of the longest wait times.
- The time spent waiting for treatment after an appointment with a specialist was longer than the wait to see a specialist after GP referral.
- The median wait time to see a psychiatrist on an urgent basis was 2.0 weeks, whereas on an elective basis it was 8.2 weeks.
- Among specific treatments surveyed, patients waited longest to enter a housing program (20.0 weeks), whereas wait times were shortest for pharmacotherapy (4.1 weeks). Wait times for an eating disorders program was 16.0 weeks.

The same conclusion reached in previous years was once again reached following the latest reports—that is, people in Canada continue to wait far too long for necessary treatment. (Barua & Fraser Institute, 2015).

The problem of long wait times continues to be a pressing national concern. It became the headline story in February 2016 when some Ontario parents said that a key factor when their daughter attacked students at her school was the hopelessness she experienced while waiting over a year and still not receiving mental health treatment. A group called the Wait Time Alliance concluded in 2014 that no significant progress has occurred in terms of reducing wait times (see www.waittimealliance.ca). Reports of wait times from at least three months to over a year have surfaced and seem far too common. Wait times of over one year for treatment for eating disorders have been discussed widely in the media. A federal report quotes psychiatrist Wendy Spettigue as having told the Parliamentary committee studying eating disorders that when the wait list for eating disorder treatment hit the one-year level, the Children's Hospital of Eastern Ontario decided to close its program because the situation was simply unacceptable; as a result, those on the waiting list were sent back to their family doctors in order to receive more immediate care (Report of the Standing Committee on the Status of Women, 2014). A web-based survey of 379 agencies in Canada found that only about 3 in 10 agencies providing treatment to children and adolescents were mostly or always able to meet the wait time benchmarks set out by the Canadian Psychiatric Association (Kowalewski, McLennan, & McGrath, 2011). Long wait times are believed to be playing a role in recent trends suggesting that there is a dramatic 53% increase in children and adolescents presenting to hospital emergency rooms due to mental health problems (Canadian Institute for Health Information, 2015). Clearly, a very important question to keep asking is what is happening in each province to proactively address unmet needs and shorten wait times in order to address not only current concerns but also anticipated concerns as the Canadian population continues to grow and there is an increasing proportion of older Canadians. The lack of timely access for seniors is also a very salient and growing concern.

Help-Seeking and Perceived Need for Help

The problem of lengthy wait times would be substantially greater if everyone in Canada who needed it asked for help. Extensive evidence indicates that the majority of people who need help do not seek it. For instance, the Ontario Health Survey (*Mental Health Supplement*) determined that 7.8% of respondents used mental health services in the past year (Lin et al., 1996). About half of those seeking help had a concurrent psychiatric diagnosis. The vast majority sought help from outpatient service providers. Over 75% of those with a disorder in the past year did not seek help; however, 27.1% of those who sought help did not qualify for a diagnosis. Lin et al. (1996) concluded that there is a mismatch between people's needs and the care received. Although the strongest predictor of help-seeking was psychiatric diagnosis, help-seeking was also associated with marital disruption and poverty.

Another study confirms that professional services are underused. The Women's Health Study conducted in Ontario found that only about 5 out of 10 women with at least one lifetime psychiatric disorder sought mental health services (Frise

et al., 2002). The presence of three or more disorders—called "comorbid" if they exist simultaneously—was associated with increased likelihood of seeking help, but it was still the case that 35% of women with three or more disorders did not seek help.

This problem of underuse may be underestimated because women are actually more willing to seek help than men. An analysis of data from the *Mental Health Supplement* to the Ontario Health Survey confirmed the existence of gender differences in the use of outpatient mental health services for mood disorders, anxiety disorders, substance-use disorders, and anti-social behaviours (Rhodes, Goering, To, & Williams, 2002). Moreover, these gender differences remain evident after controlling for differences in type of mental disorder and associated differences in social and economic factors. Vasiliadis, Tempier, Lesage, and Kates (2009) reported that men are less likely to consult with a family physician and other resources (although not with a psychiatrist). They concluded that there is a need to design promotional campaigns emphasizing the need for men to seek mental health care.

One of our motives in writing this book is to highlight issues that pertain to young people aged 15 to 24 years old, who are considered to be in a category that researchers refer to as "emerging adults." Many readers of this book are in the emerging adult category. What is known about the mental health needs and service use of emerging adults? Bergeron et al. (2005) examined a subsample of young Canadians (aged 15 to 24 years) from the CCHS data set who were identified as having a mood disorder, an anxiety disorder, or a substance-related disorder in the 12 months preceding the survey. They concluded that there is a particular need for interventions to encourage service use in young men, young persons living with their parents or unrelated others, and young people diagnosed with an anxiety or a substance-related disorder (relative to those with a mood disorder). The need to encourage help-seeking among young men was also noted by Marcus et al. (2012) in their study of mental health literacy because of a tendency for young adult males to prefer to solve mental health problems on their own.

Findlay and Sunderland (2014) investigated the mental health supports and service use for Canadians between the ages of 15 to 24 years by examining results from the 2012 Canadian Community Health Survey—Mental Health. Overall, 12% reported consulting health professionals about emotional, mental health, or substance abuse problems in the past year, but 27% consulted informal sources such as family or friends. The decision to consult other people was predicted by three factors (i.e., having a chronic physical condition, having a higher level of distress, or having experienced a traumatic experience in childhood). Two findings are particularly troubling. First, many young people relied solely on the Internet, and hopefully acquired accurate information. The authors highlighted the fact that the Internet is not regulated and as a result, there is a need to develop e-health literacy in young people (as well as people in general). Second, only about half of those with a mental disorder and only 1 in 4 with a substance disorder used professional services. Thus, it seems that many young people are not seeking help and a substantial proportion of these young people may be hiding their distress behind a front or façade. As we see below, this may help set the stage for deaths due to suicide.

Completed suicide is the second-leading cause of death for young Canadians (see Cheung & Dewa, 2007), and as indicated above, many depressed and suicidal adolescents and young adults do not receive mental health services. Cheung and Dewa (2007) used data from the CCHS to identify young people, aged 15 to 24 years, who screened positive for depression and suicidality in the past 12 months. Their findings confirmed that almost 50% of adolescents and young adults with depression and suicidality do not access any mental health services. Another stark indication of the consequences of the failure to seek help can be found in statistics from Ontario. An analysis was conducted of the 370 adolescent suicides that took place between the years 2000 to 2006 (Soor et al., 2012). Analyses were based on data obtained from the Office of the Chief Coroner of Ontario. Among Canadians of all ages, there is usually a 3:1 or 4:1 gender difference in completed suicides (that is, males are three to four times as likely as females to commit suicide). However, this study found that among younger people, there was increased suicide among females, with there being a 2:1 ratio of suicide among adolescent males versus females. More importantly, it was found that only 66 of the 370 adolescents who took their lives had previously received psychological treatment of any kind. Given that the vast majority did not receive any form of treatment, there is a strong possibility that many of the adolescents who killed themselves had a suicide without any apparent warning signs. The major clinical implications of these data are obvious: there is a need to increase service use in depressed and suicidal young people and reduce the unwillingness to seek help.

To what extent do you university students and college students seek help when it is needed? This issue is the focus of Student Perspectives 1.1.

The greater risk associated with low SES seems to be due, at least in part, to widespread socio-economic disparities in accessing the system. Steele, Glazier, and Lin (2006) made the point that simply having a system that theoretically provides universal and equitable coverage is not enough. Their study, conducted in Toronto, found that people with high SES, relative to people living in the lowest SES neighbourhoods, were 1.6 times more likely to use psychiatric services (even though poverty contributes to a greater prevalence of mental disorder). It seems that little has changed in recent years. These data point to the need to develop outreach programs that target low-income people and implement innovations that enhance their access to treatment.

The Human Costs of Deinstitutionalization and Limited Access to Service

As stated previously, Canada has undergone an extensive process of psychiatric bed reduction and closure. Unfortunately, the consequences of **deinstitutionalization** in an

Student Perspectives 1.1

Help-Seeking Attitudes and Behaviours in University and College Students

We have seen that only a relatively small proportion of those who need to seek help actually do so. Is it any different for university and college students? Unfortunately, the situation is the same and research here sometimes yields findings that seem paradoxical, at least on the surface. An investigation of 302 Australian university students found that as levels of suicide ideation went up, respondents reported less willingness to seek help from family, friends, and professional mental health care providers. This tendency was exacerbated among those who had suicide ideation and high levels of depressive symptoms (Wilson & Deane, 2010). The pattern of findings is consistent with a follow-up study of over 5,000 high school students that found once again that as depression levels increase, there is less willingness to seek help from anyone (Sawyer et al., 2012). It seems that many students are suffering in silence and they are not getting help.

Eisenberg and his colleagues conducted a much broader investigation. Online surveys assessed students from 26 campuses around the United States. Overall, among those deemed in need, only 36% received any treatment in the previous year and the proportion of students who used psychotherapy was about the same as the proportion who used medication. Predictors of not seeking help included low perceived urgency and a negative attitude about the usefulness of help (Eisenberg, Hunt, Speer, & Zivin, 2011).

What are some other predictors of negative help-seeking attitudes among students? A comprehensive analysis of 19 previous studies involving over 7,000 participants focused on nine predictors. Nam et al. (2013) found that almost all nine factors were associated with more negative help-seeking attitudes, but the three most robust predictors were self-stigma (i.e., internalized stigma beliefs), negative beliefs about anticipated benefits, and low levels of trait self-disclosure. Recent data indicate that anticipated benefits still facilitate help-seeking, while perceived barriers to help-seeking tend to contribute to more negative overall attitudes (Kim & Zane, in press). This study was conducted in the United States and found that Asian American students, relative to White American students, had less favourable attitudes overall.

One barrier for university and college students seeking psychological treatment is the coverage available to students through extended health insurance programs. A recent national survey found that most available programs in Canada cover the costs of drug treatment up to a yearly maximum of $3,000 in the majority of instances. However, the modal level of treatment coverage for psychological treatment was between $300 and $500. Thus, very few plans allow for necessary psychological treatment (see Nunes et al., 2014).

Thinking Critically

1. Do you believe that other students do in fact secretly hold stigmatizing beliefs and would react negatively to a fellow student who sought help? Or is today's university student less likely to hold negative opinions?
2. If you were going to design a brochure for students to get them to seek help, what key messages would you emphasize? What would you tell students who say they are simply too busy to get help? Do you have insights that might help explain why males are less likely to get help?

era of escalating needs for services are multiple and include homelessness and a lack of supported housing, the jailing of the mentally ill, the failure to achieve an ideal of community-focused care for people with mental disorders, a lack of home care, insufficient intensive case management, too few community-based crisis response systems, concerns about community treatment orders, and so forth. Although deinstitutionalization was a well-intended attempt to reintegrate the mentally ill with the rest of Canadian society and to prevent involuntary hospitalization and treatment, to this point many professionals and "psychiatric survivors" or "consumers" would consider it an abject failure. We will revisit some of these issues in Chapter 18.

At the beginning of this century, there were approximately 370 general-hospital psychiatric units in Canada, providing about 10,000 inpatient beds with provincially mandated services that include inpatient care, outpatient care, daycare, emergency care, and consultation (Goering et al., 2000). However, the preferred mental health service model is one that emphasizes intensive local community supports and services, along with the general-hospital psychiatric units and regional tertiary care centres (the provincial psychiatric hospitals or their replacements).

The most recent Canadian Institute for Health Information analysis (from 2008) reported that psychiatric patients are being discharged earlier. The shorter general hospital stays were hypothesized to be due to the pressure to free up hospital beds, which frequently results in people being discharged prematurely. As noted by Dr. Patrick White, President of the Canadian Psychiatric Association, "there's continuous pressure to get patients admitted, treated and out" (Tam, 2008).

We will briefly mention two national problems that are the subject of a more extensive analysis in Chapter 18: (1) homelessness and mental illness and (2) the jailing of mentally ill people. It is important to take a closer look at homelessness and mental illness due to the magnitude of the problems and the continuing need for services and effective solutions. Clearly, for some people, mental illness had contributed to homelessness, while for others, the experience of becoming homeless has contributed to mental health problems. But, of course, it is important to reiterate that only a proportion of people who are homeless are mentally ill.

While much of the research on homelessness is cross-sectional and focused on only one time point, a longitudinal study conducted with young people in the United States indicates that it is possible to use psychological vulnerabilities to identify those who are more likely to become homeless. Participants were first assessed in 1994–95 when they were between the ages of 11 to 18 and then they were followed up in 2001 when they were now in the age range of 18 to 28 years old. It was found at follow-up that among the more than 10,000 participants, 428 had been homeless at some point since first being assessed. All of the risk factors evaluated at Time 1 were significant individual predictors of subsequent homelessness, including higher levels of depression, lower levels of self-esteem, delinquency, substance use, and poorer neighbourhood quality. A regression analysis showed that the three most robust and independent predictors were poor family relationship quality, school adjustment problems, and experiences of victimization (see van den Bree et al., 2009). Thus, for many, homelessness is a reflection of earlier challenges and earlier vulnerabilities, but we must also allow for the fact that for many, homelessness is simply rooted in misfortune or possibly starting out life in a family dealing with poverty.

Multiple factors have contributed to an increase in the number of mentally ill homeless people in Canada. While the primary focus is on deinstitutionalization, organizations such as the Canadian Alliance on Mental Illness and Mental Health point to the period in the 1990s when provincial governments decreased welfare benefits and did not invest sufficiently in social housing (see www.camimh.ca).

Another pressing problem is the use of incarceration as a way of addressing mental health problems among prisoners. This is a problem experienced in many areas of the world. A shocking report in 2010 from E. Fuller Torrey and his associates, which was based on data from 2004–05, concluded that in the United States, there are many more mentally ill people in jails and in prisons than in hospitals (see Torrey et al., 2010). How many more? They reported that there were 300% more patients with serious mental illness incarcerated than in hospitals. An editorial in the journal *Current Psychiatry* called this a crisis that has reached the point where the incarceration of mentally ill people is at the levels that existed in the 1840s (see Nasrallah, 2012). The editorial stated that deinstitutionalization has gone too far and asked, "Why are we building more jails and prisons instead of therapeutic communities?" (p. 4). In 2010, there was only one psychiatric bed per 3,000 Americans, whereas in 1955, there was one psychiatric bed per 300 Americans. This editorial concluded with a plea for a modern-day Dorothea Dix to illuminate this problem.

The issue of incarcerating mentally ill people became an extremely salient one in Canada as a result of the case of Ashley Smith, who strangled herself in 2007 at the Grand Valley Institution for Women in Kitchener, Ontario. In total, Smith had been shuffled between an estimated 17 prisons and treatment centres in the past year. Prison staff members were seemingly in a position to intervene but did not stop the suicide from occurring. Did her extensive history of aggressive behaviour and acting out merit a more proactive approach that would have resulted in better treatment? Do you think her death could have been prevented?

Public debate about this situation continues at the national level. In October 2012, the Canadian Psychological Association and the Canadian Psychiatric Association issued a joint appeal for urgent action to address the mental health needs of mentally ill people in jails and prisons. In the meantime, the 2012 national report from the Office of the Correctional Investigator indicates that the problems in Canada are growing at a troubling rate (see Correctional Investigator of Canada, 2012). Rates of mental illness detected at intake doubled between 1997 and 2008. Overall, 13% of male inmates and 29% of women inmates have mental health problems at intake. The mental health needs of women are particularly acute. Estimates indicate that 50% of federally sentenced women report histories of self-harm, and over half report a current or past addiction. In addition, 85% report a history of physical abuse and 68% report a history of sexual abuse.

The Correctional Investigator of Canada, Howard Sapers, identified seven urgent mental health needs in his report, including the following:

- Create intermediate health care units.
- Increase capacity at regional treatment centres.
- Recruit and retain more mental health professionals.
- Expand the range of alternative mental health service delivery partnerships with the provinces and territories.

As noted above, these issues will be re-examined in Chapter 18 where the focus is on legal and ethical issues, including the issue of the rights of mental patients.

Community Psychology and Prevention

Much of our discussion of therapy and interventions has focused on situations in which professionals make themselves available to clients in offices, clinics, or hospitals. This type of service delivery, long referred to as "the waiting mode" (Rappaport & Chinsky, 1974), is characteristic of traditional therapy, whether inpatient or outpatient. **Community psychology** in contrast, operates in "the seeking mode." Rather than waiting for people to initiate contact, community psychologists seek out problems, or even potential problems. They often focus on **prevention**, in contrast to the more usual situation of trying to reduce the severity or duration of an existing problem. We must focus to a much greater degree on preventive measures if we are ever going to solve the problem of mental illness in Canada. In particular, there is a need for programs that promote the psychological, social, and physical well-being of all people in Canada.

Although we have had some success, we have a long way to go. For example, despite a proclamation by governments in Canada that child poverty would be eliminated by the year 2000, it actually increased (Denton, 2000). Nonetheless, there are ongoing programs that promise to fulfill prevention goals in the future. Here is one example. In 1995 the federal government established Aboriginal Head Start to help the development and school readiness of Aboriginal children by meeting their

psychological, emotional, social, health, and nutritional needs. The initiative is intended to "encourage the development of locally controlled projects in First Nations communities that strive to instill a sense of pride, a desire to learn, provide parenting skills, foster emotional and social development, increase confidence, and improve family relationships" (Health Canada, 1998, p. 1). The program has continued to expand and, as of 2010, receives $59 million annually for over 9,000 children in more than 300 Aboriginal Head Start programs.

We will examine prevention and community psychology programs throughout this book. These programs often focus on attempting to reduce "risk" factors and to facilitate the development of "protective" factors (see Chapter 2). Examples of these programs include:

- efforts to prevent educational deficits and associated social and economic disadvantages
- eating-disorder prevention programs
- programs for the early detection and prevention of schizophrenia
- school-based prevention and early intervention programs for anxiety
- school-based programs for the prevention of cigarette smoking
- the establishment of suicide prevention centres with telephone hotlines that desperate people can use to survive a suicidal crisis
- a parent and child training program for francophones in Montreal to prevent early onset of delinquent behaviour.

Consistent with the Aboriginal Head Start program, many prevention programs in Canada focus on children (see Prilleltensky & Nelson, 2000). According to Nelson, Lavoie, and Mitchell (2007), Quebec led the way in progressive prevention policies, including its $7 per day childcare program, and in developing an infrastructure for community-based prevention programs. Further, while numerous programs emphasize interventions that reduce the incidence of disorder, governments in Canada, led by the federal government (see Government of Canada, 2006), are increasingly focusing on *mental health promotion;* that is, they are concentrating on enhanced functioning, well-being, and optimal functioning. (For a discussion of the distinctions between prevention and promotion and Canadian guidelines and proposals, see Epp [1988], *Mental Health for Canadians: Striking a Balance.*) Unfortunately, widespread prevention and promotion programs are simply not possible in Canada with the current resources available. Nonetheless, the contributions of community psychologists are numerous and varied, especially in Quebec, which has made a greater commitment to promotion and prevention in health care and social policies relative to other provinces (see Nelson et al., 2007).

A New Beginning: Canada's Mental Health Strategy

A good place to end this chapter is by providing a summary of Canada's new beginning that was unveiled in 2012. The announcement of Canada's national mental health strategy was long overdue but it is clear that the time is right for building momentum for progress on the mental health front. You are encouraged to read the full document when time permits (see http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf). You will see that this extensive document, titled *Changing Directions, Changing Lives,* is built on six key strategic directions. These strategic directions represent important values and goals that touch on many themes included throughout this book. The six strategic directions are the following:

- Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
- Foster recovery and well-being for people of all ages living with mental health problems and illness, and uphold their rights.
- Provide access to the right combination of services, treatments, and supports, when and where people need them.
- Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs to diverse communities and Northerners.
- Work with First Nation, Inuit, and Metis citizens to address their distinct mental health needs, acknowledging their unique circumstances, rights, and cultures.
- Mobilize leadership, improve knowledge, and foster collaboration at all levels.

This plan will work only to the extent that public and private resources are dedicated to the mental health and well-being of people in Canada. Resources need not be entirely financial, so if you have the opportunity to volunteer your time, you should definitely consider doing so. In fact, volunteerism is a protective factor that improves most people's mental health, especially when they are simply motivated by the desire to help (Weinstein & Ryan, 2010).

Summary

1.1 The study of psychopathology is a search for why people behave, think, and feel in unexpected, sometimes bizarre, and typically self-defeating ways. Much less is known than we would like. Several characteristics are considered in evaluating whether a behaviour is abnormal: statistical infrequency, violation of societal norms, personal distress, disability or dysfunction, and unexpectedness. Each

characteristic tells us something about what can be considered abnormal, but none by itself provides a fully satisfactory definition. It is impossible to offer a simple definition that captures abnormality in its entirety.

1.2 The field of abnormal psychology has its origins in ancient demonology and crude medical theorizing. Since the beginning of scientific inquiry into abnormal behaviour, two major points of view have vied for attention: the somatogenic, which assumes that every mental aberration is caused by a physical malfunction; and the psychogenic, which assumes that the person's body is intact and that difficulties are to be explained in psychological terms. The somatogenic viewpoint originated in the writings of Hippocrates. After the fall of Greco-Roman civilization, it became less prominent, but then re-emerged in the eighteenth and nineteenth centuries through the writings of such people as Kraepelin. The psychogenic viewpoint is akin to early demonology. Its more modern version emerged in the nineteenth century from the work of Charcot and the seminal writings of Breuer and Freud. A number of issues and events are of historical and current relevance to students in a Canadian setting or to students who are particularly interested in developments in Canada. For example, Dorothea Dix played an influential role and there was a confluence of factors that led to the development of the first asylums, and that ushered in the institution-building era in Canada. Despite humane motives, the long-term results were not very positive, as can be seen by the treatment provided in some provincial psychiatric hospitals in the latter part of the twentieth century. In Canada the current emphasis is on psychiatric hospital bed reduction and closure.

1.3 There is ongoing concern about mental health stigma (i.e., negative attitudes and stereotypes about mentally ill people). Stigma internalized into a self-view is known as self-stigma. Extensive anti-stigma initiatives and mental health literacy campaigns are taking place in Canada and elsewhere. While significant progress has been made, it is still the case that a very substantial proportion of people endorse stereotyped views of mentally ill people and a proportion of these people turn these inappropriate views on themselves when they suffer mental illness.

1.4 The mental health system in Canada is closely tied to medicare, the universal health care system. The system will face many challenges in the future. There is a need for an increased focus on and funding for community-based interventions and prevention programs. The report from the Commission on the Future of Health Care in Canada (the Romanow Report) recommended that mental health be made a priority within the system. Specific recommendations included broadening medicare to include a limited number of home care services and some drug treatments. The Senate Committee Final Report (the Kirby Report) relating to mental health, mental illness, and addiction made 118 recommendations, including establishing a Canadian mental health commission to focus national attention on mental illness, and a proposal to fund the development of a community-based system of mental health service delivery.

1.5 There are many challenges related to psychotherapy and providing treatment. Deinstitutionalization and decreased government support have complicated the mental health problems experienced by certain homeless people. The timely delivery of services and growing wait lists are related challenges. Canada also has many improvements to make in terms of delivering mental health services to prisoners in jails and prisons and ensuring that people who should receive treatment do not instead end up incarcerated in a correctional facility. One positive development in the treatment of mental health problems was the release of the document *Changing Directions, Changing Lives,* which outlines our new national mental health strategy. This strategy has at its centre six strategic directions that emphasize such themes as mental health promotion, access to services and treatment, and the reduction of disparities in risk factors while remaining mindful of the rights of people from unique cultures.

Key Terms

abnormal behaviour
accountability
assessment
asylums
bedlam
Canadian Mental Health Association
cathartic method
clinical psychologist
clinicians
community psychology
community treatment order
counselling psychologist
deinstitutionalization
demonology
diagnosis
dissociative identity disorder
evidence-based treatment
exorcism
general paresis
germ theory of disease
medicare
mental health literacy
moral treatment
normal curve
prescriptive authority
prevention
provincial psychiatric hospital
psychiatrist
psychoactive drugs
psychoanalyst
psychogenesis
psychopathology
psychotherapy
schizophrenia
self-stigma
social worker
somatogenesis
stereotyping
stigmatization
syndrome
transinstitutionalization
trepanning

Reflections: Past, Present, and Future

1. Think about the material presented in this chapter and develop your own comprehensive definition of abnormal psychology. When you have finished the exercise, turn to Chapter 3 and think about how disorders are described and classified.
2. Think of someone you have heard about (or possibly someone you know) who appears to suffer from a psychological disorder or to behave abnormally at times. How would you conceptualize that person's disorder or behaviour in terms of the somatogenic and psychogenic hypotheses? We will examine modern scientific perspectives in the next chapter. You should know that current views typically integrate several perspectives or paradigms.
3. Is mental health the "orphan child" of medicare? Would you and your family and friends be willing to pay an extra nickel a drink to help cover most of the cost of the Senate Committee's proposed Mental Health Transition Fund?
4. How should we try to help the person who has a psychological disorder or problem? Are you in favour of biological interventions, psychological treatments, self-help, or social change? Do our views about the causes of psychological disorders affect our beliefs in how they should be treated?