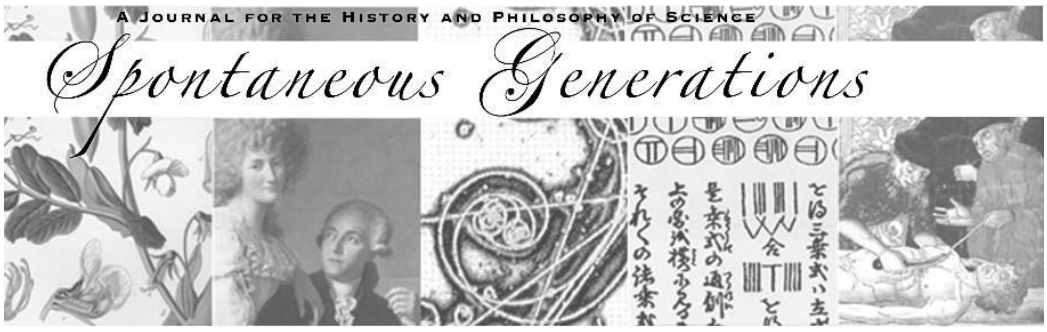

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Source: *Spontaneous Generations: A Journal for the History and Philosophy of Science*, 10 no. 1 (2022) 107-112.

Published by: The University of Toronto

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Published online at *jps.library.utoronto.ca/index.php/SpontaneousGenerations*

Spontaneous Generations **10:1** (2022). University of Toronto.

Reinventing Expertise in the History of Psychiatry and Eugenics

Erika Dyck

Abstract This reflection piece considers how expertise has been generated within the history of madness, disability, eugenics, psychiatry and anti-psychiatry. As numerous scholars and critics have pointed out, the power of rational argumentation can be persuasive, while its absence can be pathologized. Yet, in the fields of madness studies and critical disability studies we can see many examples of how the dividing line between normal and pathological states have been contested, especially where those categories correspond with notions of expertise, experience, and insight. This short paper reflects on these themes and draws from a selection of research case studies, in the hopes of encouraging other scholars to take up these questions in their own work to destabilize concepts of expertise as fixed categories of ability and skill. Instead, I use these examples to promote a more complex and diverse way of interpreting expressions of dissent as potential forms of expertise.

The history of psychiatry is fertile ground for examining the politics and consequences of expertise. The flowering of anti-psychiatry in the 1960s raised issues of power, authority, and expertise directly, stimulating intellectual critiques that coincided with social justice campaigns aimed at exposing abuses of power over minds and bodies. Many of the scholarly critiques emerged in a golden age of science, medicine, and technology, a moment characterized by a return or at least a reinvigoration of models of health that privileged biology over social or cultural context. Renewed faith in biological psychiatry, the identification of DNA's structure, the introduction of birth control pills, the establishment of the first Diagnostics and Statistical Manual (DSM) for psychiatric disorders, and a large-scale investment in psychopharmacology are just some of the elements that mark this moment in 1950s and 1960s history. These features have also attracted scholars to the thorny questions about how expertise and evidence distinguish between the normal and the pathological.[1] Questions about normalcy, tradition, and convention were not unique to psychiatry, but a concentration on how psychiatric expertise had been historically wielded, nourished deeper critiques of power in the 1960s that created space for new scholarly approaches.

In the post-war period there were a number of significant cultural and political shifts in power: a baby-boom in the west, shifting empires, whether expressed as independence in African nation states, ideological coalitions in the Soviet Bloc, or growing American political interests in Asia, redrawing political alliances and creating new economic markets. These dramatic power shifts on the international stage set the course for domestic activism, including labour strikes in Europe, feminist and gay liberation marches in North America, and environmental activism in South America. A

[1] G. Canguilhem, *The Normal and the Pathological* (Zone Books, 1989)

global reckoning of a burgeoning set of social movements sat poised to challenge the existing institutional, bureaucratic, legal and educational contexts, whether in the workplace, the bedroom, or at the United Nations. Psychiatry and its critics, of course, did not cause this moment, but they have been indelibly woven into this history either as culprits or stimulants for exercising new expressions of power and realigning identities away from older, traditional forms of power – whether nation states, patriarchy, or capitalism itself.

Beginning after the Second World War, amid the momentum of civil rights, feminism, and gay and lesbian rights movements, patients' rights groups also began campaigning for their place in a diversifying human rights movement. Disability rights activists engaged in aggressive campaigns for better access to services, while psychiatric patients and their families began lobbying for anti-stigma campaigns, alongside demands for adequate housing, basic health services, voting rights, and access to safe employment. The concept of "mad pride" emerged in the 1960s and, like other pride movements, challenged the notion that madness, or homosexuality, or femininity, were conditions to be studied and potentially treated rather than an identity to be accepted and celebrated.[2] At its heart, mad pride campaigns took aim at psychiatry for codifying mental health into a system of deficits and disorders that required medical interventions to fix, convert, or protect the individual. Conversely some critics looked to political action as a mechanism for producing a culture that envisions mental illness as part of a collective responsibility. One that might involve anti-poverty strategies, addressing basic housing and income needs, and other structural investments aimed at alleviating the kind of distress that exacerbated mental illness.

These academic critiques provided some of the intellectual, philosophical, and linguistic foundations for a more widespread social movement populated by those who had consumed and survived mental health services, or consumer/survivor movements.[3] The timing was important. In the 1960s, governments throughout North America and Europe began closing, downsizing, and repurposing large psychiatric hospitals.[4] This major transition in mental health service provision – from asylum-based care to an undifferentiated matrix of health, welfare, education, and labour supports – also gave rise to new forms of activism, as former patients and their families repositioned

[2] The first mad pride march took place in Vancouver, Canada in 1963. It was a very small event, so small that organizers barely remember it taking place. But small though it was, it helped to put madness on the map in terms of human rights movements in the 1960s. See, *The Inmates are Running the Asylum: Stories from MPA*. Ian Anderson, Magdelanye Azrael, Dave Beamish, Lanny Beckman, Megan Davies, Avi Dolgin, Arthur Giovinazzo, Patty Gazzola, John Hatfull, Jackie Hooper, Marina Marrow, Irit Shimrat, and Alex Verkade contributing. *History of Madness Publications* (2013). (Video is available on https://madnesscanada.com, accessed March 30, 2021).

[3] G. Coleman. "The Politics of Rationality: Psychiatric Survivors' Challenge to Psychiatry," in *Tactical Biopolitics: Art, Activism, and Technoscience*, eds. B. da Costa and K. Philip (MIT Press, 2008): 341-364.

[4] For more on this topic, see a few examples: K. Kendall, "From Closed Ranks to Open Doors: Elaine and John Cummings' Mental Health Education Experiment in 1950s Saskatchewan," *Histoire Sociale/Social History* 44 no. 88 (2011): 257–286; C. Dooley, "The End of the Asylum(town): Community Responses to the Depopulation and Closure of the Saskatchewan Hospital, Weyburn," *Histoire Sociale/Social History* 44 no. 88 (2011): 331–354; G. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton University Press, 1991).

themselves in civil society.

This context of questioning, resisting, and articulating counter-narratives to a story of scientific progress made its mark on scholarly approaches, but it also had the potential to invigorate a democratizing agenda when it comes to studying expertise and identifying and valuing historical evidence.

A Case for Eugenics

The history of eugenics is typically, and convincingly, explained as an egregious abuse of power, and an exercise in expertise wielded over people. While the history of abuse is clear, studying the history of eugenics also allows us to engage with a critique of expertise directly. In some ways it is easy to regard the authorities overseeing eugenics programs as unequivocal examples of experts who have abused their power. I suggest that we have another opportunity, in the case of eugenics, to interrogate expertise if we consider listening to people who are experts based on lived experience. Listening to ex-patients, victims, and survivors of the eugenics program provides a different approach to studying eugenics, and helps to recalibrate the power dynamics as we work through how to remember and what to memorialize about this past.

I focus on the province of Alberta.[5] Alberta introduced its Sexual Sterilization Act in 1928, which in effect created a body of experts who visited mental hospitals and homes for feeble minded children to determine whether any of their residents should be sterilized because they were deemed "unfit to parent." In 1937, almost a decade into the program and after a change of government, the province amended its Sterilization Act, to remove the need for informed consent for any such candidates whose IQ fell below 70. Such people, as evaluated by the Eugenics Board, were considered too disabled or too "mentally defective" to be able to appreciate concept of consent, and therefore their consent was not sought. As a result of these changes, after the Second World War the Alberta Eugenics Board increased the numbers of people cleared for sterilization surgery. In the first decades of the program Ukrainian and eastern European immigrants were sterilized at a higher rate than other ethnic or racialized groups. By the late 1960s, however, that situation changed dramatically. Between 1969 and 1972, the rates of sterilizations performed on First Nations and Métis women outpaced all other categories, representing 25% of all sterilization surgeries in this period.[6] The program ended in 1972, after nearly 3,000 people had been sterilized, often without their knowledge.

The timing of the changes in the program is significant. 1969 is the year that the Canadian government decriminalized contraception, including elective or voluntary sterilization, allegedly responding to demands from feminists for safe access to health services that enshrined the concept of reproductive choice. It was also the year that the federal government introduced its famous White Paper, which provided a roadmap for dismantling the Indian Act and removing the status associated with First Nations identity. Leaders of an emerging red power movement accused the federal government of being engaged in a form of cultural genocide. Information about a "sixties scoop" or the apprehension of Indigenous children from their homes, combined with the

[5] E. Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (University of Toronto Press, 2013).

[6] J. Grekul, J., Krahn, A., Odynak, D, "Sterilizing the "Feeble-Minded": Eugenics in Alberta, Canada, 1929–1972," *Journal of Historical Sociology*, 17: (2004): 358–384. https://doi.org/10.1111/j.1467-6443.2004.00237.x

assimilation efforts created through Residential Schools, provided ample evidence that colonial experts had been complicit in a process of cultural genocide.

Maureen Lux and I investigated this history further, finding that Indigenous women, including Inuit women living in the Northwest Territories and Métis and First Nations women living in western Canada had been confronted by a paradoxical situation: for many, the contemporary feminist models of health did not appropriately meet their needs for adequate maternal and infant health services, without pressure to embrace birth control or accept abortion options. Yet, for women voluntarily seeking these services in northern Canada, the options were also extremely limited.[7] Depending on whose voices are prioritized in this history, we get very different evaluations of both the abusive nature of the eugenics program, but also the inadequacies of elective reproductive health services, the racialized interpretation of normal and pathological, and the colonial legacy of reproductive politics and family planning.

Canada's eugenic program and its proponents have been subjects of history, but the perspective and experiences of the people sterilized continue to be cast as statistics, evidence of abuse, and rarely as experts in their own right. Some of this focus is due to the reality that experts more readily leave a documentary trail of evidence. I suggest that it is time to flip that narrative. Taking cues from social historians, critics of psychiatry, and social justice movements, I suggest we invert the study of expertise from highlighting the perspectives of paid officials to those of patients whose allegedly disordered lives justified the need for experts in the first place.

Psychiatrized Patients or Experts by Experience?

In 1944, 18-year-old Doreen was brought before the Alberta Eugenics Board who recommended her for sterilization. And, like other patients who came before the board in the 1940s, Doreen was not asked for her consent, nor was the operation explained to her; many patients were told that they were having their appendixes removed.

Studies in the 1990s to the present show that mental illness is one of the highest indicators of living below the poverty line. For Doreen, and the thousands of other men and women like her who were discharged from mental hospitals in the 1960s and 1970s, admitting to having a disorder or that you had lived in an institution often led to poverty and social alienation. Doreen, however, took a different approach to her circumstances and "leaned in" (to use Cheryl Sandberg's phrase). At the age of 50, Doreen left the institution for the first time since age 18, and not only sought out opportunities to help other deinstitutionalized people, but began organizing support groups for those who had recently left psychiatric institutions. I see her actions and accomplishments as proof of both resistance and resilience, and her life is a testament to thinking about expertise differently. Doreen's embodied experiences, her expertise-by-experience, and her commitment to sharing her life allows us to incorporate her insights. It encourages us as scholars to rethink what counts as evidence, whose voices qualify as "expert," and how we rethink our own historical craft in order to democratize expertise.

Doreen's example is one that I have written about elsewhere because it so deeply inspired me to critically engage with this idea of expertise, evidence, and how we think about experience. New approaches to understanding and categorizing illness at mid-20th century created different labels for experiences and new explanations for behaviour, character, habits, and even relationships, urging us to consider the scope or

[7] E. Dyck and M. Lux, *Challenging Choices: Canada's Population Control in the 1970s* (McGill-Queens University Press, 2020).

scale of expertise. What if patients and ex-patients were experts?

Kay Parley also reflected on what expertise meant for her, as someone who had lived through these profound social changes. She was the daughter of a man who had long been considered "difficult"; he had lived for some time in a psychiatric institution, and was later described as "incurable."[8] The precise diagnosis was neither clear, nor did it matter to her, other than to raise her curiosity and fears about the true nature of her father. He had lived in an institution since Kay was four years old. They had had no contact since she was a young child and her mother avoided talking about him, leaving Kay to wonder what was wrong with him and whether she would succumb to his fate.

Before going to college Kay was also institutionalized where she was told that she had schizophrenia. "It seems unlikely that I will be able to say anything understandable about schizophrenia, because as a sufferer I've never felt certain, to begin with, that I am living with schizophrenia."[9] She became a resident of the Saskatchewan Mental Hospital at Weyburn for 10 months. Deeply affected by her experience, and with her symptoms in remission, she resolved to work in the mental health field. At college she entered nursing and graduated as a psychiatric nurse, which further encouraged her to reflect on this period in the hospital and her diagnosis:

> I had all the symptoms of manic-depressive psychosis, paranoia, or even a character disorder coupled with neurosis. I still don't know whether I really had schizophrenia, what type of schizophrenia I had, and I don't think I want to know. It would be entirely irrelevant. I've had to adjust to this strange upsetting personality and I've learned to cope with some facets of it while others are still baffling me. Labeling it with a name wouldn't be of any use and might complicate things more by setting up a number of expectations.[10]

Kay casually pointed out how irrelevant the diagnosis was for her as a patient, excepting that it had the potential to establish "expectations." In her subsequent writing she alluded to a set of roles or characteristics that accompany such a diagnosis, which often followed an individual into another setting or even overwhelmed their identity such that they *become* known merely as a disorder, in this case schizophrenia, rather than knowing her first as a person, Kay, a woman who *has* schizophrenia. Repositioning patients in the history of psychiatry as people first, also helps to reclaim them as experts through lived experience.

The way we use evidence is political, and the way we use our expertise is worth reflecting upon. In the history of psychiatry, patients or consumers are often regarded as people in need of protection, and in the history of eugenics and psychiatric institutionalization this paternalistic attitude more often than not contributed to rendering patients voiceless. As historians we have an opportunity to change the way we engage with experts by considering lived experience as valid historical evidence. Doing so does not undo past injustices, but we might alter the historical narratives about what is worth remembering.

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[8] N. Macdonald, "The Other Side: Living with Schizophrenia," *Canadian Medical Association Journal* 82 (1969): 219.

[9] Ibid.

[10] Ibid: 218.

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