From a belief in ‘biology as destiny’ to an environmental perspective of mental health

The impact of the Canadian National Committee for Mental Hygiene on education in Ontario, Canada, 1920-50

SHIELA L. CAYANAGH, UNIVERSITY OF WESTERN ONTARIO

This article considers the impact of the Canadian National Committee for Mental Hygiene (CNCHM) on educational theory and practice in early twentieth-century Ontario, Canada. I begin with a discussion of a distinct conceptual shift that took place in the mental hygiene movement, a shift away from biological theories to a more environmentally based conceptualisation of mental health. This shift to an environmental perspective inaugurated a new concern with teacher personality, child psychological development and pedagogical relations in the classroom. Mental hygiene reformers affiliated with the CNCHM raised moral concern about existing pedagogical practice and its impact upon child psychological development, and offered theoretical support to the new child-centred movement of the period.

During the first half of the twentieth century a distinct shift in emphasis took place within the mental hygiene movement, a shift that had significant implications for educational theory and practice. While Canadian historians have written a substantial amount about the health education movement generally, and about the impact of heredity on the development of mental diseases in children and adolescence, they have devoted much less attention to the transition from a belief in the hereditary causes of mental disease to one that emphasised environmental factors and a therapeutic perspective (e.g. Dehli 1990; Lewis 1982; Sutherland 1976; Tomkins 1986). In this article I propose to elucidate the causes and timing of this transition in understanding about the nature and causes of mental health problems and to show how the paradigmatic shift inaugurated a new concern with teacher personality, child psychological development and pedagogical relations in the classroom. The change in emphasis from a predominantly hereditary orientation to an environmental (therapeutic) model raised moral concern about the impact of teacher personality upon child psychosocial development, and provided theoretical support for the new child-centred pedagogical movement gaining currency in the period.

The institutional locus of the transition lay in the Canadian National Committee for Mental Hygiene (CNCHM), which from the early twentieth century onwards was the mainstay of the mental hygiene movement. There were also a number of influential people outside of the committee—psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, occupational therapists, university deans and professors—committed to the mental hygiene perspective. The CNCHM was founded in 1918 and modelled upon the American National Committee for Mental Hygiene (NCHM), which was formed in 1909 'by a small, carefully chosen group of reform-minded academicians, social workers, physicians, and psychiatrists' (Cohen 1983). Much like the NCHM, the CNCHM attracted a number of reform-minded experts in the mental hygiene approach. The federal government funded the CNCHM annually and supported the principal objective of the committee ‘... to fight mental illness; to prevent mental illness; and to promote good mental health’ (Milestones 1918-1958). Although these aims remained more or less the same, there was an increasingly predominant emphasis placed on the preventative work of the organisation from 1920 until at least 1957. The annual government grants provided by the federal government were supplemented by a number of American foundations equally concerned with the spread of mental disease. At the provincial level, the CNCHM received funding in the form of voluntary donations. The Canadian Red Cross Society also made monetary contributions and the provincial governments provided financial support annually.

C.K. Clarke, dean of medicine at the University of Toronto and a distinguished psychiatrist, chaired the initial organising meeting of the CNCHM in February of 1918, and Clarence Hincks, a physician working in the Toronto School Health Program, served as secretary (Historical Reports 1932). Clifford Beers, organiser of the first Connecticut Society for Mental Hygiene (1908) and founder of the NCHM in the United States, was invited to attend this meeting. Having once attempted suicide, Beers was deeply concerned about his own personality adjustment. As a result of his personal concerns about mental health, he became deeply committed to improvements in the treatment of the mentally ill in North American asylums for the insane. Beers found a kindred spirit in Hincks because the Toronto physician had also suffered a nervous breakdown. Following the wisdom of American mental hygiene advocates affiliated with the NCHM, the Canadian executive decided to base their own organisation upon the American example. As George Tomkins points out, ‘Indeed, no professional movement in the two countries displayed a closer symbiotic relationship across the international boundary in terms of interaction among principal figures, the common concerns they shared and the funding sources they tapped’ (1983).

Driven by a humanitarian impulse, the CNCHM members were deeply committed to improving the quality of care received by patients confined to insane asylums (Line & Griffin 1937) and to the development of out-patient travelling clinics throughout the country. These projects were heavily influenced by a moral, patriotic concern for the well-being of the Canadian nation-state and the biological fitness of the citizenry. Although these endeavours appeared to be strictly humanitarian, they did function to further pathologize a significant segment of the population suffering from mental disease.
The humanitarian impulse of the CNCMH was strongly influenced by biological determinism, scientific eugenics (McLaren 1990) and the possibility of racial decline. In the first couple of years especially, the members of the CNCMH engaged in ‘activities [directed] towards excluding and eliminating feeble-mindedness and insanity by genetic controls’ (Sutherland 1976). Such controls involved compulsory sterilisation for the mentally ill, confinement to insane asylums for the ‘feeble-minded’ and ‘mentally defective’, control over immigration (Clarke 1920; Clarke 1916) and deportation policy. Many social ‘problems’, including juvenile delinquency, prostitution and pauperism, were believed to be the result of feeble-mindedness. Compulsory institutionalisation was understood to be the only real solution to these social ills. Speaking about the nationwide problem of school truancy, Clarke maintained that ‘truants are derived from the dull normal or high grade defective groups’ (1920). Juvenile theft was similarly understood by Clarke to be an example of antisocial activity that could only be warded off with ‘institutional treatment’ (Clarke 1920).

The eugenic influence was particularly obvious in physical descriptions of feeble-minded children. For example, Peter Sandiford, professor of psychology in the Department of Education at the University of Toronto, argued that:

Feeble-minded children often show the physical stigmata of degeneration — defects in the size and shape of the head, deformities of the external ear, deformities connected with the eyes, palate, and jaws ... They tend to be undersized ... and their body temperature was, on the average, below normal. (Sandiford 1919, p.67)

The construct of the ‘feeble-minded’ child was a product of turn-of-the-century compulsory schooling in North America (Beall 1933). For the first time in history, significant numbers of children were subjected to common tests, examinations, and medical inspections. Those who met the new norms were declared ‘normal’, those who did not were labelled as inadequate (McLaren 1990).

The executive members of the CNCMH were deeply concerned about the presence of feeble-minded children in Canadian schools. For feeble-minded youth, exclusion from the normal classroom was the answer (Hincks 1919). Although special and auxiliary classes were already established in Canada, C.K. Clarke, founder of the CNCMH, felt that the number of special and auxiliary classes was grossly inadequate (McLaren 1990). In response to the pressures applied by the mental hygiene committee, ‘over one hundred and fifty special classes for mentally retarded children [were set up] in the school system’ (Historical Reports 1932) between 1918 and 1923.

In the Canadian Journal of Mental Hygiene, Hincks underscored the pervasiveness of mental disorders in Canadian youth and the problem this posed to the education system:

mental studies in Toronto public schools have demonstrated that at least 2 per cent of the children examined were so unfit mentally, that they could not successfully cope with the ordinary curriculum. The writer was given an opportunity to study over 10,000 school children from the psychiatric standpoint, and found that slightly over 2 per cent should be placed in the abnormal class. (Hincks 1919, p.24)

In August of 1937 the Toronto Daily Star quoted a speech given by Hincks:

One out of every 19 Canadians ... would at some period of his life be admitted into a mental hospital, and there are now 75,000 children in schools, who, in the absence of prevention methods, will also be admitted. (Historical Documents 1937)

Variations on these statistics were echoed throughout the country (Silverman 1930) causing multiple expressions of moral discontent. Not unlike in the American context, mental hygiene reformers were caught up in a quasi-religious fervour about the dangers of mental illness.

The growing moral concern with mental illness impacted upon the development of special education and mental testing in Canada. George Tomkies explains that Clarence Hincks of the CNCMH ‘wanted feeble-minded and purportedly delinquency-prone youngsters excluded from public schools’. These unfortunate were to be segregated, both in their own interest and, more importantly, to prevent the moral contamination and academic retardation of normal pupils. Sutherland explains in relation to the development of special auxiliary classes that ‘the presence of the feeble-minded impeded the academic progress of normal pupils and often posed a “moral menace” to them as well’ (1976 p.74).

The executive members of the CNCMH launched a large-scale public relations campaign designed to educate the public in the principles of mental hygiene. They published the Canadian Journal of Mental Hygiene from 1919 to 1921. The committee also published a quarterly magazine entitled Understanding the Child, in affiliation with the American mental hygiene committee, designed with the interests of teachers in mind. The CNCMH continued to work towards the improvement of ‘mental hygiene instruction in Canadian universities for medical students, public health nurses, social workers [and teachers]’ (Historical Reports 1926). By 1944, 150,000 copies of a chart created by the committee entitled ‘Child Needs’, had been distributed throughout Canada to parents and teachers. This was the first document clearly outlining ‘in concise form the mental health needs of children’ (Historical Reports 1943).

Until the early 1920s the CNCMH concerned itself exclusively with the problem of feeble-minded youth. The committee did not concern itself with mentally diseased youth because it believed that the symptoms were hidden until adulthood. According to Clarke’s formulation, ‘An insane person develops as an apparently normal individual up to a certain age, say twenty, and then undergoes a deterioration’ (Clarke 1920, p.202). Unlike the mentally defective child (who exhibited an obviously slow and ‘retarding’ influence on the class), the mentally diseased (or emotionally maladjusted child) could not be identified. Given the predominant belief in the hereditary causes of mental defects and diseases of personality, it was routinely asserted that, ‘mental defectives [like the mentally diseased] are born — of mentally-defective stock — not made by errors in educational methods’ (Kerr 1916, p.163). There was little teachers and school administrators could do about diseases of personality, it appeared, even if they could detect them.

However, an important conceptual shift in understanding of the cause of mental health problems began to take place around 1920 that radically altered the belief that
teachers had little or no impact on the development of personality disorders. Mental hygiene reformers began to understand mental illness as a product of environmental, as opposed to hereditary, factors. For this reason they changed their educational campaigns (which were originally directed towards strategies of segregation and the removal of mentally defective children from the public school system), to a new kind of campaign that targeted the school itself as a potential problem, instead of the child. This shift was important because it set in motion the belief that mental and emotional maladjustment was not something children brought with them to school, but something that was caused, or at least made worse, by the school situation.

The first cause of this paradigmatic shift can be attributed to developments in the field of psychology, the emergence of psychiatry as a profession, and the spreading influence of the ideas of Sigmund Freud, which became well known to North Americans in the early part of the 1920s. The relationship between the ideas of psychologists, psychiatrists and psychoanalysts like Freud to changing conceptions about the cause and treatment of personality disorders would be crucial to the mental hygiene movement.

As psychology began to grow in popularity, mental hygiene reformers came to understand mental and emotional maladjustment not only in terms of heredity but in terms of child psychology and environmental conditioning. Although ideas about a hereditary taint did not completely disappear, they were increasingly replaced by environmental theories emerging from the psychological community. As Angus McLaren says in his discussion of scientific eugenics in 1920s Canada:

The strict hereditarianism of some of the first investigators [affiliated with the CNCAH] never totally disappeared, but for those in the newly emerging helping professions [nurses, teachers, social workers] eugenics appeared to offer too pessimistic a prospect. If mental powers were simply innate, what role could the professional play beyond testing and labelling? (McLaren 1990, p.111)

At the same time, mental hygiene reformers began to shift their concern from the mentally defective child, to the emotionally maladjusted child. The ideas of Freudian psychologists, psychiatrists and others involved in the caring professions were instrumental in bringing about the new concern with environmental theories of personality maladjustment. Reflecting on the trend, E.D. MacPhee, professor of psychology at the University of Toronto, said:

So widely accepted is this opinion that mental hygiene divisions in our schools are becoming less and less concerned about selecting children of subnormal intelligence, but concentrating rather on the study of conduct cases, not merely because these are creating difficulties in the school routine, but because they are already giving evidence of mental disturbance of some sort and it is important as in cancer to check it early. (MacPhee 1928, pp.76-77)

The result of this new formulation had consequences for the school. Based upon the pressing concern with emotional rather than mental disturbances, teachers were directed to identify problems marked by inward or outward displays of strong emotional or behavioural outbursts detrimental to the smooth operation of the classroom routine.

The possibility of prevention and treatment also enabled reformers to promote institutional change in the school (and other governmental arenas) and to focus on prevention (Anderson 1924; Clarke 1924; Lewis 1928; MacPhee 1929; Silverman 1930) and cure as opposed to older strategies of segregation and containment.

In speaking about American mental hygiene reformers in the inter-war period, Cohen explains that they were 'notoriously optimistic about the malleability of personality and the possibility of the prevention of mental illness' (Cohen 1983). Following World War One, personality was thought to be more malleable, pliable and responsive to environmental stimuli than originally presumed. This was, in part, due to the influence of Freudian psychology. In her social historical account of women, madness and English culture, Elaine Showalter argues convincingly that the ideas of Sigmund Freud dealt a fatal blow to hereditary theories of personality development in western European countries (Showalter 1985). The idea that personality was predetermined through genetic inheritance began to lose credibility. Freud argued vehemently that personality was shaped by early familiar experiences and the environmental conditions of our everyday worlds.

In distinguishing between the Canadian and American mental hygiene movements, Tomkins points out that Canadian study into early child development 'appears to have been less influenced by Freudian theory and to have been more behaviouristic and more structured than its American counterpart' (Tomkins 1986). Although Tomkins is correct in his assessment that the Canadian child study movement was less psychoanalytical than the American movement, there was an unmistakable Freudian influence in psychological writing on the recessive personalities of children in both the American and Canadian contexts. In the articles on mental hygiene written by both academics and reformers affiliated with the Canadian and American mental hygiene movements, there is also an unmistakable Freudian influence underpinning the movements in Canada as well as the United States (Hincks 1936).

The second blow to the law of heredity came as a result of World War One. As soldiers and officers returned home, it became evident that they were suffering from what was called shell-shock. In their influential book Shell-Shock and its Lessons (1917), E. Smith and T.H. Pear said the phenomenon of shell-shock was common to army soldiers, and officers in particular, who had to withstand (and suppress) the traumatic effects of war. The western European psychiatric community also began to agree that the environmental conditions of war brought on: 'Symptoms of hysteria-paralysis, blindness, deafness, contracture of a limb, autism, limping ... [and] neurasthenic symptoms, such as nightmares, insomnia, heart palpitations, dizziness, depression, or disorientation' (Showalter 1985, p.174). What was particularly troubling about the widespread problem of shell-shock was the connection established between emotional repression and psychological trauma. Experts in the psychiatric community noted that the requirements of everyday, civilised society were not unlike the conditions of wartime; both required people to suppress emotion that lead to neurosis. Cases of shell-shock were only extreme examples of emotional maladjustment that were not particular to wartime.
In 1928 E.D. MacPhee also problematised the natural boundary between sanity and insanity:

Recent advances in psychology and psychiatry have amply demonstrated that the patients who fill our mental hospitals are just the extreme instances, and that between these cases and the healthy people there come large groups of adults who are shiftless, nervous, excitable, persons who give way to temper tantrums, timid, exclusive, suspicious, dependent or delinquent folk who are just as truly mentally unwell. (MacPhee 1928, pp.76-77)

Given the fine line between normal and abnormal personalities, health care professionals and committed reformers were more and more likely to understand diseases of personality along a continuum. Mental and emotional responses were not predetermined by heredity, but shaped by environmental factors affecting all of us.

The severity of nervous disorders and mental conditions affecting soldiers returning to North America was equally astounding to the Canadian psychiatric community. In a ‘Mental Health Bulletin’ released by the CNCMH in May 1940, it was reported that during World War One '12% of invalided men who were returned to Canada from overseas were afflicted with nervous and mental disabilities' (CNCMH 1939-41). In speaking about the Canadian context, Hincks reminded the Minister of Defence in 1939 that ‘mental and nervous disabilities constituted one of the major medical problems confronting the military authorities during the World War of 1914-18’ (CNCMH 1939-41).

The impact of wartime on the psyche was also understood by health care professionals associated with the CNCMH to be a by-product of the environmental stresses associated with war (Hincks 1936). It was also believed that some people were predisposed to developing nervous disorders and mental illness. Acting upon the belief that certain recruits were predisposed to nervous disorders, the CNCMH used its influence to persuade the Department of National Defence to collect biographical data on recruits to establish their suitability for assigned tasks and to administer intelligence tests to establish the capacities of particular soldiers (CNCMH 1939-41). The CNCMH also volunteered its resources and personnel ‘to assist in the selection and training of counsellors’ appointed to work with enlisted men suffering from war-related ‘fears, anxieties and personal problems’ (CNCMH 1939-41).

At the same time, members of the CNCMH were busily collecting biographical data on school children (Lewis 1928) and assessing their mental age through routinised testing (McGhie 1930). Although personality problems stemmed from environmental factors, it was believed that certain children were prone to nervous disorders and personality defects. The task of the mental health professional was to identify these children, offer remedial assistance and prevent a disorder at its onset from developing.

Not only did the phenomenon of shell-shock contribute to the belief in the environmental causes of personality maladjustment, but it also paved the way for a preventative and curative approach. As Cohen notes, ‘the psychiatrists’ success in treating the so-called shell-shock cases confirmed their belief in the role of personality in mental disor-
the CNCMH reported that it has been ‘devoting attention to teacher-training ... Experimental work has been conducted in Toronto, and plans are being made to affect teacher training programmes in the Normal Schools of Canada’ (Historical Reports 1935). The National Committee for School Health Research (NCSH) also recommended in 1947 that ‘teachers-in-service receive instruction in child psychology and in the detection, appreciation, and solution of types of mental health problems ... That suitable provision be made for backward [and physically handicapped] pupils’ (Historical Reports 1947).

The second important educational endeavour undertaken by the CNCMH involved a number of clinical studies of the shy, overly sensitive and withdrawn student. Such a student was constructed as emotionally ill equipped and in danger of developing a mental disorder in adult life reminiscent of the shut-in personality (Lewis 1928). The Division of Education and Mental Health established by the CNCMH in 1936 conducted a ‘study of shy, exclusive, timi children in an attempt to discover ways and means of preventing such children from developing dementia praecox and other types of maladjustment in later life’ (Historical Documents 1939-41). The study was predicated on the idea that ‘from 40 to 60% of adult patients suffering from dementia praecox had, during childhood, a noticeably shy, timid, recessive type of personality’ (Historical Documents 1939-41). The study was funded by the Scottish Rite Masons of the Northern Jurisdiction of the United States and used to demonstrate the large number of mental health cases recognisable in young children, along with the remedial impact of a capable teacher. The same study said that:

> shyness among children is prevalent and that, with enlightened educational procedures, the mental health of more than half of the cases in the classroom can be safeguarded. Efforts are now underway in an endeavour to discover practicable means of assisting in the adjustment of the 40% of shy children who fail to respond to educational procedures that have been used to date. (Historical Documents 1939-41)

By 1939 the CNCMH concluded on the basis of a two-year study conducted in Toronto, Saskatoon and Montreal that ‘in reference to 6000 children ... 6.5% are shy and exclusive and ... poise can be established with more than 50% of this group when the children have the advantage of a suitable curriculum under the direction of capable teachers’ (Historical Report 1939).

One of the most significant studies undertaken by the CNCMH was a five-year longitudinal study of mental health, at Regal Road School in Toronto, Ontario, from 1925 to 1930. In this study, Dr W.E. Blatz, Prof E.D. MacPhee and Prof William Line observed behavioural problems and social and educational adjustment techniques of 1,400 school children at Regal Road School, and the impact of teacher action and influence (Historical Report 1930). The purpose of this longitudinal study was to ‘ascertain as fully as possible the facts concerning influences which affect the attitudes, work and adjustment of school children in order to derive general principles which can be utilised with advantage by the proper authorities [teachers]’ (Historical Report 1930). The research division of the CNCMH concerned itself primarily with the Regal Road experiment for the five-year period, but also studied educational and behavioural problems in children in other experiments in affiliation with the Toronto Juvenile Court, the Infant’s Home and the Ontario Hospital, Orillia (Historical Report 1930).

The results of these clinical studies were used to legitimate the need to educate teachers (and parents) in the principles of sound mental hygiene, many of which were consistent with the child-centred educational movement of the period. Consumed by the task of developing remedial programs for the introverted student based on the new clinical evidence established by their researchers, CNCMH members published articles on preventative mental health directed at both classroom teachers and parents, gave public lectures, and prepared newspaper articles and news bulletins.

In 1940, Mental Hygiene: A Manual for Teachers was published by J.D.M. Griffin, associate medical director for the CNCMH, S.R. Laycock, professor of educational psychology at the University of Saskatchewan, and W. Line, associate professor of psychology at the University of Toronto. The manual was an extensive study of the impact of schooling (and home and community life) on the mental health of the child. Particular emphasis was placed not only on the symptoms of personality disorders in children (such as ‘emotional outbursts, excuse making or rationalising, nervousness, stuttering, enuresis, antisocial tendencies, poorly progress in school’ (Griffin, Line & Laycock 1940) but on school administration and pedagogical techniques fostering healthy mental adjustment. The same position on the importance of educational practice was also advocated by Karl Bernhardt, who contributed an essay to a report prepared by the Canadian Educational Association in which he was critical of the tendency among teachers to: emphasise the boundaries between subjects without attempts to integrate material; emphasise competition; value examinations (instead of the educational process itself); deliver material without enthusiasm; adopt an authoritative role in the classroom; and, finally, refuse to forge cooperative relations with parents (Historical Report 1948). In the same report, a large-scale survey of school inspectors’ perceptions about mental hygiene revealed serious concerns about the impact of teacher character on the mental health of school children (Historical Report 1948).

Deeply committed to the full integration of mental hygiene principles into Canadian schools, the executive members of the CNCMH worked alongside educators appointed to write curriculum documents by the Ontario Department of Education (Historical Report 1937). They also addressed teachers’ conventions throughout Canada (Historical Report 1939).

The fourth way in which the CNCMH had an impact on educational theory and practice was in respect to ideas about teacher personality and the emotional adjustment of children. As psychiatric studies of child development and mental illness focused increasingly on environmental factors, mental hygiene reformers concerned themselves with the influence of role models, the teacher (along with the parents) being of primary importance. Baruch Silverman, assistant director of the Montreal Mental Hygiene Committee, stated that: ‘in many patients with mental ailments, in delinquents, psychopaths, anti-social and social individuals, one finds that their abnormal behaviour is the direct
expression of mental maladjustment which was precipitated or initiated by the emotional attitude of some adult" (Silverman 1930, p.23). Informed by the child-centred movement gaining currency in the period, Silverman says that both parents and teachers ‘do not realize the roles that affection and encouragement play in the emotional life of the child and often create in children feelings of insecurity, inferiority and self-deprecation, which result in serious mental ailments’ (p.24). The same idea is captured by other child experts in the period, including Bernhardt in his discussion of mental hygiene and education: ‘Of course, the most important feature is the teacher himself, for no matter what system is in use in the school the sympathetic, human, kindly, enthusiastic teacher manages to make the school experience for the child a happy, healthy and profitable one’ (Historical Report 1948).

The members of the joint committee on the teaching of health appointed from the Department of Education and the Department of Health of the province of Ontario wrote a handbook entitled Health: A Handbook of Suggestions for Teachers in Elementary Schools. In the book they insisted that ‘the health of the teacher exercises a definite influence on the health of his pupils. Careful and detailed observations have been made of the health of groups of pupils ... [and these records show] how the health of the class ... improves or deteriorates according to the health of the teacher’ (Phair et al 1938). Not unlike the physical health concerns associated with the school house (including lighting, ventilation, cleanliness, heating, overcrowding, etc), the teacher’s personality became an environmental concern relevant to the mental and emotional adjustment of school children.

The handbook also explained that ‘there are wide variations in ability, personal characteristics, and temperament among teachers’ (Phair et al 1938). In discussing the variety of personality types among teachers, mental hygiene reformers pointed to the problem of the rigid disciplinarian; the narrow-minded teacher preoccupied with ‘minor virtues’, ‘maintaining petty standards of deportment and becoming injudiciously indignant when these standards are disregarded’ (Phair et al 1938); the indecisive or self-righteous kind of teacher; the sarcastic teacher (McGhie 1930); the nervous teacher prone to breakdown and to emotional outbursts; the martyr or sacrificial teacher in need of sympathy; the disorganised and inefficient kind of teacher who creates chaos wherever he or she goes; the old spinster-tyrant who resents young children and makes them suffer in return for her disappointments, etc. There were numerous psychological profiles of teacher emotional disturbances, and consideration was routinely given to how these disturbances impact upon the mental health of children.

Executive members of the Ontario elementary school teachers’ federation were influenced by these psychological profiles; they published numerous articles on the problem of teachers’ mental health in their co-edited professional magazine, The Educationaional Courier, in the 1930s and 1940s. In one article published in 1945, the editors reported on a series of lectures given to elementary and secondary school teachers on mental hygiene by Laycock, Bernhardt, Griffin, Mary Northway and Roger Myers, all of whom were directly associated with the CNMCH. The article alerted teachers to a study conducted by the American NCMPH:

indicate[ing] that 1/3 to 1/6 of the lengthy absences of teachers from their duties may be attributed to mental difficulties. The NEM [National Education Association], as a result of a health inquiry, reported that nearly 1/6 of the teachers surveyed had persistent worries which interfered with their sleep, with their efficiency in teaching, and with their health. As a matter of fact, the 1950 report raises even only 2 symptoms of ill health more often than nervousness, and more than 1/6 of these were more or less frequently subject to the disorder. ‘How is your mental health?’ (1945, p.6)

As the correlation between teacher mental health and the environmental stresses of the classroom became increasingly apparent, courses on muscular relaxation for teachers were introduced (Wellham 1936). M.A. Richardson, author of The Nature and Treatment of Stammering, offered a course at the Seventh World Conference of the New Education Fellowship called ‘Relaxation for Teachers’. An Ontario teacher who attended the course said that ‘Tensions were loosened and strained facial expressions were replaced by a serenity which showed that an inner freedom was being realized’ (Wellham 1936).

Teachers were also urged by mental hygiene reformers to understand the ‘importance of a regular daily schedule that includes exercise, rest, and food in proper quantity and of suitable quality to ensure the efficient functioning of the body’ (Phair et al 1938). In their personal accommodations, the teacher was told not to be ‘morbid or unduly introspective. There is no reason for becoming depressed or anxious. All that is necessary is for a person to study himself honestly, to evaluate his condition, and to take constructive action’ (Phair et al 1938). Christine Smith, director of public information at the Canadian Mental Health Association, insisted that ‘breakdowns among teachers due to physical or emotional disorders are not rare’ (1950). Speaking on the extent to which mental disorders vary in intensity, Smith noted that ‘now and then a teacher suffers from recognizable emotional or nervous disability requiring a period of rest and possibly treatment; and in some cases a complete change of employment and environment is recommended’ (1950).

The new belief in the environmental causes of emotional strain and nervous disorders (including the environmental stresses of the classroom) can be seen clearly in the second report prepared by Bernhardt on behalf of the National Committee for School Health Research. In this report Bernhardt said that:

mental health is something that can be fostered, strengthened and maintained by education. This assumption is based on the optimistic view that human nature is not fixed and unchangeable, that no one is doomed to unhappiness or maladjustment because of heredity but that all people can be helped towards mental health by education. (Historical Report 1948)

This statement marks a radical change in the way mental hygiene reformers understood the causes of mental and emotional maladjustment. The focus on the environmental causes of nervous strain and personality disorder had never been so acute.
CONCLUSION

As evidenced in the above discussion, there was an abrupt transition from an approach based predominantly on hereditary understandings of mental and emotional disorders to an approach based upon a belief in environmental triggers. Mental hygiene reformers changed their educational reform agenda because of two interrelated events: the large number of shell-shock cases following World War One (marked by extreme manifestations of emotional and physical signs of maladjustment); and developments in the psychological community pertinent to early childhood psychosocial development and the overwhelming importance of the familial (and by extension the school) environment. Instead of advocating strategies dependent upon the removal of mentally defective children from the public school system and containing such children in special classrooms, mental hygiene reformers concerned themselves with the school itself.

The reformers affiliated with the CNMCNH involved themselves in educational theory and practice in four main ways: first, they sought to educate teachers to detect signs of emotional disturbance in children (and then refer them to the proper health care professionals); second, they conducted clinical studies of child development in Ontario schools to ascertain the impact of various educational techniques and pedagogical practices; third, they disseminated the results of their clinical studies in order to popularise the newly found educational principles consistent with the goal of mental hygiene; and fourth, they educated the public about the influence of the psychological development of child mental and emotional development. The CNMCNH focused its efforts increasingly on the school from 1920 onward, and this focus impacted heavily upon educational theory and practice concerning mental health. The shift from hereditary explanations to environmental theories of mental health set the stage for a very significant investigation into the role of the school in the mental and emotional health of Ontario children.

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NOTES

1. For a discussion of the three kinds of mentally defective types see Kerr (1916) and Clarke (1920).
2. For a discussion of the intersection between the Canadian mental hygiene movement and psychiatry see MacPhee (1928).

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