

# Antipsychiatry Movement

## 29 Wikipedia Articles

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# Anti-psychiatry

**Anti-psychiatry** is a configuration of groups and theoretical constructs that emerged in the 1960s, and questioned the fundamental assumptions and practices of psychiatry, such as its claim that it achieves universal, scientific objectivity. Its igniting influences were Michel Foucault, R.D. Laing, Thomas Szasz and, in Italy, Franco Basaglia. The term was first used by the psychiatrist David Cooper in 1967.<sup>[1]</sup>

Two central contentions of the anti-psychiatry movement are that:

- The specific definitions of, or criteria for, hundreds of current psychiatric diagnoses or disorders are vague and arbitrary, leaving too much room for opinions and interpretations to meet basic scientific standards.<sup>[2]</sup>
- Prevailing psychiatric treatments are ultimately far more damaging than helpful to patients.<sup>[3]</sup>

Other key criticisms of mainstream psychiatry include:

- Inappropriate and overuse of medical concepts and tools to understand the mind and society, including the miscategorization of normal reactions to extreme situations as psychiatric disorders;
- Scientifically and/or clinically ill-founded system of categorical diagnoses (e.g., *Diagnostic and Statistical Manual of Mental Disorders* or DSM), which stigmatizes patients;
- Unwillingness to develop and use objective tests (such as intelligence/cognitive tests) to determine patients' state (such as strong psychosis)
- Inappropriate (i.e. unvalidated) exclusion of other approaches to mental distress/disorder;
- Unexamined abuse or misuse of power over patients who are too often treated against their will;
- Relation of power between patients and psychiatrists, as well as the institutional environment, is too often experienced by patients as demeaning and controlling;
- Compromise to medical and ethical integrity because of financial and professional links with pharmaceutical companies and insurance companies in countries where these companies are a force.
- Forced use of government (both civilian and military) psychiatric treatment prevents the patient from choosing private psychiatric or alternative treatment thereby denying the patient of his or her basic rights.

Some mental health professionals and academics profess anti-psychiatry views,<sup>[4]</sup> as do a number of former and current users of psychiatric services.<sup>[5]</sup> Some critics focus their attention on what is known as biological psychiatry.<sup>[6] [7] [8]</sup> Proponents of some allegedly anti-psychiatric views seek to distance themselves from the term, both for its pejorative associations, and because they regard their theories and methods as evidence-based but not yet accepted by the mainstream psychiatric community.<sup>[9]</sup>

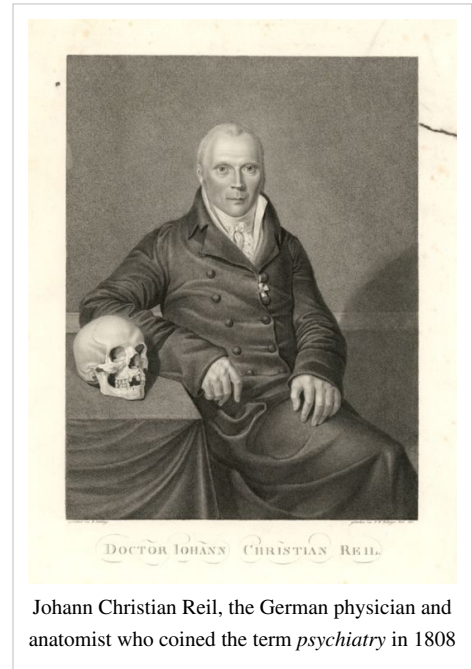


Vienna's Narrenturm — German for "lunatics' tower" — was one of the earliest buildings specifically designed as a "madhouse." It was built in 1784

## History

A number of deviant phenomena, such as alcoholism, drug addiction, and mental illness have been examined by Kittrie who demonstrated how such phenomena were originally considered as moral, then legal, and now medical problems.<sup>[10] :1[11]</sup> As a result of these perceptions, peculiar deviants were subjected to moral, then legal, and now medical modes of social control.<sup>[10] :1</sup> Similarly, Conrad and Schneider concluded their review of the medicalization of deviance by supposing that three major paradigms may be identified that have reigned over deviance designations in different historical periods: deviance as sin; deviance as crime; and deviance as sickness.<sup>[10] :1[12] :36</sup>

The word *psychiatry* was invented by Johann Christian Reil in 1808.<sup>[13] [14] [15] [16]</sup> What much later became known as the anti-psychiatry movement had its origin in concern over alleged misuse of psychiatric procedures for purposes of social control. Daniel Defoe, best known as the author of *Robinson Crusoe*, reported as far back as the eighteenth century that some husbands were using madhouses to incarcerate their disobedient—though sane—wives.<sup>[17] [18]</sup>



Johann Christian Reil, the German physician and anatomist who coined the term *psychiatry* in 1808

Psychiatry became more professionally established in the nineteenth century. As more invasive forms of treatment evolved, so too did opposition to the profession. Some disputes concerned custodial rights over those seen as *mad*, particularly if unfortunate enough to end up in one of the multiplying lunatic asylums.<sup>[19]</sup>

In the 1800s the American physician Samuel A. Cartwright had stumbled upon drapetomania, the explanation for why slaves would on occasion display an alarming tendency to run away from their masters. A further disorder afflicting slaves and, by extension, their owners was dysaesthesia aethiopica, a disease "affecting both mind and body". This explained the apparent lack of a proper work ethic among slaves. Found exclusively among blacks, dysaesthesia aethiopica—"called by overseers 'rascality'"—was characterized by partial insensitivity of the skin and "so great a hebetude of the intellectual faculties, as to be like a person half asleep."<sup>[20]</sup>

In the latter part of the nineteenth century Emil Kraepelin became an eminent deviser of novel categories of mental illness, which duly entered psychiatric usage despite their origin in extrapolation from observed behavior, rather than in clinical pathology or etiology in any strict sense.<sup>[21]</sup> The Soviet state in the twentieth century devised suitable psychiatric diagnoses for any who opposed its will with sufficiently persistent vigor but who, whether by dint of ingenuity or mere social eminence, proved difficult to criminalize. They were duly hospitalized instead.

In the 1920s extreme hostility to psychiatrists and psychiatry was expressed by the French playwright and theater director Antonin Artaud, in particular, in his book on van Gogh. To Artaud, who was himself to spend a fair amount of time in a straitjacket, imagination was reality. Much influenced by the Dada and surrealist enthusiasms of the day, he considered dreams, thoughts and visions no less real than the "outside" world. To Artaud, reality appeared little more than a convenient consensus, the same kind of consensus an audience accepts when they enter a theater and, for a time, are happy to pretend what they're seeing is real.

In the 1930s several controversial medical practices were introduced, including inducing seizures (by electroshock, insulin or other drugs) or cutting parts of the brain apart (leucotomy or lobotomy).<sup>[3]</sup> Both came into widespread use by psychiatry, but there were grave concerns and much opposition on grounds of morality, harmful effects, or misuse. In the 1950s new psychiatric drugs, notably the antipsychotic chlorpromazine,<sup>[3]</sup> were designed in laboratories and slowly came into preferred use.

Although often accepted as an advance in some ways, there was some opposition, partly due to serious adverse effects such as tardive dyskinesia.<sup>[3]</sup> Patients often opposed psychiatry and refused or stopped taking the drugs when

not subject to psychiatric control.<sup>[3]</sup> There was also increasing opposition to the large-scale use of psychiatric hospitals and institutions, and attempts were made to base services in the community.

Coming to the fore in the 1960s, *anti-psychiatry* [a term first used by David Cooper in 1962<sup>[22]</sup> and who never made clear whether anti-psychiatry was a genuine alternative to psychiatry or whether traditional psychiatry was indeed "anti-psychiatric", in the sense that, as practiced, it was anti-soul healing (to use the etymologic meaning of the word)] defined a movement that vocally challenged the fundamental claims and practices of mainstream psychiatry.

Both Cooper and his better-known colleague R.D. Laing were much influenced by *Madness and Civilization* by the French philosopher and social theorist Michel Foucault, the English translation of an abridged edition of Foucault's 1961 *Folie et déraison. Histoire de la folie à l'âge classique*. The work argues that conceptions of madness are not discoveries but cultural (legal, political, philosophical and medical) constructions of a given time and place, that vary from civilization to civilization and time to time.<sup>[23]</sup>

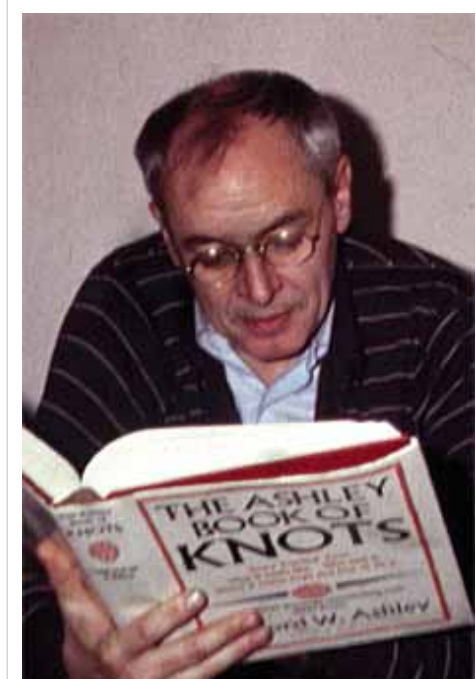
Foucault begins his history in the Middle Ages, noting the social and physical exclusion of lepers.<sup>[24]</sup> He argues that with the gradual disappearance of leprosy, madness came to occupy this excluded position. The ship of fools in the 15th century is a literary version of one such exclusionary practice, namely that of sending mad people away in ships. In 17th century Europe, in a movement that Foucault famously describes as the Great Confinement, "unreasonable" members of the population were locked away and institutionalized.<sup>[25]</sup> In the eighteenth century, madness came to be seen as the reverse of Reason, and, finally, in the nineteenth century as mental illness.

Foucault also argues that madness was silenced by Reason, losing its power to signify the limits of social order and to point to the truth. He examines the rise of scientific and "humanitarian" treatments of the insane, notably at the hands of Philippe Pinel and Samuel Tuke. He claims that these new treatments were in fact no less controlling than previous methods. Pinel's treatment of the mad amounted to an extended aversion therapy, including such treatments as freezing showers and use of a straitjacket. In Foucault's view, this treatment amounted to repeated brutality until the pattern of judgment and punishment was internalized by the patient.

Laing, Cooper, Theodore Lidz, Silvano Arieti and others went on to argue that schizophrenia could be understood as an injury to the inner self inflicted by psychologically invasive "schizophrenogenic" parents, or as a healthy attempt to cope with a sick society. Psychiatrist Thomas Szasz argues that "mental illness" is an inherently incoherent combination of a medical and a psychological concept, but popular because it legitimizes the use of psychiatric force to control and limit deviance from societal norms.

Adherents of this view referred to "the myth of mental illness" after Szasz's controversial book of that name. (Even though the movement originally described as anti-psychiatry became associated with the general counter-culture movement of the 1960s, Szasz, Lidz and Arieti never became involved in that movement.) Michel Foucault, Erving Goffman, Deleuze and Guattari, and others criticized the power and role of psychiatry in society, including the use of "total institutions", "labeling" and stigmatizing.<sup>[26]</sup>

Foucault argued that the concepts of sanity and insanity were social constructs that did not reflect quantifiable patterns of human behavior, and that, rather, were indicative only of the power of the "sane" over the "insane". The novel *One Flew Over the Cuckoo's*



R.D. Laing, perusing in 1983 *The Ashley Book of Knots* in a humorous allusion to his own work, *Knots* (1970), on the complexities of human relationships

*Nest* by counterculture icon Ken Kesey became a bestseller, resonating with public concern about involuntary medication, lobotomy and electroshock procedures used to control patients.

In addition, Holocaust documenters argued that the medicalization of social problems and systematic euthanasia of people in German mental institutions in the 1930s provided the institutional, procedural, and doctrinal origins of the mass murder of the 1940s.<sup>[27] [28] [29]</sup> The Nuremberg Trials convicted a number of psychiatrists who held key positions in Nazi regimes.

Observation of the abuses of psychiatry in the Soviet Union in the so-called Psikhushka hospitals also led to questioning the validity of the practice of psychiatry in the West.<sup>[30]</sup> In particular, the diagnosis of many political dissidents with schizophrenia led some to question the general diagnosis and punitive usage of the label schizophrenia. This raised questions as to whether the schizophrenia label and resulting involuntary psychiatric treatment could not have been similarly used in the West to subdue rebellious young people during family conflicts.<sup>[31]</sup>

New professional approaches were developed as an alternative or reformist complement to psychiatry. *The Radical Therapist*, a journal begun in 1971 in North Dakota by Michael Glenn, David Bryan, Linda Bryan, Michael Galan and Sara Glenn, challenged the psychotherapy establishment in a number of ways, raising the slogan "Therapy means change, not adjustment." It contained articles that challenged the professional mediator approach, advocating instead revolutionary politics and authentic community making. Social work, humanistic or existentialist therapies, family therapy, counseling and self-help and clinical psychology developed and sometimes opposed psychiatry.

Psychoanalysis was increasingly criticized as unscientific or harmful.<sup>[32]</sup> Contrary to the popular view, critics and biographers of Freud, such as Alice Miller, Jeffrey Masson and Louis Breger, argued that Freud did not grasp the nature of psychological trauma. Non-medical collaborative services were developed, for example therapeutic communities or Soteria houses.

The anti-psychiatry movement was also being driven by individuals with adverse experiences of psychiatric services. This included those who had been harmed by psychiatry or who felt that they could have been helped more by other approaches, including those compulsorily (including via physical force) admitted to psychiatric institutions and subjected to compulsory medication or procedures. During the 1970s, the anti-psychiatry movement was involved in promoting restraint from many practices seen as psychiatric abuses.

The gay rights movement challenged the classification of homosexuality as a mental illness and, in a climate of controversy and activism, in 1974 the American Psychiatric Association membership (following a unanimous vote by the trustees in 1973) voted by a small majority (58%) to remove it as an illness category from the DSM, replacing it with a category of "sexual orientation disturbance" and then "ego-dystonic homosexuality", which was deleted in 1987, although "gender identity disorder" and a wide variety of "paraphilias" remain. Increased legal and professional protections, and merging with human rights and disability rights movements, added to anti-psychiatry theory and action. The Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity affirm that "notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed."<sup>[33]</sup> Further, "An Activist's Guide" to the Yogyakarta Principles in Action condemn medicalization of transsexuality stating that "it is important to note that while "sexual orientation" has been declassified as a mental illness in many countries, "gender identity" or "gender identity disorder" often remains under consideration."<sup>[34]</sup>

Anti-psychiatry came to challenge a "biomedical" focus of psychiatry (defined to mean genetics, neurochemicals and pharmaceutical drugs). There was also opposition to the increasing links between psychiatry and pharmaceutical companies, which were becoming more powerful and were increasingly claimed to have excessive, unjustified and underhand influence on psychiatric research and practice. There was also opposition to the codification of, and alleged misuse of, psychiatric diagnoses into manuals, in particular the American Psychiatric Association, which publishes the *Diagnostic and Statistical Manual of Mental Disorders*.

Anti-psychiatry increasingly challenged alleged psychiatric pessimism and institutionalized alienation regarding those categorized as mentally ill. An emerging psychiatric consumer/survivor/ex-patient movement often argues for full recovery, empowerment, self-management and even full liberation. Schemes were developed to challenge stigma and discrimination, often based on a social model of disability; to assist or encourage people with mental health issues to engage more fully in work and society (for example through social firms), and to involve service users in the delivery and evaluation of mental health services. However, those actively and openly challenging the fundamental ethics and efficacy of mainstream psychiatric practice remained marginalized within psychiatry, and to a lesser extent within the wider mental health community.

## Challenges to psychiatry

### Civilization as a cause of distress

In the mid 19th century, George Miller Beard attributed "neurasthenia" to the stresses of modern life. R.D. Laing emphasized family nexus as a mechanism whereby individuals become victimized by those around them.<sup>[35] [36]</sup>

In recent years, David Smail, a psychotherapist considered part of the anti-psychiatry movement, has written extensively of the "embodied nature" of the individual in society, and the unwillingness of even therapists to acknowledge the obvious part played by power and interest in modern Western society. He argues that feelings and emotions are not, as is commonly supposed, features of the individual, but rather responses of the individual to his situation in society. Even psychotherapy, he suggests, can only change feelings inasmuch as it helps a person to change the "proximal" and "distal" influences on his life, which range from family and friends, to politics and work.<sup>[37]</sup>

### Normality and illness judgments

Critics of psychiatry generally do not dispute the notion that some people have emotional or psychological problems, or that some psychotherapies at least occasionally work for a given problem. They do usually disagree with psychiatry on the source of these problems; and on what the proper management options are.

One remarkable example of psychiatric diagnosis being used to reinforce cultural bias and oppress dissidence is the diagnosis of drapetomania. In the USA prior to the American Civil War, psychiatrists such as Samuel A. Cartwright diagnosed some slaves with drapetomania, a mental illness in which the slave possessed an irrational desire for freedom and a tendency to try to escape.<sup>[38]</sup> By classifying such a dissident mental trait as abnormal and a disease, psychiatry promoted cultural bias about normality, abnormality, health, and unhealth. This example indicates the probability for not only cultural bias but also confirmation bias and bias blind spot in psychiatric diagnosis and psychiatric beliefs.

In addition, many feel that they are being pathologized for simply being different. Some people diagnosed with Asperger syndrome or autism hold this position, particularly those involved in the autism rights movement or the autistic pride movement. While many parents of children diagnosed as autistic support the efforts of autistic activists, there are some who say they value the uniqueness of their children and do not desire a "cure" for their autism. The autistic community has coined a number of terms that would appear to form the basis for a new branch of identity politics; terms such as "neurodiversity" and "neurotypical".<sup>[39]</sup> However, an anti-psychiatric viewpoint is not found in nearly all of those advocating acceptance for autists or other "outsiders".



A madness of civilization: the American psychiatrist Samuel A. Cartwright identified what he called drapetomania, an ailment that caused slaves to be possessed by a desire for freedom and a want to escape



It has been argued by philosophers like Foucault that characterizations of "mental illness" are indeterminate and reflect the hierarchical structures of the societies from which they emerge rather than any precisely-defined qualities that distinguish a "healthy" mind from a "sick" one. Furthermore, if a tendency toward self-harm is taken as an elementary symptom of mental illness, then humans, *as a species*, are arguably insane in that they have tended throughout recorded history to destroy their own environments, to make war with one another, etc.<sup>[40]</sup>

## Psychiatric labeling

There are recognized problems regarding the diagnostic reliability and validity of mainstream psychiatric diagnoses, both in ideal and controlled circumstances<sup>[41]</sup> and even more so in routine clinical practice (McGorry *et al.* 1995).<sup>[42]</sup> Criteria in the principal diagnostic manuals, the DSM and ICD, are inconsistent.<sup>[43]</sup> Some psychiatrists who criticize their own profession say that comorbidity, when an individual meets criteria for two or more disorders, is the rule rather than the exception. There is much overlap and vaguely-defined or changeable boundaries between what psychiatrists claim are distinct illness states.<sup>[44]</sup> There are also problems with using standard diagnostic criteria in different countries, cultures, genders or ethnic groups. Critics often allege that Westernized, white, male-dominated psychiatric practices and diagnoses disadvantage and misunderstand those from other groups. For example, several studies have shown that African Americans are more often diagnosed with schizophrenia than Caucasians,<sup>[45]</sup> and women more than men. Some within the anti-psychiatry movement are critical of the use of diagnosis as it conforms with the biomedical model.

## Psychiatry and the pharmaceutical industry

Critics of psychiatry commonly express a concern that the path of diagnosis and treatment in contemporary society is primarily or overwhelmingly shaped by profit prerogatives<sup>[46]</sup> (echoing a common criticism of general medical practice in the United States, where many of the largest psychopharmaceutical producers are based).

Psychiatric research has demonstrated varying degrees of efficacy for improving or managing a number of mental health disorders through either medications, psychotherapy, or a combination of the two. Typical psychiatric medications include stimulants, antidepressants, hypnotic minor tranquilizers and neuroleptics (antipsychotics).

On the other hand, organizations such as MindFreedom International and World Network of Users and Survivors of Psychiatry maintain that psychiatrists exaggerate the evidence of medication and minimize the evidence of adverse drug reaction. They and other activists believe individuals are not given balanced information, and that current psychiatric medications do not appear to be specific to particular disorders in the way mainstream psychiatry asserts;<sup>[47]</sup> and psychiatric drugs not only fail to correct measurable chemical imbalances in the brain, but rather induce undesirable side effects. For example, though children on Ritalin and other psycho-stimulants become more obedient to parents and teachers,<sup>[48]</sup> critics have noted that they can also develop abnormal movements such as tics, spasms and other involuntary movements.<sup>[49]</sup> This has not been shown to be directly related to the therapeutic use of stimulants, but to neuroleptics.<sup>[50] [51]</sup> The diagnosis of Attention Deficit Hyperactivity Disorder on the basis of inattention to compulsory schooling also raises critics' concerns regarding the use of psychoactive drugs as a means of unjust social control of children.<sup>[48]</sup>

The influence of pharmaceutical companies is another major issue for the anti-psychiatry movement. As many critics from within and outside of psychiatry have argued, there are many financial and professional links between psychiatry, regulators, and pharmaceutical companies. Drug companies routinely fund much of the research conducted by psychiatrists, advertise medication in psychiatric journals and conferences, fund psychiatric and healthcare organizations and health promotion campaigns, and send representatives to lobby general physicians and politicians. Peter Breggin, Sharkey, and other investigators of the psycho-pharmaceutical industry maintain that many psychiatrists are members, shareholders or special advisors to pharmaceutical or associated regulatory organizations.

There is evidence that research findings and the prescribing of drugs are influenced as a result. A United Kingdom cross-party parliamentary inquiry into the influence of the pharmaceutical industry in 2005 concludes: "The influence of the pharmaceutical industry is such that it dominates clinical practice"<sup>[52]</sup> and that there are serious regulatory failings resulting in "the unsafe use of drugs; and the increasing medicalization of society".<sup>[52]</sup> The campaign organization *No Free Lunch* details the prevalent acceptance by medical professionals of free gifts from pharmaceutical companies and the effect on psychiatric practice.<sup>[53]</sup> The ghostwriting of articles by pharmaceutical company officials, which are then presented by esteemed psychiatrists, has also been highlighted.<sup>[54]</sup> Systematic reviews have found that trials of psychiatric drugs that are conducted with pharmaceutical funding are several times more likely to report positive findings than studies without such funding.<sup>[55]</sup>

The number of psychiatric drug prescriptions have been increasing at an extremely high rate since the 1950s and show no sign of abating.<sup>[3]</sup> In the United States antidepressants and tranquilizers are now the top selling class of prescription drugs, and neuroleptics and other psychiatric drugs also rank near the top, all with expanding sales.<sup>[55]</sup> As a solution to the apparent conflict of interests, critics propose legislation to separate the pharmaceutical industry from the psychiatric profession.

### **Electroconvulsive therapy**

Psychiatrists may advocate psychiatric drugs, psychotherapy or more controversial interventions such as electroshock or psychosurgery to treat mental illness. Electroconvulsive therapy (ECT) is administered worldwide typically for severe mental disorders. Across the globe it has been estimated that approximately 1 million patients receive ECT per year.<sup>[56]</sup> Exact numbers of how many persons per year have ECT in the United States are unknown due to the variability of settings and treatment. Researchers' estimates generally range from 100,000 to 200,000 persons per year.<sup>[57]</sup>

Some persons receiving ECT die during the procedure (ECT is performed under a general anaesthetic, which always carries a risk). Leonard Roy Frank cites approximately 400 deaths mentioned in psychiatric journals.<sup>[58]</sup>

### **Law**

While the insanity defense is the subject of controversy as a viable excuse for wrong-doing, Szasz and other critics contend that being committed in a psychiatric hospital can be worse than criminal imprisonment, since it involves the risk of compulsory medication with neuroleptics or the use of electroshock treatment.<sup>[59]</sup> <sup>[60]</sup> Moreover, while a criminal imprisonment has a predetermined time of end that could be anticipated, patients are typically committed to psychiatric hospitals for indefinite durations.<sup>[61]</sup>

### **Involuntary hospitalization**

Critics see involuntary committal's use of legally-sanctioned force as counter to one of the pillars of open or free societies: John Stuart Mill's principles. Mill argues that society should never use coercion to subdue an individual as long as he or she does not harm others. In contrast to the Hollywood portrait of schizophrenics, mentally ill people are essentially no more prone to violence than sane individuals.<sup>[62]</sup> <sup>[63]</sup> The growing practice, in the United Kingdom and elsewhere, of care in the community was instituted partly in response to such concerns. Alternatives to involuntary hospitalization include the development of non-medical crisis care in the community.

In the case of people suffering from severe psychotic crises, the American Soteria project used to provide, critics of psychiatry contend, a more humane and compassionate alternative to coercive psychiatry. The Soteria houses closed in 1983 in the United States due to lack of financial support. However, Soteria-like houses are presently flourishing in Europe, especially in Sweden and other North European countries.<sup>[64]</sup>

## The "Therapeutic State"

The "Therapeutic State" is a phrase coined by American psychiatrist Thomas Szasz in 1963.

“The collaboration between government and psychiatry results in what Szasz calls the "therapeutic state," a system in which disapproved thoughts, emotions, and actions are repressed ("cured") through pseudomedical interventions.”<sup>[65]</sup>

Civil libertarians warn that the marriage of the State with psychiatry could have catastrophic consequences for civilization.<sup>[66]</sup> In the same vein as the separation of church and state, Szasz believes that a solid wall must exist between psychiatry and the State.<sup>[67]</sup>

## The "Total Institution"

In his book *Asylums*, Erving Goffman coined the term 'Total Institution' for mental hospitals and similar places which took over and confined a person's whole life.<sup>[68]</sup> :150<sup>[69]</sup> :9 Goffman placed psychiatric hospitals in the same category as concentration camps, prisons, military organizations, orphanages, and monasteries.<sup>[70]</sup> In *Asylums* Goffman describes how the institutionalisation process socialises people into the role of a good patient, someone 'dull, harmless and inconspicuous'; it in turn reinforces notions of chronicity in severe mental illness.<sup>[71]</sup>

## Psychiatry as a pseudo-science

Many of the above issues lead to the claim that psychiatry is a pseudo-science.<sup>[72]</sup> According to some philosophers of science (especially Karl Popper), for a theory to qualify as hard science it needs to exhibit the following characteristics:

- *parsimony*, as straightforward as the phenomena to be explained allow (see Occam's Razor);
- *empirically testable and falsifiable* (see Falsifiability);
- *changeable*, i.e. if necessary, changes may be made to the theory as new data are discovered;
- *progressive*, encompasses previous successful descriptions and explains and adds more;
- *provisional*, i.e. tentative; the theory does not attempt to assert that it is a final description or explanation.

Psychiatrist Colin A. Ross and Alvin Pam maintain that biopsychiatry does not qualify as a science on many counts.<sup>[73]</sup>

## Scientology

Scientology has also challenged psychiatric theory and practice. L. Ron Hubbard, the founder of Scientology, who claimed the cause of insanity is always an undiagnosed or untreated distressing physical illness,<sup>[74]</sup> became increasingly at odds with psychiatry and in 1969 cofounded the Citizens Commission on Human Rights (CCHR), with Thomas Szasz. CCHR was formed as an advocacy group focused on what it calls psychiatry's "human rights crimes". In the keynote address at the 25th anniversary of CCHR, Szasz stated: "*We should all honor CCHR because it is really the organization that for the first time in human history has organized a politically, socially, internationally significant voice to combat psychiatry. This has never been done in human history before.*" Although Szasz appears in some of CCHR's keynote addresses, he has never been a Scientologist, instead self-identifying as a secular humanist.<sup>[75]</sup>

Despite sharing notable anti-psychiatrists' views on some issues, Scientology doctrine differs in some respects. Scientology doctrine holds that psychiatrists caused the decline in this universe billions of years ago,<sup>[76]</sup> and Scientologists are committed to never taking psychiatric drugs and reject psychology outright.<sup>[77]</sup>

## Notes

- [1] David Cooper, *Psychiatry and Anti-Psychiatry*, Paladin, London, 1967
- [2] *Mind games: are we obsessed with therapy?*, authored by CSICOPer Robert Baker (Prometheus Books, 1996) contains a chapter critical of the DSM-IV diagnoses.
- [3] Whitaker, Robert (2004). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. Basic Books. ISBN 0-7382-0799-3.
- [4] ICSPP page (<http://www.icspp.org>)
- [5] See MindFreedom International (<http://www.mindfreedom.org/>) and the Northampton-based Freedom Center (<http://www.freedom-center.org/>).
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- [14] Draft article for Dictionary of Eighteenth Century German Philosophers (<http://www.manchester.edu/kant/Bio/FullBio/ReilJC.html>)
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## External links

- The Antipsychiatry Coalition (<http://www.antipsychiatry.org/>)
- International Center for Humane Psychiatry and Dan L. Edmunds, Ed.D. (<http://www.drjedmunds.com/>)
- National Mental Health Consumers' Self-Help Clearinghouse (<http://www.mhselfhelp.org/>)
- Commercial influence and the content of medical journals (<http://bmj.bmjournals.com/cgi/content/full/332/7555/1444>) *British Medical Journal*.
- ICSP.org (<http://www.icspp.org/>) — International Center for the Study of Psychiatry and Psychology
- PsychRights.org (<http://psychrights.org/index.htm>) — Law Project for Psychiatric Rights
- IAAPA (<http://www.iaapa.ch/>) International Association Against Psychiatric Assault
- PSAT (<http://www.psychiatricsurvivorarchives.com/>) Psychiatric Survivor Archives of Toronto
- Critical Psychiatry Website (UK) (<http://www.critpsynet.freeuk.com/antipsychiatry.htm>) Network of Psychiatrists Critical to Psychiatry Working in the UK.

# History of anti-psychiatry

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Anti-psychiatry is a movement encompassing a diverse set of theories and practices that challenge, or stand in contrast to, the fundamental theories and practices of psychiatry, which is the branch of medicine concerned with what it describes as diagnosing, managing and treating mental illness/disorder. The **history of anti-psychiatry** includes a period centred on the 1960s and 1970s when antipsychiatry came to the fore, as well as precursors in previous decades and centuries, and more recent developments.

## Precursors

The first widespread challenge to the prevailing medical approach in Western countries occurred in the late 18th century. Part of the progressive Age of Enlightenment, a "moral treatment" movement challenged the harsh, pessimistic, somatic (body-based) and restraint-based approaches that prevailed in the system of hospitals and "madhouses" for people considered mentally disturbed, who were generally seen as wild animals without reason. Alternatives were developed, led in different regions by ex-patient staff, physicians themselves in some cases, and religious and lay philanthropists. The moral treatment was seen as pioneering more humane psychological and social approaches, whether or not in medical settings; however, it also involved some use of physical restraints, threats of punishment, and personal and social methods of control. And as it became the establishment approach in the 19th century, opposition to its negative aspects also grew.

According to Michel Foucault, there was a shift in the perception of madness, whereby it came to be seen as less about delusion, i.e. disturbed judgement about the truth, than about a disorder of regular, normal behaviour or will.<sup>[1]</sup> Foucault argued that, prior to this, doctors could often prescribe travel, rest, walking, retirement and generally engaging with nature, seen as the visible form of truth, as a means to break with artificialities of the world (and therefore delusions).<sup>[2]</sup> Another form of treatment involved nature's opposite, the theatre, where the patient's madness was acted out for him or her in such a way that the delusion would reveal itself to the patient.

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According to Foucault, the most prominent therapeutic technique instead became to confront patients with a healthy sound will and orthodox passions, ideally embodied by the physician. The cure then involved a process of opposition, of struggle and domination, of the patient's troubled will by the healthy will of the physician. It was thought the confrontation would lead not only to bring the illness into broad daylight by its resistance, but also to the victory of the sound will and the renunciation of the disturbed will. *We must apply a perturbing method, to break the spasm by means of the spasm... We must subjugate the whole character of some patients, subdue their transports, break their pride, while we must stimulate and encourage the others* (Esquirol, J.E.D., 1816<sup>[3]</sup>). Foucault also argued that the increasing internment of the "mentally ill" (the development of more and bigger asylums) become necessary not just for diagnosis and classification but because an enclosed place became a requirement for a treatment that was now understood as primarily the contest of wills, a question of submission and victory. The techniques and procedures of the asylums at this time included *isolation, private or public interrogations, punishment techniques such as cold showers, moral talks (encouragements or reprimands), strict discipline, compulsory work, rewards, preferential relations between the physician and his patients, relations of vassalage, of possession, of domesticity, even of servitude between patient and physician at times.*<sup>[4]</sup> Foucault summarised these as *designed to make the medical personage the 'master of madness'*<sup>[5]</sup> through the power the physician's will exerts on the patient. The effect of this shift then served to inflate the power of the physician relative to the patient, correlated with the rapid rise of internment (asylums and forced detention).<sup>[6]</sup>

Other analyses suggest that the rise of asylums was primarily driven by industrialization and capitalism, including the breakdown of the traditional family structures. And that by the end of the 19th century, psychiatrists often had little power in the over-run asylum system, acting mainly as administrators who rarely attended to patients, in a system where therapeutic ideals had turned into mindless institutional routines.<sup>[7]</sup> In general, critics point to negative aspects of the shift toward so-called "moral treatments", and the concurrent widespread expansion of asylums, medical power and involuntary hospitalization laws, in a way that was to play an important conceptual part in the later anti-psychiatry movement.<sup>[8]</sup>

Various 19th century critiques of the newly emerging field of psychiatry overlap thematically with 20th century anti-psychiatry, for example in their questioning of the medicalisation of "madness". Those critiques occurred at a time when physicians had not yet achieved hegemony through psychiatry, however, and so there was not such a single unified force to be "anti-".<sup>[8]</sup> Nevertheless, there was increasing concern at the ease with which people could be confined, with frequent reports of abuse and illegal confinement (for example, Daniel Defoe, the author of *Robinson Crusoe*, had previously argued that husbands used asylum hospitals to incarcerate their disobedient wives.<sup>[9]</sup>) There was general concern that physicians were undermining personhood by medicalizing problems, by claiming they alone had the expertise to judge it, and by arguing that mental disorder was physical and hereditary. The Alleged Lunatics' Friend Society arose in England in the mid-19th century to challenge the system and campaign for rights and reforms.<sup>[10]</sup> In the United States, Elizabeth Packard published a series of books and pamphlets describing her experiences in the Illinois insane asylum to which her husband had had her committed.

Throughout, the class nature of mental hospitals, and their role as agencies of control, were well recognized. And the new psychiatry was partially challenged by two powerful social institutions - the church and the legal system. These trends have been thematically linked to the later 20th century antipsychiatry movement.<sup>[11]</sup>

As psychiatry became more professionally established during the nineteenth century (the term itself was coined in 1808 in Germany, as "Psychiatriein") and developed allegedly more invasive treatments, opposition increased.<sup>[12]</sup> In the Southern US, black slaves and Abolitionists encountered Drapetomania, a pseudo-scientific diagnosis for why slaves ran away from their masters.<sup>[13]</sup>

There was some organized challenge to psychiatry in the late 1870s from the new speciality of neurology. Practitioners criticized mental hospitals for failure to conduct scientific research and adopt the modern therapeutic methods such as nonrestraint. Together with lay reformers and social workers, neurologists formed the National Association for the Protection of the Insane and the Prevention of Insanity. However, when the lay members

questioned the competence of asylum physicians to even provide proper care at all, the neurologists withdrew their support and the association floundered.<sup>[11]</sup>

## Early 20th century

Emil Kraepelin introduced a new approach to the classification of mental disorder, which eventually came into psychiatric usage despite a basis in behavior rather than medical pathology or etiology.

In the 1920s surrealist opposition to psychiatry was expressed by Antonin Artaud in his book on van Gogh.

The post-World War II decades saw an enormous growth in psychiatry; many Americans were persuaded that psychiatry and psychology, particularly psychoanalysis, were a key to happiness. Meanwhile, most hospitalized mental patients received at best decent custodial care and at worst they were abused and neglected. From the 1930s several controversial medical practices were introduced including inducing seizures (by electroshock, insulin shock therapy or other drugs) or cutting parts of the brain apart (leucotomy or lobotomy).<sup>[14]</sup> Both came into widespread use by psychiatry, and labotomies began to practiced in outpatient clinics with minimal care, but there were grave concerns and much opposition on grounds of morality, harmful effects, or misuse.

In the 1950s new psychiatric drugs, notably the antipsychotic chlorpromazine, slowly came into use. Although often accepted as an advance in some ways, there was opposition, partly due to serious adverse effects such as tardive dyskinesia, and partly due their "chemical straightjacket" effect and their alleged use to control and intimidate patients.<sup>[14]</sup> Patients often opposed psychiatry and refused or stopped taking the drugs when not subject to psychiatric control.<sup>[14]</sup> There was also increasing opposition to the large-scale use of psychiatric hospitals and institutions, and attempts were made to develop services in the community.

It has been noted that "the most persistent critics of psychiatry have always been former mental hospital patients", but that very few were able to tell their stories publicly or to openly confront the psychiatric establishment, and those who did so were commonly considered so extreme in their charges that they could seldom gain credibility.<sup>[11]</sup> In the early 20th century, ex-patient Clifford W. Beers campaigned to improve the plight of individuals receiving public psychiatric care, particularly those committed to state institutions, publicizing the issues in his book, *A Mind that Found Itself* (1908)<sup>[15]</sup> While Beers initially damned psychiatrists for tolerating mistreatment of patients, and envisioned more ex-patient involvement in the movement, he was influenced by Adolf Meyer and the psychiatric establishment, and toned down his hostility as he needed their support for reforms. His reliance on rich donors and his need for approval from experts led him to hand over to psychiatrists the organization he helped found, the National Committee for Mental Hygiene which eventually became the National Mental Health Association.<sup>[11]</sup> In the UK meanwhile, the National Society for Lunacy Law Reform was established in 1920 by angry ex-patients sick of their experiences and complaints being patronisingly discounted by the authorities who were using medical "window dressing" for essentially custodial and punitive practices.<sup>[16]</sup> In 1922, ex-patient Rachel Grant-Smith added to calls for reform of the system of neglect and abuse she had suffered by publishing "The Experiences of an Asylum Patient".<sup>[17]</sup> In the US, We Are Not Alone (WANA) was founded by a group of patients at Rockland State Hospital in New York, and continued to meet as an ex-patient group.<sup>[18]</sup>

The psychoanalyst Lacan has been identified as an influence on later antipsychiatry theory in the UK, and as being the first, in the 1940s and 50s, to professionally challenge psychoanalysis to reexamine its concepts and to appreciate psychosis as understandable. Other influences on Lacan included poetry and the surrealist movement, including the poetic power of patients' experiences. Critics disputed this and questioned how his descriptions linked to his practical work. The names that came to be associated with the antipsychiatry movement knew of Lacan and acknowledged his contribution even if they did not entirely agree.<sup>[19]</sup> The psychoanalyst Erich Fromm is also said to have articulated, in the 1950s, the secular humanistic concern of the coming antipsychiatry movement. In *The Sane Society* (1955), Fromm wrote "'An unhealthy society is one which creates mutual hostility [and] distrust, which transforms man into an instrument of use and exploitation for others, which deprives him of a sense of self, except inasmuch as he submits to others or becomes an automaton'..."<sup>[19]</sup> "Yet many psychiatrists and psychologists refuse to entertain the idea



that society as a whole may be lacking in sanity. They hold that the problem of mental health in a society is only that of the number of 'unadjusted' individuals, and not of a possible unadjustment of the culture itself"<sup>[20]</sup>

In the 1950s in the United States, a right wing anti-mental health movement opposed psychiatry, seeing it as liberal, left-wing, subversive and anti-American or pro-Communist. There were widespread fears that it threatened individual rights and undermined moral responsibility. An early skirmish was over the Alaska Mental Health Bill, where the right wing protestors were joined by the emerging scientology movement.

The field of psychology sometimes came into opposition with psychiatry. Behaviorists argued that mental disorder was a matter of learning not medicine; for example, Hans Eysenck argued that psychiatry "really has no role to play". The developing field of clinical psychology in particular came into close contact with psychiatry, often in opposition to its methods, theories and territories.<sup>[21]</sup>

## 1960s

Coming to the fore in the 1960s, "anti-psychiatry" (a term first used by David Cooper in 1967) defined a movement that vocally challenged the fundamental claims and practices of mainstream psychiatry. While most of its elements had precedents in earlier decades and centuries, in the 1960s it took on a national and international character, with access to the mass media and incorporating a wide mixture of grassroots activist organizations and prestigious professional bodies.<sup>[21]</sup>

Cooper was a South African psychiatrist working in Britain. A trained Marxist revolutionary, he argued that the political context of psychiatry and its patients had to be highlighted and radically challenged, and warned that the fog of individualized therapeutic language could take away people's ability to see and challenge the bigger social picture. He spoke of having a goal of "non-psychiatry" as well as anti-psychiatry. It has been suggested that Cooper may have seen psychiatry as analogous to apartheid.<sup>[21]</sup>

The psychiatrists R.D. Laing (from Scotland), Theodore Lidz (from America), Silvano Arieti (from Italy) and others, argued that "schizophrenia" and psychosis were understandable, and resulted from injuries to the inner self inflicted by psychologically invasive "schizophrenogenic" parents or others; it was sometimes seen as a transformative state involving an attempt to cope with a sick society. Laing, however, partially dissociated himself from his colleague Cooper's term "antipsychiatry". Laing had already become a media icon through bestselling books (such as *The Divided Self* and *The Politics of Experience*) discussing mental distress in an interpersonal existential context; Laing was somewhat less focused than his colleague Cooper on wider social structures and radical left wing politics, and went on to develop more romanticized or mystical views (as well as equivocating over the use of diagnosis, drugs and commitment). Although the movement originally described as anti-psychiatry became associated with the general counter-culture movement of the 1960s, Lidz and Arieti never became involved in the latter. Franco Basaglia promoted antipsychiatry in Italy and secured reforms to mental health law there.

Laing, through the Philadelphia Association founded with Cooper in 1965, set up over 20 therapeutic communities including Kingsley Hall, where staff and residents theoretically assumed equal status and any medication used was voluntary. Non-psychiatric Soteria houses, starting in the United States, were also developed<sup>[22]</sup> as were various ex-patient-led services.

Psychiatrist Thomas Szasz argued that "mental illness" is an inherently incoherent combination of a medical and a psychological concept. He opposed the use of psychiatry to forcibly detain, treat, or excuse what he saw as mere deviance from societal norms or moral conduct. As a libertarian, Szasz was concerned that such usage undermined personal rights and moral responsibility. Adherents of his views referred to "the myth of mental illness", after Szasz's controversial 1961 book of that name (based on a paper of the same name that Szasz had written in 1957 that, following repeated rejections from psychiatric journals, had been published in the *American Psychologist* in 1960<sup>[23]</sup>). Although widely described as part of the main antipsychiatry movement, Szasz actively rejected the term and its adherents; instead, in 1969, he collaborated with scientology to form the Citizens Commission on Human Rights. It was later noted that the view that insanity was not in most or even in any instances a "medical" entity, but a moral

issue, was also held by Christian Scientists and certain Protestant fundamentalists, as well as Szasz.<sup>[11]</sup>

Erving Goffman, Deleuze and Guattari, and others criticized the power and role of psychiatry in society, including the use of "total institutions," and stigmatizing.<sup>[24]</sup> The French sociologist and philosopher Foucault, in his 1961 publication "Madness and Civilization: A History of Insanity in the Age of Reason", analyzed how attitudes towards those deemed "insane" had changed as a result of changes in social values. He argued that psychiatry was primarily a tool of social control, based historically on a "great confinement" of the insane and physical punishment and chains, later exchanged in the moral treatment era for psychological oppression and internalized restraint. American sociologist Thomas Scheff applied Labeling theory to psychiatry in 1966 in "Being Mentally Ill". Scheff argued that society views certain actions as deviant and, in order to come to terms with and understand these actions, often places the label of mental illness on those who exhibit them. Certain expectations are then placed on these individuals and, over time, they unconsciously change their behavior to fulfill them.

The novel *One Flew Over the Cuckoo's Nest* became a bestseller, resonating with public concern about involuntary medication, lobotomy and electroshock procedures used to control patients. In addition, Holocaust documenters argued that the medicalization of social problems and systematic euthanasia of people in German mental institutions in the 1930s provided the institutional, procedural, and doctrinal origins of the mass murder of the 1940s.<sup>[25]</sup> <sup>[26]</sup> The Nuremberg Trials convicted a number of psychiatrists who held key positions in Nazi regimes. Observation of the abuses of psychiatry in the Soviet Union in the so-called Psikhushka hospitals also led to questioning the validity of the practice of psychiatry in the West.<sup>[27]</sup> In particular, the diagnosis of many political dissidents with schizophrenia led some to question the general diagnosis and punitive usage of the label schizophrenia. This raised questions as to whether the schizophrenia label and resulting involuntary psychiatric treatment could not have been similarly used in the West to subdue rebellious young people during family conflicts.<sup>[28]</sup>

## 1970s

New professional approaches were developed as an alternative or reformist complement to psychiatry. *The Radical Therapist*, a journal begun in 1971 in North Dakota by Michael Glenn, David Bryan, Linda Bryan, Michael Galan and Sara Glenn, challenged the psychotherapy establishment in a number of ways, raising the slogan "Therapy means change, not adjustment." It contained articles that challenged the professional mediator approach, advocating instead revolutionary politics and authentic community making. Social work, humanistic or existentialist therapies, family therapy, counseling and self-help and clinical psychology developed and sometimes opposed psychiatry.

Psychoanalysis was increasingly criticized as unscientific or harmful.<sup>[29]</sup> Contrary to the popular view, critics and biographers of Freud, such as Alice Miller, Jeffrey Masson and Louis Breger, argued that Freud did not grasp the nature of psychological trauma. Non-medical collaborative services were developed, for example therapeutic communities or Soteria houses.

The psychoanalytically trained psychiatrist Szasz, although professing fundamental opposition to what he perceives as medicalization and oppressive or excuse-giving "diagnosis" and forced "treatment", was not opposed to other aspects of psychiatry (for example attempts to "cure-heal souls", although he also characterizes this as non-medical). Although generally considered anti-psychiatry by others, he sought to dissociate himself politically from a movement and term associated with the radical left-wing. In a 1976 publication "Anti-psychiatry: The paradigm of a plundered mind", which has been described as an overtly political condemnation of a wide sweep of people, Szasz claimed Laing, Cooper and all of antipsychiatry consisted of "self-declared socialists, communists, or at least anti-capitalists and collectivists". While saying he shared some of their critique of the psychiatric system, Szasz compared their views on the social causes of distress/deviance to those of anti-capitalist anti-colonialists who claimed that Chilean poverty was due to plundering by American companies, a comment Szasz made not long after a CIA-backed coup had deposed the democratically elected Chilean president and replaced him with Pinochet. Szasz argued instead that distress/deviance is due to the flaws or failures of individuals in their struggles in life.<sup>[30]</sup>

The anti-psychiatry movement was also being driven by individuals with adverse experiences of psychiatric services. This included those who felt they had been harmed by psychiatry or who felt that they could have been helped more by other approaches, including those compulsorily (including via physical force) admitted to psychiatric institutions and subjected to compulsory medication or procedures. During the 1970s, the anti-psychiatry movement was involved in promoting restraint from many practices seen as psychiatric abuses.

The gay rights movement continued to challenge the classification of homosexuality as a mental illness and in 1974, in a climate of controversy and activism, the American Psychiatric Association membership (following a unanimous vote by the trustees in 1973) voted by a small majority (58%) to remove it as an illness category from the DSM, replacing it with a category of "sexual orientation disturbance" and then "ego-dystonic homosexuality," which was deleted in 1987, although "gender identity disorder" and a wide variety of "paraphilias" remain. It has been noted that gay activists at the time adopted many of Szasz's arguments against the psychiatric system, but also that Szasz had written in 1965 that: "I believe it is very likely that homosexuality is, indeed, a disease in the second sense [expression of psychosexual immaturity] and perhaps sometimes even in the stricter sense [a condition somewhat similar to ordinary organic maladies]."<sup>[31]</sup>

Increased legal and professional protections, and a merging with human rights and disability rights movements, added to anti-psychiatry theory and action.

Anti-psychiatry came to challenge a "biomedical" focus of psychiatry (defined to mean genetics, neurochemicals and pharmaceutical drugs). There was also opposition to the increasing links between psychiatry and pharmaceutical companies, which were becoming more powerful and were increasingly claimed to have excessive, unjustified and underhand influence on psychiatric research and practice. There was also opposition to the codification of, and alleged misuse of, psychiatric diagnoses into manuals, in particular the American Psychiatric Association, which publishes the *Diagnostic and Statistical Manual of Mental Disorders*.

Anti-psychiatry increasingly challenged alleged psychiatric pessimism and institutionalized alienation regarding those categorized as mentally ill. An emerging consumer/survivor movement often argues for full recovery, empowerment, self-management and even full liberation. Schemes were developed to challenge stigma and discrimination, often based on a social model of disability; to assist or encourage people with mental health issues to engage more fully in work and society (for example through social firms), and to involve service users in the delivery and evaluation of mental health services. However, those actively and openly challenging the fundamental ethics and efficacy of mainstream psychiatric practice remained marginalized within psychiatry, and to a lesser extent within the wider mental health community.

## Diverse paths

Szasz has since (2008) re-emphasized his disdain for the antipsychiatry movement, arguing that its legacy has simply been a "catchall term used to delegitimize and dismiss critics of psychiatric fraud and force by labeling them 'antipsychiatrists'". He points out that the term originated in a meeting of four psychiatrists (Cooper, Laing, Berke and Redler) who never defined it yet "counter-label[ed] their discipline as anti-psychiatry", and that he considers Laing most responsible for popularizing it despite also personally distancing himself. Szasz describes the deceased (1989) Laing in vitriolic terms, accusing him of being irresponsible and equivocal on psychiatric diagnosis and use of force, and detailing his past "public behavior" as "a fit subject for moral judgment" which he gives as "a bad person and a fraud as a professional".<sup>[32]</sup>

Daniel Burston, however, has argued that overall the published works of Szasz and Laing demonstrate far more points of convergence and intellectual kinship than Szasz admits, despite the divergence on a number of issues related to Szasz being a libertarian and Laing an existentialist; that Szasz employs a good deal of exaggeration and distortion in assassinating the character of Laing, with an overarching agenda of using Laing's personal failings and family woes to discredit his work and ideas; and that Szasz's "clear-cut, crystalline ethical principles are designed to spare us the agonizing and often inconclusive reflections that many clinicians face frequently in the course of their

work".<sup>[33]</sup> Szasz has indicated that his own views came from libertarian politics held since his teens, rather than through experience in psychiatry; that in his "rare" contacts with involuntary mental patients in the past he either sought to discharge them (if they were not charged with a crime) or "assisted the prosecution in securing [their] conviction" (if they were charged with a crime and appeared to be *prima facie* guilty); that he is not opposed to consensual psychiatry and "does not interfere with the practice of the conventional psychiatrist", and that he provided "listening-and-talking ("psychotherapy")" for voluntary fee-paying clients from 1948 until 1996, a practice he characterizes as non-medical and not associated with his being a psychoanalytically trained psychiatrist.<sup>[32]</sup>

The gay rights or gay liberation movement is often thought to have been part of antipsychiatry in its efforts to challenge oppression and stigma and, specifically, to get homosexuality removed from the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. However, a psychiatric member of APA's Gay, Lesbian, and Bisexual Issues Committee has recently sought to distance the two, arguing that they were separate in the early 70s protests at APA conventions and that APA's decision to remove homosexuality was scientific and happened to coincide with the political pressure. Reviewers have responded, however, that the founders and movements were closely aligned; that they shared core texts, proponents and slogans; and that others have stated that, for example, the gay liberation critique was "made possible by (and indeed often explicitly grounded in) traditions of antipsychiatry".<sup>[34]</sup> <sup>[35]</sup>

In the clinical setting, the two strands of antipsychiatry — criticism of psychiatric knowledge and reform of its practices — were never entirely distinct. In addition, in a sense, antipsychiatry was not so much a demand for the end of psychiatry, as it was psychiatrists and allied professionals questioning their own judgements and practices. In some cases, the suspicion of non-psychiatric medical professionals towards the validity of psychiatry was described as anti-psychiatry, as well the criticism of "tough headed" psychiatrists towards "soft head" psychiatrists. Even the leading figures of antipsychiatry were within psychiatry and equivocated over whether they were really against psychiatry, or which parts. Outside psychiatry however - for example student and lay activists and paraprofessionals such as social workers and psychologists - antipsychiatry tended to mean something more uniformly radical. And the ambiguous term "antipsychiatry" came to be associated with these stronger forms, but there was debate over whether it was a new phenomena, who "owned" it, and whether it even constituted a genuinely singular movement.<sup>[36]</sup>

In the 1990s, a tendency was noted among psychiatrists to regard the anti-psychiatric movement as having entered the annals of history, and to look back on its ideology as an attempt to flirt with polemics at the expense of scientific thought and enquiry. It was argued, however, that the movement contributed towards generating demand for grassroots involvement in guidelines and advocacy groups, and to the shift from large mental institutions to community services. In addition, in reality, community centers tended to distance themselves from the psychiatric medical model and continued to see themselves as representing a culture of resistance or opposition to psychiatry's power. Overall, while antipsychiatry may have fallen from grace and was no longer be led by eminent psychiatrists, it was argued that it had in fact only been handed over to the team.<sup>[19]</sup> On the other hand, mainstream psychiatry became more biomedical, increasing the gap between professionals.

A criticism was made in the 1990s that three decades of antipsychiatry had produced a large literature critical of psychiatry, but little discussion of the deteriorating situation of the mentally troubled in American society. Antipsychiatry crusades have thus been charged with failing to put suffering individuals first, and of thus being guilty of what they accuse psychiatrists. The rise of antipsychiatry in Italy was described by one observer as simply "a transfer of psychiatric control from those with medical knowledge to those who possessed socio-political power".<sup>[21]</sup>

In the meantime, members of the psychiatric consumer/survivor movement carried on campaigning for reform, empowerment and alternatives, with an increasingly diverse representation of views. Groups have often been opposed and undermined, especially when they proclaim to be, or when they are labelled as being, "anti-psychiatry".<sup>[37]</sup> However, as of the 1990s, more than 60 percent of ex-patient groups reportedly support anti-psychiatry beliefs and consider themselves to be "psychiatric survivors".<sup>[38]</sup> Although antipsychiatry is often

attributed to a few famous figures in psychiatry or academia, it has been pointed out that consumer/survivor/ex-patient individuals and groups preceded it, drove it and carried on through it.<sup>[39] [40]</sup>

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## Involuntary commitment

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**Involuntary commitment** or **civil commitment** is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient) or in the community (outpatient).

Criteria for civil commitment are established by law, which varies between nations and, in the U.S., from state to state. Commitment proceedings often follow a period of emergency hospitalization during which an individual with acute psychiatric symptoms is confined for a relatively short duration (e.g. 72 hours) in a treatment facility for evaluation and stabilization by mental health professionals - who may then determine whether further civil commitment is appropriate or necessary. If civil commitment proceedings follow, the evaluation is presented in a formal court hearing where testimony and other evidence may also be submitted. The subject of the hearing typically is entitled to legal counsel and may challenge a commitment order through habeas corpus rules.

Historically, until the first third of the twentieth century or later in most jurisdictions, all committals to public psychiatric facilities and most committals to private ones were involuntary. Since then, there have been alternating trends towards the abolition or substantial reduction of involuntary commitment<sup>[1]</sup>, a trend known as "deinstitutionalization."

### Purpose

In most jurisdictions, involuntary commitment is specifically applied to individuals found to be suffering from a mental illness that impairs their reasoning ability to such an extent that the laws, state or courts find that decisions must or should be made for them under a legal framework. (In some jurisdictions this is a distinct proceeding from being "found incompetent.")

Involuntary commitment is used to some degree for each of the following headings although different jurisdictions have different criteria. Some jurisdictions limit court-ordered treatment to individuals who meet statutory criteria for presenting a danger "to self or others." Other jurisdictions have criteria that are broader.

### First aid

Training is gradually becoming available in mental health first aid to equip community members such as teachers, school administrators, police officers, and medical workers in recognizing and managing situations where evaluations of behavior might be appropriate.<sup>[2]</sup> The extension of first aid training to cover mental health problems and crises is a quite recent development.<sup>[3]</sup> <sup>[4]</sup> A mental health first aid training course was developed in Australia in 2001 and has been found to improve assistance provided to persons with a mental illness or in a mental health crisis. This form of training has now spread to a number of other countries (Canada, Finland, Hong Kong, Ireland, Singapore, Scotland, England, Wales, United States).<sup>[5]</sup> Mental health triage may be used in an emergency room to

evaluate the degree of risk and prioritize treatment.

## Observation

Observation is sometimes used to determine if a person warrants involuntary commitment. It is not always clear on a relatively brief examination whether a person is psychotic or otherwise warrants commitment.

## Containment of danger

A common reason given for involuntary commitment is to prevent danger to the individual or society. People with suicidal thoughts may act on these thoughts and harm or kill themselves. People with psychoses are occasionally driven by their delusions or hallucinations to harm themselves or others. People with certain types of personality disorders can occasionally present a danger to themselves or others.

This concern has found expression in the standards for involuntary commitment in every U.S. state and in other countries as the "danger to self or others" standard, sometimes supplemented by the requirement that the danger be "imminent." In some jurisdictions, "danger to self or others" standard has been broadened in recent years to include need-for-treatment criteria such as "gravely disabled."

In Arizona, the government can mandate in-patient treatment for anyone determined to be "persistently or acutely disabled." Virtually anyone who suspects that someone has mental problems and needs help could file an application to a state-licensed healthcare agency for a court-ordered evaluation.

In Connecticut, someone can be committed only if he or she has "psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled". "Gravely disabled" has usually been interpreted to mean that the person is unable on his own to obtain adequate food, shelter and clothing.

In Iowa, any "interested person" may begin commitment proceedings by submitting a written statement to the court. If the court finds that the respondent is "seriously mentally impaired," he or she will be placed in a psychiatric hospital for further evaluation and possibly treatment. Further hearings are required at specific intervals for as long as the person is being involuntarily held.

The Michigan Mental Health Code provides that a person "whose judgment is so impaired that he or she is unable to understand his or her need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to himself or herself or others" may be subjected to involuntary commitment, a provision paralleled in the laws of many other jurisdictions. These types of provisions have been criticized as a sort of "heads I win, tails you lose". Understanding one's "need for treatment" would cause one to agree to voluntary commitment, but the Bazelon Center has said that this "lack of insight" is "often no more than disagreement with the treating professional"<sup>[6]</sup> and this disagreement might form part of the evidence to support one's involuntary commitment.

In Nevada, prior to confining someone, the state must demonstrate that the person "is mentally ill and, because of that illness, is likely to harm himself or others if allowed his liberty."

In Oregon, the standard that the allegedly mentally ill person "Peter [h]as been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs" may be substituted for the danger to self or others standard.

In Utah, the standard is that "the proposed patient has a mental illness which poses a substantial danger".<sup>[7]</sup> "Substantial danger" means the person, by his or her behavior, due to mental illness: (a) is at serious risk to: (i) commit suicide, (ii) inflict serious bodily injury on himself or herself; or (iii) because of his or her actions or inaction, suffer serious bodily injury because he or she is incapable of providing the basic necessities of life, such as food, clothing, and shelter; (b) is at serious risk to cause or attempt to cause serious bodily injury; or (c) has inflicted or attempted to inflict serious bodily injury on another.<sup>[8]</sup>

## Deinstitutionalization

Starting in the 1960s, there has been a worldwide trend toward moving psychiatric patients from hospital settings to less restricting settings in the community, a shift known as "deinstitutionalization." Because the shift typically was not accompanied by a commensurate development of community-based services, critics say that deinstitutionalization has led to large numbers of people who would once have been inpatients being incarcerated in jails and prisons or becoming homeless when outpatient services are not available or they choose not to adhere to treatment outside the hospital. In some jurisdictions, laws authorizing court-ordered outpatient treatment have been passed in an effort to compel individuals with chronic, untreated severe mental illness to accept treatment while living outside the hospital.

## Around the world

### United Nations

United Nations General Assembly (resolution 46/119 of 1991), "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" is a non-binding resolution advocating certain broadly-drawn procedures for the carrying out of involuntary commitment. These principles have been used in many countries where local laws have been revised or new ones implemented. The UN runs programs in some countries to assist in this process.

### Australia

In Australia, court hearings are not required for involuntary commitment. Mental health law is constitutionally under the state powers. Each state thus has different laws, many of which have been updated in recent years.

### Referral for service

The usual requirement is that a police officer or a physician determine that a person requires a psychiatric examination, usually through a psychiatric hospital. If the person is detained in the hospital, they usually must be seen by an authorized psychiatrist within a set period of time. In some states, after a further set period or at the request of the person or their representative, a tribunal hearing is held to determine whether the person should continue to be detained. In states where tribunals are not instituted, there is another form of appeal.

Some Australian states require that the person is a danger to the society or themselves; other states only require that the person be suffering from a mental illness that requires treatment. The Victorian Mental Health Act (1986) specifies in part that:

"(1) A person may be admitted to and detained in an approved mental health service as an involuntary patient in accordance with the procedures specified in this Act only if—

- (a) the person appears to be mentally ill; and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service; and
- (c) because of the person's mental illness, the person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

There are additional qualifications and restrictions but the effect of these provisions is that people who are assessed by doctors as being in need of treatment may be admitted involuntarily without the need of demonstrating a risk of



danger. This then overcomes the pressure described above to exaggerate issues of violence to obtain an admission.

### **Treatment**

In general, once the person is under involuntary commitment, treatment may be instituted without further requirements. Some treatments such as electroconvulsive therapy (ECT) often require further procedures to comply with the law before they may be administered involuntarily.

Community treatment orders can be used in the first instance or after a period of admission to hospital as a voluntary or involuntary patient. With the trend towards deinstitutionalization this is becoming increasingly frequent and hospital admission is restricted to people with severe mental illnesses.

## **Europe**

### **Germany**

In Germany there is a growing tendency to use the law on legal guardianship, instead of mental health law, to justify involuntary commitment or treatment. The ward's legal guardian decides that he/she must go into mental hospital for treatment, and the police will act on this decision. This is simpler for the government and family members than the formal process for commitment under mental health laws.

In German criminal law a person that was convicted of certain crimes can also be sentenced to be kept in preventive detention; see article on preventive detention.

### **Netherlands**

In Dutch criminal law a convict can be sentenced to involuntary psychiatric treatment in a special institute called a TBS-clinic. TBS is an abbreviation for "Ter Beschikkingstelling," literally meaning "being placed at disposal." Legally, such a sentence is not regarded as punishment like a prison sentence, but as a special measure. In the Netherlands, it is common practice to sentence criminals to a combination of a normal prison term and TBS. The convict will then be placed in a TBS-clinic after serving time in prison (usually two-thirds of the original prison sentence, although this practice is under discussion).

According to Dutch law, meeting three conditions is required for a convict to be sentenced to TBS. These conditions are:

- the crime committed must have been directly related to a psychiatric disorder,
- recidivism must be likely, and
- the convict can not, or only partially, be held accountable for the crime.

To determine if these conditions are met, the suspect is observed in a forensic psychiatric detention center, the Pieter Baan Centre.<sup>[9]</sup> Neither the prosecution or the defense can effectively challenge the Pieter Baan Centre's report, since it is the only institution that can conduct such investigations. Fatal mistakes have occurred, for instance, when a child molester regarded by the Pieter Baan Center as "not dangerous" killed a child upon release. The conclusions in the centre's report are not binding, the judge can decide to ignore, or only partially accept them.

Every convict detained in a TBS-clinic may get temporary leave, after serving a certain time or after some progress in treatment. This is regarded as an essential part of treatment, as the convict will be gradually re-entering society this way. At first the convict will be escorted by a therapist, and will be allowed outside the clinic for only a few hours. After evaluation, time and freedom of movement will be expanded until the convict can move freely outside the clinic without escort (usually for one day at a time). At that time, the convict will find work or follow an education. Generally, the convict is released after being in this situation for one or two years without incident.

The time to be served in TBS can be indefinite, and it may be used as a form of preventive detention. Evaluation by the court will occur every one or two years. During these evaluations the court determines if any progress is made in treatment of the convict, and if it will be safe to release the convict into society. In general, the court will follow

conclusions made by the TBS-clinic.

Average time served in a TBS-clinic by a convict is slightly over eight years.

Dutch TBS-clinics

In the Netherlands there are currently 12 institutions regarded as TBS-clinics:

- AMC de Meren/Arkin, Amsterdam
- Dr. Henri van der Hoevenstichting, Utrecht
- Dr. S. van Mesdagkliniek, Groningen
- Hoeve Boschoord, Boschoord
- FPC Veldzicht, Balkbrug
- Pompestichting, Nijmegen
- Oostvaarderskliniek, Almere
- De Kijvelanden/FPC Tweelanden, Poortugaal
- FPC Oldenkotte, Rekken
- FPC De Rooyse Wissel, Venray
- GGz Drenthe, Assen
- GGz Eindhoven/De Woenselse Poort, Eindhoven

These institutions combined currently are holding about 1840 convicts.

By the end of the 20th century, it was concluded that some convicts could not be treated and therefore could not be safely released into society. For these convicts, TBS-clinics formed special wards, called "long-stay wards". Transfer to such a ward means that the convict will no longer be actively treated, but merely detained. This is regarded as more cost-effective. In general, the convicts in these wards will be incarcerated for the rest of their lives, although their detention is eligible for regular review by the court.

### Controversy

Since the latter half of the 1990s considerable controversy has grown among Dutch society, about the TBS-system. This controversy has two main reasons. The first reason is the media increasingly reported cases of convicts committing crimes while still in, or after, treatment in a TBS-clinic.

Some examples of these cases are:

- During 1992, a truck driver was convicted for raping and murdering three young children. Eight years earlier he was released from a TBS-clinic after being treated for child molestation.
- A convict, about to be released from a TBS-clinic, murdered the owner of a garage in 1996 while under the influence of drugs.
- An ex-convict, treated in a TBS-clinic, murdered two women in 1994 and 1997.
- A convict, still treated by a TBS-clinic, randomly killed a man in the city of Groningen in 1999.
- Between 2000 and 2004, an ex-convict tortured several animals and killed a homeless man. He had been treated in a TBS-clinic.
- In 2002 an ex-convict was sentenced for triple murder. He also was released earlier.
- In 2005 a convict escaped his escort during leave. He was arrested several days later after killing a man.

Political and social commotion increased, and debate started about the effectiveness of the TBS-system and if convicts should be granted leave from TBS-clinics. Especially right-wing politicians pleaded the TBS-system should be discarded altogether. Numerous articles in newspapers, magazines, television and radio programs and a revealing book written by an ex-convict (which for the first time openly questioned the effectiveness of the TBS-system) boosted discussion. Prior to that, any problems had been mostly denied by TBS-clinics themselves.

The center of attention became a highly renowned TBS-clinic, Dr. S. Van Mesdagkliniek in the city of Groningen. Events that took place there, by the end of the 1990s and the first years of the 21st century, initiated the second

reason for controversy. Concern rose about signs of unprofessional behavior by staff working in TBS-clinics, and the Dr. S. Van Mesdagkliniek proved to be among the most infamous for these problems. This TBS-clinic has been plagued with unprofessional and even criminal acts by its staff since 1999. During that year, the Dr. S. Van Mesdagkliniek came under investigation by Dutch police after rumors about female staffmembers committing sexual offenses against convicts.<sup>[10]</sup> Five such cases were discovered during the investigation, and also numerous cases of drug-abuse, smuggling and trading of contraband such as: alcohol, mobile phones, pornographic material and hard drugs.<sup>[11]</sup> It became apparent that staff members did not have the required education, had not been informed about rules and regulations, disregarded legal procedures, gave false testimonies, tampered with evidence, uttered false accusations against convicts, and intimidated colleagues.<sup>[10]</sup> At least one psychiatrist, employed as such by the Dr. S. Van Mesdagkliniek, proved to be not qualified,<sup>[12]</sup> and treatment of convicts was in many cases simply non-existent.<sup>[13]</sup> These problems had been known for long by the management, but were always kept hidden. After public outcry about this situation, management was replaced<sup>[14]</sup> and all of the nine (at the time) TBS-clinics in the Netherlands were subjected to investigation. Six of them proved to be below the required legal standards.<sup>[15]</sup> However, problems for the expensive Dutch TBS-system did not end there. In spite of many measures taken by the government, convicts still were released without proper treatment. As a consequence, numerous crimes were committed by convicts that were regarded as treated by TBS-clinics. Also, sexual offenses against convicts by staff members and smuggling of contraband did not cease in several TBS-clinics.<sup>[16]</sup> In 2006, the Dutch government formed a committee to investigate the TBS-system. Some, however not the worst, problems were recognized and measures were proclaimed. One of the known actual results is that fewer convicts escape during temporary release.

Controversy regarding the, often praised, Dutch TBS-system does not cease to exist. In 2005, a staff member working in the Dr. S. Van Mesdagkliniek was caught while smuggling liquor to convicts suffering from alcohol-related problems.<sup>[17]</sup> In 2007, a female staff member committed sexual offenses against a convict, and had smuggled contraband.<sup>[18]</sup> She was sentenced to three months in prison in 2009. That same year, investigation proved convicts still had ample access to illicit drugs<sup>[19]</sup> and four inmates from the Dr. S. Van Mesdagkliniek were arrested for possession of child pornography.<sup>[20]</sup> Many crimes committed by released convicts treated in TBS-clinics, escape statistics because they occurred in other countries, or because they differ from the crime the convict was originally convicted for (many convicts released from TBS-clinics find their way in illegal drug trade and related crimes). Because there seems to be no acceptable alternative available, political support for the much plagued TBS-system remains, in spite of controversy.

### **United Kingdom**

In the United Kingdom, the process known in the United States as involuntary commitment is informally known as "sectioning," after the various sections of the Mental Health Act 1983 (covering England and Wales), the Mental Health (Northern Ireland) Order 1986 and the Mental Health (Care and Treatment) (Scotland) Act 2003 that provide its legal basis.

In England and Wales, Approved Mental Health Professionals have a lead role in coordinating Mental Health Act assessments, which they conduct in cooperation with usually two medical practitioners. Under the Mental Health Act, detention is determined by utility and purpose. Ward-based patients can be detained for periods of up to 3 days while further assessments are arranged. In the community, mentally ill individuals may be detained under Section 2 for a period of assessment lasting up to 28 days or Section 3 for a period of treatment lasting up to 6 months. Separate sections deal with mentally ill offenders. In all cases detention needs to be justified on the basis that the person is mentally ill and constitutes a risk of deterioration and/or of risk to themselves or others.

Under the amended Mental Health Act 2007, which came into force in November 2008, to be detained under Section 3 for treatment, treatment that is appropriate must be available in place of detention. Supervised Community Treatment means people can continue to be detained and discharged on extended conditional leave to the community in accordance with a Community Treatment Order.

## United States

Involuntary commitment is governed by state law and procedures vary from state to state. In some jurisdictions, laws regarding the commitment of juveniles may vary, with what is the *de facto* involuntary commitment of a juvenile perhaps *de jure* defined as "voluntary" if his parents agree, though he may still have a right to protest and attempt to get released. However, there is a body of case law governing the civil commitment of individuals under the Fourteenth Amendment through U.S. Supreme Court rulings beginning with *Addington v. Texas* in 1979 which set the bar for involuntary commitment for treatment by raising the burden of proof required to commit persons from the usual civil burden of proof of "preponderance of the evidence" to the higher standard of "clear and convincing" evidence.<sup>[21]</sup>

In 1975, the U.S. Supreme Court ruled that involuntary hospitalization and/or treatment violates an individual's civil rights in *O'Connor v. Donaldson*. This ruling forced individual states to change their statutes. For example, the individual must be exhibiting behavior that is a danger to himself or others in order to be held, the hold must be for evaluation only and a court order must be received for more than very short term treatment or hospitalization (typically no longer than 72 hours). This ruling has severely limited involuntary treatment and hospitalization in the U.S.<sup>[22]</sup> In the U.S. the specifics of the relevant statutes vary from state to state.<sup>[23]</sup>

This was the case in a famous United States Supreme Court decision in 1975, *O'Connor v. Donaldson*, when Kenneth Donaldson, a patient committed to Florida State Hospital, sued the hospital and staff for confining him for 15 years against his will. The decision means that it is unconstitutional to commit for treatment a person who is not imminently a danger to himself or others and is capable to a minimal degree of surviving on his own.<sup>[24]</sup>

An example of involuntary commitment procedures is the Baker Act used in Florida. Under this law, a person may be committed only if they present a danger to themselves or others. A police officer, doctor, nurse or licensed mental health professional may initiate an involuntary examination that lasts for up to 72 hours. Within this time, two psychiatrists may ask a judge to extend the commitment and order involuntary treatment. The Baker Act also requires that all commitment orders be reviewed every six months in addition to ensuring certain rights to the committed including the right to contact outsiders. Also, a person under an involuntary commitment order has a right to counsel and a right to have the state provide a public defender if they cannot afford a lawyer. While the Florida law allows police to initiate the examination, it is the recommendations of two psychiatrists that guide the decisions of the court.

In the 1990s, involuntary commitment laws were extended under various state laws commonly recognized under the umbrella term SVP laws to hold some convicted sex offenders in psychiatric facilities after their prison terms were completed.<sup>[25]</sup> (This is generally referred to as "civil commitment," not "involuntary commitment," since involuntary commitment can be criminal or civil). This matter has been the subject of a number of cases before the Supreme Court, most notably *Kansas v. Hendricks* and *United States v. Comstock*<sup>[26]</sup> in regard to the Adam Walsh Child Protection and Safety Act, which does not require a conviction on sex offences, but only that the person be in federal custody and be deemed a "sexually dangerous person".<sup>[27]</sup>

### Controversy about liberty

The impact of involuntary commitment on the right of self-determination has been a cause of concern.<sup>[28]</sup> Critics of involuntary commitment have advocated that "the due process protections... provided to criminal defendants" be extended to them.<sup>[29]</sup> The Libertarian Party opposes the practice in its platform. Thomas Szasz and the anti-psychiatry movement has also been prominent in challenging involuntary commitment.

A small number of individuals in the U.S. have opposed involuntary commitment in those cases in which the diagnosis forming the justification for the involuntary commitment rests, or the individuals say it rests, on the speech or writings of the person committed, saying that to deprive him of liberty based in whole or part on such speech and writings violates the First Amendment. Other individuals have opposed involuntary commitment on the bases that they claim (despite the amendment generally being held to apply only to criminal cases) it violates the Fifth

Amendment in a number of ways, particularly its privilege against self-incrimination, as the psychiatrically examined individual may not be free to remain silent, and such silence may actually be used as "proof" of his "mental illness".<sup>[30]</sup>

Although patients involuntarily committed theoretically have a legal right to refuse treatment, refusal to take medications or participate in other treatments is noted by hospital staff. Court reviews usually are heavily weighted toward the hospital staff, with the patient input during such hearings minimal. In *Kansas v. Hendricks*, the US Supreme Court found that civil commitment is constitutional regardless of whether any treatment is provided.<sup>[31]</sup>

### **Alternatives**

Accompanying deinstitutionalization was the development of laws expanding the power of courts to order people to take psychiatric medication on an outpatient basis. Though the practice had occasionally occurred earlier, outpatient commitment was used for many people who would otherwise have been involuntarily committed. The court orders often specified that a person who violated the court order and refused to take the medication would be subject to involuntary commitment.

Involuntary commitment is distinguished from conservatorship and guardianship. The intent of conservatorship or guardianship is to protect those not mentally able to handle their affairs from the effects of their bad decisions, particularly with respect to financial dealings.<sup>[32]</sup> For example, a conservatorship might be used to take control of the finances of a person with dementia, so that the person's assets and income are used to meet his basic needs, e.g., by paying rent and utility bills.

Advance psychiatric directives may have a bearing on involuntary commitment.<sup>[33]</sup> <sup>[34]</sup>

### **Individual state policies and procedures**

#### **US military**

The service member can be held under the so-called Boxer law.

#### **California**

5150 (Involuntary psychiatric hold)

#### **District of Columbia**

In the District of Columbia any police officer, physician, or mental health professional can request to have you evaluated at St. Elizabeths Hospital, where the physician on duty can hold the patient for up to 48 hours. A family member or concerned citizen can also petition the Department of Mental Health, but the claim will be evaluated prior to the police acting upon it. In order to be held further, a request must be filed with the Department of Mental Health. However, this only can keep the patient involuntarily admitted for up to seven days. For further commitment, the patient is evaluated by a mental health court, part of family court, for which the public defender assists the patient. This can result in the patient being held up to one year at which point the patient returns to mental health court.

This is different for someone first admitted to St. Elizabeths Hospital due to criminal charges. If found to not ever become competent for trial, they will be evaluated via a Jackson hearing for possible continued commitment to protect the public. If they have been found not guilty by reason of insanity, their dangerousness is evaluated at a Bolton Hearing.

## Maryland

In Maryland any person may request, via a Emergency Evaluation form, that another individual be evaluated against their will by an emergency room physician for involuntary admission. If the judge concurs, he will direct the police to escort the individual to the hospital. A licensed physician, psychologist, social worker, or nurse practitioner who has examined the patient or a police officer may bring a potential patient to the emergency room for forced evaluation without approval from a judge. The patient may be kept in the hospital for up to thirty hours. If by then two physicians, or one physician and one psychologist then decide that the patient meets the Maryland criteria for an involuntary psychiatric admission, then he or she may be kept inpatient involuntarily for up to ten days. During this time an administrative law judge determines if criteria for longer civil commitment are met:

- a person has a mental illness;
- a person needs inpatient care or treatment;
- a person presents a danger to themselves or to others;
- a person are unable or unwilling to be admitted voluntarily;
- there is no available, less restrictive form of care or treatment to meet the person's needs.

## Virginia

As of 2008 Virginia was one of only five states requiring imminent danger in order to involuntarily commit someone. But after the Virginia Tech Massacre, there was significant political consensus to strengthen the protections for society and allow more leniency in determining that an individual needed to be committed against their will.

- the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any
- the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs

"Imminent danger" was found to have too much variability throughout Virginia due to vagueness. The new standard is more specific in that substantial likelihood is more clear. However, in order to not limit potential detainee's freedoms too much it is characterized by the time limit of near future. "Recent acts" is legally established to require more than a mere recitation of past events.

## Politically motivated abuses

At certain places and times, the practice of involuntary commitment has been used for the suppression of dissent, or in a punitive way.

In the former Soviet Union, psychiatric hospitals were used as prisons in order to isolate political prisoners from the rest of society. The official explanation was that no sane person would declaim against Soviet government and Communism. British playwright Tom Stoppard wrote *Every Good Boy Deserves Favour* about the relationship between a patient and his doctor in one of these hospitals.

The government of the United States employed involuntary commitment against a political dissenter once. In 1927 after the execution of Sacco and Vanzetti a demonstrator named Aurora D'Angelo was sent to a mental health facility for psychiatric evaluation after she participated in a rally in support of the anarchists.<sup>[35]</sup>

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## External links

- National Mental Health Consumers' Self-Help Clearinghouse (<http://www.mhselfhelp.org/>)
- Victorian legislation and parliamentary documents (Australia) ([http://www.dms.dpc.vic.gov.au/Domino/Web\\_Notes/LDMS/PubLawToday.nsf?OpenDatabase](http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf?OpenDatabase)) - search using "mental health act" for the latest version of the act
- Mental health review board site (Victoria, Australia) (<http://www.mhrb.vic.gov.au/>) - the official site of the MHRB
- Keys to Commitment (A Guide for Family Members) by Robert J. Kaplan, J.D. (<http://www.psychlaws.org/GeneralResources/article218.htm>)
- State-by-state chart of U.S. commitment laws (<http://www.psychlaws.org/LegalResources/statechart.htm>)
- Psychiatric Imprisonment in Oregon (<http://www.progress.org/fold265.htm>)
- Rogers Law (<http://www.psychlaws.org/LegalResources/CaseLaws/Case3.htm>), concerning involuntary treatment/commitment in Massachusetts
- Comprehensive Journal Article Discussing Civil Commitment Law and Reform Regarding Sex Offenders (<http://www.freewebs.com/adamshajnfeld>)
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- Baker Act Reporting Center (related to Florida's Civil Commitment Statute) (<http://bakeract.fmhi.usf.edu/>)
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# Involuntary treatment

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**Involuntary treatment** (also referred to by proponents as **assisted treatment** and by critics as **forced drugging**) refers to medical treatment undertaken without a person's consent. In almost all circumstances, involuntary treatment refers to psychiatric treatment administered despite an individual's objections. These are typically individuals who have been diagnosed with a mental illness and are deemed by a court to be a danger to themselves or others.

## United States

### Limitations on forcible treatment

In 1975, the U.S. Supreme Court ruled in *O'Connor v. Donaldson* that involuntary hospitalization and/or treatment violates an individual's civil rights. The individual must be exhibiting behavior that is a danger to themselves or others and a court order must be received for more than a 72 hour hold. The treatment must take place in the least restrictive setting possible. This ruling has severely limited involuntary treatment and hospitalization in the United States. The statutes vary somewhat from state to state.

In 1979, the United States Court of Appeals for the First Circuit established in *Rogers v. Okin* that a competent patient committed to a psychiatric hospital has the right to refuse treatment in non-emergency situations. The case of *Rennie v. Klein* established that an involuntarily committed individual has a constitutional right to refuse psychotropic medication without a court order. *Rogers v. Okin* established the patient's right to make treatment decisions.

Additional U.S. Supreme Court decisions have added more restraints to involuntary commitment and treatment. *Foucha v. Louisiana* established the unconstitutionality of the continued commitment of an insanity acquittee who was not suffering from a mental illness. In *Jackson v. Indiana* the court ruled that a person adjudicated incompetent could not be indefinitely committed. In *Perry v. Louisiana* the court struck down the forcible medication of a prisoner for the purposes of rendering him competent to be executed. In *Riggins v. Nevada* the court ruled that a defendant had the right to refuse psychiatric medication while he was on trial, given to mitigate his psychiatric symptoms. *Sell v. United States* imposed stringent limits on the right of a lower court to order the forcible administration of antipsychotic medication to a criminal defendant who had been determined to be incompetent to stand trial for the sole purpose of making them competent and able to be tried. In *Washington v. Harper* the Supreme Court upheld the involuntary medication of correctional facility inmates only under certain conditions as determined by established policy and procedures.<sup>[1]</sup>

### Justifications and criticisms

Justification for involuntary treatment is often attempted by emphasizing the potential for severe consequences that may result from lack of treatment, such as homelessness, victimization, suicide, violence. However, critics argue that psychiatric treatment can also have severe consequences such as misdiagnosis [2], psychiatric assault and disabling drug side effects.

Involuntary treatment is generally undertaken at the behest of family members. Supporters of involuntary treatment include mainstream organizations such as the National Alliance on Mental Illness (NAMI) and the American Psychiatric Association. Involuntary treatment's biggest supporter in the United States is the Treatment Advocacy Center.

Civil and human rights activists, Anti-psychiatry groups, and members of the psychiatric survivors movement, vigorously oppose involuntary treatment on human rights grounds. Also, critics oppose involuntary treatment because of the significant potential for side effects, ranging from mild to severe structural brain damage,<sup>[3]</sup> <sup>[4]</sup> and because of its emphasis upon enforcing compliance via chemical restraints over practices aimed at achieving mental

health. Critics, such as the New York Civil Liberties Union, have denounced the strong racial and socioeconomic biases in forced treatment orders.<sup>[5] [6]</sup>

The Church of Scientology is also aggressively opposed to involuntary treatment. In the United States case law rulings have almost eliminated the legal right to involuntarily treat a patient or incarcerated inmate in non-emergency situations, starting in 1975 with *O'Connor v. Donaldson*, *Rennie v. Klein* in 1978 and *Rogers v. Okin* in 1979, to name a few.

## Methods

Psychiatric treatment primarily involves psychotropic medications, such as antidepressants, mood stabilizers, sedatives and antipsychotic medication. These medications are generally considered effective by the medical community in treating severe and persistent mental illness [7] although they have common adverse side effects. Opponents of treatment point to other studies that suggest that long-range outcomes are much worse with treatment.[8] Involuntary treatment can also include commitment to a psychiatric ward and electroconvulsive therapy without consent.

## Mental health law

All but four states in the U.S. allow for some form of involuntary treatment for mental illness for short periods of time under emergency conditions, although criteria vary.[9] Since the late 1990s, a growing number of states have adopted *Assisted Outpatient Commitment (AOC)* laws.[10]

Under "assisted" outpatient commitment, people committed involuntarily can live outside the psychiatric hospital, sometimes under strict conditions including reporting to mandatory psychiatric appointments, taking psychiatric drugs in the presence of a nursing team, and proving medication blood levels. Forty-two states presently allow for outpatient commitment.[11]

## Effects of involuntary medication

In some studies, the majority of people retrospectively agreed that involuntary medication had been in their best interest, with little or no consideration given to those who disagreed with their treatment. Anecdotal reports from opponents of involuntary medication, indicating that involuntary treatment has widespread, devastating, and lasting effects, are downplayed by studies cited by supporters, including TAC.<sup>[12]</sup> However, other studies cast doubt on the efficacy of involuntary treatment.<sup>[13]</sup>

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## External links

- National Mental Health Consumers' Self-Help Clearinghouse (<http://www.mhselfhelp.org/>)
- Psychlaws.org (<http://www.psychlaws.org/GeneralResources/article218.htm>) - 'Keys to Commitment' (a guide for family members), Robert J. Kaplan, JD
- Rogers Law (<http://www.psychlaws.org/LegalResources/CaseLaws/Case3.htm>), concerning involuntary treatment/commitment in Massachusetts

# Against Therapy

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<i>Against Therapy</i>	
<b>Author(s)</b>	Jeffrey Moussaieff Masson
<b>Genre(s)</b>	Nonfiction
<b>Publisher</b>	Common Courage Press
<b>Publication date</b>	1988
<b>Pages</b>	340
<b>ISBN</b>	1567510221

*Against Therapy: Emotional Tyranny and the Myth of Psychological Healing* is a 1988 book by Jeffrey Moussaieff Masson which claims that psychotherapy is a form of socially sanctioned abuse. *Psychiatric Times* called it "a "battle cry" for the abolition of psychotherapy".<sup>[1]</sup>

According to Masson, therapists ask patients to do more than is reasonably possible, they "distort another person's reality" to try to change people in ways that conform to the therapist's concepts and prejudices. Therapists are, in Masson's opinion, inevitably corrupted by power and "abuse of one form or another is built into the very fabric of psychotherapy".

*Time* magazine wrote, "Although the author's slash-and-burn style of argument can be entertaining, readers should keep their hands on their wallets. Assertions tend to be sold as established facts."<sup>[2]</sup> *The New York Times* argued that "Masson has failed to put a stake through the heart of therapy - in fact, he's greatly missed the mark."<sup>[3]</sup>

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## External links

- Official site (<http://www.jeffreymasson.com/other-publications/against-therapy.html>)
  - Against Therapy (<http://www.amazon.co.uk/Against-Therapy-Dorothy-Rowe/dp/0006373879>)
  - Book review of Against Therapy ([http://www.adpca.org/Journal/Vol1\\_1/against.htm](http://www.adpca.org/Journal/Vol1_1/against.htm))
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# Dialectics of Liberation

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The **Dialectics of Liberation** Congress was an international congress organised in London between 15th and 30th July 1967.<sup>[1]</sup>

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[1] 1967 Dialectics of Liberation (<http://www.dialecticsofliberation.com/1967-dialectics/>), accessed 2nd June 2011

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# Hearing Voices Movement

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**Hearing Voices Movement** is a philosophical trend in how people who hear voices are viewed. It was begun by Marius Romme, a professor of social psychiatry at the University of Limburg in Maastricht, the Netherlands; and Sandra Escher, a science journalist, who began this work after being challenged by a voice hearer as to why they could not accept the reality of her voice hearing experience.

Followers of the Hearing Voices Movement advocate the use of techniques employed by those who have successfully coped with their voices. This can include acceptance and negotiation with the voices.

## The movement

The Hearing Voices Movement can be said to have been established in 1987, by Romme and Escher, both from the Netherlands, with the formation of Stichting Weerklank (Foundation Resonance), an organization for voice hearers and others interested in this phenomenon. In 1988, an organization The Hearing Voices Network was established in England, with the active support of Romme.<sup>[1]</sup> In following years, further networks have been established in other countries including Italy, Finland (1995), Wales, Scotland, Switzerland, Sweden, Austria, Germany (1998), Norway, Denmark, Japan (1996), Israel, New Zealand, Australia and the USA (2006).

In 1997 a meeting of voice hearers and mental health workers was held in Maastricht to discuss developing the further promotion and research into the issue of voice hearing. The meeting decided to create a formal organizational structure to provide administrative and coordinating support to the wide variety of initiatives in the different involved countries. The new network was called **INTERVOICE** (The International Network for Training, Education and Research into Hearing Voices). INTERVOICE holds annual steering group meetings, encourages and supports exchanges and visits between member countries and the translation and publication of books and other literature on the subject of hearing voices. INTERVOICE was incorporated in 2007 as a not for profit company under UK law. Its president is Marius Romme.

INTERVOICE is supported by people who hear voices, relatives and friends and mental health professionals including nurses, psychiatrists and psychologists. INTERVOICE members assert that the most important factor in the success of their approach is the importance placed on the personal engagement of the people involved, meaning that all participants are considered an expert of their own experience. They see each other first as people, secondly as equal partners, and thirdly as all having different but mutually valuable expertise to offer. This can either be through direct experience of hearing voices or having worked with voice hearers (and/or a desire to be involved).

INTERVOICE is critical of psychiatry in relation to the way the profession generally understands and treats people who hear voices and holds that their research has led them to the position that schizophrenia is an unscientific and unhelpful hypothesis which should be abandoned.<sup>[2]</sup>

The Hearing Voices Movement regards itself as being a post-psychiatric organisation,<sup>[3]</sup> positioning itself outside of the mental health world in recognition that voices, in their view, are an aspect of human differentness, rather than a mental health problem and that, as with homosexuality (also regarded by psychiatry in historical times as an illness),

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one of the main issues is about human rights. As with homosexuality, members of the movement intend to change the way society perceives the experience, and psychiatry's attitude will follow.

The Hearing Voices Movement is also seeking more holistic health solutions to problematic and overwhelming voices that cause mental distress than what it regards as the generally reductionist, disease based model offered by mainstream psychiatry. Based on their research, they hold the opinion that many people successfully live with their voices and that in themselves voices are not the problem. For this reason they are prepared to accept a range of explanations offered by people who hear voices, including spiritual ones and assert that recovery (see recovery model) from overwhelming voices can be achieved by seeking to understand the meaning of the voices to the voice hearer. This approach informed the British television documentary *Voices in My Head* (2005) by director David Malone.

A detailed and neutral account of the significance of the Hearing Voice Movement entitled "Can You Live With the Voices in Your Head?"<sup>[4]</sup> was published in *New York Times Magazine* in 2007. Its author Daniel B. Smith writes that the movement's

brief against psychiatry can be boiled down to two core positions. The first is that many more people hear voices, and hear many more kinds of voices, than is usually assumed. The second is that auditory hallucination — or "voice-hearing," H.V.N.'s more neutral preference — should be thought of not as a pathological phenomenon in need of eradication but as a meaningful, interpretable experience, intimately linked to a hearer's life story and, more commonly than not, to unresolved personal traumas.

## Position

The position of the hearing voices movement can be summarised as follows:

- Hearing voices is not *in itself* a sign of mental illness.
- Hearing voices is experienced by many people who do not have symptoms that would lead to diagnosis of mental illness.
- Hearing voices is often related to problems in life history.
- If hearing voices causes distress, the person who hears the voices can learn strategies to cope with the experience. This is often achieved by confronting the past problems that lie behind the experience.

## Movement history

In an overview of the challenging new research and practise initiatives developing across Europe,<sup>[5]</sup> Baker charts the progress made from a view of voice hearing as bizarre and dangerous<sup>[6]</sup> towards a recognition of voices as real, meaningful, and related to people's lives. This recognises that the experience can be overwhelming and deeply distressing, but also, that the attempt to understand their meaning can be part of a solution.

## Leudar and Thomas

In a recent book, Leudar and Thomas (2000): *Voices of Reason, Voices of Insanity*, review almost 3,000 years of voice-hearing history, including that of Socrates, Schreber, and Janet's patient 'Marcelle', amongst others, to show how we have moved the experience from a socially valued context to a pathologised and denigrated one. Foucault has argued that this process can generally arise when a minority perspective is at variance with dominant social norms and beliefs.

## Romme and Escher

The work of Romme and Escher<sup>[7]</sup> provides a theoretical framework for these new initiatives, and provides much of the impetus for the self-help movement in recent years. They demonstrate:

1. Not everyone who hears voices becomes a patient. Over a third of 400 voice hearers in Holland had not had any contact with psychiatric services. These people either described themselves as being able to cope with their voices and/or described their voices as life enhancing.
2. Romme cites demographic research<sup>[8]</sup> indicating that hearing voices in itself is not a symptom of an illness, but is apparent in 2–4% of the population (some research gives higher estimates); and even more (about 8%) have peculiar personal convictions, also known as delusions, and do so without being ill. His own research has provided further verification of this.
3. Comparisons between people. People who cope well with their voices and those who did not show clear differences in terms of the nature of the relationship they had with their voices.
4. People who cope better also differed in terms of the kinds of strategies they adopted to manage their voices and its personal impact.
5. 70% of voice hearers reported that their voices had begun after a severe traumatic or intensely emotional event, such as an accident, divorce or bereavement, sexual or physical abuse, love affairs, or pregnancy. Romme et al. (1998) found that the onset of voice hearing amongst a 'patient' group was preceded by either a traumatic event or an event that activated the memory of an earlier trauma. There was a high association with abuse. These findings are being substantiated further in an on-going study with voice hearing amongst children.<sup>[9]</sup>
6. Some people who hear voices, regardless of being able to cope with this or not, may have a burning need to construct a personal understanding for their experiences and to talk to others about it without being designated as mad.
7. A long-term developmental process of psychological adjustment was identified by surveying the considerable range of experience and the negotiation methods that people reported. Romme<sup>[10]</sup> has developed this approach with several studies showing that hearing voices can be associated with memories of emotionally 'undigested' events, usually connected with key relationships.

Romme et al. (1999) finds that these important connections can be addressed using cognitive behaviour therapy (CBT) and self-help methods.

Romme describes a three phase model of recovery.

- Startling. Initial confusion; emotional chaos, fear, helplessness and psychological turmoil.
- Organization. The need to find meaning, arrive at some understanding and acceptance. The development of ways of coping and accommodating voices in everyday living. This task may take months or years and is marked by the attempt to enter into active negotiation with the voice(s).
- Stabilisation. The establishment of equilibrium, and accommodation, with the voice(s), and the consequent re-empowerment of the person.

## Alternative to medical model

The Hearing Voices Movement reflects significant disenchantment with the medical model and the practises of mental health services through much of the Western World.

Brown et al. (1998) finds that 23% of people diagnosed with a psychotic illness experience positive symptoms that are resistant to medication. It has been reported that only a minority (roughly 35%) obtain significant benefits from antipsychotic drug treatment.<sup>[11]</sup> Further, there is a range of secondary problems and withdrawal effects associated with both traditional and atypical antipsychotic drugs.<sup>[12]</sup>

The movement also focuses on the complexity of the experience of hearing voices. In addition, emotional problems (such as depression and anxiety) are found in 25–40% of those diagnosed with psychosis,<sup>[13]</sup> and the risk of suicide

is increasingly recognised.<sup>[14]</sup>

Apart from the issue of medical effectiveness, 'getting better' must be as much a personal process, to do with the nature of the experience, as a medical one.<sup>[15]</sup> Many service users have reported negative experiences of mental health services because they are discouraged from talking about their voices as these are seen solely as symptoms of psychiatric illness.<sup>[16]</sup>

Slade and Bentall (1988) conclude that the failure to attend to hallucinatory experiences and/or have the opportunity for dialogue about them is likely to have the effect of helping to maintain them.

Romme (1991) describes several case stories to show how the acceptance or non-acceptance of voice hearing is socially and culturally determined, which can influence the outcome of treatment with people diagnosed with schizophrenia. Baker (1995) suggests that the extent to which nurses accept the experience of people they believe to have psychotic disorders has an effect on the extent to which they can discuss it with them. Martin (2000) describes the creation of an environment conducive to discussing the experience. Such strategies do not demand textbook answers, but emerge from service users living, in a supported way, with the experience of voice hearing.

Increasingly, in acknowledgement of the methodological weaknesses, poor prognostic power, symptomatic variability and general weaknesses inherent in the diagnostic validity of the term *schizophrenia*, the psychological literature has increasingly tended to focus on specific or discrete symptoms or aspects associated with it.<sup>[17]</sup>

Thus, there has been a rapid growth in research investigating theory and treatment of strange beliefs, attention and concentration deficits, self-esteem, family processes (such as the Expressed Emotion literature), to mention but a few, as well as 'voices'. In addition, recent developments in the theory and treatment of post-traumatic stress disorder and dissociative conditions offer new understandings emphasising the close links between severe trauma in earlier life and voice hearing subsequently along with other potentially very disabling psychological symptoms. Romme et al., for example report that the disability incurred by hearing voices is associated with previous trauma and abuse, in some way (Romme et al., 1998). Similarly, in a follow-up study (Romme et al., 1999) find that these important connections can be effectively addressed clinically using a mixture of psychological therapy and self-help methods.

Romme and Escher (2000) have developed a method they call "Making sense of voices" to explore the problems in the life of the voice hearer that lie at the roots of the hearing voices experience. This approach was adopted as a consequence of the results of the studies they carried out, that they claimed, showed that to hearing voices, in itself, is not a symptom of an illness, but in most people is a reaction to severe traumatic experiences that made the person powerless, and are in effect, a kind of survival strategy.

## Recent work

Recent work has focused on beliefs about voices in addition to the voices themselves. Chadwick, Birchwood and Trower (1996) and Bentall (1994) have proposed a number of psychological theories for understanding the experience of hearing voices and the beliefs associated with them. Chadwick and Birchwood, (1997) reported marked reductions in voice hearing, and associated distress based on their cognitive model.

In an intriguing study, Birchwood et al. (2000) found close parallels between the experience of subordination by voices and the experience of subordination and marginalisation in social relationships generally. This suggests that distress arising from voices may not only be linked to voice characteristics but also social and interpersonal beliefs based on life experience.

A range of other psychological and psychosocial treatment approaches are also reported in the literature. In Slade and Bentall (1988) a number of psychological strategies and the evidence supporting their efficacy are reported in terms of distress and anxiety reduction as well as in the frequency and/or intensity of the voice hearing experience.

The importance of respecting and supporting voice hearers' own capacity to develop their own understandings and personal coping resources has been emerging in recent years (Warnes et al. 1996). In a single case study, Davies (1999) was able to demonstrate the value of a dialogical approach, which supported the voice-hearers' own



development of a meaningful and helpful personal narrative. McNally and Goldberg (1997), as has Romme and Escher (1994, 1998) emphasised the importance of the individuals own coping resources and beliefs in developing effective intervention strategies. They identified a variety of ways in which 'self-talk' and other naturalistic coping strategies can be actively deployed towards managing voices and related experiences. Warnes (1996, 1999) discusses the value of interventions that maximises and supports the person's own experience of control of their experience.

Researchers are also seeking to discover what are the distinctive features of positive experiences (including pleasurable ones) of auditory hallucinations in people with psychosis who experience both positive and negative voices, *and* amongst people in the "normal" population.<sup>[18]</sup> Beavan's research, for instance, found nearly half the people who heard voices said their hallucinations were mostly friendly or helpful.

### **Living with Voices: 50 Stories of Recovery (2009)**

Living with Voices: 50 Stories of Recovery: Marius Romme, Sandra Escher, Jacqui Dillon, Mervyn Morris, Dirk Corstens (Editors), Living with Voices: 50 Stories of Recovery (2009), Publisher PCCS Books <sup>[19]</sup> in association with Birmingham City University, United Kingdom, ISBN13 9781906254223

This new study is based on 50 stories of voice hearers who claim to have recovered. The accounts are intended to form an evidence base for the effectiveness of hearing voices approach alongside an analysis of the hearing voices experience outside the illness model, resulting in accepting and making sense of voices. This book seeks to demonstrate that it is possible to overcome problems with hearing voices and to take back control of one's life.

The central message of the book is that the path to recovery from overwhelming voices can be achieved by addressing the main problems voice-hearers describe – the threats, the feelings of powerlessness, the anxiety of being mad – and helping them to find their way back to their emotions and spirituality and to realise their dreams. This book also claims to hold true for those who have been given a diagnosis of schizophrenia. At the heart of this book are the stories of fifty people who have recovered from the distress of hearing voices, it documents how they have changed their relationship with their voices in order to reclaim their lives.

### **Children Hearing Voices - What You Need to Know and What You Can Do**

Children Hearing Voices - What You Need To Know and What You Can Do: Marius Romme and Sandra Escher (2010), Publisher PCCS Books <sup>[19]</sup>, United Kingdom, ISBN 978 1 906254 35 3

Children Hearing Voices provides support and practical solutions for the experience of hearing voices. It is in two parts, one part for voice-hearing children, the other part for parents and adult carers. Escher and Romme have over twenty-five years experience of working with voice-hearers, pioneering the theory and practice of accepting and working with the meaning in voices. The children's section: This book has mainly been written for children who hear voices. The information in this book is largely derived from a three-year study amongst 80 children and adolescents who were interviewed about their experiences; children who ranged in age from 8 to 19 years at first contact. Little is known about voice hearing in children. Most people still have this notion that it is a disease for life. In this book, readers will find extensive information about how to look differently at voice hearing; learning to deal with it and discovering what might help to cope with the voices. The parents'/adults' section: It became increasingly clear to us how little information parents of children hearing voices were getting and that if parents found information, it was almost always based on the assumption that voice hearing was a serious disease. The authors noticed that the children of those parents who determined to search and go their own way were doing better. This book is for these parents.

## Articles

- Treatment of Schizophrenia Challenged In Western Australia <sup>[20]</sup> The NewsMaker (Australia) 9 June 2011, "The Psychiatrist, the psychologist and the ex patient: a frank discussion on schizophrenia" Dr Dirk Corstens from the Netherlands, award-winning psychologist Eleanor Longden, and ex patient and Voices advocate Ron Coleman, discuss their expertise and experience on schizophrenia and voice hearing, as well as share innovative ways on the treatment of schizophrenia and management the experience.
- A first-class recovery: From hopeless case to graduate <sup>[21]</sup> The Independent (UK) 25 October 2009, Eleanor Longden was a diagnosed schizophrenic and heard menacing voices in her head for 10 years.
- Embracing the dark voices within <sup>[22]</sup> BBC News Online (UK), 3 September 2009
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- A dialogue with myself <sup>[24]</sup> The Independent (UK), 15 April 2008, When Ruth began hearing voices, she turned to a controversial drug-free therapy programme. Now, her story is told in a powerful TV film
- Listening Cure <sup>[25]</sup> Time/CNN (USA), 21 February 2008
- Can You Live With the Voices in Your Head? <sup>[26]</sup> New York Times (USA), 25/03/2007
- Voices carry <sup>[27]</sup> Boston Globe (USA), 25/03/2007
- The mad doctor: The extraordinary story of Dr Rufus May, the former psychiatric patient <sup>[28]</sup> The Independent (UK), 18 March 2007
- Mad Medicine: A New Group for People Who Hear Voices Celebrates Mental Diversity <sup>[29]</sup> Portland Mercury June 25 2009

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## External links

- Hearing Voices Network Australia (HVNA) (<http://www.hvna.net.au/>) A collection of Hearing Voices Groups and affiliated members (such as service providers, consumers, carers and friends) working toward promoting recovery, acceptance and education.
- HEARING VOICES NETWORK AOTEAROA NZ- Te Reo Orooro (<http://www.hearingvoices.org.nz/>) Te Reo Orooro - providing information & support for voices & visions
- StemmeHørernetværket i Danmark (<http://www.hearingvoices.dk/>) Hearing Voices Network Denmark
- Hearing Voices Network England (<http://www.hearing-voices.org/>)
- SUOMEN MONIÄÄNISET RY (<http://www.kolumbus.fi/suomen.moniaaniset.ry/>) Hearing Voices Network Finland
- Hearing voices (auditory hallucinations) (<http://www.mentalhealth.org.uk/information/mental-health-a-z/hearing-voices/>) Information from the Mental Health Foundation (UK)
- Hearing Voices Ireland (HVI) (<http://www.voicesireland.com/Home.htm>) Started in 2006 to 'promote and foster acceptance of 'voice hearing' as a valid human experience'.
- Hearing voices that are distressing: Self-help resources and strategies (<http://www.power2u.org/articles/selfhelp/voices.html>) National Empowerment Center (USA)
- Hearing Voices (<http://www.hearing-voices.com/>): mainly in Dutch language
- Hope Hearing Voices Network NSW, Australia (<http://www.hvnns.org.au/>) The primary objective of HVNNSW, is to establish, facilitate and support self help groups for voice hearers, throughout Metropolitan Sydney, as well as regional NSW.
- INTERVOICE: International Network for Training, Education and Research into Hearing Voices (<http://www.intervoiceonline.org/>)
- Intervoice Oberösterreich – Netzwerk Stimmenhören (<http://www.8ung.at/stimmenhoeren/>) Hearing Voices Network Austria
- Italy Hearing Voices Network (<http://www.parlaconlevoci.it/chi.php>)
- Netzwerk Stimmenhören (<http://www.stimmenhoeren.de/>) Website of German HVN formed in 1997
- "The voice inside: A practical guide to coping with hearing voices" ([http://www.mind.org.uk/help/medical\\_and\\_alternative\\_care/the\\_voice\\_inside\\_coping\\_with\\_hearing\\_voices](http://www.mind.org.uk/help/medical_and_alternative_care/the_voice_inside_coping_with_hearing_voices))
- Audio of Will Hall Talk at Canada Hearing Voices Gathering Toronto, 2010 (<http://www.madnessradio.net/will-hall-talk-hearing-voices-toronto-voices-conference-audio>)
- Echoes (<http://www.echoesgroup.blogspot.com/>) (Shetland Hearing Voices Group)
- Stichting Weerklank (<http://www.stemmenhoren.nl/index.html>) Resonance, Netherlands: A foundation for and by people with: Hearing voices, Special psychic experience, Psychotic experiences, Extrasensory experiences
- Hører stemmer (<http://www.romforstemmer.no/>) Hearing voices Network Norway
- (<http://www.HVN-Canada.bravehost.com/>) Hearing voices Canada
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# Icarus Project

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**The Icarus Project** <http://theicarusproject.net> is a mental health movement characterized by the view that many phenomena commonly labeled as mental illness should actually be regarded as "dangerous gifts". The name is derived from the Icarus mythology and is metaphorically used to convey that these experiences can lead to "potential[ly] flying dangerously close to the sun."<sup>[1]</sup>

## History

In 2002, Sascha Altman DuBrul wrote an article published by the San Francisco Bay Guardian entitled *Bipolar World*, relating to his personal experiences being diagnosed with bipolar disorder. Among the dozens of e-mails and other correspondence that he received after this publication was a letter from Ashley McNamara, an artist and writer who identified strongly with his experiences.<sup>[1]</sup> The two founders, DuBrul and McNamara, corresponded for a few weeks before finally meeting in person and deciding to start The Icarus Project. The first step, they decided, was creating a website where people who identified with "bipolar and other 'mental illness' [could] find real community and contribute to it."<sup>[2]</sup>

## Mission

The Icarus Project's stated aims are to provide a viable alternative to current methods of approaching and treating mental illnesses. The national Icarus Collective staff is set up to support local groups instead of creating the smaller organizations themselves. The responsibilities of the local group are to gather people locally for support, education, activism, and access to alternatives.<sup>[3]</sup> The Project advocates self-determination and caution when approaching psychiatric care. It encourages harm reduction, alternatives to the medical model, and self-determination in treatment and diagnosis.

## Structure/Funding

The Icarus Project is currently under the fiscal sponsorship of FJC, a non-profit 501(c)3 umbrella organization arm of an investment firm, based in New York City. The Icarus Project currently gets the bulk of its money from foundation grants, but also has many individual donors.. There has been considerable talk for many years of alternate funding structures, and efforts are currently underway to explore 501c3 and cooperative structures. The Icarus Project maintains a financial transparency page<sup>[4]</sup> The Icarus Project does not accept funding from pharmaceutical companies.<sup>[3]</sup>

## The Icarus Project network

A full listing of local Icarus affiliated groups can be found on The Icarus Project's website.<sup>[5]</sup>

Some of the local groups currently meet in

- Anchorage, Alaska
  - Asheville, North Carolina
  - Chicago, Illinois
  - Minneapolis, Minnesota
  - Madison, Wisconsin
  - New York City, New York
  - Northhampton, Massachusetts (Freedom Center)
  - Philadelphia, Pennsylvania
  - Portland, Oregon
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- San Francisco (Bay Area), California
- Columbus, Ohio
- Gainesville, Florida

## Publications

*Navigating the Space Between Brilliance and Madness; A Reader and Roadmap of Bipolar Worlds*, was self-published by the Icarus Project in March 2004. The book is currently in its 6th printing.<sup>[6]</sup>

In July, 2006, The Icarus Project released the first draft of *Friends Make the Best Medicine: A Guide to Creating Community Mental Health Support Networks*.<sup>[7]</sup>

In 2008 The Icarus Project released *Through the Labyrinth; A Harm Reduction Guide to Coming Off Psychiatric Drugs*, and in 2009 this publication was translated into Spanish and German and made available for free download on the The Icarus Project website.<sup>[8]</sup>

## Media Mentions

The Icarus Project has been mentioned in the New York Times,<sup>[9]</sup> by Frontline 20/20, and many local media outlets.<sup>[10] [11]</sup>

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# Liberation by Oppression: A Comparative Study of Slavery and Psychiatry

*Liberation by Oppression: A Comparative Study of Slavery and Psychiatry* (ISBN 978-0-7658-0145-6) is a 2002 work on, and a critique of, psychiatry by Thomas Stephen Szasz. The text compares the justification of psychiatry with the justification of slavery in the United States – both necessarily denying the subject's right to personhood.

## MindFreedom International

**MindFreedom International** is an international coalition of over one hundred grassroots groups and thousands of individual members from fourteen nations. It was founded in 1990 to advocate against forced medication, medical restraints, and involuntary electroconvulsive therapy. Its stated mission is to protect the rights of people who have been labeled with psychiatric disorders. A majority of MindFreedom members identify themselves as survivors of human rights violations in the mental health system; membership, however, is open to anyone who supports human rights, including mental health professionals, advocates, activists and family members.<sup>[1]</sup> MindFreedom has been recognized by the United Nations Economic and Social Council as a human rights NGO with Consultative Roster Status.<sup>[2]</sup>



### Origins and purpose

MindFreedom International is rooted in the psychiatric survivors movement, or more widely the consumer/survivor/ex-patient movement,<sup>[3]</sup> which arose out of the civil rights ferment of the late 1960s and early 1970s and the personal histories of psychiatric abuse experienced by some ex-patients rather than the intradisciplinary discourse of antipsychiatry.<sup>[4]</sup> The precursors of MFI include ex-patient groups of the 1970s<sup>[5]</sup> such as the Portland based Insane Liberation Front and the Mental Patients' Liberation Front in New York.<sup>[3]</sup> The key text in the intellectual development of the survivor movement was Judi Chamberlin's 1978 text, *On Our Own: Patient Controlled Alternatives to the Mental Health System*.<sup>[3]</sup> <sup>[6]</sup> Chamberlin was an ex-patient and co-founder of the Mental Patients' Liberation Front.<sup>[7]</sup> Coalescing around the ex-patient newsletter *Dendron*,<sup>[8]</sup> in late 1988 leaders from several of the main national and grassroots psychiatric survivor groups felt that an independent, human rights coalition focused on problems in the mental health system was needed. That year the Support Coalition International (SCI) was formed. In 2005 the SCI changed its name to MFI with David W. Oaks as its director.<sup>[4]</sup> SCI's first public action was to stage a counter-conference and protest in New York City, in May, 1990, at the same time as (and directly outside of) the American Psychiatric Association's annual meeting.<sup>[9]</sup>

Many of the members of MFI, who feel that their human rights were violated by the mental health system, refer to themselves as 'psychiatric survivors'.<sup>[3]</sup> MFI is a contemporary and active coalition of grassroots groups which are carrying forward the historical tradition of survivor opposition to coercive psychiatry.<sup>[3]</sup> It does not define itself as an antipsychiatry organization and its members point to the role which 'compassionate' psychiatrists have played in MFI.<sup>[4]</sup> Activists within the coalition have been drawn from both left and right wing of politics.<sup>[4]</sup>

MFI functions as a forum for its thousands of members to express their views and experiences, to form support networks and to organize activist campaigns in support of human rights in psychiatry.<sup>[5]</sup> <sup>[4]</sup> The coalition regards the psychiatric practices of 'unscientific labeling, forced drugging, solitary confinement, restraints, involuntary commitment, electroshock' as human rights violations.<sup>[4]</sup> <sup>[10]</sup>

## Range of campaigns

- In 2003 eight MFI members, led by David W. Oaks, went on hunger strike to publicize a series of "challenges" they had set to the American Psychiatric Association (APA), the US Surgeon General and the National Alliance on Mental Illness (NAMI). Prominent among their challenges was that unambiguous proof that mental illness is brain disorder should be produced. By sustaining the hunger-strike for more than one month MFI forced the APA and NAMI to enter into a debate with them on this and other issues.<sup>[3]</sup>
- Psychiatric Industry Watch: Criticizes what it sees as pharmaceutical industry financial and political influences upon the direction of 'mental health.' For example, the Watch focuses on the pharmaceutical industry's indirect support and direct lobbying for laws that create civil "outpatient commitment" that enable authorities to administer psychiatric medication involuntarily in the community, e.g., in a patient's home without involuntary hospitalization. MFI's activities have placed it in direct opposition to the pharmaceutical industry, resulting in legal action against MFI.<sup>[11]</sup>
- The Right to Remember: Seeks to end involuntary electroconvulsive therapy by publicizing instances of forced electroconvulsive treatment and lobbying decision-makers to stop such practices.
- Oral Histories: Compiles and publicizes psychiatric survivor stories detailing the experiences of those who have been through the mental health system. The stories promulgated aim to document abuse by the mental health system and the success stories of individuals who attained a state of stable remission and were able to regain self-direction, usually by disengaging from traditional mental health treatment,
- Mad Pride: Advocates self-determination among those deemed 'mad'. The coalition has proclaimed July as "Mad Pride Month", and supports events around the world celebrating some of the myriad aspects of 'madness,' i.e., those aspects which are seen as positive.<sup>[12]</sup>
- International Association for the Advancement of Creative Maladjustment (IAACM): Promotes the right to be nonviolently maladjusted. IAACM is currently chaired by Patch Adams, MD.

## MindFreedom Shield Program

MindFreedom describes their Shield Program as "an all for one and one for all" network of members. When a registered member is receiving (or is being considered for) involuntary psychiatric treatment, an alert is sent to the MindFreedom Solidarity Network on that person's behalf. Members of the network are then expected to participate in organized, constructive, nonviolent actions---e.g., political action, publicity and media alerts, passive resistance, etc.---to stop or prevent the forced treatment.<sup>[13]</sup>

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# Positive Disintegration

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The **Theory of Positive Disintegration (TPD)** by Kazimierz Dąbrowski describes a theory of personality development.

Unlike mainstream psychology, Dąbrowski's theoretical framework views psychological tension and anxiety as necessary for growth. These "disintegrative" processes are therefore seen as "positive," whereas people who fail to go through positive disintegration may remain for their entire lives in a state of "primary integration." Advancing into disintegration and into the higher levels of development is predicated on having developmental potential, including overexcitabilities, above-average reactions to stimuli.

Unlike some other theories of development such as Erikson's stages of psychosocial development, it is not assumed that even a majority of people progress through all levels. TPD is not a theory of stages, and levels do not correlate with age.

## Dąbrowski's theory

Kazimierz Dąbrowski (1902–1980), a Polish psychiatrist and psychologist, developed the Theory of Positive Disintegration over his lifetime of clinical and academic work. The Theory of Positive Disintegration is a novel approach to personality development.

Dąbrowski's theory of personality development emphasized several major features including:

- personality is not a given universal trait, it must be created—shaped—by the individual to reflect his or her own unique character (personality shaping)
  - personality develops as a result of the action of developmental potential (DP) (overexcitability and the autonomous factor), not everyone displays sufficient DP to create a unique personality.
  - developmental potential is represented in the population by a normal (bell) curve. Dąbrowski used a multilevel approach to describe the continuum of developmental levels seen in the population.
  - developmental potential creates crises characterized by strong anxieties and depressions—psychoneurosis—that precipitate disintegration
  - for personality to develop, initial integrations based on instinct and socialization must disintegrate—a process Dąbrowski called positive disintegration
  - the development of a hierarchy of individual values—emotional reactions—are a critical component in developing one's personality and one's autonomy, thus, in contrast to most psychological theories, emotions play a major role in this approach
  - emotional reactions guide the individual in creating his or her individual personality ideal, an autonomous standard that acts as the goal of individual development
  - the individual must examine his or her essence and subsequently make existential choices that emphasize those aspects of essence that are higher and "more myself" and inhibit those aspects that are lower or "less myself" based upon his or her own personality ideal
  - critical components of individual development include autoeducation and autopsychotherapy
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## Factors in development

Dąbrowski observed that most people live their lives in a state of "primary or primitive integration" largely guided by biological impulses ("first factor") and/or by uncritical endorsement and adherence to social convention ("second factor"). He called this initial integration Level I. Dąbrowski observed that at this level there is no true individual expression of the autonomous human self. Individual expression at Level I is influenced and constrained by the first two factors.

The first factor channels energy and talents toward accomplishing self-serving goals that reflect the lower instincts and biological ego — its primary focus is on survival and self-advancement. Often talents are used in antisocial or asocial ways. For example, at the lowest edge of Level I many criminals display this type of selfish behavior. They advance their own goals at the expense of others.

The second factor, the social environment (milieu) and peer pressure, constrains individual expression and creativity by encouraging a group view of life and discouraging unique thought and expression. The second factor externalizes values and mores, thereby externalizing conscience. Social forces shape expectations. Behavior and one's talents and creativity are funneled into forms that follow and support the existing social milieu. "My mom says we should always be aware of what our lawn looks like because we want other people to think well of us when they drive by." Because conscience is derived from an external social context, so long as society holds ethical standards people influenced by second factor will behave ethically. However if a society, church, or government becomes corrupt, as in Nazi Germany, people strongly influenced by second factor will not dissent. Socialization without individual examination leads to a rote and robotic existence (the "robopath" described by Ludwig von Bertalanffy). Individual reactions are not unique, they are based upon social contexts ("I cry at funerals and laugh at weddings — everyone does"). According to Dąbrowski, people primarily motivated by second factor represent a significant majority of the general population.

Dąbrowski felt that our society was largely influenced by these lower two factors and could be characterized as operating at Level I. For example, our emphasis on corporate success ("a dog eat dog mentality") means that many CEOs operate on the basis of first factor — they will quickly sacrifice another to enhance their own advancement. As well, our educational, political, corporate, and media systems are self promoting and discourage real examination or individual autonomy — the second factor. Alternatively, social justifications are often used: "of course I break the speed limit, everyone does." Or a soldier may explain that he or she was simply "following orders." Thus, this external value system absolves the individual of any individual responsibility.

Dąbrowski also described a group of people who display a different course: an individualized developmental pathway. These people break away from an automatic, rote, socialized view of life (which Dąbrowski called negative adjustment) and move into and through a series of personal disintegrations. Dąbrowski saw these disintegrations as a key element in the overall developmental process. Crises challenge our status quo and cause us to review our self, ideas, values, thoughts, ideals, etc. If development continues, one goes on to develop an individualized, conscious and critically evaluated hierarchical value structure (called positive adjustment). This hierarchy of values acts as a benchmark by which all things are now seen, and the higher values in our internal hierarchy come to direct our behavior (no longer based on external social mores). These higher, individual values characterize an eventual second integration reflecting individual autonomy and for Dąbrowski, mark the arrival of true human personality. At this level, each person develops his or her own vision of how life ought to be and lives it. This higher level is associated with strong individual approaches to problem solving and creativity. One's talents and creativity are applied in the service of these higher individual values and visions of how life could be - how the world ought to be. The person expresses his or her "new" autonomous personality energetically through action, art, social change and so on.

## Development potential

Advanced development is often seen in people who exhibit strong developmental potential ("DP"). Developmental potential represents a constellation of genetic features, expressed and mediated through environmental interaction. Many factors are incorporated in developmental potential but three major aspects are highlighted: overexcitability (OE), specific abilities and talents, and a strong drive toward autonomous growth, a feature Dąbrowski called the "third factor."

### *Overexcitability*

The most evident aspect of developmental potential is overexcitability (OE), a heightened physiological experience of stimuli resulting from increased neuronal sensitivities. The greater the OE, the more intense are the day-to-day experiences of life. Dąbrowski outlined five forms of OE: psychomotor, sensual, imaginal, intellectual and emotional. These overexcitabilities, especially the latter three, often cause a person to experience daily life more intensely and to feel the extremes of the joys and sorrows of life profoundly. Dąbrowski studied human exemplars and found that heightened overexcitability was a key part of their developmental and life experience. These people are steered and driven by their value "rudder", their sense of emotional OE. Combined with imaginal and intellectual OE, these people have a powerful perception of the world.<sup>[1]</sup>

Although based in the nervous system, overexcitabilities come to be expressed psychologically through the development of structures that reflect the emerging autonomous self. The most important of these conceptualizations are dynamisms: biological or mental forces that control behavior and its development. Instincts, drives and intellectual processes combined with emotions are dynamisms.<sup>[2]</sup> With advanced development, dynamisms increasingly reflect movement toward autonomy.

### *Abilities and talents*

The second arm of developmental potential, specific abilities and talents, tends to serve the person's developmental level. As outlined, people at lower levels use talents to support egocentric goals or to climb the social and corporate ladders. At higher levels, specific talents and abilities become an important force as they are channeled by the person's value hierarchy into expressing and achieving the person's vision of his or her ideal personality and his or her view of how the world ought to be.

### *The third factor*

The third aspect of developmental potential, which is simply referred to as 'the third factor', is a drive toward individual growth and autonomy. The third factor is critical as it applies one's talents and creativity toward autonomous expression, and second, it provides motivation to strive for more and to try to imagine and achieve goals currently beyond one's grasp. Dąbrowski was clear to differentiate third factor from free will. He felt that free will did not go far enough in capturing the motivating aspects that he attributed to third factor. For example, an individual can exercise free will and show little motivation to grow or change as an individual. Third factor specifically describes a motivation—a motivation to become one's self. This motivation is often so strong that in some situations we can observe that one needs to develop oneself and that in so doing, it places one at great peril. This feeling of "I've gotta be me" especially when it is "at any cost" and especially when it is expressed as a strong motivator for self-growth is beyond the usual conceptualization ascribed to free will.

A person whose DP is high enough *will generally* undergo disintegration, despite any external social or family efforts to prevent it. A person whose DP is low will *generally not* undergo disintegration (or positive personality growth) even in a conducive environment.

The notion that some people have an innate potential for development that is determined by a higher sensitivity or overexcitability (analogous to the first aspect of DP) and by a related tendency to develop individual differences and autonomy from the group (analogous to the third aspect of DP) was independently developed by Elaine Aron (see Highly sensitive person).<sup>[3]</sup> (although it should be noted that Aron's approach is substantially different than Dąbrowski's.)

### **A mixed blessing?**

Dąbrowski called OE "a tragic gift" to reflect that the road of the person with strong OE is not a smooth or easy one. Potentials to experience great highs are also potentials to experience great lows. Similarly, potentials to express great creativity hold the likelihood of experiencing a great deal of personal conflict and stress. This stress both drives development and is a result of developmental conflicts, both intrapsychic and social. Suicide is a significant risk in the acute phases of this stress. The isolation often experienced by these people heightens the risk of self-harm.

Dąbrowski advocated autopsychotherapy, educating the person about OEs and the disintegrative process to give him or her a context within which to understand intense feelings and needs. Dąbrowski suggested giving people support in their efforts to develop and find their own self-expression. Children and adults with high DP have to find and walk their own path, often at the expense of fitting in with their social peers and even with their families. At the core of autopsychotherapy is the awareness that no one can show anyone else the "right" path. Everyone has to find their own path for themselves. As Joseph Campbell described the knights on the Grail Quest: If a path exists in the forest, don't follow it, for though it took someone else to the Grail, it will not take you there, because it is not your path.

### **The levels**

The first and fifth levels are characterized by psychological integration, harmony, and little inner conflict. There is little internal conflict at Level I because just about every behavior is justified — it is either good for the individual and is therefore "right," or the individual's society endorses it and it is therefore "right." In either case, with a high level of confidence the individual acts as he or she perceives anyone else would, and does what anyone is "supposed to do." At Level V there is no internal conflict because what a person does is always in accord with their own internal sense of values. Of course, there is often external conflict at both Levels I and V.

Levels II, III and IV describe various degrees and types of dis-integration and literal dis-ease.

Dąbrowski was very clear that the levels he presents "represent a heuristic device". In the process of development the structures of two or even three contiguous levels may exist side by side, although it must be understood that they exist in conflict. The conflict is resolved when one of the structures is eliminated, or at least comes under complete control of another structure.<sup>[4]</sup>

### **Level I: Primary Integration**

As outlined above, the first level is called primitive or primary integration. People at this level are often influenced primarily by either prominent first factor (heredity/impulse) and/or second factor (social environment) forces. The majority of people at Level I are integrated at the environmental or social level (Dąbrowski called them average people); however, many also exhibit shades of both impulse and socialization. Dąbrowski distinguished the two subgroups of Level I by degree: "the state of primary integration is a state contrary to mental health. A fairly high degree of primary integration is present in the average person; a very high degree of primary integration is present in the psychopath".<sup>[5]</sup> Marked by selfishness and egocentrism (both reticent and explicit), those at level one development generally seek self-fulfillment above all, justifying their pursuits through a sort of "it's all about me" thinking; or, more simply put, they adhere strongly to the phrase "the end justifies the means", sometimes disregarding the severity of the "means". Many people who are considered "leaders" often fall into this category.

A vast majority of people either do not break down their primitive integration at all, or after a relatively short period of disintegration, usually experienced at the time of adolescence and early youth, end in a reintegration at the former level or in partial integration of some of the functions at slightly higher levels, without a transformation of the whole mental structure.<sup>[6]</sup>



## Level II: Unilevel Disintegration

The character of level II is reflected in its name: unilevel disintegration. The prominent feature of this level is an initial, brief and often intense crisis or series of crises. Crises are spontaneous and only occur on one level (and often involve only one dimension). These crises involve alternatives that may appear to be different but ultimately are on the same level.

Unilevel disintegration occurs during developmental crises such as puberty or menopause, in periods of difficulty in handling some stressful external event, or under psychological and psychopathological conditions such as nervousness and psychoneurosis. Unilevel disintegration consists of processes on a single structural and emotional level; there is a prevalence of automatic dynamisms with only slight self consciousness and self-control.<sup>[7]</sup>

Conflicts on the same level (horizontal) produce ambitemperies and ambivalences: the person is equally attracted by different but equivalent choices on the same level (ambitemperies) and is not able to decide what to do because he or she has no real preference between the choices (ambivalences). If developmental forces are strong enough, ultimately, the person is thrust into an existential crisis: one's social rationales no longer account for one's experiences and there are no alternative explanations. During this phase, existential despair is the predominant emotion. The resolution of this phase begins as individually chosen values begin to replace social mores that have been ingrained by rote and are integrated into a new hierarchy of personal values. These new values often conflict with the person's previous social values. Many of the status quo explanations for the "way things are," learned through education and from the social order, collapse under conscious, individual scrutiny. This causes more conflicts focused on the person's analysis of his or her own reactions to the world at large and of the behavior of self and others. Common behaviors and the ethics of the prevailing social order come to be seen as inadequate, wrong or hypocritical. Positive maladjustment prevails. For Dąbrowski, these crises represent a strong potential for development toward personal growth and mental health. Using a positive definition, mental health reflects more than social conformity: it involves a careful, personal examination of the world and of one's values, leading to the development of an individual personality.

Level II is a transitional period. Dąbrowski said you either fall back (reintegration on a lower level), move ahead or end negatively, in suicide or psychosis.<sup>[8]</sup>

The transition from Level II to Level III involves a fundamental shift that requires a phenomenal amount of energy. This period is the crossroads of development: from here one must either progress or regress. The struggle between Dąbrowski's three factors reflects this transitional crisis: "Do I follow my instincts (first factor), my teachings (second factor) or my heart (third factor)?" The developmental answer is to transform one's lower instincts (automatic reactions like anger) into positive motivation, to resist rote and social answers, and to listen to one's inner sense of what one ought to do.

## Level III: Spontaneous Multilevel Disintegration

Level III describes a new type of conflict: a vertical conflict between two alternatives that are not simply different, but that exist on different levels. One is genuinely higher and the other is lower in comparison. These vertical conflicts initially arise from involuntary perceptions of higher versus lower choices in life (because they are involuntary, Dąbrowski called it spontaneous multilevel disintegration). You just look at something, maybe for the 1000th time (to use the words of G. K. Chesterton), and it strikes you — you see this one thing differently and once you do, it changes things. You can no longer "go back and see it the way you did before." Dąbrowski called this vertical dimension multilevelness. Multilevelness is a gradual realization of the "possibility of the higher" (a phrase Dąbrowski used frequently) and of the subsequent contrasts between the higher and the lower in life. These vertical comparisons often illustrate the lower, actual behavior of a person in contrast to higher, imagined ideals and alternative idealized choices. Dąbrowski believed that the authentic individual would choose the higher path as the clear and obvious one to follow (erasing the ambivalences and ambitemperies of unilevel conflicts). If the person's actual behavior subsequently falls short of the ideal, internal disharmony and a drive to review and reconstruct one's

life often follow. Multilevelness thus represents a new and powerful type of conflict, a conflict that is developmental in Dąbrowski's approach.

These vertical conflicts are critical in leading to autonomy and advanced personality growth. If the person is to achieve higher levels, the shift to multilevelness must occur. If a person does not have the developmental potential to move into a multilevel view, then he or she will fall back from the crises of Level II to reintegrate at Level I. In the shift to multilevelness, the horizontal (unilevel), stimulus-response model of life is replaced by a vertical and hierarchical analysis. This vertical view becomes anchored by one's emerging individual value structure, and all events are seen in relation to personal ideals. These personal value ideals become the personality ideal: how the person wants to live his or her life. As events in life are seen in relation to this multilevel, vertical view, it becomes impossible to support positions that favor the lower course when higher goals can be identified (or imagined).

### **Level IV: Directed Multilevel Disintegration**

In Level IV the person takes full control of his or her development. The involuntary spontaneous development of Level III is replaced by a deliberate, conscious and self-directed review of life from the multilevel perspective. This level marks the real emergence of the third factor, described by Dąbrowski as an autonomous factor "of conscious choice (valuation) by which one affirms or rejects certain qualities in oneself and in one's environment".<sup>[9]</sup> The person consciously reviews his or her existing belief system and tries to replace lower, automatic views and reactions with carefully thought out, examined and chosen ideals. These new values will increasingly be reflected in the person's behavior. Behavior becomes less reactive, less automatic and more deliberate as behavioral choices fall under the influence of the person's higher, chosen ideals.

Social mores are reviewed and re-accepted by a conscious internalization when the individual feels it is appropriate. Likewise, when the person feels it is proper, a social value is reviewed and may be rejected to be replaced by a self perceived higher alternative value. One's social orientation comes to reflect a deep responsibility based on both intellectual and emotional factors. At the highest levels, "individuals of this kind feel responsible for the realization of justice and for the protection of others against harm and injustice. Their feelings of responsibility extend almost to everything".<sup>[10]</sup> This perspective results from seeing life in relation to one's hierarchy of values (the multilevel view) and the subsequent appreciation of the potential of how life could be, and ought to be, lived. One's disagreements with the (lower level) world are expressed compassionately in doing what one can to help achieve the "ought."

Given their genuine (authentic) prosocial outlook, people achieving higher development also raise the level of their society. Prosocial here is not just support of the existing social order. If the social order is lower and you are adjusted to it, then you also reflect the lower (negative adjustment in Dąbrowski's terms, a Level I feature). Here, prosocial is a genuine cultivation of social interactions based on higher values. These positions often conflict with the status quo of a lower society (positive maladjustment). In other words, to be maladjusted to a low-level society is a positive feature.

### **Level V: Secondary Integration**

The fifth level displays an integrated and harmonious character, but one vastly different from that at the first level. At this highest level, one's behavior is guided by conscious, carefully weighed decisions based on an individualized and chosen hierarchy of personal values. Behavior conforms to this inner standard of how life ought to be lived and, thus, little inner conflict arises.

Level V is often marked by creative expression. Especially at Level V, problem solving and art represent the highest and noblest features of human life. Art captures the innermost emotional states and is based on a deep empathy and understanding of the subject. Often, human suffering and sacrifice are the subjects of these works. Truly visionary works, works that are unique and novel, are created by people expressing a vision unrestrained by convention. Advances in society, through politics, philosophy and religion, are therefore commonly associated with strong individual creativity or accomplishments.

## Applications of the theory of positive disintegration

### Therapy

The theory of positive disintegration has an extremely broad scope and has implications for many areas. One central application applies to psychological and psychiatric diagnosis and treatment. Dąbrowski advocated a comprehensive, multidimensional diagnosis of the person's situation, including symptoms and developmental potentials.

#### *Symptoms and developmental potentials*

If the disintegration appears to fit into a developmental context, then the person is educated in the theory and encouraged to take a developmental view of his or her situation and experiences. Rather than being eliminated, symptoms are reframed to yield insight and understanding into life and the person's unique situation.

#### *The importance of narratives*

Dąbrowski illustrated his theory through autobiographies of and biographies about those who have experienced positive disintegration. The gifted child, the suicidal teen or the troubled artist is often experiencing the features of TPD, and if they accept and understand the meaning of their intense feelings and crises, they can move ahead, not fall apart. The completion of an extensive autobiography to help the individual gain perspective on his or her past and present is a very important component in the autopsychotherapy process. In this process, the therapist plays a very small role and acts more as an initial stimulus than an ongoing therapist. Dąbrowski asked clients to read his books and to see how his ideas may relate to their lives.

#### *Autopsychotherapy*

For Dąbrowski, the goal of therapy is to eliminate the therapist by providing a context within which a person can understand and help oneself, an approach to therapy that he called autopsychotherapy. The client is encouraged to embark on a journey of self-discovery with an emphasis on looking for the contrast between what is higher versus what is lower within his or her personality and value structure. The person is encouraged to further explore his or her value structure especially as it relates to the rationale and justification of positions. Discrepancies between values and behavior are highlighted. The approach is called autopsychotherapy to emphasize the important role that the individual must play in his or her own therapy process and for that matter, in the larger process of personality development. The individual must come to see that he or she is in charge of determining or creating his or her own unique personality ideal and value structure. This includes a critical review of social mores and values that have been learned.

Dąbrowski was very concerned about what he called one-sided development. In a nutshell, Dąbrowski was concerned that many people display significant advanced development in only one aspect of life, usually intellectual. Dąbrowski used to say that we should try to ignore our strengths and focus on our weaknesses, the mathematical prodigy should focus less on mathematics—he or she is already a whiz at that, and focus more on other topics—the introvert should try to be more extroverted, the extrovert should try to be more introverted. In this way, we do not simply keep enlarging upon our strengths leading towards one-sided development; rather we focus on trying to balance out our development.

#### *Overexcitability*

Dąbrowski also encouraged people to see their reactions (overexcitabilities) and their phenomenological view of the world in the context of their developmental potential. The experience of and reaction to, crises are a very important aspect of this approach and people are encouraged to experience personal crises with a positive and developmental view.

Dąbrowski reminds clients that without internal disease there is little stimulus for change or growth. Rather than trying to rapidly ameliorate symptoms, this approach encourages individuals to fully experience their feelings and to try to maintain a positive and developmental orientation to what they may perceive as strong depression or anxiety. Of course, this is a unique approach in today's world of seeking immediate and total relief of any unpleasant

psychological experience (although it can be compared to Aron's to some extent).

## Education

Another primary focus is on education, in particular, over the past 25 years, on the experience of creative and gifted students. Dąbrowski hypothesized that these students will disproportionately show strong overexcitability and therefore will be prone to the disintegrative process.

## Dąbrowski and the gifted individual

In an appendix to Dąbrowski (1967), results of investigations done in 1962 with Polish youth are reported. Specifically, "a group of gifted children and young people, aged 8 to 23" were examined (p. 251). Of the 80 youth studied, 30 were "intellectually gifted" and 50 were from "drama, ballet, and plastic art schools" (p. 251). Dąbrowski found that every one of the children displayed overexcitability, "which constituted the foundation for the emergence of neurotic and psychoneurotic sets. Moreover it turned out that these children also showed sets of nervousness, neurosis, and psychoneurosis of various kinds and intensities, from light vegetative symptoms, or anxiety symptoms, to distinctly and highly intensive psychasthenic or hysterical sets" (p. 253). Dąbrowski asked why these children should display such "states of nervousness or psychoneurosis" and suggested that it was due to the presence of OE (p. 255). "Probably the cause is more than average sensitivity which not only permits one to achieve outstanding results in learning and work, but at the same time increases the number of points sensitive to all experiences that may accelerate anomalous reactions revealing themselves in psychoneurotic sets" (p. 255).

The association between OE and giftedness appears to be borne out in the research (Lysy and Piechowski 1983; Piechowski 1986; Piechowski and Miller 1995). It appears that at the least OE is a marker of potential for giftedness/creativity. Dąbrowski's basic message is that the gifted will disproportionately display this process of positive disintegration and personality growth.

## Key ideas

The theory is based on numerous key ideas:

- That our lower animal instincts (first factor) must be inhibited and transformed into "higher" forces for us to be Human (this ability to transform our instincts is what separates us from animals).
- That the common initial personality integration, based upon socialization (second factor), does not reflect true personality.
- At the initial level of integration, there is little internal conflict as when one "goes along with the group," there is little sense of individual wrong doing. External conflicts often relate to the blockage of social goals – career frustrations for example. The social mores and values prevail with little question or conscious examination.
- True personality must be based upon a system of values that are consciously and volitionally chosen by the person to reflect their own individual sense of "how life ought to be" and their "personality ideal" — the ideal person they feel they "ought to be."
- The lower animal instincts and the forces of peer groups and socialization are inferior to the autonomous self (personality) constructed by the conscious person.
- To break down the initial integration, crises and disintegrations are needed, usually provided by life experience.
- These disintegrations are positive if the person can achieve positive and developmental solutions to the situation.
- "Unilevel crises" are not developmental as the person can only choose between equal alternatives (go left or go right?).
- A new type of perception involves "multilevelness," a vertical view of life that compares lower versus higher alternatives and now allows the individual to choose a higher resolution to a crisis over other available, but lower,

alternatives — the developmental solution.

- "Positive disintegration" is a vital developmental process.
- Dąbrowski developed the idea of "developmental potential" to describe the forces needed to achieve autonomous personality development.
- Developmental potential includes several factors including innate abilities and talents, "overexcitability" and the "third factor."
- Overexcitability is a measure of an individual's level of nervous response. Dąbrowski found that the exemplars he studied all displayed an overly sensitive nervous system, also making them prone to angst, depression and anxiety - psychoneuroses in Dąbrowski's terms, a very positive and developmental feature.
- The third factor is a measure of an individual's drive toward autonomy.
- Dąbrowski's approach is very interesting philosophically as it is Platonic, reflecting the bias of Plato toward essence — an individual's essence is a critical determinant of his or her developmental course in life. However, Dąbrowski also added a major existential aspect as well, what one depends upon the anxieties felt and on how one resolves the day to day challenges one faces. Essence must be realized through an existential and experiential process of development. The characterization advanced by Kierkegaard of "Knights of faith" may be compared to Dąbrowski's autonomous individual.
- Reviewed the role of logic and reasoning in development and concludes that intellect alone does not fully help us know what to do in life. Incorporates Jean Piaget's views of development into a broader scheme guided by emotion. Emotion (how one feels about something) is the more accurate guide to life's major decisions.
- When multilevel and autonomous development is achieved, a secondary integration is seen reflecting the mature personality state. The individual has no inner conflict; they are in internal harmony as their actions reflect their deeply felt hierarchy of values.
- Rejected Maslow's description of self-actualization (Dąbrowski was a personal friend and correspondent of Maslow's). Actualization of an undifferentiated human self is not a developmental outcome in Dąbrowski's terms. Dąbrowski applied a multilevel (vertical) approach to self and saw the need to become aware of and to inhibit and reject the lower instinctual aspects of the intrinsic human self (aspects that Maslow would have us "embrace without guilt") and to actively choose and assemble higher elements into a new unique self - this process is what differentiates Man from the Animals. Dąbrowski would have us differentiate the initial self into higher and lower aspects, as we define them, and to reject the lower and actualize the higher in creating our unique personality.

## **Secondary Integration versus self-actualization.**

People have often equated Maslow's concept of self-actualization with Dąbrowski's level of secondary integration. There are some major differences between these two ideas. Fundamentally, Maslow described self-actualization as a process where the self is accepted "as is" so, both higher and lower aspects of the self are actualized. Dąbrowski introduces the notion that although the lower aspects may initially be intrinsic to the self, as human beings, we are able to become aware of their lower nature. We are able to develop self-awareness into how we feel about these low levels—if we feel badly about behaving in these lower ways, then we are able to cognitively and volitionally decide to inhibit and eliminate these behaviors. In this way, the higher aspects of the self are actualized while the lower aspects are inhibited and, for Dąbrowski, this is what is unique about humans and sets us apart from animals—animals are not able to differentiate their lower instincts and therefore can not inhibit their animalistic impulses. Dąbrowski has gone beyond Maslow's idea of self-actualization and it is not appropriate to equate the two authors on this point.

## Obstacles to the theory

Both Dąbrowski and his work have faced many obstacles. Personally, he was severely affected by both World Wars. His work always went against the grain. One can imagine a humanistic theory promoting personal growth in the political atmosphere of Poland in the 1950s and 1960s. Another problem has been language. Dąbrowski wrote in Polish and translated his works into French and Spanish. English was the last language he learned and likely the most difficult in terms of capturing the subtleties of his ideas. In spite of these problems, Dąbrowski persevered with his studies of human development, developed his theory and practiced psychiatry all his life.

Dąbrowski died in 1980 and his students went on to explore careers of their own. Many of these students continue to study and speak on the theory, most advancing a deeply personal understanding of what the theory means to them. For many, the theory has become a lifelong friend.

Since 1980, there has been a small but consistent demand for Dąbrowski's works. This demand has largely evolved in the United States where Michael Piechowski applied his vision of the theory to gifted education. Many in education and in gifted education have looked to Dąbrowski's theory to help provide a context for their students. Although a small part of the overall theory, this aspect has generated a number of Master's and Ph.D. theses and introduced the theory to a large audience, an audience eager to learn more about Dąbrowski and his theory.

The reader interested in Dąbrowski has faced a serious scarcity of resources, especially of Dąbrowski's English works. His books are long out of print and rare, and his papers are held by a few people but not circulated. There are also many excellent Polish works by Dąbrowski (about 20 books) on the theory, on psychotherapy, on education and on philosophy that await translation into English. Several efforts are underway to remedy this scarcity, including the Dąbrowski website (see below), a current initiative to reprint Dąbrowski's English books (they are currently available as pdf files on a CD) and ongoing conferences and workshops.

## Notes

[1] Dąbrowski 1972, p. 6

[2] Dąbrowski 1972, p. 294

[3] Aron, E. N. (2006). "The Clinical Implications of Jungs Concept of Sensitiveness" ([http://www.junginstitute.org/pdf\\_files/JungV8N2p11-44.pdf](http://www.junginstitute.org/pdf_files/JungV8N2p11-44.pdf)). *Journal of Jungian Theory and Practice* 8: 11–43. . "Sensitive persons can certainly have mood disorders, but should not be mistaken for being chronically depressed only because of a pessimistic view of the future of the world or of their own abilities (a pessimism which may well be accurate, as in the case of depressive realism). Likewise they do not have an anxiety disorder merely because they worry more than the nonsensitive, and they do not have a personality disorder (avoidant, dependent, obsessive-compulsive, etc.) merely because their unusualness has been present throughout their lives as an impediment to the cheerful, resilient functioning expected of most people most of the time.... They cannot shut out the world's achingly subtle, fleeting beauty or its inexplicable cruelty and suffering. They must find their own meaning in it."

[4] Dąbrowski 1996, p. 17

[5] Dąbrowski 1964, p. 121

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## External links

- The Theory of Positive Disintegration by Kazimierz Dąbrowski (<http://positivedisintegration.com/>)
- The Polish website dedicated to Kazimierz Dąbrowski and his Theory of Positive Disintegration (<http://www.dezintegracja.pl>)

# Radical Psychology Network

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The **Radical Psychology Network** (RadPsyNet) began in Toronto in 1993 when two dozen people attended a discussion at the American Psychological Association convention entitled "Will Psychology Pay Attention to its Own Radical Critics?"

Today the group has more than 500 members in over three dozen countries. Members include psychologists and others, academics and practitioners, faculty and students, psychotherapists and consumer-survivors. It publishes the online *Radical Psychology Journal* and sponsors an active email discussion list.

The aim of the group is to change the *status quo* of psychology. Challenging psychology's traditional focus on minor reform, members emphasise enhancing human welfare by working for fundamental social change. They claim that psychology itself has too often oppressed people rather than liberated them and they work to redress this imbalance. In keeping with this aim, RadPsyNet co-founders Dennis Fox and Isaac Prilleltensky co-edited *Critical Psychology: An Introduction* in 1997, and many RadPsyNet members are active in academic critical psychology as well as in opposition to psychological abuses.

## External links

- New Ideas and Old Values in Psychotherapy <sup>[1]</sup>
- Radical Psychology Network homepage <sup>[2]</sup>
- Critical Psychology: An Introduction (book) <sup>[3]</sup>

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[1] <http://www.transtherapy.org/>

[2] <http://www.radpsynet.org/>

[3] <http://www.dennisfox.net/critpsy/book.html>

# Rosenhan experiment

The **Rosenhan experiment** was a famous experiment into the validity of psychiatric diagnosis conducted by psychologist David Rosenhan in 1973. It was published in the journal *Science* under the title "**On being sane in insane places.**"<sup>[1]</sup> The study is considered an important and influential criticism of psychiatric diagnosis.<sup>[2]</sup>

Rosenhan's study was done in two parts. The first part involved the use of healthy associates or "pseudopatients" (three women and five men) who briefly simulated auditory hallucinations in an attempt to gain admission to 12 different psychiatric hospitals in five different states in various locations in the United States. All were admitted and diagnosed with psychiatric disorders. After

admission, the pseudopatients acted normally and told staff that they felt fine and had not experienced any more hallucinations. Hospital staff failed to detect a single pseudopatient, and instead believed that all of the pseudopatients exhibited symptoms of ongoing mental illness. Several were confined for months. All were forced to admit to having a mental illness and agree to take antipsychotic drugs as a condition of their release. The second part involved an offended hospital challenging Rosenhan to send pseudo-patients to its facility, whom its staff would then detect. Rosenhan agreed, but sent no pseudopatients. Yet, out of 195 new patients in the following weeks, the staff identified 42 ordinary patients as impostors and suspected 48 more.

The study concluded, "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals" and also illustrated the dangers of dehumanization and labeling in psychiatric institutions. It suggested that the use of community mental health facilities which concentrated on specific problems and behaviors rather than psychiatric labels might be a solution and recommended education to make psychiatric workers more aware of the social psychology of their facilities.



St. Elizabeth's psychiatric hospital, Washington, D.C., one of the sites of the Rosenhan experiment.



## The pseudopatient experiment

Rosenhan himself and eight mentally healthy associates, called "pseudopatients", attempted to gain admission to psychiatric hospitals by calling for an appointment and feigning auditory hallucinations. The hospital staffs were not informed of the experiment. The pseudopatients included a psychology graduate student in his twenties, three psychologists, a pediatrician, a psychiatrist, a painter and a housewife. None had a history of mental illness. Pseudopatients used pseudonyms, and those who worked in the mental health field were given false jobs in a different sector to avoid invoking any special treatment or scrutiny. Apart from giving false names and employment details, further biographical details were truthfully reported.

During their initial psychiatric assessment, they claimed to be hearing voices of the same sex as the patient which were often unclear, but which seemed to pronounce the words "empty", "hollow", "thud" and nothing else. These words were chosen as they vaguely suggest some sort of existential crisis and for the lack of any published literature referencing them as psychotic symptoms. No other psychiatric symptoms were claimed. If admitted, the pseudopatients were instructed to "act normally," reporting that they felt fine and no longer heard voices. Hospital records obtained after the experiment indicate that all pseudopatients were characterized as friendly and cooperative by staff.

All were admitted, to 12 different psychiatric hospitals across the United States, including rundown and underfunded public hospitals in rural areas, urban university-run hospitals with excellent reputations, and one expensive private hospital. Though presented with identical symptoms, 11 were diagnosed with schizophrenia at public hospitals, and one with manic-depressive psychosis, a more optimistic diagnosis with better clinical outcomes, at the private hospital. Their stays ranged from 7 to 52 days, and the average was 19 days. All were discharged with a diagnosis of schizophrenia "in remission," which Rosenhan takes as evidence that mental illness is perceived as an irreversible condition creating a lifelong stigma rather than a curable illness.

Despite constantly and openly taking extensive notes on the behavior of the staff and other patients, none of the pseudopatients were identified as impostors by the hospital staff, although many of the other psychiatric patients seemed to be able to correctly identify them as impostors. In the first three hospitalizations, 35 of the total of 118 patients expressed a suspicion that the pseudopatients were sane, with some suggesting that the patients were researchers or journalists investigating the hospital.

Hospital notes indicated that staff interpreted much of the pseudopatients' behavior in terms of mental illness. For example, one nurse labeled the note-taking of one pseudopatient as "writing behavior" and considered it pathological. The patients' normal biographies were recast in hospital records along the lines of what was expected of schizophrenics by the then-dominant theories of its etiology.

The pseudopatients were required to get out of the hospital on their own by getting the hospital to release them, though a lawyer was retained to be on call for emergencies when it became clear that the pseudopatients would not ever be voluntarily released on short notice. Once admitted and diagnosed, the pseudopatients were not able to obtain their release until they agreed with the psychiatrists that they were mentally ill and began taking antipsychotic medications, which they flushed down the toilet. No staff member noticed that the pseudopatients were flushing their medication down the toilets and did not report patients doing this.

Rosenhan and the other pseudopatients reported an overwhelming sense of dehumanization, severe invasion of privacy, and boredom while hospitalized. Their possessions were searched randomly, and they were sometimes observed while using the toilet. They reported that though the staff seemed to be well-meaning, they generally objectified and dehumanized the patients, often discussing patients at length in their presence as though they were not there, and avoiding direct interaction with patients except as strictly necessary to perform official duties. Some attendants were prone to verbal and physical abuse of patients when other staff were not present. A group of bored patients waiting outside the cafeteria for lunch early were said by a doctor to his students to be experiencing "oral-acquisitive" psychiatric symptoms. Contact with doctors averaged 6.8 minutes per day.

"I told friends, I told my family, 'I can get out when I can get out. That's all. I'll be there for a couple of days and I'll get out.' Nobody knew I'd be there for two *months* ... The only way out was to point out that they're [the psychiatrists] correct. They had said I was insane, 'I *am* insane; but I am getting better.' That was an affirmation of their view of me." — David Rosenhan in the BBC program "The Trap."<sup>[3]</sup>

## The non-existent impostor experiment

For this experiment, Rosenhan used a well-known research and teaching hospital, whose staff had heard of the results of the initial study but claimed that similar errors could not be made at their institution. Rosenhan arranged with them that during a three month period, one or more pseudopatients would attempt to gain admission and the staff would rate every incoming patient as to the likelihood they were an impostor. Out of 193 patients, 41 were considered to be impostors and a further 42 were considered suspect. In reality, Rosenhan had sent no pseudopatients and all patients suspected as impostors by the hospital staff were ordinary patients. This led to a conclusion that "any diagnostic process that lends itself too readily to massive errors of this sort cannot be a very reliable one". Studies by others found similarly problematic diagnostic results.

## Impact and controversy

Rosenhan published his findings in *Science*, criticizing the reliability of psychiatric diagnosis and the disempowering and demeaning nature of patient care experienced by the associates in the study. His article generated an explosion of controversy.

Many defended psychiatry, arguing that as psychiatric diagnosis relies largely on the patient's report of their experiences, faking their presence no more demonstrates problems with psychiatric diagnosis than lying about other medical symptoms. In this vein psychiatrist Robert Spitzer quoted Kety in a 1975 criticism of Rosenhan's study:

*If I were to drink a quart of blood and, concealing what I had done, come to the emergency room of any hospital vomiting blood, the behavior of the staff would be quite predictable. If they labeled and treated me as having a bleeding peptic ulcer, I doubt that I could argue convincingly that medical science does not know how to diagnose that condition.*<sup>[4]</sup>

Rosenhan replied that if they go on thinking that you still have an ulcer during x weeks despite having no other symptoms of ulcer, that makes for a big problem. Even K. Pollock agreed on that.

## Related experiments

American investigative journalist Nellie Bly feigned symptoms of mental illness to gain admission to a lunatic asylum in 1887 and report on the terrible conditions therein. The results were published as *Ten Days in a Mad-House*.

Maurice K. Temerlin split 25 psychiatrists into two groups and had them listen to an actor portraying a character of normal mental health. One group was told that the actor "was a very interesting man because he looked neurotic, but actually was quite psychotic" while the other was told nothing. Sixty percent of the former group diagnosed psychoses, most often schizophrenia, while none of the control group did so.<sup>[5]</sup>

In 1988, Loring and Powell gave 290 psychiatrists a transcript of a patient interview and told half of them that the patient was black and the other half white; they concluded of the results that "Clinicians appear to ascribe violence, suspiciousness, and dangerousness to black clients even though the case studies are the same as the case studies for the white clients".<sup>[6]</sup>

The science writer Lauren Slater may have conducted a very similar experiment for her 2004 book *Opening Skinner's Box*.<sup>[2]</sup> She claims to have presented herself at 9 different psychiatric emergency rooms with auditory hallucinations, resulting in being diagnosed "almost every time" with psychotic depression. However, when

challenged to provide evidence of actually conducting her experiment, she could not.<sup>[7]</sup>

In 2008, the BBC's Horizon science program performed a somewhat related experiment over two episodes entitled "How Mad Are You?". The experiment involved ten subjects, five living with previously-diagnosed mental health conditions, and five with no such diagnosis. They were observed by three experts in mental health diagnoses and their challenge was to identify the five with mental health problems.<sup>[8]</sup> The experts correctly diagnosed two of the ten patients, misdiagnosed one patient, and incorrectly identified two healthy patients as having mental health problems.<sup>[9]</sup>

## External links

- On being Sane in Insane Places<sup>[10]</sup>
- Rosenhan experiment summary<sup>[11]</sup>
- Clip from the BBC's *The Trap*, 11th March 2007<sup>[12]</sup>
- BBC Radio 4, "Mind Changers", Series 4 Episode 1: The Pseudo-Patient Study<sup>[13]</sup>

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- [3] An excerpt from the BBC program with this statement by David Rosen can be viewed here (<http://www.yoism.org/?q=node/234#laing>).
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- [9] How Mad Are You? - Spotlight (<http://www.spotlightradio.net/listen/how-mad-are-you/>)
- [10] <http://www.bonkersinstitute.org/rosenhan.html>
- [11] <http://www.holah.karoo.net/rosenhan.htm>
- [12] <http://www.youtube.com/watch?v=Kq-7uvVOoyk>
- [13] <http://www.bbc.co.uk/programmes/b00lny48>

# World Network of Users and Survivors of Psychiatry

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The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation representing, and led by users (consumers) and survivors of psychiatry. As of 2003, over 70 national organizations were members of WNUSP, based in 30 countries.[1] The network seeks to protect and develop the human rights, disability rights, dignity and self-determination of those labeled as 'mentally ill'.

## Activities

WNUSP has special consultative status with the United Nations. It contributed to the development of the UN's Convention on the Rights of Persons with Disabilities.[2][1] WNUSP has produced a manual to help people use it called "Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities." [3]

WNUSP joined with other organizations to create the International Disability Caucus, which jointly represented organizations of people with disabilities and allies during the CRPD negotiations. WNUSP was part of the steering committee of the IDC, which maintained a principle of respecting the leadership of diverse constituencies on issues affecting them, and also maintained that the convention should be of equal value to all persons with disabilities irrespective of the type of disability or geographical location. Tina Minkowitz, WNUSP's representative on the IDC steering committee, coordinated the IDC's work on key articles of the CRPD, including those on legal capacity, liberty, torture and ill-treatment and integrity of the person. Since the adoption and entry into force of the CRPD, WNUSP has worked with other organizations in the International Disability Alliance and its CRPD Forum to guide the interpretation and application of the CRPD on these issues.[4]

In 2007 at a Conference held in Dresden on "Coercive Treatment in Psychiatry: A Comprehensive Review", the president and other leaders of the World Psychiatric Association met, following a formal request from the World Health Organization, with four representatives from the user/survivor movement, including Judi Chamberlin, co-chair of WNUSP, who participated in her personal capacity.[5]

Moosa Salie is the current Chair of WNUSP.

Current International Representative and former co-chair of WNUSP is Tina Minkowitz, an international advocate and lawyer.[6] She represented WNUSP in the Working Group convened by the UN to produce a draft text of the Convention on the Rights of Persons with Disabilities[7] and contributed to a UN seminar on torture and persons with disabilities[8][9] that resulted in an important report on the issue by Special Rapporteur on Torture Manfred Nowak in 2008.[10]

## Core values

The core values of WNUSP, in representing a diversity of perspectives within the user/survivor movement or psychiatric survivors movement, guide its activities and assists in determining the focus of the network. These values stress empowerment, equality, self-determination, respect, dignity, independence, hearing voices, mutual support, self-help, advocacy, education, and the right to pursue individual spiritual beliefs.

WNUSP values exposure to information and knowledge as means to enabling empowerment and individual self-direction, understanding that knowledge results in better-informed choices and opportunities to enhance quality of life. The network ascribes to person-centred values where the individual is more important than any diagnostic label or experience in dealing with the mental health system. WNUSP believes the experiences of living with madness or mental health problems can be valuable in exploring human experience, both to individuals and society, and that those suffering distress may offer invaluable insights to necessary changes in mental health diagnosis, treatment and laws.

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## History

Since the 1970s, the psychiatric survivors movement has grown from a few scattered self-help groups to a world-wide network engaged in protecting civil rights and facilitation of efforts to provide housing, employment, public education, research, socialisation and advocacy programmes. The term 'psychiatric survivor' is used by individuals who identify themselves as having experienced human rights violations in the mental health system. WNUSP was established to further promote this movement and to respond on an international level to the oppression survivors continue to experience.

After initially meeting, in 1991, as the World Federation of Psychiatric Users at the biennial World Federation for Mental Health conference in Mexico, the network's name was changed to WNUSP in 1997. In 2000, the WNUSP Secretariat was established in Odense, Denmark. In 2001, the network held its First General Assembly in Vancouver, British Columbia, with 34 groups from twelve countries represented, and adopted its governing statutes.

In 2004, the network held its Second General Assembly in Vejle, Denmark with 150 participants from 50 countries attending.

In 2007 WNUSP received ECOSOC special consultative status at the United Nations.

In 2009, WNUSP held its third General Assembly in Kampala, Uganda. It adopted the Kampala Declaration stating its positions on the CRPD, which was later expanded into a longer version adopted by consensus of the board and the participants in the Kampala GA.[11]

## ENUSP

The European Network of (Ex)Users and Survivors of Psychiatry is the most important European NGO of (ex-)users and survivors. Forty-two representatives from 16 European countries met at a conference to found it in the Netherlands in October 1991. Every 2 years, delegates from the ENUSP members in more than 40 European countries meet at a conference where the policies for the coming period are set out. All delegates are (ex-)users and survivors of psychiatry. ENUSP is officially involved in consultations on mental health plans and policies of the European Union, World Health Organization and other important bodies. Initial funding came from the Dutch government and from the European Commission but has since proved more difficult to secure. ENUSP is involved in commenting and debating declarations, position papers, policy guidelines of the EU, UN, WHO and other important bodies.[12]

## External links


- WNUSP <sup>[13]</sup> - World Network of Users and Survivors of Psychiatry (WNUSP main web site)
- ENUSP <sup>[14]</sup> - European Network of (ex-)Users and Survivors of Psychiatry (ENUSP)
  - ENUSP.org <sup>[15]</sup> - 'ENUSP Press Release' (July 20, 2004)
- Inclusion-International.org <sup>[16]</sup> - International Disability Alliance
- Moosa-Salie.oism.info <sup>[17]</sup> - 'Launching Conference of the Pan African Network of Users and Survivors of Psychiatry (PANUSP)', Moosa Salie (WNUSP board co-chair)
- CHRUSP <sup>[18]</sup> - Center for the Human Rights of Users and Survivors of Psychiatry
- UN.org <sup>[2]</sup> - 'Contribution by World Network of Users and Survivors of Psychiatry', United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (January, 2004)

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  - [17] <http://moosa-salie.oism.info/>
  - [18] <http://www.chrusp.org>
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# Loren Mosher

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<b>Loren Mosher</b>	
	
<b>Born</b>	3 September 1933Monterey, California, US
<b>Died</b>	10 July 2004 (aged 70)Berlin, Germany
<b>Citizenship</b>	<span><span><span></span></span><span> </span></span> USA
<b>Nationality</b>	American
<b>Fields</b>	Psychiatry
<b>Institutions</b>	National Institute of Mental Health, Uniformed Services University of the Health Sciences, University of California, MindFreedom International, Mosher's consulting company Soteria Associates
<b>Alma mater</b>	Stanford University, Harvard University
<b>Known for</b>	Creating Soteria, founding <i>Schizophrenia Bulletin</i>
<b>Influenced</b>	R. D. Laing

**Loren Richard Mosher** (September 3, 1933, Monterey — July 10, 2004, Berlin)<sup>[1] [2]</sup> was an American psychiatrist,<sup>[2] [3] :21</sup> clinical professor of psychiatry,<sup>[1] [4] [5]</sup> expert on schizophrenia<sup>[4] [5]</sup> and the chief of the Center for Studies of Schizophrenia in the National Institute of Mental Health (1968—1980)<sup>[1] [2] [4]</sup>. Mosher spent all his professional career seeking more humane and effective treatment for people diagnosed as having schizophrenia<sup>[2]</sup> and was instrumental in developing an innovative, residential, home-like, non-hospital, non-drug treatment model for newly identified acutely psychotic persons.<sup>[1]</sup>

Loren Mosher founded the Soteria experience, having showed that treating psychosis also in the acute phase is possible without using restraint methods.<sup>[6]</sup>

He was dismissed from the National Institute of Mental Health,<sup>[5]</sup> and later resigned from the American Psychiatric Association in 1998, for controversially disagreeing with prevailing psychiatric practice and the influence of pharmaceutical companies.

## Biography

Loren Mosher was born on the 3rd of September 1933 in Monterey, California, to the married couple of a teacher and boat builder.<sup>[1]</sup> He earned his undergraduate degree from Stanford University and his medical degree from Harvard University,<sup>[4]</sup> starting work at NIMH in 1964.<sup>[5]</sup> He undertook research training at the Tavistock Clinic in London from 1966 to 1967 and developed an interest in alternative treatments for schizophrenia.<sup>[2]</sup>

The house, known as Soteria, was opened in an area of San Jose, California, in April 1971.<sup>[3]</sup> :22 Mosher believed that the violent and controlling atmosphere of psychiatric hospitals and the over-use of drugs hindered recovery. Despite its success (it achieved superior results than the standard medical treatment with drugs<sup>[7]</sup>), the Soteria Project closed in 1983 when, according to Loren Mosher and Robert Whitaker further funding was denied because of the politics of psychiatry that was increasingly controlled by the influence of pharmaceutical companies.<sup>[8]</sup>

Mosher is said to have had a far more nuanced view of the use of drugs than has been generally thought, and did not reject drugs altogether but insisted they be used as a last resort and in far lower doses than usual in the United States.<sup>[2]</sup>

After dismissal from NIMH, he taught psychiatry at the Uniformed Services University of the Health Sciences in Bethesda and became head of the public mental health system in Montgomery County.<sup>[5]</sup> He started a crisis house in Rockville, McAuliffe House, based on Soteria principles.<sup>[5]</sup>

During the Ritalin phenomenon of the 1990s, he was often featured as a dissenting view in scores of articles. He was the founder and first editor in chief of *Schizophrenia Bulletin*.<sup>[2]</sup>

Mosher edited or co-authored some books, including *Community Mental Health: A Practical Guide*, and published more than 100 reviews and articles.<sup>[1]</sup> He held professorships and ran mental health programmes on both the US coasts.<sup>[1]</sup> Mosher also headed his own consulting company, Soteria Associates, providing research, forensic and mental health consultation<sup>[1]</sup> and cooperated for years with numerous advocacy groups, including the psychiatric survivor group MindFreedom International.<sup>[2]</sup>

Dr. Mosher moved to San Diego from Washington in 1996. He became clinical professor of psychiatry at the University of California at San Diego medical school.

He was married to, and later divorced, Irene Carleton Mosher.

At the time of his death he was in Berlin for experimental cancer treatment.

Survivors included his wife, Judy Schreiber, three children from the first marriage, a granddaughter, and two brothers.

## Mosher archive

His work is archived at Stanford University and can be accessed via their website. Anyone interested in further pursuing his work can arrange to have it brought to the Stanford Green Library.<sup>[9]</sup>

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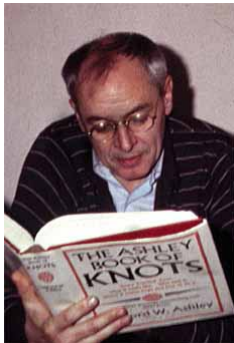
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# R. D. Laing

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<b>Ronald David Laing</b>	
 <p>The author of <i>Knots</i> (1970) perusing in 1983 The Ashley Book of Knots</p>	
<b>Born</b>	7 October 1927 Govanhill, Glasgow, Scotland.
<b>Died</b>	23 August 1989 (aged 61)
<b>Cause of death</b>	Heart attack
<b>Occupation</b>	Psychiatrist
<b>Known for</b>	Author of psychiatry books

**Ronald David Laing** (7 October 1927 – 23 August 1989) was a Scottish psychiatrist who wrote extensively on mental illness – in particular, the experience of psychosis. Laing's views on the causes and treatment of serious mental dysfunction, greatly influenced by existential philosophy, ran counter to the psychiatric orthodoxy of the day by taking the expressed feelings of the individual patient or client as valid descriptions of lived experience rather than simply as symptoms of some separate or underlying disorder. Laing was associated with the anti-psychiatry movement, although he rejected the label.<sup>[1]</sup> Politically, he was regarded as a thinker of the New Left.<sup>[2]</sup>

## Early years

Laing was born in the Govanhill district of Glasgow on 7 October 1927 the only child of David Park MacNair Laing and Amelia Glen Laing (née Kirkwood).<sup>[3]</sup> Laing described his parents – his mother especially – as being somewhat odd. Although his biographer son largely discounted Laing's account of his childhood, an obituary by an acquaintance of Laing asserted that about his parent – "the full truth he told only to a few close friends".<sup>[4]</sup> <sup>[5]</sup>

He was educated at Hutchesons' Grammar School, going on to study medicine at the University of Glasgow. Though he failed his exams on his first attempt, in 1950, he passed them in a subsequent re-sit.

## Career

Laing spent a couple of years as a psychiatrist in the British Army (Royal Army Medical Corps; drafted despite his asthma that made him unfit for combat), where he found an interest in communicating with mentally distressed people. In 1953 Laing left the Army and worked at Gartnavel Royal Hospital becoming the youngest consultant in the country.<sup>[6]</sup> During this period he also participated in an existentialism-oriented discussion group in Glasgow, organised by Karl Abenheimer and Joe Schorstein.<sup>[7]</sup> In 1956 Laing went on to train on a grant at the Tavistock Clinic in London, widely known as a centre for the study and practice of psychotherapy (particularly psychoanalysis). At this time, he was associated with John Bowlby, D. W. Winnicott and Charles Rycroft. He remained at the Tavistock Institute until 1964.<sup>[8]</sup>

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In 1965, Laing and a group of colleagues created the Philadelphia Association and started a psychiatric community project at Kingsley Hall, where patients and therapists lived together.<sup>[9]</sup> The Norwegian author Axel Jensen became a close friend and Laing often visited him onboard his ship, *Shanti Devi*, in Stockholm.

Inspired by the work of American psychotherapist Elizabeth Fehr, Laing began to develop a team offering "rebirthing workshops" in which one designated person chooses to re-experience the struggle of trying to break out of the birth canal represented by the remaining members of the group who surround him or her.<sup>[10]</sup> Many former colleagues regarded him as a brilliant mind gone wrong but there were some who thought Laing was somewhat psychotic<sup>[11]</sup>

### **Laing and anti-psychiatry**

Laing was seen as an important figure in the anti-psychiatry movement, along with David Cooper, although he never denied the value of treating mental distress. He challenged the core values of a practice of psychiatry which he thought considered mental illness as a biological phenomenon without regard for social, intellectual and cultural dimensions.

He also challenged psychiatric diagnosis itself, arguing that diagnosis of a mental disorder contradicted accepted medical procedure: diagnosis was made on the basis of behavior or conduct, and examination and ancillary tests that traditionally precede the diagnosis of viable pathologies (like broken bones or pneumonia) occurred after the diagnosis of mental disorder (if at all). Hence, according to Laing, psychiatry was founded on a false epistemology: illness diagnosed by conduct, but treated biologically. Laing maintained that schizophrenia was "a theory not a fact"; he believed the models of genetically inherited schizophrenia being promoted by biologically based psychiatry were not accepted by leading medical geneticists.<sup>[12]</sup> He rejected the "medical model of mental illness"; according to Laing diagnosis of mental illness did not follow a traditional medical model; and this led him to question the use of medication such as antipsychotics by psychiatry. His attitude to recreational drugs was quite different; privately, he advocated an anarchy of experience.<sup>[13]</sup>

### **Personal life**

Laing's parents led a life of extreme denial, exhibiting bizarre behaviour. His father David, an electrical engineer, seems often to have come to blows with his own brother, and himself had a breakdown when Laing was a teenager. His mother Amelia was described as "still more psychologically peculiar". According to one friend and neighbour, "everyone in the street knew she was mad".<sup>[14]</sup> Laing was troubled by his own personal problems, suffering from both episodic alcoholism and clinical depression, according to his self-diagnosis in his 1983 BBC Radio interview with Dr. Anthony Clare,<sup>[15]</sup> although he reportedly was free of both in the years before his death. These admissions were to have serious consequences for Laing as they formed part of the case against him by the General Medical Council which led to him ceasing to practice medicine. He died at age 61 of a heart attack while playing tennis with his colleague and friend Robert W. Firestone.<sup>[16]</sup>

Laing fathered six sons and four daughters by four women. His son Adrian, speaking in 2008, said, "It was ironic that my father became well known as a family psychiatrist, when, in the meantime, he had nothing to do with his own family."<sup>[17]</sup> Adam, his oldest son by his second marriage, was found dead in May 2008, in a tent on a Mediterranean island. He had died of a heart attack, aged 41.<sup>[18]</sup> His daughter Susan died in March 1976, aged 21, of leukemia.

## Works

### On mental illness

Laing argued that the strange behavior and seemingly confused speech of people undergoing a psychotic episode were ultimately understandable as an attempt to communicate worries and concerns, often in situations where this was not possible or not permitted. Laing stressed the role of society, and particularly the family, in the development of "madness" (his term). He argued that individuals can often be put in impossible situations, where they are unable to conform to the conflicting expectations of their peers, leading to a "lose-lose situation" and immense mental distress for the individuals concerned. (In 1956, in Palo Alto, Gregory Bateson and his colleagues Paul Watzlawick, Donald Jackson, and Jay Haley<sup>[19]</sup> articulated a related theory of schizophrenia as stemming from double bind situations where a person receives different or contradictory messages.) The perceived symptoms of schizophrenia were therefore an expression of this distress, and should be valued as a cathartic and trans-formative experience.

Psychiatrist and philosopher Karl Jaspers had previously pronounced, in his work *General Psychopathology*, that many of the symptoms of mental illness (and particularly of delusions) were "un-understandable", and therefore were worthy of little consideration except as a sign of some other underlying primary disorder. Laing saw psychopathology as being seated not in biological or psychic organs – whereby environment is relegated to playing at most only an accidental role as immediate trigger of disease (the "stress diathesis model" of the nature and causes of psychopathology) – but rather in the social cradle, the urban home, which cultivates it, the very crucible in which selves are forged. This re-evaluation of the locus of the disease process – and consequent shift in forms of treatment – was in stark contrast to psychiatric orthodoxy (in the broadest sense we have of ourselves as psychological subjects and pathological selves). Laing was revolutionary in valuing the content of psychotic behavior and speech as a valid expression of distress, albeit wrapped in an enigmatic language of personal symbolism which is meaningful only from within their situation. According to Laing, if a therapist can better understand his or her patient, the therapist can begin to make sense of the symbolism of the patient's psychosis, and therefore start addressing the concerns which are the root cause of the distress.

Laing expanded the view of the "double bind" hypothesis put forth by Bateson and other anthropologists, and came up with a new concept to describe the highly complex situation that unfolds in the process of "going mad" - an "incompatible knot". Laing compared this to a situation where your right hand can exist but your left hand cannot. In this untenable position, something has got to give, and more often than not, what gives is psychological stability; a self-destruction sequence is set in motion.

Laing never denied the existence of mental illness, but viewed it in a radically different light from his contemporaries. For Laing, mental illness could be a transformative episode whereby the process of undergoing mental distress was compared to a shamanic journey. The traveler could return from the journey with (supposedly) important insights, and may have become (in the views of Laing and his followers) a wiser and more grounded person as a result.

### Ontological insecurity, family nexus, and the double-bind

In *The Divided Self* (1960), Laing contrasted the experience of the "ontologically secure" person with that of a person who "cannot take the realness, aliveness, autonomy and identity of himself and others for granted" and who consequently contrives strategies to avoid "losing his self".<sup>[20]</sup> Laing explains how we all exist in the world as beings, defined by others who carry a model of us in their minds, just as we carry models of them in our minds. In later writings he often takes this to deeper levels, laboriously spelling out how "A knows that B knows that A knows that B knows ..."! Our feelings and motivations derive very much from this condition of "being in the world" in the sense of existing for others, who exist for us. Without this we suffer "ontological insecurity", a condition often expressed in terms of "being dead" by people who are clearly still physically alive.

In *Self and Others* (1961), Laing's definition of normality shifted somewhat.<sup>[21]</sup>

In *Sanity, Madness and the Family* (1964), Laing and Esterton give accounts of several families, analysing how their members see each other and what they actually communicate to each other. The startling way in which lies are perpetuated in the interest of family politics rings true to many readers from "normal" families, and Laing's view is that in some cases these lies are so strongly maintained as to make it impossible for a vulnerable child to be able to determine what truth actually is, let alone what the truth of their situation is.

He uses the term 'family nexus' to describe the consensus view within the family, but from there on much of his writing appears ambivalent, as Andrew Collier has pointed out in *The Philosophy and Politics of Psychotherapy* (with a contribution from Laing, 1977). One strand of Laing's thinking, traceable to Marx and Sartre, condemns society for shackling humankind against its will, taking away individual freedom. Left to their own devices, people are healthy, and people with so-called mental illness are just trying to find their way back to their natural state. This was the basis for his approach to psychotherapy, as in the case of his most famous "patient" Mary Barnes. An idea typical of his work is the following quote in his book, *The Politics of Experience*, "We are effectively destroying ourselves with violence masquerading as love".

A paradox arising from Laing's interpretations is that it is the very need for ontological security Laing discussed in his first book that is the driving force that builds societies. Laing characterised the family nexus as often placing children in a double bind, unable to obey conflicting injunctions from family members, but he does not *blame* those family members. The family members are usually unaware that they are doing such things, and are just as confused as the children within the situation. The Preface to the Second Edition and Introduction to *Sanity, Madness and the Family* offer a concise articulation of this issue.

## Influence

In 1965 Laing co-founded the UK charity the Philadelphia Association, which he also chaired.<sup>[22]</sup> His work influenced the wider movement of therapeutic communities, operating in less "confrontational" (in a Laingian perspective) psychiatric settings. Other organizations created in a Laingian tradition are the Arbour Association<sup>[23]</sup> and the New School of Psychotherapy and Counselling in London.<sup>[24]</sup>

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## Films and plays on R.D. Laing

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- *Cain's Film* (1969). Short film by Jamie Wadhawan on Alexander Trocchi, featuring other counter-cultural figures in London at the time including Laing, William Burroughs and Davy Graham.
- *Family Life* (1971). Reworking of the Wednesday play *In Two Minds* that "explored the issue of schizophrenia and the ideas of the radical psychiatrist R. D. Laing"<sup>[28]</sup>. Directed by Ken Loach.
- *Asylum* (1972). Documentary directed by Peter Robinson showing Laing's psychiatric community project where patients and therapists lived together. Laing also appears in the film.
- *Knots* (1975). Film adapted from Laing's 1970 book and Edward Petherbridge's play.
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## External links

- The International R.D. Laing Institute (Switzerland) (<http://www.lainginstitut.ch/>)
- The Society for Laingian Studies (<http://www.laingsociety.org/>)
- R.D. Laing Discussion forum (<http://www.laingsociety.org/giardino/>)
- Biography at The Society for Laingian Studies (<http://www.laingsociety.org/biograph.htm>)
- Special Issue of Janus Head (<http://www.janushead.org/4-1/index.cfm>), Edited by Daniel Burston
- The Philadelphia Association (<http://www.philadelphia-association.co.uk/>)
- RD Laing: The Abominable Family Man ([http://women.timesonline.co.uk/tol/life\\_and\\_style/women/families/article6058901.ece](http://women.timesonline.co.uk/tol/life_and_style/women/families/article6058901.ece)) from The Sunday Times
- Life before Death (<http://www.rdlaing-lifebeforedeath.com/>) - 1978 album of sonnets and other poems performed by R. D. Laing to an original musical score

# Thomas Szasz

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Thomas Szasz	
<b>Born</b>	April 15, 1920Budapest, Kingdom of Hungary
<b>Nationality</b>	Hungarian
<b>Fields</b>	Psychiatry
<b>Institutions</b>	State University of New York Upstate Medical University

**Thomas Stephen Szasz** (<sup>ⓘ</sup>) /ˈsɑːs/ *sahss*; born April 15, 1920) is a psychiatrist and academic. Since 1990<sup>[1]</sup> he has been Professor Emeritus of Psychiatry at the State University of New York Health Science Center in Syracuse, New York. He is a well-known social critic of the moral and scientific foundations of psychiatry, and of the social control aims of medicine in modern society, as well as of scientism. His books *The Myth of Mental Illness* (1960) and *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (1970) set out some of the arguments with which he is most associated.

His views on special treatment follow from classical liberal roots which are based on the principles that each person has the right to bodily and mental self-ownership and the right to be free from violence from others, although he criticized the "Free World" as well as the communist states for their use of psychiatry and "drogophobia". He believes that suicide, the practice of medicine, use and sale of drugs and sexual relations should be private, contractual, and outside of state jurisdiction.

In 1973, the American Humanist Association named him Humanist of the Year and in 1979 he was honored with an honorary doctorate<sup>[2]</sup> at Universidad Francisco Marroquín.

## Life

Thomas Szasz was born to Gyula and Lily Szasz on April 15, 1920, in Budapest, Hungary. In 1938 Szasz moved to the United States, where he attended the University of Cincinnati for his Bachelor of Arts in medicine, and received his medical degree from the same university in 1944.<sup>[3]</sup> Szasz completed his residency requirement at the Cincinnati General Hospital, then worked at the Chicago Institute for Psychoanalysis from 1951–1956, and then for the next five years was a member of its staff—taking twenty-four months out for active duty with the U.S. Navy.<sup>[4]</sup>

In 1962 Szasz received a tenured position in medicine at the State University of New York.<sup>[5]</sup> Szasz had first joined SUNY in 1956.

Szasz's views of psychiatry were influenced by the writings of Frigyes Karinthy.

## The rise of Szasz's arguments

Szasz first presented his attack on "mental illness" as a legal term in 1958 in the *Columbia Law Review*. In his article he argued that mental illness was no more a fact bearing on a suspect's guilt than is possession by the devil.<sup>[6]</sup>

In 1961 Szasz gave testimony before a United States Senate committee in which he argued that the use of mental hospitals to incarcerate people defined as insane violated the general assumptions of patient- and doctor-relationships and turned the doctor into a warden and a keeper of a prison.<sup>[7]</sup>



## Szasz's main arguments

Szasz is a critic of the influence of modern medicine on society, which he considers to be the secularisation of religion's hold on humankind. Criticizing scientism, he targets in particular psychiatry, underscoring its campaigns against masturbation at the end of the 19th century, its use of medical imagery and language to describe misbehavior, its reliance on involuntary mental hospitalization to protect society, or the use of lobotomy and other interventions to treat psychosis. To sum up his description of the political influence of medicine in modern societies imbued by faith in science, he declared:

*Since theocracy is the rule of God or its priests, and democracy the rule of the people or of the majority, pharmacracy is therefore the rule of medicine or of doctors.*<sup>[8]</sup>

Szasz consistently pays attention to the power of language in the establishment and maintenance of the social order, both in small interpersonal as well as wider socio-political spheres:

*"The struggle for definition is veritably the struggle for life itself. In the typical Western two men fight desperately for the possession of a gun that has been thrown to the ground: whoever reaches the weapon first shoots and lives; his adversary is shot and dies. In ordinary life, the struggle is not for guns but for words; whoever first defines the situation is the victor; his adversary, the victim. For example, in the family, husband and wife, mother and child do not get along; who defines whom as troublesome or mentally sick?...[the one] who first seizes the word imposes reality on the other; [the one] who defines thus dominates and lives; and [the one] who is defined is subjugated and may be killed."*<sup>[9]</sup>

His main arguments can be summarised as follows:

- *The myth of mental illness:* "Mental illness" is an expression, a metaphor that describes an offending, disturbing, shocking, or vexing conduct, action, or pattern of behavior, such as schizophrenia, as an "illness" or "disease". Szasz wrote: "If you talk to God, you are praying; If God talks to you, you have schizophrenia. If the dead talk to you, you are a spiritualist; If you talk to the dead, you are a schizophrenic."<sup>[9]</sup> While people behave and think in ways that are very disturbing, and that may resemble a disease process (pain, deterioration, response to various interventions), this does not mean they actually have a disease. To Szasz, disease can only mean something people "have," while behavior is what people "do". Diseases are "malfunctions of the human body, of the heart, the liver, the kidney, the brain" while "no behavior or misbehavior is a disease or can be a disease. That's not what diseases are" Szasz cites drapetomania as an example behavior which many in society did not approve of, being labeled and widely cited as a 'disease' and likewise with women who did not bow to men's will as having "hysteria"<sup>[10]</sup> Psychiatry actively obscures the difference between (mis)behavior and disease, in its quest to help or harm parties to conflicts. By calling certain people "diseased", psychiatry attempts to deny them responsibility as moral agents, in order to better control them.

People who are said (by themselves or others) to "have" a mental illness can only have, at best, a "fake disease." Diagnoses of "mental illness" or "mental disorder" (the latter expression called by Szasz a "weasel term" for mental illness) are passed off as "scientific categories" but they remain merely judgments (judgments of disdain) to support certain uses of power by psychiatric authorities. In that line of thinking, schizophrenia is not the name of a disease entity but a judgment of extreme psychiatric and social reprobation. Szasz calls schizophrenia "the sacred symbol of psychiatry" because those so labeled have long provided and continue to provide justification for psychiatric theories, treatments, abuses, and reforms. The figure of the psychotic or schizophrenic person to psychiatric experts and authorities, according to Szasz, is analogous with the figure of the heretic or blasphemer to theological experts and authorities. According to Szasz, to understand the metaphorical nature of the term "disease" in psychiatry, one must first understand its literal meaning in the rest of medicine. To be a true disease, the entity must first, somehow be capable of being approached, measured, or tested in scientific fashion. Second, to be confirmed as a disease, a condition must demonstrate pathology at the cellular or molecular level.

A genuine disease must also be found on the autopsy table (not merely in the living person) and meet pathological definition instead of being voted into existence by members of the American Psychiatric Association. "Mental illnesses" are really problems in living. They are often "like a" disease, argues Szasz, which makes the medical metaphor understandable, but in no way validates it as an accurate description or explanation. Psychiatry is a pseudo-science that parodies medicine by using medical sounding words invented especially over the last 100 years. To be clear, heart break and heart attack, or spring fever and typhoid fever belong to two completely different logical categories, and treating one as the other constitutes a category error, that is, a myth. Psychiatrists are the successors of "soul doctors", priests who dealt and deal with the spiritual conundrums, dilemmas, and vexations — the "problems in living" — that have troubled people forever.

Psychiatry's main methods are those of conversation or rhetoric, repression, and religion. To the extent that psychiatry presents these problems as "medical diseases," its methods as "medical treatments," and its clients — especially involuntary — as medically ill patients, it embodies a lie and therefore constitutes a fundamental threat to freedom and dignity. Psychiatry, supported by the State through various Mental Health Acts, has become a modern secular state religion according to Thomas Szasz. It is a vastly elaborate social control system, using both brute force and subtle indoctrination, which disguises itself under the claims of scientificity. The notion that biological psychiatry is a real science or a genuine branch of medicine has been challenged by other critics as well, such as Michel Foucault in *Madness and Civilization* (1961), and Erving Goffman in *Asylums* (1961).

- *Separation of psychiatry and the state*: State government by enforcing the use of shock therapy has abused Psychiatry with impunity.<sup>[11]</sup> If we accept that "mental illness" is a euphemism for behaviors that are disapproved of, then the state has no right to force psychiatric "treatment" on these individuals. Similarly, the state should not be able to interfere in mental health practices between consenting adults (for example, by legally controlling the supply of psychotropic drugs or psychiatric medication). The medicalization of government produces a "therapeutic state," designating someone as "insane" or as a "drug addict".

In *Ceremonial Chemistry* (1973), he argued that the same persecution which has targeted witches, Jews, Gypsies or homosexuals now targets "drug addicts" and "insane" people. Szasz argued that all these categories of people were taken as scapegoats of the community in ritual ceremonies. To underscore this continuation of religion through medicine, he even takes as example obesity: instead of concentrating on junk food (ill-nutrition), physicians denounced hypernutrition. According to Szasz, despite their scientific appearance, the diets imposed were a moral substitute to the former fasts, and the social injunction *not to be overweight* is to be considered as a moral order, not as a scientific advice as it claims to be. As with those thought bad (insane people), those who took the wrong drugs (drug-addicts), medicine created a category for those who had the wrong weight (obeses).

Szasz argued that psychiatrics were created in the 17th century to study and control those who erred from the medical norms of social behavior; a new specialization, drogophobia, was created in the 20th century to study and control those who erred from the medical norms of drug consumption; and then, in the 1960s, another specialization, bariatrics, was created to deal with those who erred from the medical norms concerning the weight which the body should have. Thus, he underscores that in 1970, the American Society of Bariatric Physicians (from the Greek *baros*, weight) had 30 members, and already 450 two years later.

- *Presumption of competence*: Just as legal systems work on the presumption that a person is innocent until proven guilty, individuals accused of crimes should not be presumed incompetent simply because a doctor or psychiatrist labels them as such. Mental incompetence should be assessed like any other form of incompetence, i.e., by purely legal and judicial means with the right of representation and appeal by the accused.
- *Death control*: In an analogy to birth control, Szasz argues that individuals should be able to choose when to die without interference from medicine or the state, just as they are able to choose when to conceive without outside interference. He considers suicide to be among the most fundamental rights, but he opposes state-sanctioned euthanasia. In his 2006 book about Virginia Woolf he stated that she put an end to her life by a conscious and deliberate act, her suicide being an expression of her freedom of choice.<sup>[12] [13]</sup>

- *Abolition of the insanity defense*: Szasz believes that testimony about the mental competence of a defendant should not be admissible in trials. Psychiatrists testifying about the mental state of an accused person's mind have about as much business as a priest testifying about the religious state of a person's soul in our courts. Insanity was a legal tactic invented to circumvent the punishments of the Church, which, at the time included confiscation of the property of those who committed suicide, which often left widows and orphans destitute. Only an insane person would do such a thing to his widow and children, it was successfully argued. Legal mercy masquerading as medicine, said Szasz.
- *Abolition of involuntary hospitalization*: No one should be deprived of liberty unless he is found guilty of a criminal offense. Depriving a person of liberty for what is said to be his own good is immoral. Just as a person suffering from terminal cancer may refuse treatment, so should a person be able to refuse psychiatric treatment.
- *Our right to drugs*: Drug addiction is not a "disease" to be cured through legal drugs (Methadone instead of heroin; which forgets that heroin was created in the first place to be a substitute to morphine, which in turn was created as a substitute to opium), but a social habit. Szasz also argues in favor of a drugs free-market. He criticized the war on drugs, arguing that using drugs was in fact a victimless crime. Prohibition itself constituted the crime. He shows how the war on drugs leads states to do things that would have never been considered half a century before, such as prohibiting a person from ingesting certain substances or interfering in other countries to impede the production of certain plants (e.g. coca eradication plans, or the campaigns against opium; both are traditional plants opposed by the Western world). Although Szasz is skeptical about the merits of psychotropic medications, he favors the repeal of drug prohibition.

"Because we have a free market in food, we can buy all the bacon, eggs, and ice cream we want and can afford. If we had a free market in drugs, we could similarly buy all the barbiturates, chloral hydrate, and morphine we want and could afford." Szasz argued that the prohibition and other legal restrictions on drugs are enforced not because of their lethality, but in a ritualistic aim (he quotes Mary Douglas's studies of rituals). He also recalls that *pharmakos*, the Greek root of pharmacology, originally meant "scapegoat". Szasz dubbed pharmacology "pharmacomythology" because of its inclusion of social practices in its studies, in particular through the inclusion of the category of "addictiveness" in its programs. "Addictiveness" is a social category, argued Szasz, and the use of drugs should be apprehended as a social ritual rather than exclusively as the act of ingesting a chemical substance. There are many ways of ingesting a chemical substance, or drug (which comes from *pharmakos*), just as there are many different cultural ways of eating or drinking. Thus, some cultures prohibit certain types of substances, which they call "taboo", while they make use of others in various types of ceremonies.

Szasz has been wrongly associated with the anti-psychiatry movement of the 1960s and 1970s. He is not opposed to the practice of psychiatry if it is non-coercive. He maintains that psychiatry should be a contractual service between consenting adults with no state involvement. In a 2006 documentary film called *Psychiatry: An Industry of Death* released on DVD Szasz stated that involuntary mental hospitalization is a crime against humanity. Szasz also believes that, if unopposed, involuntary hospitalization will expand into "pharmacratic" dictatorship.

## Relationship to Citizens Commission on Human Rights

In 1969, Szasz and the Church of Scientology co-founded the Citizens Commission on Human Rights (CCHR) with the aim of helping to "clean up" the field of human rights abuses. Szasz remains on CCHR's Board of Advisors as Founding Commissioner,<sup>[14]</sup> and continues to provide content for the CCHR.<sup>[15]</sup> In the keynote address at the 25th anniversary of CCHR, Szasz stated: *"We should all honor CCHR because it is really the organization that for the first time in human history has organized a politically, socially, internationally significant voice to combat psychiatry. This has never been done in human history before."*<sup>[16]</sup> Szasz, himself, does not have any membership or involvement in Scientology. In 2003, the following statement, authorized by Szasz, was posted to the official Szasz web site by its owner, Jeffrey Schaler, explaining Szasz's relation to CCHR:

"Dr. Szasz co-founded CCHR in the same spirit as he had co-founded — with sociologist Erving Goffman and law professor George Alexander — The American Association for the Abolition of Involuntary Mental Hospitalization...

Scientologists have joined Szasz's battle against institutional psychiatry. Dr. Szasz welcomes the support of Jews, Christians, Muslims, and any other religious or atheist group committed to the struggle against the Therapeutic State. Sharing this battle does not mean that Dr. Szasz supports the unrelated principles and causes of any religious or non-religious organization. This is explicit and implicit in Dr. Szasz's work. Everyone and anyone is welcome to join in the struggle for individual liberty and personal responsibility — especially as these values are threatened by psychiatric ideas and interventions."<sup>[17]</sup>

## Criticism

Szasz's critics maintain that, contrary to his views, such illnesses are now regularly "approached, measured, or tested in scientific fashion." The list of groups that reject his opinion that mental illness is a myth include the American Medical Association (AMA), American Psychiatric Association (APA) and the National Institute of Mental Health (NIMH).

The effectiveness of medication has been used as an argument against Szasz's idea that depression is a myth. In a debate with Szasz, Donald F. Klein, M.D explained:

"It is that elementary fact, that the antidepressants do little to normals, and are tremendously effective in the clinically depressed person, that shows us that this is an illness."<sup>[18]</sup>

But as the New England Journal of Medicine reported on January 17, 2008, in published trials, about 60 percent of people taking the drugs report significant relief from depression, compared with roughly 40 percent of those on placebo pills. But when the less positive, unpublished trials are included, the advantage shrinks: the drugs outperform placebos, but perhaps only by a modest margin and for a brief period.<sup>[19]</sup>

In the same debate Frederick K. Goodwin, M.D, asserts:

"The concept of disease in medicine really means a cluster of symptoms that people can agree about, and in the case of depression we agree 80% of the time. It is a cluster of symptoms that predicts something."<sup>[18]</sup>

Szasz argues that only mental illnesses are defined based on consensus and symptom clusters. It has been argued this is not the case. Critics claim physical illnesses such as Kawasaki syndrome (a disorder of the heart and blood vessels)<sup>[20]</sup> and Ménière's disease (a disorder of the inner ear)<sup>[21]</sup> are similarly defined.

There is also the criticism that many physical diseases were identified and even treated with at least some success decades, centuries, or millennia before their etiology was accurately identified. Diabetes is one notable example. In the eyes of Szasz's critics, such historical facts tend to undermine his contention that mental illnesses must be "fake diseases" because their etiology in the brain is not well understood.

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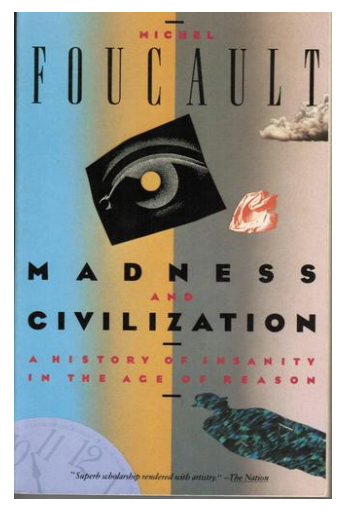
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## External links

- Honorary Doctoral Degrees, [[Universidad Francisco Marroquín (<https://www.ufm.edu/cms/es/honorary-doctoral-degrees>)]]
- The Szasz Site published and owned by Jeffrey A. Schaler, Ph.D. (<http://www.szasz.com/>)
- The Web Site of Jeffrey A. Schaler, Ph.D. (<http://www.schaler.net/>)
- The Foucault Tribunal. April 30 — May 3, 1998, in the Volksbuehne Theatre in Berlin, Germany (<http://www.freedom-of-thought.de/videos/video2.wmv>) (video of the Foucault Tribunal on [foucault.de](http://www.foucault.de)) (<http://www.foucault.de>)
- "Diseases are malfunctions of the human body, of the heart, the liver , the kidney, the brain." Audio on youtube (<http://www.youtube.com/watch?v=f4Gr4OIkums>)
- The Thomas S. Szasz Cybercenter for Liberty and Responsibility (<http://www.szasz.com/>)
- The Case Against Psychiatric Coercion, by Thomas S. Szasz (<http://www.iatrogenic.org/library/case.html>)
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- Thomas Szasz's OISM Honorary Membership Website (<http://thomas-szasz.oism.info/english.htm>)
- Thomas Szasz's Manifesto (<http://www.szasz.com/manifesto.html>)
- RealPlayer Video (or chose audio only) of Thomas Szasz (<http://www.cato.org/events/030925f.html>)
- YouTube Szasz interview 26:44 audio ( Part 1 (<http://www.youtube.com/watch?v=mojxtnm3fA4>), Part 2 ([http://www.youtube.com/watch?v=X\\_FVMvDDuDU](http://www.youtube.com/watch?v=X_FVMvDDuDU)), Part 3 (<http://www.youtube.com/watch?v=x7ct9qVF73U>))
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# Madness and Civilization

<i>Madness and Civilization: A History of Insanity in the Age of Reason</i>	
	
1988 Vintage Books edition	
<b>Author(s)</b>	Michel Foucault
<b>Country</b>	France
<b>Language</b>	English
<b>Genre(s)</b>	Philosophy
<b>Publisher</b>	Pantheon Books
<b>Publication date</b>	1964

*Madness and Civilization: A History of Insanity in the Age of Reason* (1964) by Michel Foucault, is the English edition of *Histoire de la folie à l'âge classique*, a 1964 abridged edition of the 1961 *Folie et déraison. Histoire de la folie à l'âge classique*. An English translation of the complete 1961 edition, entitled *History of Madness*, was published in June 2006.<sup>[1]</sup> This was Foucault's first major book, written while he was the director of the Maison de France in Sweden. It is an examination of the cultural, legal, political philosophical and, finally, medical construction of madness in Europe, from the Middle Ages to the end of the eighteenth century; and a critique of the idea of history and historical method. It marks a turning in Foucault's philosophical thought from phenomenology toward structuralism. Though he uses the language of phenomenology to describe an evolving experience of the other as mad, he attributes the change in this experience over time to specific powerful social structures.<sup>[2]</sup>

## On madness

Foucault traces the evolution of the concept of madness through three phases: the Renaissance, the "Classical Age" (the later seventeenth and most of the eighteenth centuries) and the modern experience. He argues that in the Renaissance the mad were portrayed in art as possessing a kind of wisdom, a knowledge of the limits of our world, and portrayed in literature as revealing the distinction between what men are and what they pretend to be. Renaissance art and literature depicted the mad as engaged with the reasonable, but it marked the beginning of an objective description of madness and reason, as though seen from above, compared with the more intimate medieval descriptions from within society.<sup>[2]</sup>

In the mid-seventeenth century, in the midst of the age of reason, madness began to be conceived of as unreason and the mad, previously consigned to society's margins, were now separated from society and confined, along with prostitutes, vagrants, blasphemers, orphans and the like, in newly created institutions all over Europe. Their condition was seen as one of moral error, they were viewed as having freely chosen the path of unreason, and the institutional regimes were meticulous programs of punishment and reward aimed at causing them to reverse that choice. The social forces Foucault sees as driving this confinement include the provision of an extrajudicial mechanism for getting rid of undesirables and the regulation of unemployment and wages (the cheap labour of the workhouses applied downward pressure on the wages of free labour). Foucault argues that this confinement made the mad conveniently available to medical doctors who then began to view madness as a natural object, worthy of inquiry; and that the conceptual distinction between the mad and the reasonable was in a sense a product of this physical separation into confinement.<sup>[2]</sup>

The modern experience began at the end of the eighteenth century with the creation of places devoted solely to the care of the mad under the supervision of medical doctors; born out of a blending of two motives: the new goal of curing the mad away from the family who could not afford the necessary care at home, and the old purpose of confining undesirables for the protection of society. These distinct purposes were soon lost sight of and the institution came to be seen as the only place where therapeutic treatment can be administered.<sup>[2]</sup> Foucault sees the nominally more enlightened treatment in these new institutions as just as cruel and controlling as that of their rational predecessors.

...modern man no longer communicates with the madman [...] There is no common language: or rather, it no longer exists; the constitution of madness as mental illness, at the end of the eighteenth century, bears witness to a rupture in a dialogue, gives the separation as already enacted, and expels from the memory all those imperfect words, of no fixed syntax, spoken falteringly, in which the exchange between madness and reason was carried out. The language of psychiatry, which is a monologue by reason *about* madness, could only have come into existence in such a silence.

Foucault, *Preface to the 1961 edition*.<sup>[3]</sup>

## Impact

Although *Madness and Civilization* has widely been read as a criticism of psychiatry, and often quoted in the anti-psychiatric movement, Foucault himself criticized, especially in retrospect, the "Romanticism of Madness", which tended to see madness as a form of genius which modern medicine represses. He did not contest the reality of psychiatric disorders, as some of his readers have concluded. Rather, he explored how "madness" could be constituted as an object of knowledge on the one hand, and, on the other hand, as the target of intervention for a specific type of power: the disciplinary institution of the asylum.<sup>[4]</sup>

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# Psychiatric consumer/survivor/ex-patient movement

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The **psychiatric consumer/survivor/ex-patient movement**, also known as the **psychiatric survivor movement**, is a diverse association of individuals (and organizations representing them) who are either currently "consumers" (clients) of mental health services, or who consider themselves survivors of psychiatry or mental health services, or who simply identify as "ex-patients" of mental health services. The movement typically campaigns for more choice and improved services, and/or empowerment and user-led alternatives, and against prejudice in society more generally. Common themes are "talking back to the power of psychiatry", rights protection and advocacy, and self-determination. While activists in this movement may share a collective identity, individuals can be seen as enacting their concerns along a continuum from conservative to radical, according to their position in relation to psychiatric treatment and their relative levels of resistance and patienthood.<sup>[1]</sup> This can in turn relate to an individual's experiences of the mental health system, particularly if subject to forced detention and/or forced medication, electroshock or other practice.

## Human rights

People with mental illnesses often "suffer from widespread systemic discrimination and are consistently denied the rights and services to which they are entitled".<sup>[2]</sup> According to members of the Psychiatric Survivors movement, coerced and/or forced psychiatric interventions are a violation of a person's basic human rights; including the right to autonomy, the freedom to make one's own choices, the right to liberty and security of the person, the right to physical and mental integrity, freedom from torture, the right to health care on the basis of free and informed consent, etc. Many people who have experienced forced institutionalization, forced drugging and forced electroshock respond with outrage because they consider there to be a prejudice within society that ignores their human rights and over-rates the judgment of psychiatrists, pharmaceutical companies, the police, and the legal oversight of the mental health system. According to the movement, many also view such interventions made in the name of help to be coercive and inherently violent in nature.

## History

### Precursors

The modern self-help and advocacy movement in the field of mental health services developed in the 1970s, but former psychiatric patients have been campaigning for centuries to change laws, treatments, services and public policies. "The most persistent critics of psychiatry have always been former mental hospital patients", although few were able to tell their stories publicly or to openly confront the psychiatric establishment, and those who did so were commonly considered so extreme in their charges that they could seldom gain credibility.<sup>[3]</sup> In 1620 in England, patients of the notoriously harsh Bethlem Hospital banded together and sent a "Petition of the Poor Distracted People in the House of Bedlam (concerned with conditions for inmates)" to the House of Lords. A number of ex-patients published pamphlets against the system in the 18th century, such as Samuel Bruckshaw (1774), on the "iniquitous abuse of private madhouses", and William Belcher (1796) with his "Address to humanity, Containing a letter to Dr Munro, a receipt to make a lunatic, and a sketch of a true smiling hyena". Such reformist efforts were generally opposed by madhouse keepers and medics.<sup>[4]</sup>

In the late 18th century, moral treatment reforms developed which were originally based in part on the approach of French ex-patient turned hospital-superintendent Jean-Baptiste Pussin and his wife Margueritte. From 1848 in England, the Alleged Lunatics' Friend Society campaigned for sweeping reforms to the asylum system and abuses of the moral treatment approach. In the United States, *The Opal* (1851–1860) was a ten volume Journal produced by

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patients of Utica State Lunatic Asylum in New York, which has been viewed in part as an early liberation movement. Beginning in 1868, Elizabeth Packard, founder of the Anti-Insane Asylum Society, published a series of books and pamphlets describing her experiences in the Illinois insane asylum to which her husband had had her committed.

### **Early 20th century**

A few decades later, another former psychiatric patient, Clifford W. Beers, founded the National Committee on Mental Hygiene, which eventually became the National Mental Health Association. Beers sought to improve the plight of individuals receiving public psychiatric care, particularly those committed to state institutions. His book, *A Mind that Found Itself* (1908),<sup>[5]</sup> described his experience with mental illness and the treatment he encountered in mental hospitals. Beers' work stimulated public interest in more responsible care and treatment. However, while Beers initially damned psychiatrists for tolerating mistreatment of patients, and envisioned more ex-patient involvement in the movement, he was influenced by Adolf Meyer and the psychiatric establishment, and toned down his hostility as he needed their support for reforms. His reliance on rich donors and his need for approval from experts led him to hand over to psychiatrists the organization he helped establish.<sup>[3]</sup> In the UK, the National Society for Lunacy Law Reform was established in 1920 by angry ex-patients sick of their experiences and complaints being patronisingly discounted by the authorities who were using medical "window dressing" for essentially custodial and punitive practices.<sup>[6]</sup> In 1922, ex-patient Rachel Grant-Smith added to calls for reform of the system of neglect and abuse she had suffered by publishing "The Experiences of an Asylum Patient".<sup>[7]</sup>

We Are Not Alone (WANA) was founded by a group of patients at Rockland State Hospital in New York in the mid to late 1940s, and continued to meet as an ex-patient group. Their goal was to provide support and advice and help others make the difficult transition from hospital to community. By the early 1950s WANA dissolved after it was taken over by mental health professionals who transformed it into Fountain House, a psychosocial rehabilitation service for people leaving state mental institutions. The founders of WANA found themselves pushed aside by professionals with money and influence, who made them "members" of the new organization. During that period, people who received psychiatric treatment identified themselves as patients, and this term was generally unchallenged as a self-description until the 1970s. A perceived patronizing attitude by health care workers led to resentment among some current and former patients, which eventually found expression in more militant groups beginning in the early 1970s.<sup>[8]</sup>

Originated by crusaders in periods of liberal social change, and appealing not so much to other sufferers as to elite groups with power, when the early reformer's energy or influence waned, mental patients were again mostly friendless and forgotten.<sup>[3]</sup>

### **1950s to 1970s**

The 1950s saw the reduction in the use of lobotomy and shock therapy. These used to be associated with grave concerns and much opposition on grounds of basic morality, harmful effects, or misuse. Towards the 1960s, psychiatric medications came in to widespread use and also caused controversy relating to adverse effects and misuse. There were also associated moves away from large psychiatric institutions to community-based services (later to become a full-scale deinstitutionalization), which sometimes empowered service users, although community-based services were often deficient.

Coming to the fore in the 1960s, an anti-psychiatry movement vocally challenged the fundamental claims and practices of mainstream psychiatry. The ex-patient movement of this time contributed to, and derived much from, antipsychiatry ideology, but has also been described as having its own agenda, described as humanistic socialism. For a time, the movement shared aims and practices with "radical therapists", who tended to be Marxist. However, the consumer/survivor/ex-patients gradually felt that the radical therapists did not necessarily share the same goals and were taking over, and they broke away from them in order to maintain independence.

By the 1970s, the women's movement, gay rights movement, and disability rights movements had emerged. It was in this context that former mental patients began to organize groups with the common goals of fighting for patients' rights and against forced treatment, stigma and discrimination, and often to promote peer-run services as an alternative to the traditional mental health system. Unlike professional mental health services, which were usually based on the medical model, peer-run services were based on the principle that individuals who have shared similar experiences can help themselves and each other through self-help and mutual support. Many of the individuals who organized these early groups identified themselves as psychiatric survivors. Their groups had names such as Insane Liberation Front and the Network Against Psychiatric Assault. They saw the mental health system as destructive and disempowering.

With more people out of mental hospitals, there was a larger number of people who could now make links with one another for progressive causes. Dorothy Weiner and about 10 others, including Tom Wittick, established the Insane Liberation Front in the spring of 1970 in Portland, Oregon. Though it only lasted 6 months, it had a notable influence in the history of North American ex-patients groups. News that former inmates of mental institutions were organizing was carried to other parts of North America. Individuals such as Howard Geld, known as Howie the Harp for his harmonica playing, left Portland where he been involved in ILF to return to his native New York to help found the Mental Patients Liberation Project in 1971. During the early 1970s, groups spread to California, New York, and Boston, which were primarily antipsychiatry, opposed to forced treatment including forced drugging, shock treatment and involuntary committal.<sup>[8]</sup> In 1972, the first organized group in Canada, the Mental Patients Association, started to publish *In A Nutshell*, while in the US the first edition of the first national publication by ex-mental patients, *Madness Network News*, was published in Oakland, continuing until 1986.<sup>[8]</sup> A well-known book of the time by an ex-patient was Judi Chamberlin's 1978 "On Our Own: Patient-Controlled Alternatives to the Mental Health System." Chamberlin publicized the concept of mentalism, a form of stereotyping and oppression of those associated with psychiatric treatment and diagnosis.

The major spokespeople of the movement have been described in generalities as largely white, middle-class and well-educated. It has been suggested that other activists were often more anarchistic and anti-capitalist, felt more cut-off from society and more like a minority with more in common with the poor, ethnic minorities, feminists, prisoners & gay rights than with the white middle classes. The leaders were sometimes considered to be merely reformist and, because of their "stratified position" within society, to be uncomprehending of the problems of the poor. The "radicals" saw no sense in seeking solutions within a capitalist system that creates mental problems. However, they were united in considering society and psychiatric domination to be the problem, rather than people designated mentally ill.<sup>[3]</sup>

Some activists condemned psychiatry under any conditions, voluntary or involuntary, while others believed in the right of people to undergo psychiatric treatment on a voluntary basis. Voluntary psychotherapy, at the time mainly psychoanalysis, did not therefore come under the same severe attack as the somatic therapies. The ex-patients emphasized individual support from other patients; they espoused assertiveness, liberation, and equality; and they advocated user-controlled services as part of a totally voluntary continuum. However, although the movement espoused egalitarianism and opposed the concept of leadership, it is said to have developed a cadre of known, articulate, and literate men and women who did the writing, talking, organizing, and contacting. Very much the product of the rebellious, populist, anti-elitist mood of the 1960s, they strived above all for self-determination and self-reliance. In general, the work of some psychiatrists, as well as the lack of criticism by the psychiatric establishment, was interpreted as an abandonment of a moral commitment to do no harm. There was a deep anger and resentment toward a profession that had the authority to label them as mentally disabled and was perceived as infantilizing them and disregarding their wishes.<sup>[3]</sup>

## 1980s and 1990s

By the 1980s, individuals who considered themselves "consumers" of mental health services rather than passive "patients" had begun to organize self-help/advocacy groups and peer-run services. While sharing some of the goals of the earlier movement, consumer groups did not seek to abolish the traditional mental health system, which they believed was necessary. Instead, they wanted to reform it and have more choice. Consumer groups encouraged their members to learn as much as possible about the mental health system so that they could gain access to the best services and treatments available. In 1985, the National Mental Health Consumers' Association was formed in the United States.<sup>[8]</sup>

A 1986 report on developments in the United States noted that "there are now three national organizations ... The 'conservatives' have created the National Mental Health Consumers' Association ... The 'moderates' have formed the National Alliance of Mental Patients ... The 'radical' group is called the Network to Abolish Psychiatry".<sup>[8]</sup> Many, however, felt that they had survived the psychiatric system and its "treatments" and resented being called consumers. The National Association of Mental Patients in the United States became the National Association of Psychiatric Survivors. "Phoenix Rising: The Voice of the Psychiatrized" was published by ex-inmates (of psychiatric hospitals) in Toronto from 1980 to 1990, known across Canada for its antipsychiatry stance.<sup>[8]</sup>

In late 1988, leaders from several of the main national and grassroots psychiatric survivor groups decided an independent coalition was needed, and Support Coalition International (SCI) was formed in 1988, later to become MindFreedom International. In addition, the World Network of Users and Survivors of Psychiatry (WNUSP), was founded in 1991 as the World Federation of Psychiatric Users (WFPU), an international organisation of recipients of mental health services.

An emphasis on voluntary involvement in services is said to have presented problems to the movement since, especially in the wake of deinstitutionalization, community services were fragmented and many individuals in distressed states of mind were being put in prisons or re-institutionalized in community services, or became homeless, often distrusting and resisting any help.<sup>[3]</sup>

## The movement today

In the United States, the number of mental health mutual support groups (MSG), self-help organizations (SHO) (run by and for mental health consumers and/or family members) and consumer-operated services (COS) was recently estimated to be 7,467.<sup>[9]</sup> The movement may express a preference for the "survivor" label over the "consumer" label, with more than 60 percent of ex-patient groups reported to support anti-psychiatry beliefs and considering themselves to be "psychiatric survivors."<sup>[10]</sup> There is some variation between the perspective on the consumer/survivor movement coming from psychiatry, anti-psychiatry or consumers/survivors themselves.<sup>[11] [12]</sup>

The most common terms in Germany are "Psychiatrie-Betroffene" (people afflicted by/confronted with psychiatry) and "Psychiatrie-Erfahrene" (people who have experienced psychiatry). Sometimes the terms are considered as synonymous but sometimes the former emphasizes the violence and negative aspects of psychiatry. The German national association of (ex-)users and survivors of psychiatry is called the Bundesverband Psychiatrie-Erfahrener (BPE).<sup>[13]</sup>

There are many grassroots self-help groups of consumers/survivors, local and national, all over the world, which are an important cornerstone of empowerment. A considerable obstacle to realizing more consumer/survivor alternatives is lack of funding.<sup>[13]</sup> Alternative consumer/survivor groups like the National Empowerment Center<sup>[14]</sup> in the US which receive public funds but question orthodox psychiatric treatment, have often come under attack for receiving public funding<sup>[8]</sup> and been subject to funding cuts.

As well as advocacy and reform campaigns, the development of self-help and user/survivor controlled services is a central issue. The Runaway-House in Berlin, Germany, is an example. Run by the Organisation for the Protection from Psychiatric Violence, it is an antipsychiatric crisis centre for homeless survivors of psychiatry where the

residents can live for a limited amount of time and where half the staff members are survivors of psychiatry themselves.<sup>[13]</sup> In Helsingborg, Sweden, the Hotel Magnus Stenbock is run by a user/survivor organization "RSMH" that gives users/survivors a possibility to live in their own apartments. It is financed by the Swedish government and run entirely by users.<sup>[13]</sup> Voice of Soul is a user/survivor organization in Hungary. Creative Routes is a user/survivor organization in London, England, that among other support and advocacy activities puts on an annual "Bonkersfest". WNUSP is a consultant organization for the United Nations. After a "long and difficult discussion", ENUSP and WNUSP (European and World Networks of Users and Survivors of Psychiatry) decided to employ the term (ex-)users and survivors of psychiatry in order to include the identities of the different groups and positions represented in these international NGOs.<sup>[13]</sup> WNUSP contributed to the development of the UN's Convention on the Rights of Persons with Disabilities<sup>[15]</sup> <sup>[16]</sup> and produced a manual to help people use it called "Implementing the Disability Rights Treaty, for Users, Survivors of Psychiatry"<sup>[17]</sup> and ENUSP is consulted by the European Union and World Health Organization.

In 2007 at a Conference held in Dresden on "Coercive Treatment in Psychiatry: A Comprehensive Review", the president and other leaders of the World Psychiatric Association met, following a formal request from the World Health Organization, with four representatives from leading consumer/survivor groups.<sup>[18]</sup>

The National Coalition for Mental Health Recovery (formerly known as National Coalition for Mental Health Consumer/Survivor Organizations) campaigns in the United States to ensure that consumer/survivors have a major voice in the development and implementation of health care, mental health, and social policies at the state and national levels, empowering people to recover and lead a full life in the community.

The United States Massachusetts-based Freedom Center provides and promotes alternative and holistic approaches and takes a stand for greater choice and options in treatments and care. The center and the New York-based Icarus Project (which does not self-identify as a consumer/survivor organization but has participants that identify as such) have published a Harm Reduction Guide To Coming Off Psychiatric Drugs and were recently a featured charity in Forbes business magazine.<sup>[19]</sup>

Mad pride events, organized by loosely connected groups in at least seven countries including Australia, South Africa, the United States, Canada, the United Kingdom and Ghana, draw thousands of participants. For some, the objective is to continue the destigmatization of mental illness. Another wing rejects the need to treat mental afflictions with psychotropic drugs and seeks alternatives to the "care" of the medical establishment. Many members of the movement say they are publicly discussing their own struggles to help those with similar conditions and to inform the general public.<sup>[20]</sup>

Survivor David Oakes, Director of MindFreedom, hosts a monthly radio show<sup>[21]</sup> and the Freedom Center initiated a weekly FM radio show now syndicated on the Pacifica Network, Madness Radio [22], hosted by Freedom Center co-founder Will Hall.<sup>[23]</sup>

A new International Coalition of National Consumer/User Organizations was launched in Canada in 2007, called Interrelate.<sup>[24]</sup>

## Impact

There has been some substantial research into consumer/survivor initiatives (CSIs). Many of the studies have been cross-sectional or retrospective and have not used comparison groups, which limits the firm conclusions that can be drawn. However, the findings suggest that CSIs can help with social support, empowerment, mental wellbeing, self-management and reduced service use, identity transformation and enhanced quality of life. However, studies have focused on the support and self-help aspects of CSIs, neglecting that many organizations locate the causes of members' problems in political and social institutions and are involved in activities to address issues of social justice.<sup>[25]</sup>

A recent series of studies in Canada compared individuals who participated in CSIs with those who did not. The two groups were comparable at baseline on a wide range of demographic variables, self-reported psychiatric diagnosis, service use, and outcome measures. After a year and a half, those who had participated in CSIs showed significant improvement in social support and quality of life (daily activities), less days of psychiatric hospitalization, and more were likely to have stayed in employment (paid or volunteer) and/or education. There was no significant difference on measures of community integration and personal empowerment, however. There were some limitations to the findings; although the active and nonactive groups did not differ significantly at baseline on measures of distress or hospitalization, the active group did have a higher mean score and there may have been a natural pattern of recovery over time for that group (regression to the mean). The authors noted that the apparent positive impacts of consumer-run organizations were achieved at a fraction of the cost of professional community programs.<sup>[26]</sup>

Further qualitative studies indicated that CSIs can provide: safe environments that are a positive, welcoming place to go; social arenas that provide opportunities to meet and talk with peers; an alternative worldview that provides opportunities for members to participate and contribute; and effective facilitators of community integration that provide opportunities to connect members to the community at large.<sup>[27]</sup> System-level activism was perceived to result in changes in perceptions by the public and mental health professionals (about mental health or mental illness, the lived experience of consumer/survivors, the legitimacy of their opinions, and the perceived value of CSIs) and in concrete changes in service delivery practice, service planning, public policy, or funding allocations. The authors noted that the evidence indicated that the work benefits other consumers/survivors (present and future), other service providers, the general public, and communities. They also noted that there were various barriers to this, most notably lack of funding, and also that the range of views represented by the CSIs appeared less narrow and more nuanced and complex than previously, and that perhaps the consumer/survivor social movement is at a different place than it was 25 years ago.<sup>[28]</sup>

There has also been criticism of the movement. Well-positioned forces in the USA, led by figures such as psychiatrists E. Fuller Torrey and Sally Satel, and some leaders of the National Alliance for the Mentally Ill, have lobbied against the funding of consumer/survivor groups that promote antipsychiatry views or promote social and experiential recovery rather than a biomedical model, or who protest against outpatient commitment.<sup>[29] [30]</sup> Torrey has said the term "psychiatric survivor" used by ex-patients to describe themselves is just political correctness and has blamed them, along with civil rights lawyers, for the deaths of half a million people due to suicides and deaths on the street. Such claims have been controverted by recent publications such as U.S.A. Today which published an article indicating that the medical model and the way persons with mental illness are treated today cause people to die 25 years early on average. More generally, organized psychiatry often views radical consumerist groups as extremist, as having little scientific foundation and no defined leadership, as trying to restrict "the work of psychiatrists and care for the seriously mentally ill", and as promoting disinformation on the use of involuntary commitment, electroconvulsive therapy, stimulants and antidepressants among children, and neuroleptics among adults.<sup>[11]</sup>



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## External links

- Guide on the History of the Consumer Movement ([http://www.mhselfhelp.org/tehasst/view.php?tehasst\\_id=16](http://www.mhselfhelp.org/tehasst/view.php?tehasst_id=16)) from the National Mental Health Consumers' Self-Help Clearinghouse
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- Transcript of interview with Peter Breggin, M.D. (<http://www.math.missouri.edu/~rich/psych/breggin.txt>), author of "Toxic Psychiatry," Talking Back To Prozac" and "Brain-Disabling Treatments in Psychiatry: Drugs, Electroshock and the Psychopharmaceutical Complex."
- Psychiatry chapter (<http://www.upalumni.org/medschool/psychiatry.html>) from *Heart Failure - Diary of a Third Year Medical Student* by Michael Greger, M.D.

# Mad Pride

**Mad Pride** is a mass movement of mental health services users and their allies. The first known event specifically organized as a Pride event by people who identify as psychiatric survivors/consumer/ex-patients was in Toronto, Canada when it was called "Psychiatric Survivor Pride Day", held on September 18, 1993. It was first held in response to local community prejudices towards people with a psychiatric history living in boarding homes in the Parkdale area of the city, and has been held every year since then in this city except 1996.<sup>[1]</sup> By the late 1990s similar events were being organized as Mad Pride in London, England and around the globe from Australia to South Africa and the United States, drawing thousands of participants, according to MindFreedom International, a United States mental health advocacy organization that promotes and tracks events spawned by the movement.<sup>[2]</sup>

Mad Pride activists seek to reclaim terms such as 'mad', 'nutter' and 'psycho' from misuse, such as in tabloid newspapers. Through a series of mass media campaigns, Mad Pride activists seek to re-educate the general public on such subjects as the causes of mental disorders, the experiences of those using the mental health system, and the global suicide pandemic. One of Mad Pride's founding activists was Pete Shaughnessy, who later committed suicide.<sup>[3]</sup> Robert Dellar and 'Freaky Phil' Murphy were among the other founders of the movement. *Mad Pride: A celebration of mad culture* records the early Mad Pride movement.<sup>[4]</sup>



A flyer for a 2003 Mad Pride event.

## History

Mad Pride was launched alongside a book of the same name, *Mad Pride: A celebration of mad culture*, published in 2000.<sup>[4]</sup> On May 11, 2008, Gabrielle Glaser documented Mad Pride in The New York Times.<sup>[5]</sup> Glaser stated, "Just as gay-rights activists reclaimed the word queer as a badge of honor rather than a slur, these advocates proudly call themselves mad; they say their conditions do not preclude them from productive lives." The Mad Pride (see gay pride for more on gay rights) movement was further mentioned in The Huffington Post.<sup>[6]</sup>

## Mad culture and events

The Mad Pride movement has spawned recurring cultural events in Toronto, London, and other cities around the world. These events often include music, poetry readings, film screenings, and street theatre, such as 'bed push' protests, which aim to raise awareness about the poor levels of choice of treatments and the widespread use of force in psychiatric hospitals.<sup>[7]</sup> Commentaries on the Mad Pride movement have been made by such literary luminaries as the English Republican Jonathan Freedland<sup>[8]</sup> and popular novelist Clare Allan.<sup>[9]</sup> Mad Pride cultural events take a variety of forms, such as the South London collective Creative Routes, the Chipmunka Publishing enterprise, and the many works of Dolly Sen.<sup>[10]</sup>



Mad Pride parade in Salvador, Brazil, in 2009.

## Bed push

Mad Pride Week in Toronto is proclaimed as such by the city itself. Highlighted by the MAD! Pride Bed Push, the festival is now in its fourteenth year. A series of bed push events take place around London each year.<sup>[11]</sup>

The ABC-TV show *Primetime Outsiders* ran a segment about Mad Pride on August 25, 2009 that included interviews with actor Joey Pantoliano; musician Madigan Shive; and David W. Oaks, Director, MindFreedom International.<sup>[12]</sup>

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## External links

- Mad Pride Network (<http://madpridenetwork.com>)

# Ted Chabasinski

<b>Ted Chabasinski</b> <b>Juris Doctoris</b>	
<b>Born</b>	Theodore Chabasinski March 20, 1937 New York, U.S.A.
<b>Residence</b>	Berkeley, California
<b>Citizenship</b>	American
<b>Occupation</b>	Former Directing Attorney for Mental Health Consumer Concerns
<b>Years active</b>	1971-
<b>Known for</b>	Psychiatric survivor activist Leading successful campaign to ban the use of ECT in Berkeley, California (1982)
<b>Board member of</b>	(Former President) Support Coalition International (renamed as MindFreedom International)
<b>Spouse</b>	Judi Chamberlin (1972-1985)
<b>Notes</b>	Chabasinski and Chamberlin separated in 1974, two years after their marriage, and remained close friends. They divorced in 1985 when Chabasinski wanted to remarry.

**Ted Chabasinski** (born March 20, 1937) is an American psychiatric survivor, human rights activist and attorney who lives in Berkeley, California. At the age of six he was taken from his foster family's home and committed to a New York psychiatric facility. Diagnosed with childhood schizophrenia he underwent intensive electroshock therapy (now termed electroconvulsive therapy or ECT) and remained an inmate in a state psychiatric hospital until the age of seventeen. He subsequently trained as a lawyer and became active in the psychiatric survivors movement. In 1982 he led a successful campaign seeking to ban the use of electroshock in Berkeley, California.

## Early life

Chabinski was born in New York to a Polish-born immigrant woman. His father was of Russian descent. In the period just before and after Chabasinski's birth his birth-mother, who was poor, unmarried and had been given a diagnosis of schizophrenia, was committed to a psychiatric facility.<sup>[1]</sup> He was subsequently placed in the care of a foster family in the Bronx, New York.<sup>[2]</sup> While an intelligent child his social worker from the Foundling Hospital, a Miss Callaghan,<sup>[1]</sup> thought him withdrawn and suspected that he was exhibiting the initial signs of an incipient schizophrenia.<sup>[2]</sup> Chabasinski himself attributes this diagnosis to the then widespread opinion that mental illness was hereditary<sup>[2]</sup> and thus, he contends, the social worker supervising his foster home placement was "looking for symptoms".<sup>[3]</sup>

In 1944, at six years of age, Chabasinski, then a shy and withdrawn child, was taken from his foster family and committed to the children's ward of the psychiatric division of the Bellevue Hospital in Manhattan, New York.<sup>[3]</sup> While in this ward, known as Unit PQ6,<sup>[4]</sup> he was brought under the care of the celebrated child psychiatrist Laretta Bender, now deceased, who is the clinician commonly credited with founding the study of childhood schizophrenia in the United States.<sup>[5]</sup> She formally diagnosed Chabasinski as suffering from schizophrenia. He was one of the first children ever to receive ECT, which was then given in its unmodified form without either anaesthetic or muscle relaxant. Despite the strenuous protests of his foster parents against the treatment,<sup>[6]</sup> he underwent ECT under a regressive and experimental protocol where the treatment was given at a more intensive frequency than was the norm for shock therapy.<sup>[7]</sup> Chabasinski received ECT daily for a period of about three weeks, comprising approximately twenty sessions of the procedure.<sup>[2] [5] [8] [9]</sup>

Recalling the experience, Chabasinski stated:

"I was one of 300 children involved in an experimental program ... I remember being dragged down a hallway, thrown on a table and having a handkerchief stuffed in my mouth."<sup>[10]</sup>

"It made me want to die ... I remember that they would stick a rag in my mouth so I wouldn't bite through my tongue and that it took three attendants to hold me down. I knew that in the mornings that I didn't get any breakfast that I was going to get shock treatment."<sup>[2]</sup>

I wanted to die but I didn't really know what death was. I knew that it was something terrible. Maybe I'll be so tired after the next shock treatment I won't get up, I won't ever get up, and I'll be dead. But I always got up. Something in me beyond my wishes made me put myself together again. I memorized my name, I taught myself to say my name. Teddy, Teddy, I'm Teddy ... I'm here, I'm here, in this room, in this hospital. And my mommy's gone ... I would cry and realize how dizzy I was. The world was spinning around me and coming back to it hurt too much. I want to go down, I want to go where the shock treatment is sending me. I want to stop fighting and die...and something made me live, and go on living. I had to remember never to let anyone near me again.<sup>[7]</sup>

In 1947 Bender published on 98 children aged between four and eleven years old who had been treated in the previous five years with intensive courses of ECT. These children received ECT daily for a typical course of approximately twenty treatments.<sup>[11]</sup> This formed part of an experimental trend amongst a cadre of psychiatrists to explore the therapeutic impact of intensive regimes of ECT, which is also known as either regressive ECT or annihilation therapy.<sup>[5]</sup> In the 1950s Bender abandoned ECT as a therapeutic practice for the treatment of children. In the same decade the results of her published work on the use of ECT in children was discredited after a study showing that the condition of the children so treated had either not improved or deteriorated.<sup>[2]</sup>

Commenting on his experience as part of Bender's therapeutic program Chabasinski said that, "It really made a mess of me ... I went from being a shy kid who read a lot to a terrified kid who cried all the time."<sup>[12]</sup> Following his treatment, he spent ten years as an inmate of Rockland State Hospital, a psychiatric facility now known as the Rockland Psychiatric Center.<sup>[8]</sup>

Chabasinski was discharged from the Rockland State Hospital at the age of seventeen. He eventually went to college where he qualified as a lawyer.<sup>[6]</sup>

## Activism

Chabasinski has been active in the psychiatric survivors movement since 1971.

### The Berkeley ban

Chabasinski was Chairman of the Coalition to Stop Electroshock which in 1982 qualified an initiative measure, titled Initiative T,<sup>[12]</sup> for municipal ballot to make the application of electroconvulsive therapy a misdemeanour in Berkeley, California, punishable with a \$500 dollar fine or up to six months imprisonment.<sup>[8] [13]</sup> Chabasinski was the author of the ballot question<sup>[9] [13]</sup> and, along with fellow psychiatric survivor Leonard Roy Frank, he was a leader in the campaign.<sup>[14]</sup> The campaign group, supported by human rights organisations such as the Berkeley based ex-patient group Network Against Psychiatric Assault,<sup>[9] [10]</sup> consisted of some 250 people approximately half of whom were former psychiatric patients with the majority of the remainder consisting of students from Berkeley and individual doctors who were opposed to ECT.<sup>[8]</sup> The coalition's entire campaign fund was in the region of \$1,000.<sup>[8]</sup> The American Psychiatric Association provided funds of \$15,000 to campaign against the initiative.<sup>[8]</sup> 2,500 people petitioned in support of the initiative exceeding the 1,400 signatures required to put the motion on the ballot.<sup>[13]</sup>

At the time Chabasinski argued that the enforcement of the law governing consent to ECT in psychiatric facilities in the state of California was so lax that a total ban on the procedure was required.<sup>[15]</sup> He and his fellow campaigners also claimed that ECT was a dangerous and barbaric treatment that could cause either long or short term memory

loss, brain damage and that the procedure could even result in death. They also charged that when resident in a psychiatric institution the very concept of informed consent is meaningless.<sup>[16]</sup>

During the campaign dozens of ex-psychiatric patients gave testimony against electroshock at a Berkeley City Council hearing.<sup>[9]</sup> Protests were also held outside the Herrick Hospital, then the only facility in Berkeley where ECT was provided.<sup>[12]</sup> In 1981 that facility administered ECT to 45 individuals.<sup>[10]</sup> In order to collect and exceed the requisite number of signatures required to place Initiative T. on the ballot paper, members of the coalition campaigned outside supermarkets and went from door to door soliciting support.<sup>[12]</sup>

The ballot was held on Tuesday 2 November 1982<sup>[9]</sup> and the measure passed with 25,380 voters, or 61.7 percent, supporting the ballot calling for a ban on ECT while 15,756 residents, or 38.2 percent, voted against the measure.<sup>[13]</sup> Giving his perspective on why the measure had passed so resoundingly, Chabasinski stated that: "I think it's a very sympathetic issue ... Basically, they're going ahead and causing brain damage just to subdue people."<sup>[9]</sup> Speculating on the possibility of extending the ban across the state of California<sup>[17]</sup> and alluding to the wider aims behind the campaign he also said: "To be honest, this is one way of having a referendum on mental patients' rights and the way they are treated".<sup>[9]</sup>

In response to the passage of the initiative the American Psychiatric Association asserted that plebiscite was not an appropriate means to arrive at a medical judgement on a complex issue. A spokesman for the association stated: "The voters have passed a law we believe is unnecessary, probably unconstitutional and ... dangerous ... We hope it will be overturned before doing harm by denying a seriously ill person access in Berkeley to treatment that could be lifesaving,"<sup>[17]</sup> One of the two doctors who administered ECT at Herrick Hospital, Dr. Martin Rubinstein, contended that the vote to ban the procedure reflected "pathological consumerism" and constituted "another case of the inmates trying to run the asylum". He further epitomised the ballot result as stemming from "an uninformed electorate [deliberating] on esoteric matters."<sup>[17]</sup>

In June 1983 Donald McCullom, an Alameda County Superior Court Judge, issued an injunction on the implementation of the ban on ECT.<sup>[18]</sup> Initiative T. was overturned shortly thereafter following a successful legal challenge initiated by the American Psychiatric Association, on the constitutionality of the measure.<sup>[2]</sup>

## **Other roles**

Chabasinski is the former directing attorney for Mental Health Consumer Concerns, (MHCC), and a former president of the board of Support Coalition International (SCI) board president. He was also a board of the successor organisation to the SCI, MindFreedom International, for whom he also served as an attorney.<sup>[19]</sup>

## **Eli Lilly and Zyprexa**

In January 2007 Chabasinski acted as the attorney for the late psychiatric survivor activist and author Judi Chamberlin, the medical journalist and author of *Mad in America* and *Anatomy of an Epidemic* Robert Whitaker, and the director of MindFreedom International David Oaks in opposing a motion by Eli Lilly to extend an injunction to conceal documents that revealed that the company had known for the previous decade of the potentially lethal effects of Zyprexa and had engaged in an illegal off-label marketing campaign.<sup>[20]</sup>

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# Lyn Duff

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**Lyn Duff** is an American journalist with the Pacific News Service and KPFA radio's "Flashpoints", an evening drive-time public affairs show heard daily on Pacifica Radio.

## Early years

Born in California in 1976, Duff began her journalistic career as the founder of an underground school newspaper, *The Tiger Club*, while an 8th grader at South Pasadena Junior High School in 1989. After five published issues, she was suspended from school by the principal for refusing to stop disseminating the newspaper.<sup>[1]</sup>

After seeking help from the American Civil Liberties Union (ACLU), the South Pasadena Unified School District agreed to allow her to return to school. She completed her 8th grade year and was then accepted as an early entrance student to California State University, Los Angeles (CSULA), which she attended for a year and a half.

While at CSULA Duff was on staff of an alternative newspaper published by Los Angeles art-critic Mat Gleason who, at the time, was a graduate student in the school of journalism and president of an alternative Greek organization, Omega Omega Omega, and later went on to publish *Coagula Art Journal*.

## Involuntary conversion therapy

In 1991 Duff, then fourteen, came out publicly as lesbian.<sup>[2] [3] [4]</sup> Reportedly concerned about her daughter's sexual orientation, Duff's mother had her transported against her will to Rivendell Psychiatric Center in West Jordan, Utah. During the drive from California to Utah, Duff covertly called journalist Bruce Mirken, a friend who then wrote for both the *Los Angeles Weekly* and *The Advocate*.<sup>[5]</sup> The two had had plans to meet for dinner prior to her forced detention and upon hearing of her situation, Mirken phoned Public Council, a public interest legal aid society which secured pro bono services of corporate attorney Gina M. Calabrese of the Los Angeles firm Adams, Duque & Hazeltine. Duff was admitted to Rivendell Psychiatric Center on December 19, 1991, at age fifteen.<sup>[6]</sup>

Although Rivendell was not officially affiliated with The Church of Jesus Christ of Latter-day Saints, Duff later said that she was visited by Mormon missionaries during her six months at the Utah facility and that the treatment she received was heavily influenced by religion. Duff says that Rivendell therapists told her that a gay and lesbian orientation was caused by negative experiences with people of the opposite gender and that having a lesbian sexual identity would lead to sexually abusing other people or engaging in bestiality. Duff was diagnosed with Gender Identity Disorder (GID) and clinical depression.<sup>[2] [7] [8]</sup>

Duff was subjected to a regimen of conversion therapy. This involved aversion therapy, which consisted of being forced to watch same-sex pornography while smelling ammonia.<sup>[9]</sup> She was also subjected to hypnosis, psychotropic drugs, solitary confinement, and therapeutic messages linking lesbian sex with "the pits of hell."<sup>[10]</sup> Behavior modification techniques were also used including: requiring girls to wear dresses, unreasonable forms of punishment for small infractions similar to hazing like having to cut the lawn with small scissors and scrubbing floors with a toothbrush and "positive peer pressure" group sessions in which patients demeaned and belittled each other for both real and perceived inadequacies.<sup>[6] [11] [12] [13] [14]</sup>

On May 19, 1992, after 168 days of incarceration, Duff escaped from Rivendell and traveled to San Francisco, where she lived on the streets and in safe houses.<sup>[15]</sup>

## Emancipation and adoption

In late 1992, with the help of Legal Services for Children and the National Center for Lesbian Rights, and with legal assistance provided by the National Center for Youth Law, Duff petitioned the courts to have her mother's parental rights terminated. She was one of a handful of children who divorced their parents that year,<sup>[16]</sup> an issue that gained national attention when reporters revealed that first lady Hillary Rodham Clinton had completed her master's thesis on the legal right of children to divorce their parents.<sup>[17]</sup> In October 1992, a lesbian couple in San Francisco adopted Duff. She lived with them until the age of eighteen, when she began living independently and returned to college.<sup>[12]</sup>  
[18] [19]

## Youth rights activism

From 1992 through 1998, Duff was an outspoken critic of the mental health system, appearing on CNN, ABC's *20/20*, and numerous print, radio and television media outlets.<sup>[20]</sup> She also spoke at a number of human rights, civil rights, mental health and youth services conferences about her experiences and the rights of young people to live free of discrimination and oppression on the basis of their sexual orientation.<sup>[21]</sup> [22] During these years she also served on the board of several national organizations including the National Center for Youth Law (board member from 1994–2001) and the National Child Rights Alliance (board member from 1992–1993, board chairperson from 1994–1999). In 1996, Duff was honored as a keynote speaker and given a human rights award at the international conference of the Metropolitan Community Church.

During these same years, Duff was emerging as a journalist in her own right, writing for *Youth Outlook*, a column in the *San Francisco Examiner*, and the *Pacific News Service*. She joined the staff of *Flashpoints*, a daily hour-long drive-time show broadcast on Pacifica Radio's KPFA in 1994. Her writings have appeared in the *San Francisco Chronicle*, the *San Francisco Examiner*, *Salon* online, the *Utne Reader*, *Sassy Magazine*, the *Washington Post*, *Seventeen*, the *Miami Herald* and the *National Catholic Reporter*.<sup>[23]</sup> [24] [25] [26] [27]

In 1995, Duff traveled to Haiti where she established Radyo Timoun ("Children's Radio"), that country's first radio station run entirely by children under the age of seventeen.<sup>[28]</sup> She reportedly worked closely with Haitian President Jean Bertrand Aristide.<sup>[29]</sup> [30]

In 1998, Duff graduated with a BA in International Affairs and Labor Law from Skidmore College in Saratoga Springs, New York.

## International journalism

By the late 1990s, Duff was a well-established international journalist with postings in Haiti, Israel, Croatia, several African countries, and Vietnam. After the United States invaded Afghanistan, she traveled to the front lines as one of the few non-embedded Western journalists.<sup>[31]</sup>

In early 2000 she began to cover religious affairs from her posting in Jerusalem, writing widely on the problems and conflicts between Christians, Jews and Muslims. In 2002, Duff earned an MA in Theology.<sup>[32]</sup>

In February 2004, Duff, who was then living six months out of every year in Jerusalem, was home in the United States on a brief visit when a group of ex-soldiers overthrew the democratically elected government of Haiti. She quickly traveled to Haiti, arriving in Port-au-Prince when the coup was only days old and reporting on the situation extensively for several national media outlets.<sup>[33]</sup>

From 2004-2006, Duff regularly covered the situation in Haiti for the *San Francisco Bay View*, Pacifica Radio's *Flashpoints*, and Pacific News Service. Her reporting is a blend of in-depth investigative reports and "as told to" first person commentaries by Haitian nationals. Subjects have included politically motivated mass rape,<sup>[34]</sup> the United Nations mission in Haiti, killings by American Marines in Port-au-Prince,<sup>[35]</sup> civilians taking over the neighborhood of Bel Air<sup>[36]</sup> and murders of street children by police and ex-soldiers.<sup>[37]</sup>

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# Clifford Whittingham Beers

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**Clifford Whittingham Beers** (1876 – 1943) was the founder of the American mental hygiene movement.

Beers was born in New Haven, Connecticut to Ida and Robert Beers on March 30, 1876. He was one of five children, all of whom would suffer from psychological distress and would die in mental institutions, including Beers himself (see "Clifford W. Beers, Advocate for the Insane"). He graduated from the Sheffield Scientific School at Yale in 1897.

In 1900 he was first confined to a private mental institution for depression and paranoia. He would later be confined to another private hospital as well as a state institution. During these periods he experienced and witnessed serious maltreatment at the hands of the staff. After the publication of *A Mind That Found Itself* <sup>[1]</sup> (1908), an autobiographical account of his hospitalization and the abuses he suffered during, he gained the support of the medical profession and others in the work to reform the treatment of the mentally ill.

In 1909 Beers founded the "National Committee for Mental Hygiene", now named Mental Health America, in order to continue the reform for the treatment of the mentally ill. He also started the Clifford Beers Clinic in New Haven in 1913, the first outpatient mental health clinic in the United States. He was a leader in the field until his retirement in 1939.

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## External links

- Works by Clifford Whittingham Beers <sup>[2]</sup> at Project Gutenberg
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# Social hygiene movement

The **social** or **mental hygiene movement** of the late 19th and early 20th centuries was an attempt by Progressive-era reformers to control venereal disease, regulate prostitution and vice, and disseminate sexual education through the use of scientific research methods and modern media techniques.

The social hygiene movement represented a rationalized, professionalized version of the earlier social purity movement.<sup>[1]</sup> Many reformers, such as Dr Marie Stopes, were also proponents of eugenics. Inspired by Charles Darwin's theory of natural selection, they argued for the sterilisation of certain groups, even racial groups, in society. This link between racial hygiene and social hygiene can be seen in Australia, where the Racial Hygiene Association of New South Wales is now named The Family Planning Association.<sup>[2]</sup>

Social hygiene as a profession grew alongside social work and other public health movements of the era. Social hygienists emphasized sexual continence and strict self-discipline as a solution to societal ills, tracing prostitution, drug use and illegitimacy to rapid urbanization.

The American Social Hygiene Association was formed in 1913 and later renamed to the American Social Health Association.

The movement remained alive throughout the 20th century and found its way into American schools, where it was transmitted in the form of classroom films about menstruation, sexually transmitted disease, drug abuse and acceptable sexual behavior in addition to an array of pamphlets, posters, textbooks and films.



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- American Social Hygiene Posters (<http://special.lib.umn.edu/swha/IMAGES/home.html>) - Online repository of social hygiene posters from the University of Minnesota
- The Prelinger Archives at the Internet Archive (<http://www.archive.org/details/prelinger>)
- AV Geeks at the Internet Archive (<http://www.archive.org/details/avgeeks>)

# Elizabeth Packard

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**Elizabeth Parsons Ware Packard** (28 December 1816 – 25 July 1897) was an advocate for the rights of women and people accused of insanity.

## Life

At the insistence of her parents, Elizabeth Parsons Ware married the Reverend Theophilus Packard on 21 May 1839. The couple had six children. The family resided in Kankakee County, Illinois and, for many years, appeared to have a peaceful marriage.

But Theophilus Packard held quite decisive religious beliefs. After many years of marriage, Elizabeth Packard outwardly questioned her husband's beliefs and began expressing opinions that were contrary to his. While the main subject of their dispute was religion, the couple also disagreed on child rearing, family finances, and the issue of slavery.

When Illinois opened its first hospital for the mentally ill in 1851, the State Legislature passed a law that required a public hearing before a person could be committed against their will. There was one exception, however; a husband could have his wife committed without either a public hearing or her consent. In 1860, Theophilus Packard judged that his wife was "slightly insane" and arranged for a doctor, J.W. Brown, to speak with her. The doctor pretended to be a sewing machine salesman. During their conversation, Elizabeth complained of her husband's domination and his accusations to others that she was insane. Dr Brown reported this conversation to Theophilus (along with the observation that Mrs Packard "exhibited a great dislike to me"). Theophilus decided to have Elizabeth committed. She learned of this decision on June 18, 1860, when the county sheriff arrived at the Packard home to take her into custody.

Elizabeth Packard spent the next three years at the Jacksonville Developmental Center/ Illinois State Hospital at Jacksonville, IL. She was regularly questioned by the doctors but refused to agree that she was insane or to change her religious views.<sup>[1]</sup> Finally, after public pressure, Mrs. Packard was brought out for a jury trial before Judge Starr of Kankakee City; the jury declared her falsely imprisoned, and she was released<sup>[2]</sup>. In 1863, in part due to pressure from her children who wished her released, the doctors declared that she was incurable and discharged her.



Elizabeth Parsons Ware Packard

When Mrs. Packard returned to the home she shared with her husband in Manteno, Illinois, she found that the night before her release, her husband had rented their home to another family, sold her furniture, and had taken her money, notes, wardrobe, and children and left the state.<sup>[3]</sup> She appealed to both the Supreme Court of Chicago and Boston, where her husband had taken her children<sup>[4]</sup>, but had no legal recourse, as married women in these states at the time had no legal rights to their property or children.

## Packard v. Packard

At the subsequent trial of *Packard v. Packard*,<sup>[5]</sup> Theophilus' lawyers produced witnesses from his family who testified that Elizabeth had argued with her husband and tried to withdraw from his congregation. These witnesses concurred with the Reverend that this was a sign of insanity. The record from the Illinois State Hospital stating that Mrs Packard's condition was incurable was also entered into the court record.

Elizabeth's lawyers, Stephen Moore and John W. Orr, responded by calling witnesses from the neighbourhood that knew the Packards but were not members of the Reverend's church. These witnesses testified they never saw Elizabeth exhibit any signs of insanity, while discussing religion or otherwise. The final witness was Dr. Duncanson, who was both a physician and a theologian. Dr. Duncanson had interviewed Elizabeth Packard and he testified that while not necessarily in agreement with all her religious beliefs..."I do not call people insane because they differ with me. I pronounce her a sane woman and wish we had a nation of such women."

The jury took only seven minutes to find in Elizabeth Packard's favor. She was legally declared sane, and Judge Charles Starr issued an order that she should not be confined.

## Life after the trial

Elizabeth did not return to her home. While the Packards never formally divorced, they remained separated for the rest of their lives. Elizabeth did stay close to her children and retained their support.

Elizabeth realized how narrow her legal victory had been. While she had escaped confinement, it was largely a measure of luck. The underlying social principles which had led to her confinement still existed. She founded the Anti-Insane Asylum Society and published several books, including *Marital Power Exemplified, or Three Years Imprisonment for Religious Belief* (1864), *Great Disclosure of Spiritual Wickedness in High Places* (1865), *The Mystic Key or the Asylum Secret Unlocked* (1866), and *The Prisoners' Hidden Life, Or Insane Asylums Unveiled* (1868).<sup>[6]</sup> In 1867, the State of Illinois passed a "Bill for the Protection of Personal Liberty" which guaranteed all people accused of insanity, including wives, had the right to a public hearing. She also saw similar laws passed in three other states.

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## Literary uses

Barbara Hambly refers to Mrs. Packard in some detail in her novel on the insanity of Mary Todd Lincoln. Emily Mann wrote a play on *Mrs Packard*, which premiered in May 2007.

Emily Mann's play, *Mrs. Packard* describes her life fully in the insane asylum and is very historically accurate.

## Further reading

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- Packard, Elizabeth, *Marital Power Exemplified in Mrs. Packard's Trial* Fred B Rothman & Co (October 1994) ISBN 978-0837725529
- Sapinsley, Barbara (1991), *The Private War of Mrs. Packard* (<http://books.google.com/?id=nQXbAAAAMAAJ&q>), Saint Paul, Minnesota: Paragon House Books, pp. 220, ISBN 978-1557783301



# Judi Chamberlin

## Judi Chamberlin



Judi Chamberlin upon the publication of the National Council on Disability's federal report *From Privileges to Rights*

<b>Born</b>	Judi RossOctober 30, 1944Brooklyn, New York, U.S.A.
<b>Died</b>	January 16, 2011 (aged 66)Arlington, Massachusetts, U.S.A.
<b>Nationality</b>	American
<b>Education</b>	Midwood High School, Brooklyn College, Bedford Avenue, Brooklyn, N.Y.C.
<b>Occupation</b>	Director of Education National Empowerment Center Co-chair WNUSP
<b>Years active</b>	1971-2011
<b>Known for</b>	Internationally known psychiatric survivor movement activist and author
<b>Notable works</b>	<i>On Our Own: Patient Controlled Alternatives to the Mental Health System</i> (1978) <i>From Privileges to Rights</i> (2000)
<b>Board member of</b>	MindFreedom International
<b>Spouse</b>	Howard Cahn (divorced) Robert Chamberlin (divorced) Ted Chabasinski(1972–1985)
<b>Partner</b>	Marty Federman (2006–2011)
<b>Children</b>	1
<b>Awards</b>	Distinguished Service Award of the President of the United States
<b>Website</b>	
<a href="#">/judi-tribute-book.html</a> <sup>[1]</sup>	
<b>Notes</b>	Ted Chabasinski and Judi Chamberlin divorced in 1985 so that he could marry his second wife. However, they separated as couple c. 1974. They remained close friends.

**Judi Chamberlin** (née Ross, October 30, 1944 – January 16, 2010) was an American activist, leader, organizer, public speaker and educator in the psychiatric survivors movement. Her political activism followed her involuntary confinement in a psychiatric facility in the 1960s.<sup>[2]</sup> <sup>[3]</sup> She was the author of *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, which is a foundational text in the *Mad Pride* movement.<sup>[4]</sup>

## Early life

Judi Chamberlin was born **Judi Ross** in Brooklyn in 1944. She was the only daughter of Harold and Shirley Jaffe Ross. Her father worked as an executive in the advertising industry while her mother was employed as a school administrator.<sup>[2]</sup>

## Psychiatric experience

“There are real indignities and real problems when all facets of life are controlled — when to get up, to eat, to shower — and chemicals are put inside our bodies against our will”

—Judi Chamberlin, New York Times, 1981

In 1966, at the age of twenty-one and recently married, Chamberlin suffered a miscarriage and, according to her own account, became severely depressed.<sup>[3] [5] [4]</sup> Following psychiatric advice, she voluntarily signed herself into a psychiatric facility as an in-patient. However, after several voluntary admissions she was diagnosed with schizophrenia<sup>[6]</sup> and involuntarily committed to a psychiatric ward in a New York state hospital for a period of five months.<sup>[2] [7]</sup>

As an involuntary patient she witnessed and experienced a range of abuses. Seclusion rooms and refractory wards were used for resistive patients, even when their forms of resistance were non-violent. The psychiatric medication she was given made her feel tired and affected her memory. As an involuntary patient she was unable to leave the facility and became, she said, "a prisoner of the system".<sup>[2]</sup> The derogation of her civil liberties that she experienced as an inmate provided the impetus for her activism as a member of the psychiatric survivor movement.<sup>[6] [5]</sup>

## Activism

“Remember back in MPLF? You put up a sign on the office wall that said, 'End Psychiatric Oppression by Tuesday.' That's what I want. End psychiatric oppression by Tuesday.”

—Judi Chamberlin in conversation with David W. Oaks, October 2010

Following her discharge, Chamberlin became involved in the nascent psychiatric patients' rights movement.<sup>[2]</sup> In 1971 she joined the Boston based Mental Patients Liberation Front (MPLF),<sup>[6]</sup> and she also became associated with the Center for Psychiatric Rehabilitation at Boston University.<sup>[5]</sup> Her affiliation with this center facilitated her role in co-founding the Ruby Rogers Advocacy and Drop-in-Centers,<sup>[5]</sup> which are self-help institutions staffed by former psychiatric patients.<sup>[6]</sup> and was also a founder and later a Director of Education of the National Empowerment Center.<sup>[3]</sup> The latter is also an ex-patient run organization that provides information, technical assistance, and support to users and survivors of the psychiatric system.<sup>[6]</sup> Its mission statement declares its intent is to "carry a message of recovery, empowerment, hope and healing to people who have been labeled with mental illness".<sup>[8]</sup>

She was also involved with the National Association for Rights Protection and Advocacy and she was an influential leader in the Mad Pride movement. Having first met the current chief executive of MindFreedom International, David Oaks, in 1976 when they were both members of the Mental Patients Liberation Front, she later became a board member of MindFreedom International,<sup>[9] [10]</sup> which describes itself as an umbrella organization for approximately one hundred grass roots groups campaigning for the human rights of people deemed to be mentally ill.<sup>[11]</sup>

In 1978 her book *On Our Own: Patient Controlled Alternatives to the Mental Health System* was published.<sup>[2]</sup>

She was a major informant for and assisted in the drafting of the National Council on Disability's federal report *From Privileges to Rights*, which was published in 2000.<sup>[12] [13]</sup> The report argued that psychiatric patients should enjoy the same basic human rights as other citizens and that patient privileges contingent on good behavior within the

psychiatric system, such as the ability to wear their own clothes, leave the confines of psychiatric facility, or receive visitors, should instead be regarded as basic rights.<sup>[2]</sup>

Chamberlin was elected as co-chair of the World Network of Users and Survivors of Psychiatry (WNUSP) at the launching conference and General Assembly in Vancouver, Canada in 2001, and served in this capacity until the next General Assembly in 2004. During this period she also served on the Panel of Experts advising the United Nations special rapporteur on disability, on behalf of WNUSP in its role as a Non-governmental organization, representing psychiatric survivors.

## Personal life

Her marriages to Howard Cahn and then Robert Chamberlin both ended in divorce. Her third marriage in 1972 was to Ted Chabasinski, also a psychiatric survivor movement activist, whom she met at the Mental Patients Liberation Project in 1971. They married in 1972 and separated two years later. They remained close friends following this and only divorced in 1985 when Chabasinski wanted to marry his second wife. Since 2006 her partner was Marty Federman. She had one daughter, Julie Chamberlin, and three grandchildren.<sup>[2]</sup>

## Death

Chamberlin died of pulmonary disease at her home in Arlington, Massachusetts on January 16, 2010.<sup>[14]</sup>

## Published works

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- Chamberlin, Judi (1998). 'Confessions of a noncompliant patient'<sup>[21]</sup>. *Journal of Psychosocial Nursing and Mental Health Services*. 36(4): 49-52.
- Chamberlin, Judi (1998). 'Citizens rights and psychiatric disability'<sup>[22]</sup>. *Psychiatric Rehabilitation Journal*. 21: 405-08.

## Awards

- 1992: Distinguished Service Award of the President of the United States, National Council on Disability
- 1992: David J. Vail National Advocacy Award, Mental Health Association of Minnesota
- 1995: N. Neal Pike Prize for Services to People with Disabilities, Boston University School of Law

## See Also

- MindFreedom International
- Psychiatric survivors movement
- World Network of Users and Survivors of Psychiatry
- National Council on Disability
- National Empowerment Center
- Anti-psychiatry
- Psychiatric consumer/survivor/ex-patient movement
- Involuntary commitment
- Biopsychiatry controversy
- Involuntary treatment

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- [21] <http://www.bu.edu/cpr/resources/articles/1998/chamberlin1998b.pdf>
- [22] <http://www.bu.edu/cpr/resources/articles/1998/chamberlin1998a.pdf>

**External links**

- National Empowerment Center (<http://Power2U.org/>)
  - Judi Chamberlin's virtual memorial (<http://judi-chamberlin.virtual-memorials.com>)
  - MindFreedom International: Tribute to Judi Chamberlin (David Oakes) (<http://www.mindfreedom.org/about-us/mfi-board/judi-chamberlin>)
  - Judi's Tribute Book (<http://www.power2u.org/judi-tribute-book.html>)
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# Kate Millett

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<b>Kate Millett</b>	
	
Millett in 1970	
<b>Born</b>	September 14, 1934St. Paul, Minnesota
<b>Nationality</b>	United States

**Kate Millett** (born **Katherine Murray Millett**; September 14, 1934) is an American feminist writer and activist. She is best known for her 1970 book *Sexual Politics*.

## Career

Kate Millett received her B.A. at the University of Minnesota in 1956, where she was a member of the Kappa Alpha Theta sorority. She later obtained a first-class degree, with honors, from St Hilda's College, Oxford in 1958.

Millett moved to Japan in 1961. Two years later, Millett returned to the United States with fellow sculptor Fumio Yoshimura whom she married in 1965. The two divorced in 1985. She was active in feminist politics in late 1960s and the 1970s. In 1966, she became a committee member of National Organization for Women.

*Sexual Politics* originated as her Ph.D. dissertation, which was awarded by Columbia University in 1970. Here Millett offers a comprehensive critique of patriarchy in Western society and literature. In particular, Millett critiques the sexism and heterosexism of the modern novelists D. H. Lawrence, Henry Miller, and Norman Mailer, contrasting their perspectives with the dissenting viewpoint of the homosexual author Jean Genet.

In 1971, Millett started buying and restoring fields and buildings near Poughkeepsie, New York. The project eventually became the Women's Art Colony/Tree Farm, a community of female artists and writers that is supported by the sale of Millett's silk-screen prints and by selling Christmas trees that have been hand-sheared by the artists in residence.

Millett's 1971 film *Three Lives* is a 16mm documentary made by an all-woman crew, including co-director Susan Kleckner, cameraperson Lenore Bode, and editor Robin Mide, under the name Women's Liberation Cinema. The 70-minute film focuses on reminiscences of three women recounting the stories of their lives. The subjects are Mallory Millett-Jones (the director's sister), Lillian Shreve, a chemist, and Robin Mide, an artist.

Her book *Flying* (1974) tells of her marriage with Yoshimura and her love affairs with women. *Sita* (1977) is a meditation on Millett's doomed love affair with a female college administrator who was ten years her senior. In 1979, Millett went to Iran to work for women's rights, was soon deported, and wrote about the experience in *Going to Iran*. In *The Loony-Bin Trip* (1990), she describes her experience of being incarcerated in psychiatric facilities, her experience of being diagnosed as "bipolar", and her decision to discontinue lithium therapy. She won her own sanity trial in St. Paul. On a dare with her lawyer, together they changed the State of Minnesota's commitment law.

Millett was a contributor to On The Issues Magazine and was interviewed at length for an article <sup>[1]</sup> in the magazine by Merle Hoffman.

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Millett is active in the anti-psychiatry movement. As a representative of MindFreedom International, she spoke out against psychiatric torture at the United Nations during the negotiations of the text of the Convention on the Rights of Persons with Disabilities (2005).

In the late 1990s and early 2000s, Millett was involved in a dispute with the New York City authorities who wanted to evict her from her home at 295 Bowery as part of a massive redevelopment plan. Millett and others held out, but ultimately lost their battle. Their building was demolished, and the residents were re-located.<sup>[2]</sup>

## Controversy

*The Basement: Meditations on a Human Sacrifice*, Millett's semi-fictional book about the murder of Silvia Likens, drew controversy for her defense of the abuse committed against and murder of Likens. Millett explained the murder in feminist terms.<sup>[3]</sup>

[The murder of Sylvia Likens] is the story of the suppression of women. Gertrude seems to have wanted to administer some terrible truthful justice to this girl: that this was what it was to be a woman.

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- *Sita* (1977)
- *The Basement* (1979)
- *Going to Iran* (1979)
- *The Loony-Bin Trip* (1990)
- *Believe me, you don't want a picture of that!* (1991)
- *The Politics of Cruelty* (1994)
- *A.D.: A Memoir* (1995)
- *Mother Millett* (2002)<sup>[4]</sup>

## Films

- *Des fleurs pour Simone de Beauvoir* (2007)
- *The Real Yoko Ono* (2001) (TV)
- "Bookmark" .... (1 episode, 1989)
  - *Daughters of de Beauvoir* (TV episode, 1989)
- *Not a Love Story: A Film About Pornography* (1981)
- *Three Lives* (1971, Producer)
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# Leonard Roy Frank

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**Leonard Roy Frank** (born July 15, 1932) is an American human rights activist, electroconvulsive therapy (ECT) survivor and writer from New York. Since 1959 he has lived in San Francisco, where he managed an art gallery before he began collecting great quotations.<sup>[1]</sup> (It was Leonard Roy Frank who discovered notable artist G. Mark Mulleian in 1969 and displayed his work at the Frank gallery.)<sup>[2]</sup>

Leonard was a graduate of the Wharton School at University of Pennsylvania. He then served in the US Army and later, sold real estate. In 1962 in San Francisco, Leonard was committed to a psychiatric hospital for being 'paranoid schizophrenic' and given insulin shock treatments and dozens of ECT treatments.<sup>[3]</sup>

By 1972 Leonard was staff at Madness Network News, and in December 1973 he and Wade Hudson founded Network Against Psychiatric Assault, (NAPA), a patients' advocacy group.<sup>[4]</sup> <sup>[5]</sup>

Of ECT, Mr. Frank has written:

"Over the last thirty-five years I have researched the various shock procedures, particularly electroshock or ECT, have spoken with hundreds of ECT survivors, and have corresponded with many others.

From all these sources and my own experience, I have concluded that ECT is a brutal, dehumanizing, memory-destroying, intelligence lowering, brain-damaging, brainwashing, life-threatening technique."

Due to his years of anti-ECT testimony and activism, Linda Andre wrote of Leonard in "Doctors of Deception", "If Marilyn Rice was the Queen of Shock, Leonard Roy Frank was the King."<sup>[6]</sup>

A published author, Leonard has compiled numerous books of great quotes and passages, as well as writing about his own experiences.

## Published works

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- [8] ([http://google.com/search?q=cache:gl5Q1ItRiAgJ:www.endofshock.com/102C\\_ECT.PDF+ted+chabasinski&cd=75&hl=en&ct=clnk&gl=us&client=safari](http://google.com/search?q=cache:gl5Q1ItRiAgJ:www.endofshock.com/102C_ECT.PDF+ted+chabasinski&cd=75&hl=en&ct=clnk&gl=us&client=safari)) Electroshock Quotationary

## External links

- (<http://www.mindfreedom.org/personal-stories/frankleonardr/>) Mindfreedom International-Leonard Frank

## Linda Andre

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**Linda Andre** is an American psychiatric survivor activist and writer, living in New York City, who is the director of the Committee for Truth in Psychiatry (CTIP), an organization founded by Marilyn Rice in 1984 to encourage the U.S. Food and Drug Administration (FDA) to regulate ECT (electroconvulsive therapy) machines.<sup>[1] [2] [3]</sup>

### Anti-ECT activism

Since receiving ECT in the early 1980s at age 25, Andre has been writing and doing research to help other ECT survivors cope with their cognitive and memory losses, and inform the general public about the risks of ECT. Linda has been interviewed by *20/20*, *The Atlantic*, the *New York Times*<sup>[4]</sup> and the Washington Post.<sup>[5]</sup>

Interviewed by the Los Angeles Times in 2003, Linda commented on a British study that found that when patients helped design or conduct ECT surveys, only one third of the respondents claimed to find ECT helpful, but when doctors designed and conducted the surveys, three-fourths claimed to find ECT beneficial. "This is what happens when you ask patients what they think," said patient turned prominent ECT critic Linda Andre,..."you get a completely different story from the one psychiatrists are telling."<sup>[6]</sup>

In 2009 her book *Doctors of Deception: What they don't want you to know about shock treatment* was published. Reviewing this work, James Woods, of the University of Edinburgh and writing in the journal the *Social History of Medicine* commented:

“Over the course of its 17 often meticulously researched chapters, Andre provides a useful contrast to the claims made in Edward Shorter and David Healy's recent paean to ECT and the men who were instrumental in its development (Edward Shorter and David Healy, *Shock Therapy*, 2007), and offers a potentially devastating critique of both ECT and the modern American psychiatric profession.

—James Woods, *Social History of Medicine* <sup>[7]</sup>, 2010]

## Published works

- Andre, Linda (2001). "Memory loss: from polarization to reconciliation" <sup>[8]</sup>. *Journal of ECT* **17** (3): 228–29.
- Andre, Linda (2005). "ECT then and now" <sup>[9]</sup>. *Psychiatric Services* **56** (4): 490–91.
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- [2] (<http://books.google.com/books?id=-BE43JbezmgC&pg=PA70&lpg=PA70&dq=Linda+Andre+ECT&source=bl&ots=iZa90Jw6JY&sig=eW-ChX40TFRo5kAJA>) Pushbutton Psychiatry, by Timothy W. Kneeland and Carol A. B. Warren, 2002
- [3] Wood, J. (15 February 2010). "Linda Andre, Doctors of Deception: What They Don't Want You to Know About Shock Treatment". *Social History of Medicine* **23** (1): 218–219. doi:10.1093/shm/hkp135.
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- [9] <http://psychservices.psychiatryonline.org/cgi/content/full/56/4/490-a>
- [10] <http://books.google.com/books?id=dVM005VKwqYC&pg=PA347&lpg=PA347&dq=linda+andre%2Bdocto>

## External links

- Madness Radio, May 11, 2009, 'Electroshock Deceptions Linda Andre' (<http://www.madnessradio.net/madness-radio-electroshock-deception-linda-andre>)

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