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CRITICS AND DISSENTERS: REFLECTIONS ON "ANTI-PSYCHIATRY" IN THE UNITED STATES

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During the 1970s various professionals and social activists adopted an explicitly anti-psychiatry position which was perceived by many as a new phenomenon. Hostility to psychiatry actually predates the establishment of psychiatry as a profession in 1844, and organized opposition to psychiatric practices appeared in the late nineteenth century. The deinstitutionalization of the 1970s, which was aided by developments within psychiatry, had a strong anti-psychiatry component, but the novel aspect was the organization of ex-mental patients themselves. By the 1980s the decline of psychiatric power, dissension among ex-patients, and new social trends vitiated the anti-psychiatry movement.

Psychiatry today is possibly the most criticized profession in the United States. This is a new phenomenon. Although they never lacked detractors, physicians specializing in the treatment of persons deemed insane enjoyed from the beginning widespread esteem. Even when organized opposition to hospital psychiatry first appeared in the late nineteenth century and then waxed and waned in the twentieth, psychiatrists and psychiatry still commanded respect. They had their serious critics and experienced growing loss of faith among the public; nevertheless they retained authority in managing mental disorders. This is no longer true. During the past three decades a number of forces—religious, legal, scientific, and intellectual developments; internal contradictions within psychiatry; new approaches to patient care and mental disorder; and the rise of a new social activism and the patients' rights movement—converged to place psychiatry on the defensive in a way never before experienced in its history.

Modern psychiatry began its ascendency in the United States in the late eighteenth and early nineteenth centuries, when hospitals specifically for the care, cure, and confinement of the mentally disordered were built on new European models. Founded by influential laymen and staffed by distinguished physicians, these institutions contributed to the gradual public acceptance of naturalistic and optimistic attitudes toward mentally disturbed persons. Several hospitals offered a new form of therapy, moral treatment, that combined moral suasion and a benevolent environment with deemphasis on traditional bloodletting, restraint, and dosing with emetics, opiates, and other drugs. The success that Dorothea Dix met before the Civil War in persuading state legislatures and the federal government to construct mental hospitals, headed by medical superintendents, testifies to the respected position achieved by psychiatry and psychiatrists, who in 1844

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organized themselves into the Association of Medical Superintendents of American Institutions for the Insane, predecessor of the American Psychiatric Association.

The new psychiatry was problematical, at least in theory, for two powerful social institutions—the church and the legal system. Although the Protestant ministry and the courts acknowledged the legitimacy of psychiatry as a medical specialty by the mid-nineteenth century, psychiatrists would inevitably invade their domains. The belief that God and the devil competed for man's soul and that through the mind one reads the soul had always made the subject of mental derangement of special interest to Christian churches. Also at issue was the matter of free will, the ability to make moral decisions, a trait that supposedly distinguished humans from beasts. In matters both religious and legal, individuals were regarded as responsible agents. The church saw human beings as struggling between God and Satan and answerable for the outcome; the law was predicated on personal accountability.

Many American psychiatrists believed in the existence of an immortal, immutable soul, but in their medical practice they largely disregarded the concept, and as time went on they lost interest in the theological implications of their work. They came to consider the mind, as distinct from the soul, as a function of the material brain, and they also inclined to a less judgmental attitude toward their patients than earlier physicians. Unhealthy life styles, they thought, could bring on insanity—wild living and excessive alcohol consumption, for example—but the essential cause was somatic, some malfunction to which the organism might be predisposed by heredity. This view, which became more scientifically determinist with time, plus clinical experience, drew psychiatrists away from moralism and eventually toward a stance that increasingly absolved patients from responsibility for their acts.[1] So far did psychiatry stray from traditional religion and law that in the mid-nineteenth century prominent practitioners identified a form of mental disorder called moral insanity (the latterday psychopathic personality), in which the patient exhibited apparently unmotivated, amoral viciousness. Both the church and the legal profession, as well as certain psychiatrists, were outraged at this conversion of sin and crime to insanity.

The materialist and determinist directions of psychiatric thought were not enough, however, to cause a serious break between psychiatry and the religious establishment. Not wanting to be thought scientifically backward and wanting to take part in the social reform efforts of their day, leading Protestant clergymen generally accepted the authority of psychiatry in dealing with insanity; they supported the construction of mental hospitals and served there as chaplains. Exceptions to this accommodation with psychiatry appeared at the end of the nineteenth century within some evangelical sects, then as now unreconciled to the naturalism of medicine and psychiatry, and new religious movements, like Christian Science, that took shape outside of conventional religion. These faiths, part of what has been called the Metaphysical Movement, agreed that healing was a consequence of a "right relationship with the ultimate power of the Universe, Creative Mind . . . since man in his real nature is essentially divine."[2]

The new religious alternatives to psychiatry did not have the influence that might have been expected in a society committed to religious belief and practice. There was no joining of forces among the different sects questioning psychiatry, nor were alliances made with secular groups in order to attack the right of physicians to treat and confine mentally troubled people in hospitals.[3] Sects like Christian science, their wide appeal notwithstanding, were fringe groups, isolated from the centers of ecclesiastical power, competing with them, and particularly in the case of Christian Science, considered by

mainstream denominations to be anti-Christian.[4] Psychiatry could thus be in effect protected from the full impact of sectarian religious objections to its validity. Only in the twentieth century, with the formal organization of the fundamentalist and Pentecostal religious movements committed to healing mental disorders by spiritual means, have fundamentalists gained sufficient political power to influence legislation respecting psychiatry.[5]

In their relationship with the legal system, which operated upon the assumption of human rationality and the free choice between good and evil, right and wrong, psychiatrists had perpetual problems, even thought they came to be accepted by the courts as expert witnesses. They stood on somewhat shaky ground regarding the matter of individual responsibility. On the one hand psychiatrists claimed that mental hospital patients could, if properly motivated, usually be brought to exercise some control over their actions; they were therefore partly responsible agents. On the other hand, prominent psychiatrists maintained in legal proceedings that the mere fact of a defendant's being declared insane should free him or her from responsibility and that the accepted legal grounds for a finding of nonresponsibility, the inability to know right from wrong—the M'Naghten decision of 1843 in England, more or less followed in the United States—was much too narrow. Such inconsistencies in psychiatry were matched by those in the law, which, psychiatrists complained, often recognized irresponsibility only by Christian standards. It was possible to find not guilty a defendant who committed murder at the behest of an alleged command from God but to convict him if he attributed the order to the devil.

Contrary to the view of some social historians that psychiatrists invariably buttressed the status quo, the early asylum superintendents were challenging the prevailing system of social control by advocating, in their writings and testimony at trials, treatment rather than punishment or death for certain offenders. These psychiatrists thus helped to legitimatize the insanity defense and the use of expert psychiatric testimony. In the mid-nineteenth century this was seen as a significant extension of the rights of defendants and particularly those who might be insane; in a time when capital punishment was common enough, such a defense could save a life.

Despite problems and inconsistencies nineteenth-century lawyers and judges continued to employ psychiatrists as expert witnesses, to view mental hospitals as necessary institutions, and to recognize the existence of mental illness.[6] Indeed, the judicial system, under the influence of late nineteenth-century progressives and twentieth-century liberals, themselves influenced by the promise of psychiatry, came in many respects to substitute noncriminal procedures for traditional reliance upon the criminal law. Psychiatrists were thus given a good deal of power in society, just as they were losing power and status in the mental hospital—in the care and management of those whom psychiatry was established to treat, the seriously mentally disturbed (the "lunatics" or "insane" of an earlier day). This trend began with the decline of the mental hospital system after the Civil War. By then the earlier high hopes for cures through moral treatment faded; public hospitals became overcrowded, underfinanced, and burdened with chronic patients; and psychiatrists grew pessimistic about illnesses they now saw as greatly influenced by heredity and unyielding to known treatments. Under such conditions it was easy for neglect and even abuse to become the rule for chronic and troublesome inmates. At best the prevailing modus operandi was custodialism rather than, as at the beginning, therapy.

The first organized effort to change this situation arose in New York City in the late 1870s. Practitioners of a new medical specialty, neurology (concerned with diseases

of the nervous system), criticized mental hospitals for failure to conduct scientific research and adopt modern therapeutic methods, including nonrestraint. Together with lay reformers and social workers, neurologists formed in 1880 the National Association for the Protection of the Insane and the Prevention of Insanity. But when the lay members questioned the competence of hospital physicians or even of any physicians to provide proper patient care, the neurologists became alarmed. Interested in eliminating the hospitals or running them themselves, not in repudiating medical authority over insanity, they withdrew their support from the association, which, for this and other reasons, subsequently foundered.[7] Certain neurologists, or neuro-psychiatrists, as they came to be called, did succeed in administering mental institutions, and many treated emotionally troubled middle-class patients (the so-called neurasthenics, for example) on an outpatient basis. Silas Weir Mitchell, one of the most famous physicians of the day and popularizer of the "rest cure" for nervous breakdown, thought that hospitalization was unwarranted under any conditions except "Poverty and Peril."[8] Poverty and peril were the rule, however, for the preponderance of patients. Even if, as psychiatrist John Chapman warned, public confidence in mental hospitals was being destroyed by criticism,[9] there seemed to be no alternative to them.

The assumption that mental hospitals were necessary underlay a new reform crusade that emerged early in the twentieth century during the Progressive era of social change and optimism about improving society and the human condition. Clifford Beers, a former mental patient, launched this movement with the publication in 1908 of his classic, powerful autobiography *A Mind That Found Itself* and then the founding in 1909 of the National Committee for Mental Hygiene, the progenitor of mental health associations in the United States and abroad and in time an important force in developing psychiatric research, training psychiatrists, and promoting preventive mental health. Although Beers could be severely critical of psychiatrists he did not oppose psychiatry. Rather he sought the cooperation of the reform-minded, progressive wing of the field in order to upgrade, not abolish mental hospitals. This goal proved elusive. Beers was able to effect some improvements in mental hospitals, but he could not significantly change them, an accomplishment, if possible at all, that would have required a massive effort for which the small, always underfunded National Committee for Mental Hygiene and local mental health organizations lacked the resources. In the 1920s the mental health movement shifted from primary concern for hospitalized mental patients to the pursuit of seemingly more realizable goals – prevention, training, and research. Mental hospital inmates, while not entirely forgotten, got left behind.

The profession of psychiatry was at the same time undergoing a somewhat similar shift. From a rather small, unified, institutionally based specialty, it evolved into a large bifurcated field: on one side was hospital practice to treat "psychoses"; and on the other was private practice to treat another, "new" set of disorders, the "neuroses," and with new, psychologically based techniques (psychotherapy), most notably psychoanalysis. In the 1920s and 1930s practice in private offices and then also in community agencies became more attractive and more lucrative than practice in hospitals, where conditions discouraged physicians who wanted to work effectively and build careers. Prestige in the field was devolving upon the private practitioners, particularly those offering psychoanalysis, which gained intellectual and cultural luster beyond its value as psychotherapy. By the 1940s and certainly the 1950s the popularity of psychoanalysis, as well as the claims of the mental health movement to offer people a path to positive mental health, enabled psychotherapy to win a place second perhaps only to economic

progress as a guarantee of happiness among the upper middle classes. If Sigmund Freud himself remained skeptical about the possibility of resolving human problems, many of his American followers had no such doubts. Thomas Jefferson's pursuit of happiness was becoming a right to happiness, and by the post-World War II decades, which witnessed an enormous growth in psychiatry, many Americans were persuaded that psychiatry and psychology, particularly psychoanalysis, constituted a key to happiness. By enabling us to understand human nature, psychiatry, especially psychoanalysis, could not only eliminate mental disorders and emotional discomfort, but also would lead the way to a crime-free, conflict-free utopia.[10]

The emphasis on psychotherapy and psychogenesis (psychological causes) made the new office psychiatry fashionable, but it also made psychiatry vulnerable. The rationale for the acceptance of psychiatry as a medical specialty had always been that insanity was a natural disorder like any other; emotional disturbances could start the process and symptoms might be behavioral, but only when the soma became involved was the actual "disease" present, and treatment would be both somatic and "moral."[11] Twentieth-century psychiatrists and neuropsychiatrists, Freud included, continued to believe in an ultimately physical etiology of insanity while their practice, in the absence of proof of such etiology and of potent somatic therapies, stressed nonsomatic elements.[12] In the United States psychoanalysis in particular emphasized the psychogenesis of emotional and behavioral disorder and ignored or denied the relevance of medical procedures in favor of almost total reliance upon talk, which became more prestigious as therapy than drugs or other medical means. But if talk alone was applicable even to so-called psychotics, upon what logic could psychiatry claim to be a medical specialty? Only physicians could legally prescribe medication, but educated laymen could understand and apply psychoanalysis, and they did. The traditional link, imprecise as it was, between psyche and soma was broken. The monopoly of psychiatry over the secular treatment of emotional and behavioral disorders, now no longer seen as involving the soma, could not be assured. Psychiatry has been losing ground ever since.[13]

Meanwhile hundreds of thousands of seriously disturbed people—the so-called insane—vegetated in mental hospitals. For them psychiatry still had little to offer. Any successes in discovering causes and then cures for the psychoses were attributed not to psychiatry but to medical science generally, and the disease concerned would be removed from the lists of psychiatric disorders. Take, for example, paresis, which, once found to be caused by the spirochete of syphilis and then amenable to chemical therapy, was no longer considered a psychiatric entity. Hospital psychiatry was left to deal with disorders not well understood and for which no effective treatment existed; the new insulin and electroshock therapies had limited value and dubious side effects, and lobotomy, introduced in the 1930s, was a radical and controversial procedure. Most hospitalized mental patients received decent custodial care at best; at worst they were abused and neglected.

When a new effort to reform the care of psychotic patients surfaced after the Second World War, hospital psychiatrists were open to attack. They could not control the movement, fraught with bitter condemnation of their practices, that ultimately led to mass discharges of patients from mental hospitals in the United States. The speed with which the vast system of state mental hospitals, despite all the latter's financial resources and political connections, could be virtually denuded of patients bespeaks more a desire of state governments to save money and a lack of public support for hospitals than a great faith in alternatives—community mental health centers and services—which fairly quickly

proved ineffective for many former hospital patients and came to serve a different, less seriously disturbed clientele. The twentieth-century tendency of psychiatry to abandon the "psychotic" hospital patient in favor of treating less disturbed people, instead of being reversed, was only confirmed by the rise of the new community mental health centers.

The liberalism of the John F. Kennedy and Lyndon Johnson years gave ideological support to the deinstitutionalization and mainstreaming of mental patients. Probably more important in the thinking of many activists as compared with mental health professionals and public officials were the ideas of contemporary radicals who distrusted all institutions and saw them as oppressing the poor and the handicapped and depriving them of control over their lives. This stance was part of a worldwide liberation movement of subject peoples, a movement that went beyond traditional political and economic struggles to almost every aspect of life and society.

Most influential among the new socially determinist anti-psychiatric views of mental disorder were those of counterculture writers like R. D. Laing, David Cooper, and Michel Foucault, sociologist Erving Goffman, and psychiatrist Thomas Szasz. Although the theories they propounded were disparate, these men had in common a sharply critical attitude toward traditional psychiatry.[14] They also questioned the "medical model" of mental disorder and even the concept of mental illness itself. Laing and his fellow psychiatrist Cooper proclaimed that schizophrenia, far from being a degrading condition, was an understandable, even normal response of sensitive people to a mad world and a possible vehicle for personal growth;[15] philosopher Foucault termed insanity a social and cultural invention of the eighteenth century; Goffman saw asylums as closed systems that infantilized and oppressed the inmates. For Szasz, mental illness did not exist as a medical entity; some people had problems in living but medicine had no special competence in helping more than a very few. There was also the "Marxist" view, advocated by mental health professionals calling themselves radical therapists, that capitalism creates conditions leading some persons to exhibit behavior that is labeled mental illness and which could be eliminated through structural social change, from capitalism to socialism.[16] By the 1980s a new brand of critics of psychiatry appeared who sought, through research, to understand why the anti-psychiatry of the past accomplished so little for the mental patient and proved so ineffective in the broader political struggles against capitalism.[17]

The ideas of these various modern critics of psychiatry are not without precedent. Some Christian theologians from the beginning believed that insanity was not in most or even in any instances a "medical" entity, a view held in our time by Christian Scientists and certain Protestant fundamentalists as well as Szasz. The idea that hospitals were the worst place to send the mentally ill did not originate with Goffman: Weir Mitchell's contention that mental hospitals were incapable of providing the requisite individual attention for the patients had itself a precedent in the thinking of Dr. John Minson Galt II, head of the Eastern Lunatic Asylum at Williamsburg, Virginia, from 1841 to 1862, and before him John Conolly, the British advocate of nonrestraint who called in 1830 for home care.[18] Throughout history and of course in the nineteenth century the class nature of mental hospitals and their role as agencies of social control were well recognized, whether Foucault acknowledged it or not. Closer to our day, in the 1920s, there were writers who "examined psychiatry in the context of social structure and social processes."[19] That the experience of schizophrenia might be a means of growth leading to mental health or even to a new and better life conformed to the old Christian

belief that in some cases personal tragedy was God's way of improving the individual; and the nonreligious Beers believed that his breakdowns and "miraculous" recovery had made him a new man with enhanced powers and a purpose in life.[20]

But ideas and attitudes, powerful as they may be, could not and did not by themselves account for the mass deinstitutionalization of the 1960s and 1970s. Critical here was the conviction that community mental health centers would serve as inexpensive yet more effective alternatives to mental hospitals. This belief enabled critics of psychiatry to win support from public officials, jurists, and some psychiatrists. Also very important were new forms of medication. Without the new psychopharmaceutical agents—tranquilizers, anti-depressants, and other drugs—that help to control symptoms, many thousands of patients would not have been released into the community, and it is likely that the community mental health and ex-patient movements would have been greatly diminished in scope if not stillborn. While critics disputed the medical model of mental illness, their reforms depended substantially upon treatments that assumed such a model.[21] It is another irony that the discovery of these new techniques which helped some patients feel better and enabled them to function outside the hospital provoked new criticisms, this time from discharged patients themselves, organized and vocal as never before.

This ex-patient movement is the newest and most interesting component of recent anti-psychiatry manifestations. On that account and also because it has not yet been studied by social historians or historians of psychiatry and mental illness, most of the remainder of this paper will be an analysis of the ex-patient movement of the 1970s and 1980s and its impact on the psychiatric establishment, within the context of past reform efforts and protest movements.

The most persistent critics of psychiatry have always been former mental hospital patients, but until now very few would have the courage to tell their stories publicly or openly to confront the psychiatric establishment, and those who did so were commonly so extreme in their charges that they seldom could gain credibility. One to whom public officials did listen was the famous Elizabeth P. W. Packard, an advocate of the rights of married women, who in the 1860s accused her husband of incarcerating her in the Jacksonville Insane Asylum of Illinois (with the complicity of Superintendent Dr. Andrew McFarland) because she rejected Calvinist religious views.[22] After finally winning her freedom, Packard campaigned for legislation to protect married women and succeeded in having a law passed in Illinois in 1867 requiring a jury trial in sanity hearings involving civil commitment to hospitals; a few other states followed suit. Packard published many versions of her story, begun while she was still in the hospital, in which she called for the destruction of the existing hospital system in favor of home care for the insane. She sought, unsuccessfully, to form an "Anti-Insane Asylum Society" whose activity would apparently consist of soliciting pledges from people never to send their loved ones to mental hospitals until they were reconstructed "on a righteous basis."[23]

Packard insisted that she had never been insane; she did not deny either the existence of insanity or the value of mental hospitals, properly run. Neither did Beers, who in many ways resembled Packard but who built his career on his admitted history as a former psychotic. On the basis of that experience he founded a respected and influential group of organizations and achieved respectability and worldwide fame. In the process Beers was outspoken about abuse of mental patients and passionate in defending their rights and damning psychiatrists for tolerating mistreatment of patients. But

he eventually toned down his hostility to psychiatry as it became obvious that for his reform movement to gain the support he sought at the highest levels of society it would have to include leading psychiatrists. Although he envisioned that eventually former mental patients and their families would be recruited into the movement, the public's persistent prejudice against mentally disturbed people and Beers's own doubts and inclinations, plus pressures from psychiatrists, drew him away from this goal.

This failure to cultivate and involve a deeply, personally interested constituency characterized all reform efforts until our own day[24] and in part accounts for their limited success. Originated by singleminded crusaders working in periods of liberal social change, these movements appealed for support not to the victims of mental disorder but to elite groups in positions of power or having access to those in power. Such reformers accomplished a good deal: hospital care for the neglected "insane" in Dorothea Dix's time and the promotion of psychiatry and mental hygiene in Beers's. But when the reformers' energies waned and reform went out of style so did their movements, leaving the mental patients again mostly friendless and forgotten, if not quite so badly treated, to be rediscovered by another generation in a new era of social change.

The past thirty years have witnessed such change. Activists published exposés of conditions in mental hospitals, fought in the courts and legislatures for patients' rights, and buoyed by the civil rights struggles and the campaigns in behalf of the physically handicapped, worked to remove the stigma attached to mental disorders. Out of the counterculture of the 1960s emerged hundreds of free mental health clinics designed to circumvent bureaucracy, authoritarianism, hierarchy, and even technology. (A decade later, unable to resist economic and other pressures to become more or less conventional service agencies with clear distinctions between staff and clients, most of the surviving clinics were themselves considered part of the establishment by the growing movement of former mental hospital inmates, who in turn have themselves been going through the same process of accommodation in the 1980s.)[25] The times were such that some ex-patients—the vast majority remained quiescent—could feel free to speak out forcefully and act in their own behalf. The authority of all professional practitioners was being challenged by a new consumerism in which clients were encouraged to be active, knowledgeable participants in dealing with their problems, and a new accountability in which those giving service would be held responsible for its effectiveness. For the first time in American history ex-patients created their own organizations;[26] they openly expressed their anger and hurt; they denied that the therapies offered them were either effective or appropriate; they insisted that they were best qualified to pass judgment on how they were or should be treated; they sought to establish their own programs as alternatives to hospitals and community mental health facilities.

The organized ex-patients of the 1970s constituted a conglomeration of groups and individuals. The major spokespeople were largely white, middle-class, well educated—the very class from which psychiatry traditionally drew its staunchest support. Lower-class activists, more anarchistic and anti-capitalist in outlook than their middle-class colleagues, saw themselves as an underclass, cut off from society, an exploited minority having more in common with the poor, blacks, Chicanos, feminists, prisoners, and homosexuals than with the white middle classes.[27] All of the activists were most united in considering society in general and psychiatry in particular the problem, not the people designated as mentally ill, and they viewed psychiatry as an agency of domination over deviant people labeled mentally ill and cast into the role of victims.

There are by now some seventy to a hundred ex-patient organizations in the United States, Canada, Europe, and South America, with the United States in the vanguard. Most states have at least one association or network of ex-patients, who participate in national meetings and activities; there is sporadic contact among organizations in different countries. In 1986 amid controversy the National Organization of Consumers and the competing National Alliance of Mental Patients were formed.[28] Best known among many publications in the field until it ceased publication in 1987 was *Madness Network News*, a quarterly published in California that appeared for over a decade.[29] In New York City the listener supported radio station WBAI-FM broadcast a monthly program, "The Madness Network," where members of the anti-psychiatry movement and their sympathizers could express views and discuss issues.[30] Although the movement espoused egalitarianism and opposed the concept of leadership, it clearly developed a cadre of known, articulate, and literate men and women who did the writing, talking, organizing, and contacting.

The ex-patient groups derived much of their ideology from the same sources as other secular critics of psychiatry and reformers of the mental health care system—Laing, Cooper, Foucault, Goffman, Szasz, and others. But the ex-patients had their own agenda, including a widespread commitment to humanistic socialism. Although they broke with their original allies, the Marxist radical therapists, for many reasons, most importantly in order to maintain their independence,[31] the more radical ex-patients shared the Marxists' belief that structural social change is the only solution to the plight of those deemed mentally ill, and they stressed class struggle and alliances with other revolutionary movements here and abroad. But in actual programs and activities virtually all the activists devoted much of their time and energy to practical, immediate concerns. A good deal of attention was given to physical mistreatment[32] and controversal psychiatric therapies—electroshock, lobotomy, and chemotherapy. Ex-patients campaigned to outlaw electroshock and lobotomy[33] and to make chemotherapy voluntary, partly on account of the side effects like memory loss and a neurological disorder, tardive dyskinesia, induced by drugs used to control symptoms and resembling Parkinson's Disease. Ex-patients contended, and the American Psychiatric Association seems now to agree,[34] that the heavy reliance on chemicals during the past three decades has produced and will continue to produce drug-induced disorders in patients.[35] History offers precedents enough for such a judgment. From the beginning, like their colleagues in general medicine, psychiatrists experimented on their patients with an enormous variety of substances. In the absence of any therapeutically effective drugs they tried anything that might work. They prescribed heavy dosages of mercury and opiates, uncomfortable and often painful mechanical devices, extensive bloodletting, and water and other shock-provoking treatments, all with dubious if not disastrous results. And physicians could do so with impunity. Serious opposition to medical "experimentation" on mental patients is a recent occureence, as is public concern about the ethics of such experimentation generally.[36]

Psychiatrists and other mental health professionals have come to be excluded from the ex-patient groups, a policy not unlike that of Alcoholics Anonymous and calculated to preserve the members' independence. Beers faced this issue seventy-five years ago: his reliance on rich donors and his need for approval from experts led him to hand over to psychiatrists the National Committee for Mental Hygiene. In so doing Beers was a man of his time and his class; he also had no real alternative. The 1970s activists were

a different breed. Very much the product of the rebellious, populist, anti-elitist mood of the 1960s,[37] they strived above all for self-determination and self-reliance. Judi Chamberlin, former mental patient, member of the President's Commission on Mental Health and of the Mental Patients' Liberation Front of Boston, chairperson of the National Committee on Patients' Rights, and author of what some regarded as the "Bible" of the movement, *On Our Own* (1978), wrote, "Instead of creating clear and stigmatizing distinctions between those who are competent to give help and those who are weak enough to need it," there needs to be created "new communities of equals, counteracting the alienation and powerlessness most people rightly sense is the prime cause of their unhappiness."[38]

A troubling aspect of the movement's resolve to be entirely independent has been the relationship with sympathetic professionals whose cooperation has frequently been necessary to win financial support. Allen Markman, host of the Madness Network radio program, conceded that there will always be "a delicate compromise between autonomy and heteronomy, between the ideal of us being on our own, and the reality of getting funding in the real world."[39] This reality confronts ex-patients, who had few resources, in their attempts to establish voluntary residences and treatment centers for discharged mental patients. The financial and other difficulties of going it alone and on a small, local scale, especially in a time of public indifference to the poor and disabled, were factors in the recent founding by ex-patients of the National Organization of Consumers and the National Alliance of Mental Patients.

This matter of connection with the larger society was the subject of a sharp internal debate among ex-patient groups.[40] Although the movement was never monolithic, whatever consensus it had is obviously now broken; conflicts previously kept in the background were by 1986 being openly aired and even exaggerated in a struggle to determine future directions.[41] Should the movement advocate reformist objectives or should it exist in absolute opposition to capitalist society in general and psychiatry in particular? The pragmatically oriented middle-class leaders were considered by their more class-conscious opponents to be reformist and, because of their "stratified position," uncomprehending of the problems of the poor. The "radicals" saw no sense in seeking solutions within a capitalist system that creates mental problems.[42] Any compromise or dealing with the enemy, such as accepting funds from government agencies (which supposedly dispense grants to coopt the recipients) or engaging in debate with mental health professionals, would take the movement down the slippery slope of full accommodation and abandonment of the ex-patients' basic needs.[43] Even the "pragmatists" complained that the movement was stagnating and needed to reach the millions of ex-patients who are its natural constituency; they were tired of talking to themselves, of living in splendid isolation, and of being unable to effect major change.[44] These arguments, historically endemic to radical politics, figured in the discussion among ex-patient activists about sending representatives to the 1985 annual conference of the American Psychiatric Association, an invitation that came after years of demonstrations and civil disobedience at psychiatrists' meetings and outside mental hospitals. After much debate, despite fears of being coopted, and in face of a good deal of opposition, some individuals accepted the invitation.

In the concern among activists about threats to their independence probably no issue has been more important than that of voluntarism, which was the heart of their philosophy. Some activists condemned psychiatry under any conditions, voluntary or involuntary, while others, usually middle-class types, conceded the right of people to

undergo psychiatric treatment on a voluntary basis. Psychotherapy, especially psychoanalysis because it is usually voluntary, as such has not come under the same severe attack as the somatic therapies, but it was valued, if at all, only as a possibly helpful technique if applied by laypersons, including ex-patients themselves, rather than professional therapists. The ex-patients emphasized individual support from other patients;[45] they espoused assertiveness, liberation, and equality; and they advocated user-controlled services as part of a totally voluntary continuum.[46]

The commitment to voluntarism, understandable as it was, presented problems. Followed absolutely, voluntarism inhibits the formulation of programs to reach all mentally troubled people, which means that only those who seek help will get it. Concentration on voluntary, alternative, participative treatment centers may fulfill the ex-patient movement's ideological aims and the need to protect its members' ability to control their lives, but in effect it leaves out large masses of people needing some kind of assistance. These include such subgroups as the "chronically ill" still in hospitals; the "criminally insane"; and the chronic and aged "mentally ill" who have been transinstitutionalized into nursing homes. Then there are troubled men and women released from hospitals who resist medication and any form of institutional or formalized care; others have never been hospitalized, never professionally treated, and never legally labeled "insane." Not perceived to be dangerous, these freely existing persons are, under present laws or judicial practice, usually beyond the reach of the health care system. Many are homeless; some are committed to prison. Voluntarism leaves the poorest and neediest with the least preferential help or no help at all.[47]

Judi Chamberlin acknowledged this problem in *On Our Own* but believed that the alternative facilities promoted by the movement were appropriate only for certain clients. These are people "motivated to make changes in their lives" and not in need of control by incarceration in hospitals; they have suffered terribly from the "prison like atmosphere" of hospitals, the lack of "warm, supporting human contact," and from the stigma of hospitalization. Besides, she asserted, "two hundred years of institutional psychiatry have shown that mental hospitals cannot help the unwilling."[48] In fact, there is no known correlation between willingness to undergo hospitalization and rate of "recovery" or improved ability to function. Over the past two hundred years or so, when nearly all patients were hospitalized against their will and informed consent was almost unknown, approximately thirty percent of new admissions would be discharged each year as "recovered," that is, able to function about as well as before the onset of their disorder. It is not evident that the rate of recovery, by that standard or any other for that matter, is higher today, when voluntary commitment has become more common. Even in England, where there has been a much higher frequency of voluntary commitment and over more time than in the United States, revovery rates have not noticeably improved.

The issue of voluntarism and its ramifications has been under constant discussion among ex-patient activists, but until recently their published literature and public statements emphasized consciousness raising and anti-psychiatric propaganda.[49] There is also a growing literature detailing the activities of various governmental agencies that have utilized psychiatrists in all sorts of clandestine human experiments.[50] Also cited are the practice of sterilization, condoned by psychiatrists, of mental patients in the United States,[51] and revelations of the leadership role of prominent German psychiatrists in the sterilization and murder of hundreds of thousands of mentally ill patients during the Nazi era, a subject overlooked in histories of psychiatry and largely ignored within the American psychiatric profession.[52] Some critics even link American and German

psychiatric abuses. Lenny Lapon claims that thousands of mental "patients" die each year from the use of chemicals, electric shock, lobotomies, and other treatments prescribed by American psychiatrists.[53] Although Lapon does not argue that these deaths were intentional, as were those in Nazi Germany—a quite significant difference—he postulates an underlying similarity in attitudes toward the mentally disabled.[54] R. D. Laing commented in this vein in his recent autobiography: the prevailing "psychiatric doctrine of the abyss of difference between us [the sane] and them [the insane] takes us to the brink of another sort of abyss. . . . The Nazi regime in Germany in the late thirties took this doctrine to its logical conclusion."[55] (This is a rather puzzling statement, since many psychiatrists do not make a sharp distinction between the sane and the insane.) And a German historian goes so far as to write that "maybe this is the secret weapon Goebbels boasted about which would lead to the rebirth of the Reich—not a super-bomb and not a death ray, but a blueprint for a psychiatric slave state."[56]

Some of these points are well taken, others are of dubious validity.[57] The horrible misdeeds of German psychiatrists are real enough, and it is interesting, to say the least, that American psychiatry, as an organized profession, has, except in the case of the Soviet Union, continued to this day to avoid the issue of psychiatric violations of the physician's obligation not to harm his patients. Psychiatrists here have been more typical than exceptional; all professions tend to be reticent in criticizing their members' ethical lapses. There is now a question as to whether in fact psychiatry as a profession any longer adheres to the Hippocratic Oath not to do harm. Certainly the secret experimentation with LSD and electric shock conducted by the Canadian Dr. Ewen Cameron in the 1950s and similar work by other psychiatrists as well as the lack of criticism by the psychiatric establishment was interpreted by ex-patient critics as an abandonment of a moral commitment to do no harm.[58]

In dealing with the recent American situation the ex-patient literature seems to confuse the power of individual psychiatrists over particular patients with their power in a social sense. This literature exhibits a striking disparity between the reality of a psychiatric profession whose power in some respects has suffered a palpable decline and the continued perception of critics that psychiatrists retain undiminished or even growing authority and control. The ex-patient activists dwell on the wrongs committed by psychiatrists and downplay a mental health care system that has been largely replaced by agencies and services run by nonpsychiatric professionals or by laypersons—nursing homes and community mental health centers, for example—a new "system" that has generated its own abuses. If I have read the relevant literature and heard the speeches correctly, it seems that some activists are driven at least in part by a sense of betrayal and anger against psychiatrists, from whom, they are convinced, they vainly sought sympathy and help.[59] Perhaps this explains the anomaly of calling for abolishing psychiatry and then demanding an "end to . . . kicking patients out of the hospital . . . when we exercise our right to refuse treatment or engage in political activity."[60] There is also a deep anger and resentment,[61] (evident in Beers as well) toward a profession that has the authority to label them as mentally disabled and that is perceived as infantilizing them and disregarding their wishes. In essence Beers wanted to be treated like a sane man even while admitting that he was "insane." Indeed he wanted to be indulged because he was mentally ill and he also wanted to determine his own treatment, so that those who took care of him were frequently in a no-win situation.[62] To many ex-patient activists the existence of psychiatry legitimatizes the existence of mental illness. But even if that were true that is not to say, as some assume, that if there were no psychiatrists there would be no such disorder.

In any case, psychiatrists constitute a much more diverse group than their opponents admit. Although traditionally self-congratulatory, unself-critical, and imperialist, psychiatry as a profession always included among its members a minority who recognized and rejected these tendencies, and there are few specific criticisms of their field that establishment psychiatrists have not themselves expressed.[63] Leading psychiatrists encouraged deinstitutionalization and supported community mental health; a number of them have opposed electroshock and lobotomy and never used them and have had reservations about chemotherapy.

A central claim of many ex-patients, that medicine is irrelevant to psychiatry and that the origin of mental disorder is not somatic, is one that psychiatrists, especially psychoanalysts, have debated for years. They nevertheless are not ready to turn in their M.D.s. Conveniently they argue that whatever psychiatrists do is medical because the intent is therapeutic,[64] and of course the contemporary treatment of psychotic persons relies heavily on psychopharmacological agents whose use must be monitored by qualified physicians. Some of the latter concede that ex-patients who consider this medication a form of chemical restraint, and with bad side effects, have a valid point, but the same physicians also say that control of symptoms is as legitimate a function of psychiatry as it is of other branches of medicine and that most drugs have negative as well as positive effects. It can indeed be claimed that the somatic approach to mental illness is the only one to have yielded demonstrably positive results. Not only can drugs now moderate or eliminate symptoms, but some of the most fruitful research in progress in the field today is neurobiological; and to date the only instances where etiology has been established are in those disorders traceable to somatic causes, such as, for example, paresis, pellagra, and Alzheimer's Disease. The many other explanations of serious mental and emotional difficulties remain unproven hypotheses.[65]

All the same, psychiatrists have begun to realize that they must respond seriously to their critics. It has become obvious that much of the clinical practice under question cannot be defended on "scientific" grounds and that psychiatry has of necessity always depended largely on anecdotal evidence to justify many of its procedures. Investigation is now under way on a host of questions—for example, the prediction and extent of dangerousness in mentally disordered persons, the actual effectiveness of drugs, and the effects of refusal to take medication. There are discussions of the moral and legal aspects of compelling patients to take medication of often unproven effectiveness and with possibly deleterious consequences.

The invitation to attend its 1985 conference that was extended by the American Psychiatric Association to ex-patient groups signified a new departure for the psychiatric profession. It constituted official recognition of the challenge presented by the ex-patient movement (about which many psychiatrists knew little) as well as awareness of a need for allies at a time when even Supreme Court justices have been censuring psychiatrists[66] and funds for research and programs have been short. The 1984 report of the American Psychiatric Association[67] decrying the effect of deinstitutionalization on the mentally ill is an implied criticism of those psychiatrists who promised too much in advocating the return of patients to the community and who did not appreciate the economic, political, and social implications of such a policy.

Not that the hospitals of the 1950s and 1960s deserved praise. A recent president of the Association, Dr. John A. Talbott, speaking in 1984 on "psychiatry's unfinished business," cited the remarks of a former president, Dr. Harry Solomon, made in 1958. Our large mental hospitals, Solomon said, were "antiquated, outmoded, and . . . obsolete. . . . bankrupt beyond remedy," institutions that should be replaced by

"community-oriented intensive treatment" for acutely ill patients and moderate-sized homes or colonies for the chronically disabled. Talbott addressed the present situation in equally strong terms: "Our public facilities are deteriorating physically, clinically, and economically; our chronically ill are either 'transinstitutionalized' to nursing homes or deinstitutionalized to our cities' streets, lost in the vast army of the homeless. . . ." He warned, "Make no mistake. The APA and its elected officers can advocate for the members' economic and professional well-being only if we are willing to take on and attempt to address these public concerns. In addition, we will have credibility with the public only if our *primary* concern is the well-being of our patients, not ourselves. To that end our need, indeed our independence, on healing the schism between ourselves and the relatives of the mentally ill is critical. No longer will an insurance company or a mental health program adequately fund or reimburse services on the basis of our word alone; we need allies, coalitions, and friends." Most difficult but very necessary would be the "support of articulate patients and ex-patients, just as kidney-transplant surgeons and burn-unit physicians have."[68]

Self-interest on both sides has created conditions favorable to a degree of collaboration between psychiatrists and some organized ex-patients. It is, however, perhaps unrealistic to expect that psychiatrists, by tradition and training accustomed to being in charge and, like most professional practitioners, often guilty of social and cultural prejudice, will find it possible to treat patients and ex-patients as "equals," whatever that means. All physicians have had to reckon with patients' desires to participate in informed decisionmaking about their own lives; whether psychiatrists or even society at large will accept a thoroughgoing voluntarism for mental patients is a question.[69]

The issue of involuntary commitment remains a deep concern not only of psychiatrists[70] but of the public generally. State legislatures and the courts have made it much more difficult to hospitalize involuntarily any but the so-called dangerous mentally ill, and the courts, responding to arguments in behalf of patients' rights, have upheld restrictions on both involuntary commitment and involuntary treatment. When mental hospitals were first built in the eighteenth and nineteenth centuries, society was persuaded that insanity was a curable disorder and that imprisonment and neglect of the insane doomed them to a life of misery. Once this optimistic view is abandoned or people become convinced that psychiatry could not help the "insane" or indeed that there is no such thing as mental illness, the involuntary civil commitment of "nondangerous" people to mental hospitals loses its justification. Even if the so-called nondangerous patient might demonstrably benefit from involuntary hospitalization and treatment, some jurists maintain that such an imposition is unwarranted.[71] The "new legal approach to psychiatry," writes attorney Larry O. Gostin, is not anti-psychiatry, but in those cases where psychiatry "claims an ability to identify an 'illness' which is not apparent to the rest of us [and] where compulsion is involved," psychiatrists must present some "objective behavioral criteria" for their decisions. If the courts "delegate authority to the doctor to impose admission and treatment, it must also place reasonable fetters and boundaries on the exercise of that authority."[72] In a way psychiatry can be seen as being hoisted on its own petard. Throughout history only the most incapacitated and disturbed or presumably dangerous people were institutionalized, and few persons doubted that they needed to be controlled for their own and society's sake. As psychiatry and the mental health movement gained prestige and influence, the number of people said to be in need of psychiatry grew; these included many who were not considered seriously disabled or dangerous

by psychiatrists and therefore would be candidates for voluntarism when it became more or less the rule.

Nevertheless the public, as in the past, has had doubts about the balance struck in our time between freedom and public safety, between the right to choose and the judgments of experts. People still fear that mentally disturbed persons are dangerous, and they still believe that involuntary commitment is a public safety measure as well as often being in the best interests of the mentally ill, who, they were told for years, should have professional care. Community members wonder about the tradeoff between freedom and treatment as they watch disturbed persons wandering the alleys and byways—hungry, cold, and homeless. And it is a question whether the public will support the ex-patient movement's demand that such persons be funded by public agencies but left free to determine their own fate.[73]

However these dilemmas are resolved (or more likely not resolved), whatever the nomenclature, and whoever is in charge, people continue to suffer from behavioral, emotional, and cognitive disorders. Deinstitutionalization and relabeling have only served to point up this reality. The key problem, the toughest enemy, remains the perplexing, disturbing phenomenon of mental disorder, imperfectly understood, bound up with public policy and public opinion, and resistant to known therapies. This is, I believe, a conclusion justified by the history of at least two hundred years of ups and downs, optimism and pessimism, and reform and reaction in the treatment of mental disorders the world over.

The new players on the scene, ex-patients acting in their own behalf, can be vital to the concerted action needed against forces in American society that would deprive the mentally disabled of resources and support, forces that can derive comfort, ironically, from some critics of psychiatry. Witness the Reagan administration's attempt to discontinue social security payments to many of the disabled, including the mentally disabled. This was the logic of Szaszian laissez faire: turn the so-called mentally ill, really only people who in Szasz's view "shirk their burdens," out on their own to make their way as best they can.[74] The Szaszian critique of psychiatry as the imposition of an erroneous concept of illness and treatment upon misfits can serve to justify neglect and impoverishment in the name of freedom and self-reliance. Psychiatry as a profession does not embrace such an outlook; its severest critics, the ex-patients, certainly cannot afford to do so.[75]

Szasz is not alone in his fear of the unwarranted power of psychiatry. The psychoanalyst and lawyer Jonas Robitscher, writing in 1980, worried that society was "tending toward a 'psychiatrocracy', a state in which psychiatry has expanded to fill the roles of police, judges, educators, social workers, and eventually politicians." Writing in 1980, he believed that government expansion of the health care system would cause the role of psychiatry to continue to grow.[76] Apart from the fact that this prediction was wrong, at least during the Reagan years, this kind of power is somewhat illusory. It is granted to psychiatrists by the law and by social consent and has no independent base, as does, say, corporate power; those who give authority can also withdraw it. And psychiatrists are no longer allowed, legally and morally, the authoritarian control that they traditionally wielded over hospitalized mental patients. But in losing that sort of power psychiatry is not in danger of immediate demise, the hopes of their most negative critics notwithstanding. The abandonment by psychiatrists of public mental hospitals in favor of private and community practice and the low status to which hospital prac-

tice was reduced were phenomena that long predated contemporary anti-psychiatry and indeed can be seen as helping to set the stage for it. The recent denunciations of psychiatry have, moreover, contributed to strengthening psychiatry's ties to general medicine and thereby weakened the position of those psychiatrists, the psychotherapists, who stressed sociological, cultural, political, and economic factors in the causation of mental disorders. Many of the latter psychiatrists went further in considering war, racism, crime, and poverty etiological forces that must be combatted by psychiatry.[77] Society, searching for ways to cope with social pathology, increasingly gave psychiatrists opportunities to implement some of their theories, especially in the criminal justice system. If that system proved incapable of preventing crime and rehabilitating criminals perhaps psychiatry would succeed: if the criminal is sick rather than bad he might be cured. And psychiatrists promised a good deal; they succumbed to the typically American tendency to oversell themselves. Each new therapy or therapeutic approach was touted as a great advance, only in most cases later to be abandoned as useless or reevaluated as of limited usefulness. The disparity between claims and accomplishments exposed psychiatry to censure and ridicule. The leading neuropsychiatrist of his day, Adolf Meyer, a sober scientist and careful psychiatrist, foresaw this predicament when he worried in the 1920s and 1930s that psychiatry and the mental health movement were moving away from the real problem, the hospitalized mental patient, in order to chase the chimera of prevention, a desirable but as yet largely unattainable goal.[78] Meyer, himself a virtually archetypical authoritarian physician, did not address either the problem of authoritarianism in psychiatry or the possibly negative effects of institutionalizing people for years and decades without the knowledge to cure them. When some psychiatrists did reckon with these questions in the 1960s by supporting deinstitutionalization, their critics cried: too little and too late.

The secular anti-psychiatry "movement" is itself in disarray, its chief theorists either discredited or outdated, the supporting leftist movements weakened, and the ex-patient crusade bursting the bounds of small, alienated, politically leftist groups and becoming more representative of the mass of the ex-patients, who probably differ little politically from the general public. The majority of activists seem still to have in common a denial of the relevance of medicine to so-called mental illness. The logic of their emphasis on societal conditions as causing mental problems has led some to call for political action as the true and only way to solve the problems of persons with so-called mental disorders.[79] In this respect the ex-patient critics of psychiatry are no less speculative than were psychiatrists: the psychiatrists wanted to use psychiatry to improve society and prevent "mental illness"; the critics want to eliminate psychiatry and "mental illness" by changing society. Both groups, perceiving connections, not well understood, between the larger social system and mental disorders, found it difficult to distinguish between helping disturbed people and curing society of its problems. The socially oriented psychiatrists, though less influential than they have been, remain part of a still entrenched profession; the ex-patients have lost their original allies, the political radicals who in the 1970s thought that anti-psychiatry could help foment a social revolution. Not only is the political left of the 1980s weak, but in both the United States and Europe its leaders lost interest in anti-psychiatry. The theoretical base for anti-psychiatry also eroded. Laing rethought his positions; Cooper is isolated; new research has confirmed that much of Foucault's analysis has no historical basis; and Szasz, supporting services only for the minority who could pay for them, has nothing but his version of freedom to offer the vast majority of the mentally troubled. And while Goffman pointed out serious weaknesses in mental hospitals, deinstitutionalization has revealed that they performed

some important functions. On the practical side, although concerned Americans responded sympathetically to the trenchant critiques of psychiatry, it proved very hard, as it always has, to work out practicable, humane, socially acceptable alternatives to traditional systems of care for mentally troubled people, who are still with us. What form both psychiatry and anti-psychiatry will take in the future is unclear. It is probably safe to say that short of achieving definitive knowledge about mental disorder and how to treat and prevent it and without the public will to care adequately for mentally disabled persons, both psychiatry and anti-psychiatry do have a future.

NOTES

1. See Janet Ann Tighe, "A Question of Responsibility: The Development of American Forensic Psychiatry, 1838-1930," Ph.D. diss., University of Pennsylvania, 1983. For the thinking of a prominent asylum superintendent on the subject of religion and mental illness see Amariah Brigham, *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind* (1835; reprint, New York: Arno Press, 1973).

2. Charles S. Braden, *Spirits in Rebellion: The Rise and Development of New Thought* (Dallas, Tex.: Southern Methodist University Press, 1963), p. 4.

3. See, for example: E. Mansell Pattison, Nikolajs A. Lapin, and Hans A. Doerr, "Faith Healing: A Study of Personality and Function," *Journal of Nervous and Mental Disease* 157 (December 1977): 400; E. M. Pattison, *Problems and Possibilities of Interprofessional Cooperation in Community Mental Health: The Role of Church and Temple*, ed. H. J. Clinebell (Nashville, Tenn.: Abingdon Press, 1970).

4. On the subject of mainstream denominations and challenges to them in the United States see R. Laurence More, *Religious Outsiders and the Making of Americans* (New York: Oxford University Press, 1986). Christian Science was also compromised by Mary Baker Eddy, its founder, using conventional physicians to perform an autopsy on her husband and also later by her taking of medicine to alleviate pain. See, for example, A. M. Bellwald, *Christian Science and the Catholic Faith, Including a Brief Account of New Thought and Other Modern Mental Healing Movements* (New York: The Macmillan Company, 1922), pp. 106, 122-124.

5. G. Allison Stokes, "Ministry After Freud in American Protestantism, 1906-1945," Ph.D. diss., Yale University, 1981; Elwood Worcester, Samuel McComb, and Isador H. Coriat, *Religion and Medicine: The Moral Control of Nervous Disorders* (New York: Moffat, Yard & Company, 1908); J. A. C. Murray, *An Introduction to a Christian Psycho-Therapy* (New York: Charles Scribner's Sons, 1938); Karl R. Stolz, *The Church and Psychotherapy* (New York: Abingdon-Cokesbury Press, 1943). One critic of psychoanalysis complains that in the twentieth century, ministers, priests, and rabbis taking courses in pastoral counseling make "many members of the cloth seem more Freudian than Christian. The Union Theological Seminary, in collaboration with a New York growth center, . . . has offered a certified program in human relations education" (Martin L. Gross, *The Psychological Society: A Critical Analysis of Psychiatry, Psychotherapy, Psychoanalysis and the Psychological Revolution* [New York: Random House, 1978], p. 11).

6. For a discussion of current legal opinion see: Virginia Aldigé Hiday, "Are Lawyers Enemies of Psychiatrists? A Survey of Civil Commitment Counsel and Judges," *American Journal of Psychiatry* 140 (March 1983): 323-326.

7. Barbara Sicherman, "The Quest for Mental Health in America, 1880-1917," Ph.D. diss., Columbia University, 1967; Bonnie Ellen Blustein, "'A Hollow Square of Psychological Science': American Neurologists and Psychiatrists in Conflict," *Madness, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), pp. 241-270.

8. Quoted from a letter from Mitchell to Clifford W. Beers, 2 April 1908 (copy) in Norman Dain, *Clifford W. Beers, Advocate for the Insane* (Pittsburgh: University of Pittsburgh Press, 1980), p. 98.

9. Sicherman, "The Quest for Mental Health," p. 70.

10. See, for example, the dust jacket of Rollo May's *Power and Innocence: A Search for the Sources of Violence* (New York: W. W. Norton, 1972). This utopian thinking was not confined to psychiatrists. Anton T. Boisen, for example, a psychologist-minister who had suffered several acute attacks of "insanity" and later served as chaplain at Worcester State Hospital, wrote, "The more I deal with the experience of the mentally ill, the more I am convinced that in so far as we attain to any true understanding of them, individual and collective," we should "be well on our way toward building the city of brotherhood and co-operation" (Anton Boisen, *Religion in Crisis and Custom* [New York: Harper, 1945], p. 48; see also his *The Exploration of the Inner World: A Study of Mental Disorder and Religious Experience* [New York: Harper, 1936] and *Out of the Depths* [New York: Harper, 1960].)

11. Norman Dain, *Concepts of Insanity in the United States 1789-1865* (New Brunswick, N.J.: Rutgers University Press, 1964), pp. 84-88. In the late nineteenth century critics within the field noted the "contradiction," as they believed, between a somatic etiology and behavioral or psychological treatment, but the issue remained

unresolved. There, of course, need be no contradiction; one might find psychological means helpful or essential in treating physical disorders and vice versa. It should also be noted that "psychological" did not mean nonsomatic to early psychiatrists.

12. Frank J. Sulloway, *Freud, Biologist of the Mind; Beyond the Psychoanalytic Legend* (New York: Basic Books, 1979).

13. For early protests against nonphysicians competing with psychiatrists see W. L. Russell, "The Presidential Address: The Place of the American Psychiatric Association in Modern Psychiatric Organization and Progress," *American Journal of Psychiatry* 12 (1932): 1-8; J. V. May, "Presidential Address: The Establishment of Psychiatric Standards by the Association," *American Journal of Psychiatry* 13 (1933): 1-15.

14. See Peter S. Sedgwick, *Psycho Politics: Laing, Foucault, Goffman, Szasz and the Future of Mass Psychiatry* (New York: Harper & Row, 1982).

15. R. D. Laing, *The Politics of Experience and the Bird of Paradise* (New York: Ballantine Books, 1967), p. 129. For an earlier expression of similar ideas, first published in 1961, see Gregory Bateson, ed., *Percival's Narrative: A Patient's Account of His Psychosis, 1830-1832* (New York: William Morrow, 1974).

16. David Cooper, *Psychiatry and Anti-Psychiatry* (New York: Ballantine Books, 1971); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N.Y.: Anchor Books, 1961); Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper & Row, 1964); The Radical Therapist Collective, *The Radical Therapist*, produced by Jerome Agel (New York: Ballantine Books, 1971). One of the better-known advocates of the labeling theory, Thomas J. Scheff, has modified his position. "I am not arguing [he writes] that the neurotransmitter hypothesis is incorrect, or that tranquilizers are worthless; [but] that it is much too early to discard the labeling theory of mental illness, despite the significant gains that have been made. . . . In recent years, there has been a tendency in sociology to overstate the claims of labeling theory" (Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory*, 2nd ed. (New York: Aldine Publishing Company, 1984), pp. ix-x.

17. See, for example: *Critical Psychiatry: The Politics of Mental Health*, ed. David Ingleby (New York: Pantheon Books, 1980). For an extended critical view of theories of insanity see Jeff Coulter, *Approaches to Insanity: A Philosophical and Sociological Study* (Bath, England: Martin Robertson, 1973); H. C. Erik Midelfort, "Madness and Civilization in Early Modern Europe: A Reappraisal of Michel Foucault," in *After the Reformation: Essays in Honor of J. H. Hexter*, ed. Barbara Malament (Philadelphia: University of Pennsylvania Press, 1980); pp. 247-265; Lawrence Stone, "Madness," *The New York Review of Books* 29 (16 December 1982): 28-36.

18. Norman Dain, *Disordered Minds: The First Century of Eastern State Hospital in Williamsburg, Virginia, 1766-1866* (Williamsburg, Va.: The Colonial Williamsburg Foundation, 1971), pp. 128-134.

19. Park E. Dietz, "Social Discrediting of Psychiatry: The Protasis of Legal Disfranchisement," *American Journal of Psychiatry* 134 (December 1977): 1357.

20. For recent religious expressions of this position one could turn most notably to Boisen, cited above, who early in this century considered his mental breakdowns a means of deepening and giving purpose to his life and who noted the similarity between the ecstatic experiences of the saints and the insane (Anton Boisen, *The Exploration of the Inner World* [New York: Harper, 1936]). This is not an uncommon view among religious counselors today. See John Foskett, *Meaning in Madness: The Pastor and the Mentally Ill* (London: Society for Promulgation of Christian Knowledge, 1984).

21. The issue is not the effectiveness of this new medication but the belief of psychiatrists and the public that its use rendered safe the discharge of hospital patients into the community.

22. Today, it is charged, more efficient means accomplish the same goals. "'Dr. Walter Freeman, known in some circles as the 'Dean of Lobotomy,' says that women who have received lobotomies make good housekeepers" (Alliance for the Liberation of Mental Patients, Philadelphia, *Newsletter Update*, 25 October 1977): 1).

23. Mrs. E. P. W. Packard, *The Prisoners' Hidden Life, or Insane Asylums Unveiled; As Demonstrated by the Report of the Investigating Committee of the Legislature of Illinois* (Chicago: Published the Author, 1868), pp. 98, 295, 139; *Marital Power Exemplified in Mrs. Packard's Trial* (Hartford: Published by Case, Lockwood & Company, 1866); *Great Disclosures of Spiritual Wickedness!! in High Places, with an Appeal to the Governments to Protect the Inalienable Rights of Married Women*, Written under the Inspection of Dr. M'Farland, Superintendent of the Insane Asylum, Jacksonville, Illinois (Boston: Published by the Authoress, 1865), p. 54; *Mrs. Packard's Reproof to Dr. McFarland for His Abuse of His Patients, and for Which He Called Her Hopelessly Insane, Given him in Jacksonville Insane Asylum Illinois, Nov. 12th 1860* (Chicago: Published by the Authoress?, 1864).

24. The first successful effort to establish an organization of former mental patients, Recovery, Inc., was founded by Dr. Abraham A. Low in 1937.

25. Gordon P. Halleband and Walter H. Abrams, *Alternatives in Community Mental Health* . . . (Boston: Beacon Press, 1975), pp. 120ff. For a discussion from a radical perspective see Robert Castel, Françoise Castel, and Anne Lovell, *The Psychiatric Society*, trans. Arthur Goldhammer (New York: Columbia University Press, 1982), chap. 7.

26. In 1845 ex-patients in England founded an organization, Alleged Lunatics' Friend Society (Nicholas Harvey, "Advocacy or Folly: The Alleged Lunatics' Friend Society, 1845-63" *Medical History* 30 [1986]: 245-274; also *Perceval's Narrative*). In the United States there were attempts to involve ex-patients in various organizations (see Dain, *Clifford W. Beers*, pp. 301-303), but not until recently did they create organizations on their own.

27. Yet there are, one activist observed, "very few Black and other Third World people . . . in the psychiatric inmates liberation movement (Lenny Lapon, *Mass Murderers in White Coats: Psychiatric Genocide in the United States* [Springfield, Mass.: Psychiatric Genocide Research Institute, 1986], pp. 206-207). One might guess that blacks have so suffered from a lack of services generally available to whites that they are not inclined to join a movement that rejects psychiatric services. When two ex-patient activists were asked why there were so few blacks within their movement no explanation was forthcoming (Conversation with ex-patient activists at the Annual Meeting of the American Psychiatric Association, 22 May 1985, Dallas).

28. National Alliance of Mental Patients, *Newsletter*, and "Position Paper," n.d., received July 1986. In an unpublished mimeographed document, probably produced in 1982 ("Towards A Socialist-Communist Anti-Psychiatry Movement, A Proposal") Bob Harris, an ex-patient activist, outlined a radical position. He argued that most ex-patient activists agreed that psychiatry must be abolished or at least have its coercive power to "treat" eliminated. But "conflicting class interests . . . within the movement . . . are real." Those with middle class backgrounds generally reject an anti-capitalist position, he said, so that there was no class outlook and therefore no strategy for the 1980s. To develop the necessary analysis he proposed forming a national collective of inmate/ex-inmate anti-psychiatry activists who consider themselves socialists or communists. Harris's recommendation was not implemented, but the conflicts he described played a role in the eventual formation of several competing organizations. Yet another group represented by members of the Madness Network News Collective has opposed all national organizations.

29. Editorial, *Madness Network News*, 8 (Summer 1986): 2.

30. These interviews are available in mimeographed form, published by the Association for the Preservation of Anti-Psychiatric Artifacts, Box 9, Bayside, N.Y. 11361.

31. Here is how one ex-patient described the early history of the relationship: In the early 1970s "interaction began between the radical therapists and ex-inmates. Active collaboration lasted until the mid-seventies, when the ex-inmates came to feel that their own experience was being invalidated by these therapists as much as by the more conservative professionals. . . . The new fad of middle-class people seeing psychiatrists for 'life enhancement' and 'personal growth', and . . . the springing up of trendy therapies such as EST and primal therapy [and] Scientology . . . [caused] ex-inmates to wonder if perhaps their so-called enemies—the psychiatrists—were less harmful than their so-called friends." (Mel Starkman, "The Movement" [1982] [mimeographed], pp. 3-4.) Ex-patients felt constrained when working in the same organization with therapists even if they were radical therapists (Lena Madwoman "The Creative Madness," *State and Mind* 6 [Winter 1977]: 41-43). For a Radical Marxist critique of the ex-patient movement see Mark Seem and John Parkin, "Mental Health, Normalization and Resistance, Two Statements," *State and Mind*, 6 (Fall 1977): 16-17. These authors protested the attempt of ex-patients to take over the field of psychiatric practice and they sought to assert their right to practice psychotherapy. Psychiatric oppression, they insisted, affects all people, not just mental patients. One must seek alternatives to the "radical monopoly of the 'mental health industry'." The "mental patient movement proclaim their [sic] own expertise in psychiatric matters. In many cases . . . they merely establish parallel institutions that in no way endanger or counter the institutions of psychiatry." The movement excludes psychiatric professionals "only to internalize this professional expertise within [its] own ranks, thereby reproducing alienated patterns of interactions."

32. See, for example: "The Farview Papers, a Previously Secret Pa. Justice Dept. Report on Farview State Hospital for the 'Criminally Insane'," Alliance for the Liberation of Mental Patients, Philadelphia, *Newsletter Update* (October 1977): 1-7. This document "contains numerous allegations of 'patients' being beaten and murdered by Farview doctors and guards" (5). See also "Patient Beaten to Death at Rosen's Florida Torture Center," *Newsletter Update* (Winter-Spring 1980): 10. "Dr. Rosen's "bizarre" treatment gained notoriety in the 1950s; . . . called 'direct psychoanalysis' [it] mimics the behavior of 'patients' and verbally abuses them [and] has often led to" physical violence.

33. Ernest Hemingway's famous complaint after his second bout with shock therapy and just a few days before he commited suicide is often quoted: "What is the sense of ruining my head and erasing my memory which is my capital and putting me out of business?" (Lenny Lapon, *Mass Murderers in White Coats*, pp. 207-208). Authorities commonly cited for opposition to all forms of physical treatment include Peter R. Breggin, "The Return of Lobotomy and Psychosurgery," in *Psychiatry and Ethics: Insanity, Rational Autonomy, and Mental Health Care*, ed. Rem B. Edwards (Buffalo, N.Y.: Prometheus Books, 1982, pp. 350-388; [David L. Richman], *Dr. Caligari's Psychiatric Drugs* (Berkeley, Calif.: Network Against Psychiatric Assault, 1984); *The History of Shock Treatment*, ed. Leonard Roy Frank (San Francisco, 1978).

34. Communication from Peter Weiden, M.D., Director, Schizophrenia and Movement Disorder Clinic, The New York Hospital-Cornell Medical Center, Department of Psychiatry, Payne Whitney Psychiatric Clinic, 28 January 1985: "To the Faculty at Payne Whitney Clinic, January 28, 1985: Recent work on chronic psychotic illness (schizophrenia, schizoaffective disorder) has underscored risks as well as benefits of long-term antipsychotic use. Recently the APA sent a letter to all of its members alerting clinicians to the risks of tardive dyskinesia. However, not only tardive dyskinesia, but other side effects, compliance, and quality of life issures for these patients are undergoing general reevaluation in the psychiatric profession. We would like to draw your attention to the existence of the Schizophrenia and Movement Disorders Clinic at Payne Whitney. The goals of the clinic are research, teaching and improvement of clinical care in these areas. Specific projects now include use of new experimental antipsychotic medication that *does not* cause tardive dyskinesia or other movement disorders, use of Sinemet in the treatment of interactable tardive dyskinesia in patients who cannot be taken off medication, eye-tracking studies in schizophrenia, biochemical studies, neurologic movement disorder evaluations, and medication compliance evaluations."

35. According to one ex-patient, patients and ex-patients believe that the phenothiazines "seriously diminish one's intellectual effectiveness and severely compromise one's emotional integrity. . . . Psychiatrists [usually argue that this complained of] deterioration [is] part of the natural history of schizophrenia." Many mental health workers now believe that this end result of schizophrenia is caused by "the pervasive lack of stimulation, purposeful activity, and absence of emotionally meaningful relationships within the hospital that reduce the patient to a vegetative existence" (Linda Ladew, "Thorazine as Miracle: But Who Are the Blessed?" *Coping* [December 1983]: 3).

36. By the 1970s professionals expressed fears that government regulation and court decisions might prevent further research in behavior modification. See David B. Wexler, "Behavior Modification and Legal Developments," *American Behavioral Scientist* 18 (May/June 1975): 679-683; C. R. Jeffery and Ina A. Jeffery, "Psychosurgery and Behavior Modification: Legal Control Techniques Versus Behavior Control Techniques," ibid., 685-721; Alan R. Mabe, "Coerced Therapy, Social Protection, and Moral Autonomy," ibid., 599-615. The origin of these feared regulations include, according to one commentator, the "legal defense of the concept of subjects' rights [and] the evaluation [of] political characterizations and caricatures of many forms of research" (David Reiss, "Freedom of Inquiry and Subjects' Rights: An Introduction," *American Journal of Psychiatry* 134 [August 1977]: 891). For a historical discussion of many relevant issues see Elliot S. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986).

37. An ex-patient activist responded to this observation that at the time, the 1970s, those involved in founding the new organizations were really not aware of how their attitudes resembled that of the original founders of free clinics a decade before.

38. Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (New York: Hawthorn Books, 1978), p. 105. See also "ALMP Plans Center in West Philly," Alliance for the Liberation of Mental Patients, Philadelphia, *Newsletter* [Fall 1970]; "Alternatives to Mental Institutions," Psychiatric Inmates Rights Collective, Santa Cruz, Calif., *Newsletter* [1978], 1-20. Only one of the seventy alternatives studied came close to meeting the standards set by Judi Chamberlin and not one was patient controlled (ibid., 3).

39. Allen Markman to Norman Dain, 20 July 1985; also Allen Markman, "Speech to Conference of the Network Alternative to Psychiatry," Belo Horizonte, Brazil, 31 October 1983 (Mimeographed), pp. 1-2.

40. Mel Starkman ("The Movement," pp. 4a-5a) divides the history of the Mental Patients' Liberation Movement into three stages: first, working with radical therapists; second, withdrawal into self-directed groups, still common; third, some groups beginning to gain substantial funding, which requires emphasis upon structure. "Funded groups were, on the one hand, in a better position to address such concerns as housing and employment and, on the other hand, less inclined to be purely political . . . and to make a priority of radical protest against the psychiatric establishment." The issue became "collaborate . . . with professionals and established voluntary agencies" or remain totally anti-professional and isolated. This history that Starkman describes is, in many respects, a replay of the experience of the free clinics of the 1960s.

41. Expressions of this conflict are sprinkled throughout the literature written by ex-patient activists but until recently the emphasis was on how to insure unity. Alliance for the Liberation of Mental Patients, Philadelphia, *Newsletter* (Winter 1982): 5-6.

42. *Madness Network News* 8 (Fall 1985): 2.

43. Lenny Lapon argues: "The National Institute of Mental Health, along with state Departments of Mental Health and the various Mental Health Associations have increased their attempts to co-opt the psychiatric inmates liberation movement to unprecedented levels. The carrot-offering arm of NIMH, lately known as Community Support Services, and other government agencies are offering tens of thousands of dollars to groups and individuals who are willing to do watered-down depoliticized 'organizing' of 'mental patients'. They are presently paying salaries and nationwide and worldwide travel expenses and honorariums to safe and/or token ex-inmate speakers at conferences of 'mental health professionals'. Several compromised and/or opportunistic ex-inmates are going for the bait. NIMH is also funding a national ex-'patient- teleconference

and supporting 'self-help' projects in an attempt to neutralize our militancy, direct energies away from political confrontation of the psychiatric establishment, and, of course, to control groups' purse strings. The American Psychiatric Association is also stepping up its cooptation effort by inviting certain ex-inmates to participate in the APA's annual meeting in Dallas, Texas in May 1985 to 'look for common ground'. *Mass Murderers in White Coats*, of course, argues, and I hope persuasively, against the existence of such common ground" (*Mass Murderers in White Coats*, pp. 222-223). A challenge to this view toward the politics of government grants is offered by Bob Harris: "This position [against accepting Government aid] is tantamount to one of guilt-tripping people who accept welfare or SSI rather than starve or submit to exploitative and/or alienating labor. After all, welfare is also 'government money'. "But such money is "actually people's money . . . stolen by American imperialism." (Alliance for Liberation of Mental Patients, Philadelphia, *Newsletter* [Winter/Spring, 1980]: 10.)

44. See "Where Do We Go From Here," *Madness Network News* 7s [Summer, 1985]: 18-19, 21.

45. The radical therapists advocated psychotherapy as a self-help process practiced in small groups in which all members have therapeutic skills and where therapy serves as a means to "free our personal lives of power imbalances and oppressive interactions," a process "linked directly to our work in attempting to formulate a society free of the same problems" (Editorial, "Where We Stand," *Issues in Radical Therapy* 11 [1984]: 7). More common in the movement are numerous complaints about psychotherapists' power to institutionalize clients and about the treatment received at their hands. See, for example, Eliot Char, "My Beef with Psychotherapy," *State and Mind* [Summer 1980]: 41-45. Then there is an extensive literature rejecting psychoanalysis as largely ineffective and even harmful for some patients. See, for example, Martin L. Gross, *The Psychological Society: A Critical Analysis of Psychiatry, Psychotherapy, Psychoanalysis and the Psychological Revolution* (New York: Random House, 1978), chap. 2, pp. 204-206. Gross argues that "wherever medicine is uncertain, psychiatry and psychology proudly fill the gap" (p. 85).

46. Activists do express uncertainty about the feasability of these alternatives. One comments that "the only thing that will work for an alternative project is if society's values are not imposed on it. Yet to actually operate [such an alternative] one must necessarily work with the "enemies" who will thereby become known and consequently no longer enemies. (Sally Clay, "Maine People Join Protest Against Psychiatric Oppression," *Coping* [June, 1983]: p. 3).

47. Ex-patient activists are not necessarily impressed by this criticism. For example: "If the homeless and other 'mentally ill' persons were treated voluntarily in an atmosphere of respect and dignity, many more would seek help. Of course others would remain miserable . . . No way of dealing with 'mentally ill' people can be entirely cost free. But lives of liberty and dignity, even at the risk of misery, are surely better than even more pain in a system of forcible 'compassion' which hurts, degrades, and humiliates" (*Madness Network News* 8 [Spring 1986]: 12).

48. Chamberlin, *On Our Own*, p. 19.

49. A *Madness Network News* article by Howie the Harp, "On Homelessness: A Position Paper" (7 [Summer 1985]: 1, 3) argued that "most people with psychiatric histories who are homeless" are so "partially to significantly because of psychiatric treatment" that incapacitated them. The suggested solution includes providing resources and services to enable homeless ex-patients to live independent lives.

50. See for example, Robitscher, *The Powers of Psychiatry*, esp. chap. 18, and Martin A. Lee and Bruce Shlain, *Acid Dreams: The CIA, LSD, and the Sixties Rebellion* (New York: Grove Press, 1985).

51. Tanya Temkin, "Sterilization Abuse, Social Darwinism, and Psychiatric Control-Part 2," *Madness Network News* 6s (Winter 1981): 8-9.

52. Bernhard Schreiber, *The Men Behind Hitler* (San Francisco: Section 5 Boks, 1983); Lenny Lapon, "Psychiatry: Tool of Fascism," *Madness Network News* 6 (Summer 1982): 1, 3; Lenny Lapon, "From the Third Reich," *Madness Network News* 7 (Winter 1983-1984): 18-19; Frederic Wertham, *A Sign For Cain: An Exploration of Human Violence* (London: Macmillan Company, 1960), chap. 8, pp. 163, 164-165; Robert Jay Lifton, "German Doctors and the Final Solution," *New York Times Magazine*, 21 September 1968, pp. 64, 66, 70-74; Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986).

53. See, for example, Lapon, *Mass Murderers in White Coats*, esp. chap. 3.

54. Of special interest in recent years has been the work of the late former president of the American Psychiatric Association, D. Ewen Cameron, who in the 1950s conducted "brainwashing" experiments with Canadian government and United States CIA funding. Nine Canadian "victims" of his experiments are suing the CIA for nine million dollars. One critic argues that Cameron, not the CIA, is the principal culprit, for he "solely conceived, directed, controlled and performed the experiments" and that he "was only the latest of a long infamous line of world-celebrated psychiatrists who have tortured their victims in the humanitarian name of 'treating' them." (O. G. Pamp, "Psychiatry's to Blame, Not the CIA," *Phoenix Rising* 6 [June 1986]: 40; also Don Weitz, "A Psychiatric Holocaust: Canadian Government CIA Supported Experimentation in Two Montreal Institutions," ibid., 8-14, 36-39.

55. R. D. Laing, *Wisdom, Madness and Folly: The Making of a Psychiatrist* (New York: McGraw-Hill, 1985), pp. 6-8. Presumably Laing is referring to the recent tendency in psychiatry to stress the somatic nature of mental disorders.

56. Schreiber, *The Men Behind Hitler*, p. 79.

57. Lapon argues that German psychiatrists initiated the "euthanasia" program which Hitler only later approved. Lifton on the other hand contends, as had Wertham earlier, that Hitler used psychiatrists to implement his own program of "euthanasia" but sought to hide his role because he feared opposition from the German population. Lapon, like other anti-psychiatry authors, sees psychiatrists as the initiators of all sorts of monstrous programs that harm their patients while men like Hitler or the CIA learn from and adopt what psychiatrists initiate.

58. On Cameron see Don Grillmor, *I Swear by Apollo: Dr. Ewen Cameron and the CIA-Brainwashing Experiments* (Montreal: Eden Press, 1987); see also Lee and Shlain, *Acid Dreams*.

59. Listen to an ex-patient, self-described as schizophrenic: The worst effect of medication is not physical but "that indescribable misery of frantic restlessness and overpowering lethargy simultaneously impelling the same desperate body toward irreconcilable needs [which] is most often met with a slightly raised brow" and increases in medication. "When the psychiatrist acknowledges the problem at all, he sees it as merely physical, a temporary discomfort, having no concept of this ultimate torment. . . ." (Linda Ladew, "Thorazine as Miracle: But Who Are the Blessed?" *Coping* 1 [1983]: 3.)

60. Quoted (without comment) by Lenny Lapon (*Mass Murderers in White Coats*, p. 177), from a report of the 4th Annual Conference on Human Rights and Psychiatric Oppression, Boston, 1976. It seems to have been dropped subsequently as one of the ex-patients' demands.

61. As one activist commented, "As I learned from Judi Chamberlin, the activation of righteous anger triggers a spark that, in effect *empowers* a mental health client to step, however briefly, from disenfranchisement to authority" (Sally Clay, "Anger and Empowerment," *Portland Coalition Advocate*, 1 [Fall 1984]: 4).

62. This anger is not only against the psychiatric profession. Parents are also seen by some ex-patients as exploitative of their children. See, for example, the following quotation from "Waiting for Warren Burger to Die: The High Court Stomps on Inmates Rights," in Association for the Liberation of Mental Patients, Philadelphia, *Newsletter* [Summer 1979]: 3: "The Supreme Court . . . declared that parents should play the dominant role in determining what is in the 'best interests' of the children. . . . [But this decision] ignores that most children are locked up in mental institutions because they have resisted parental oppression—running away, skipping school, physically defending themselves against beatings . . . engaging in sexual activity, attempting suicide, etc. For many parents—not just a few exceptions—mental institutions serve as the ultimate control mechanism to keep their children in line. This practice now has been formally sanctioned as within the framework of the Constitution."

63. See for example Jerrold S. Maxmen, *The New Psychiatrist: How Modern Psychiatrists Think About Their Patients, Theories, Diagnoses, Drugs, Psychotherapies, Power, Training, Families, and Private Lives* (New York: William Morrow and Company, 1985).

64. As critic Jonas Robitscher noted, "No matter how ridiculous the therapeutic method is, if it is performed by a doctor or under his direction, it is eligible for medical reimbursement under insurance policies. . . . Every therapy done on a psychiatrist's recommendation qualifies as *medical* treatment. (*The Powers of Psychiatry*, p. 95.)

65. Surprisingly, a recent "Working Draft to Abolish Psychiatry" presented by the *Madness Network News* Collective (*Madness Network News* 8 [Summer 1986]: 3) made an important concession: "We remain open to the possibility that there may be a physical basis for some things now labelled 'mental illness'—but if and when a physical hypothesis can be proven, it immediately would become a physical entity outside the realm of psychiatry." Not necessarily. It is possible that as opposed to the past psychiatrists would retain control over patients presumed to suffer from such physical entities.

66. Paul S. Appelbaum, "The Supreme Court Looks at Psychiatry," *American Journal of Psychiatry* 141 (July 1984): 827-835.

67. *New York Times*, 13 September 1984, p. 1.

68. John A. Talbott, "Response to the Presidential Address: Psychiatry's Unfinished Business in the 20th Century," *American Journal of Psychiatry* 141 (August 1984): 927-930. See also Robert L. Okin, "The Future of State Hospitals: Should There Be One? *American Journal of Psychiatry* 140 (May 1983): 577-581. Talbott's interest in critics of psychiatry is longstanding. In 1974 he wrote, "Radicals, revolutionaries, or social activists frequently raise issues before they are recognized by the majority in a field and, if they are heeded, the problems can often be handled effectively and expeditiously" (Talbott, "Radical Psychiatry: An Examination of the Issues," *American Journal of Psychiatry* 131 [February 1974]: 121).

69. Eugene B. Brody, "Patients' Right: A Cultural Challenge to Western Psychiatry," *American Journal of Psychiatry* 142 (January 1985): 5-6.

70. In 1973 the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-II) was amended so that homosexuality was no longer a mental disorder if a person did not present conflict about homosexuality or a desire to change. The subject's own evaluation was to determine whether his or her homosexuality would be considered pathological. This was a radical change in position for the APA. If applied to all those with nonconflictual conditions—exhibitionism or addictive gambling, for example—there could be a considerable reduction of those subject to involuntary hospitalization.

71. See Alan A. Stone, *Law, Psychiatry and Morality* (Washington, D.C.: American Psychiatric Press, 1984); Andrew Scull, "The Theory and Practice of Civil Confinement," review of *The Court of Last Resort: Mental Illness and the Law*, by Carol A. B. Warren *Michigan Law Review* 28 (February 1984): 793-809; Janet A. Tighe, "Frances Wharton and the Nineteenth-Century Insanity Defense: The Origins of a Reform Tradition," *American Journal of Legal History* 27 (1983): 223-253.

72. Larry O. Gostin, "The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry," in *Mental Illness: Changes and Trends*, ed. Philip Bean, (New York: John Wiley, 1983), p. 40. Ex-patients complain that lawyers got "carried away with rights issues. . . . The legal issue should be the most basic right to protect oneself from harm; and yet the lawyers have never argued that issue. . . . After one or more bouts with psychiatric drugs, [patients] become reactive, sometimes hostile. . . . The worsening of their condition . . . is entirely a result of damage to their nerve systems which psychiatric drugs create" (Gary Novak, "Establishing Some Truth," *Madness Network News* 8 [Spring 1986]: 13).

73. Judi Chamberlin to Norman Dain, 7 July 1985. There has been a tendency during the past few years for state legislatures to extend the conditions for committing people to mental hospitals beyond that of dangerousness, which is difficult to determine. Increasingly, the pre-1960s involuntary criteria of "in need of treatment," "in need of care and treatment in a hospital," "lacking judgment for the need of treatment," or "likelihood of further 'deterioration'" are being reintroduced. See, for example, Ronald Sullivan, "U. S. Trend Aids Hospitalization of Mentally Ill," *Catalyst—A New Voice* 1 (August 1986): 4.

74. Thomas Szasz, "'Back Wards to Back Streets'," *TV Guide*, 17-23 May 1980, reprinted in his *The Therapeutic State: Psychiatry in the Mirror of Current Events* (Buffalo, N.Y.: Prometheus Books, 1984), p. 84. Szasz holds that no mental illness exists (except for a few people who suffer from known physical diseases with mental symptoms) and therefore that those so designated have no claim upon society for assistance or for exemption from punishment for breaking its rules. The so-called mentally ill who make such claims either "shirk their burdens" or are criminals seeking unjustified exemption from responsibility for their actions. In "Back Wards to Back Streets," Szasz also comes out against involuntary deinstitutionalization, and in a 1979 essay, "Psychiatric Diversion in the Criminal Justice System" (in Nancy J. Beran and Berley G. Toomey, *Mentally Ill Offenders and the Criminal Justice System* [New York: Praeger, 1979], p. 79) he writes, "I distinguish between punishment and treatment on the basis of the subject's choice or consent. . . . I'd want to give the patient a choice about whether he wants to go to a hospital or not; and once he has been in for a long time, when that's his only home, I'd give him a choice about whether he wants to stay or not." But if, as Szasz, following Goffman, has long argued, prolonged hospitalization infantilizes patients and saps their will, can patients really exercise free choice to stay there? And what of old, senile inmates or those who may have been involuntarily committed in the first place?

75. See Peter Sedgwick, *Psycho Politics*, p. 10, chap. 6. Sedgwick details the "striking congruence between Szasz and [Herbert] Spencer [in their] fierce opposition . . . to any generalised sympathy for people in trouble" (p. 163).

76. Robitscher, *The Powers of Psychiatry*, pp. 473-474.

77. After World War I Thomas W. Salmon, medical director of The National Committee for Mental Hygiene, came back from serving in the Army in Europe to argue that many of the mental breakdowns observed in soldiers resulted from the stress they experienced, not innate defect. The best treatment was quickly to integrate them into their units; this experience was forgotten only to be relearned by psychiatrists during World War II. Psychiatrists again advocated that their profession become active in promoting policies that would prevent stress rather than devote themselves to treating people after they broke down. When treatment became necessary it should be in the community rather than in isolated hospitals.

78. Dain, *Clifford W. Beers*, pp. 251-252, 271-272.

79. In the last few years the Midwest Radical Therapy Conference "shifted from therapy and therapists to social change and community organizations. . . . Historically, many RT adherents have been active in support of mental patient's rights in an out of institutions. . . . However, there have not been any continuing formal relationships with social change groups still working in this area" (Patty Parsons, "Overcoming Structurelessness," *Issues in Radical Therapy* 12, no. 2 [1986]: 12.)